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LONG-TERM CARE INSURANCE STANDARDS

HEARING

BEFORE THE

SUBCOMMITTEE ON
MEDICARE AND LONG-TERM CARE

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

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SECOND SESSION

ON

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LONG-TERM CARE INSURANCE STANDARDS

TUESDAY, JUNE 23, 1992

U.S SENATE,
SUBCOMMITTEE ON MEDICARE AND LONG-TERM CARE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2:35 p.m., in room SD–215, Dirksen Senate Office Building, Hon. John D. Rockefeller IV (chairman of the subcommittee) presiding.

Also present: Senators Pryor and Grassley.

[The press release announcing the hearing follows:]

[Press Release No. H–36. June 19, 1992]

MEDICARE SUBCOMMITTEE TO DISCUSS LONG-TERM CARE INSURANCE, ROCKEFELLER WARNS OF "ABUSIVE MARKETING PRACTICES"

WASHINGTON, DC—Senator John D. Rockefeller IV, Chairman of the Senate Finance Subcommittee on Medicare and Long-Term Care, Friday announced a hearing on standards for private long-term care insurance policies.

The hearing will be at *2:30 p.m. Tuesday, June 23, 1992* in Room SD–215 of the Dirksen Senate Office Building.

"The purpose of this hearing is to focus on the need for Federal action to create and enforce a consistent regulatory policy for the marketing of private long term care insurance. It will review the various legislative proposals that address the regulation of the long term care insurance market," Rockefeller said.

"Without swift Congressional action, American consumers will remain at risk of abusive marketing practices by unscrupulous dealers and of purchasing policies that do not offer reasonable minimum benefits," Rockefeller said.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA, CHAIRMAN OF THE SUBCOMMITTEE

Senator ROCKEFELLER. This hearing will come to order. The purpose of the hearing today is to take a look at the various legislative proposals and recommendations to establish minimum Federal standards for a burgeoning private long-term care insurance market. We will hear from consumers, regulators, and the industry.

Let me say that I think our overall goal ought to be a national long-term care policy that assures protection for all Americans and their families from the ravages of chronic care costs.

Americans live in constant peril of the financial and physical blows when a catastrophic illness strikes. As the Baby Boom generation ages, this fear will become reality for more and more of our citizens until we act to build a responsive system.

As the chairman of the Pepper Commission, I helped forge, with the help of Senator Pryor, what I think was, at that time, an un-

precedented bipartisan consensus—in fact, the vote was 11 to 4—on the principles of long-term care reform.

Our recommendations are embodied in the Long-Term Care Family Security Act introduced in April. All of us who offered this bill agree that comprehensive long-term care services should be available for all Americans of every income and every age level, and in the most appropriate setting.

We may not enact our recommendations this year, but we can move to improve the current patchwork system as we work to make the entire structure a better one.

Thousands of Americans are relying on the private long-term care insurance market to provide them with protection. An entire title in the Long-Term Care Family Security Act is devoted to improvements in insurance standards.

We have been urged by consumer and elderly advocates to make these provisions, in fact, even tougher. Our bill, however, does set out a framework for protection. If every State required and enforced the provisions of this bill, the market would work a lot better for the people who purchase long-term care insurance.

I doubt that, after learning more about this market, there will be very much disagreement on the need for change, given the fact that there are over 2 million policyholders with some version of long-term care insurance. It is an area that Congress needs to understand better than it does.

We are hearing about some very disturbing practices on the parts of some—not all—policies and companies; problems such as policies that are too limited or too costly to justify their price; problems such as marketing approaches that are deceptive and sometimes downright abusive.

Janet Shikles, of the Government Accounting Office, will be our first witness. She will testify that additional consumer protections are desperately needed. The GAO advocates the adoption of minimum Federal standards as the best way to protect consumers.

The President of the National Association of Insurance Commissioners, William McCartney, will be our second panelist. He will discuss the weakness of the present market and where government can help. States are currently responsible for regulating long-term care insurance.

NAIC issued a model act in 1986 with guidelines for States on minimum standards to protect policyholders. The model act has been updated annually, but many States have yet to adopt even the initial guidelines, leaving enormous gaps in protection for policyholders.

There is little assurance that a consumer who purchases long-term care insurance in 1992, somebody, let us say, 72 years old, on average, will be covered for the long-term care services that they need a decade from now.

In fact, the statistics show they are likely to allow their coverage to lapse within the 5 years, losing all benefits they may have accumulated.

Our third panel will be a group of experts and consumer advocates. Josh Wiener, of the Brookings Institution, who has done incredible work on the needs of American seniors, will outline his

views on long-term care insurance standards and appropriate Federal action.

Gail Shearer, from the Consumer's Union, will talk about her organization's ideas about needed improvements in the market. They have been monitoring its activities for many years.

Mildred McCauley, a member of the board of directors of the AARP, will testify about why they believe long-term care insurance standards are necessary.

Finally, our last panel will be industry representatives; the agents and the insurance industry association, as well as a representative of a coalition of industry and long-term care organizations that endorse Federal standards.

Susan Van Gelder, of the Health Insurance Association of America, who will express the industry's reservations about the standards that are being advocated; the Association of Health Insurance Agents, represented by Robert DeCoursey, to express their groups concerns about the ramifications of standards on their members, while concurring on the need for additional protections. That will be interesting.

And Ron Hagen, representing the Independent Coalition for Private Long-Term Care Insurance Standards, to tell us why a variety of insurance companies and service organizations have decided to break with the rest of industry and support Federal standards to provide consumers with stronger protection in the market.

I see a lot of potential for agreement on the extent and the appropriateness of Federal standards. I very much want to work, as does my colleague, Senator Pryor, in a bipartisan manner to enact legislation that will provide a consistent regulatory policy for private long-term care insurance.

We need a policy that will put an end to some of the market's past abuses. Long-term care policyholders must be assured that they have paid for coverage that will be there for them.

I ask everyone testifying today to help us determine the way to properly protect the millions of Americans who are mostly elderly, but certainly not all, by a long shot, in their hour of need.

I would ask something else. Two more things. All of our witnesses' statements will be in the record, and if somebody has not handed it in, we will get it in the record so fast that you will not even believe it. So, we will run the 5-minute clock. That will not apply, of course, to David and myself.

And I would also ask something that occurs to me increasingly and adds to my frustration increasingly. I perfectly understand the way Washington works, and that is that people are on retainer. I mean, that is the way we all live. I am on retainer by my people in West Virginia. I can be let off at any time. And some 58 House members can tell you about that already.

But I also understand that one of the reasons that health care progress is very slow in Washington, DC, is that everybody defends their turf, and they defend their turf above all other interests, including the public interest. In fact, usually including the public interest. I am getting very tired of that. I am getting very frustrated about that.

And, as chairman of the Senate Subcommittee on Long-Term Care and Medicare, I intend to hassle people who take that approach. My interest is, how do we improve this?

If there are people who come to the witness stand and describe simply everything that is wrong with what has been proposed, then I will expect, and, indeed, demand from them either now, or in writing within 10 days to know what they would do to make it better.

I am not interested in hearing what is wrong about something. Part of your job also is to tell us how to make the system work.

I do not know about the Senator from Arkansas, but my guess is, given a note that he wrote me about a month ago, he said in the note which he had no thought that I was going to make public, "I am tired of talk, I want action." Well, I share that view.

So, for those of you who are here to defend, please have solutions. For those of you who do not like what lies in some of the proposals, please have counter-offers. If you do not have them verbally today, I want them within 10 days of this hearing, in writing, to the committee.

Janet, I would ask if you would come forward first, since the GAO has answers to everything. And we welcome your testimony. But only after I ask my distinguished senior colleague from Arkansas what wisdom he has.

OPENING STATEMENT OF HON. DAVID PRYOR, A U.S. SENATOR FROM ARKANSAS

Senator PRYOR. Thank you, Mr. Chairman. I want you to know, Mr. Chairman, I enjoyed what you said. I think everything you said was so important and so critical in this overall debate that we are having right now in Washington, and, by the way, in all the 50 State capitals on health care and how we deliver it, and how we protect those who purchase health care insurance, et cetera.

Mr. Chairman, I think that this is probably, today, one of those traditional historical debates in Washington that we always get into every few years on what should the Federal Government do, if anything, and, if anything, how much? And that is how I look at it.

Should we get into this field of regulating this particular market? I think the answer is increasingly, yes. And I think that is a reluctant yes. I think there is a reluctance on this side, too, to admit that finally, at long last, we may have no other alternative but for the Federal Government to regulate this particular field of interest and this industry itself.

I do not think any of us here want to or look forward to the idea of going out and regulating all the insurance policies that are sold to not only the elderly, but also the young. I think that we have enough to look after without doing that.

However, it seems to me that when there is a void and a vacuum and when we feel that we must and there is no other alternative, then the Federal Government moves in.

And I have a sense that there may not be another alternative. I think that many of us are becoming resigned to that, even though it is a reluctant resignation.

The number of the private long-term care policies, the explosion of their growth has been rapid; the number of policies sold, the number of companies selling the policies, we have seen a doubling in the last 3 years.

Despite the recent improvements in long-term care insurance products, many of these policies still contain overly restrictive limitations on benefits, they do not meet basic standards recommended by the National Association of Insurance Commissioners.

Mr. Chairman, I received a letter the other day in the Aging Committee. I do not know whether it was addressed just to me, or all of us on the committee, or to all of us in the Senate, but I will quote a line. It said, "I would like you to know what has happened to me. I bought a long-term care policy. I was paying $91.88 a month for it.

"Several months later, with no explanation whatsoever, they increased my premiums to $230 a month. My insurance department told me there is no law that stops companies from doing this. The problem is now that I am past the age to try another company."

This is happening throughout this industry. It is happening throughout our whole country, and it is happening too often. Today, our Federal system, I am afraid, is going to have to have a much more stringent involvement.

I want to thank you, Mr. Chairman, for the work you have done on this, and not only on the Pepper Commission. I have had the privilege of working with you, with you and Senator Bentsen, Senator Mitchell, and all of us together in trying to shape and put together a program and policy for this country that would work to the benefit of our consumers and all of those who are participants in this great experiment to see if we can make all of this come together and work to serve people.

Mr. Chairman, once again, thank you for having this meeting. I look forward to our witnesses this afternoon.

Senator ROCKEFELLER. Thank you, Senator Pryor. Oh. Janet. There are several of you. Please introduce your colleagues and proceed with your testimony.

STATEMENT OF JANET SHIKLES, DIRECTOR OF HEALTH FINANCING AND POLICY ISSUES, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC, ACCOMPANIED BY MARYANNE P. KEENAN, SOCIAL SCIENCE ANALYST, AND JOEL HAMILTON, POLICY ANALYST, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Ms. SHIKLES. Thank you, Mr. Chairman and members of the subcommittee. I would like to introduce my colleagues, Maryanne Keenan and Joel Hamilton, who have been working the past several years on the long-term care studies that I am going to testify on today.

And today, actually, we are going to report on two studies that we recently issued on long-term care insurance. And, as a result of these studies, we believe that consumers still are at considerable risk when they purchase long-term care insurance.

I am just going to highlight these studies very briefly. But one study found that States and insurers continue to lag quite a bit behind national NAIC standards.

These standards were first put in place in 1986 and NAIC has worked very hard to upgrade them constantly. When we surveyed all 50 States, we found that many States have not even adopted some of the standards first put in place in 1986. In 19 States, you can still sell an insurance policy that excludes people with Alzheimer's disease, something which is prohibited by an NAIC standard.

In our study, we also looked at insurance policies being sold in States. We found that insurers are doing a better job than States in adopting NAIC standards, but they still also do not meet all the standards, particularly in the area of inflation protection.

We were also concerned in our study about several areas that are not yet addressed by NAIC. One really serious area—it sounds very boring—is the area of definitions of services and criteria for eligibility.

And it becomes a real serious problem when people spend thousands of dollars a year in premiums. They think they are covered for nursing home or home health services, but they may find that their policies do not define such services and that their companies will determine that they are not eligible to receive services. We found problems concerning terms or definitions in most of the policies we reviewed.

There is also no grievance procedure in most of the policies we reviewed. There is no mechanism to require the insurance company to respond to your attempts to dispute an eligibility determination. Another area of concern is the lack of non-forfeiture benefits.

This is a problem because, as you mentioned, Senator Pryor, in your statement, prices can increase unpredictably, and this is an expensive product to start with.

What may happen if a policy's price is increased, and after you have been paying thousands of dollars in premiums for several years, you may find that you cannot keep up your payments. For 42 of the 44 policies we reviewed, people would lose their entire investment in premiums if they dropped or lapsed their policies. Internal memoranda of these insurance companies indicated that they expect, on average, 60 percent of their original policyholders to allow their policies to lapse within 10 years. So, they are expecting you to not keep up your policy. One company expects an 89 percent lapse rate.

We were also concerned about the high first-year sales commissions that insurance agents receive. Of the 16 policies for which data was available on commissions, only 1 policy met NAIC's suggested standard.

The policies paid, on average, a 60-percent commission on that first year of sale. For one policy you could receive as much as $2,000 the first year. This provides a terrific incentive to sell to people who should not be buying this insurance.

The other study we recently released looked at eight companies and their policies toward selling long-term care insurance to low-income elderly. And what we found is that they really do not have such policies. They told us that people will not buy long-term care insurance if they cannot afford it.

And, yet, a recent HIAA study finds that about 30 percent of the elderly who are buying these policies have annual incomes less than $20,000. These people should not be buying these policies.

However, we found that the companies, except for one, did not have any criteria on who should buy it, and did not train their agents on who should buy it. Half of the companies did not have marketing materials to inform low-income elderly consumers that long-term care insurance may not be appropriate for them.

So, in conclusion, we believe that standards in addition to those already established by NAIC are needed. These are in such areas as: uniform terms and definitions for long-term care services and facilities, what you have to do to become eligible if you really need these services, upgrading a policy, grievance procedures—for example, a requirement that a company has to respond to you in writing within a month if they are going to deny benefits—and a sales commission that might be similar to what is required for Medigap insurance.

However, even if these standards are developed, we are concerned that consumers still are not going to be adequately protected. As I mentioned, many States have not adopted the very early NAIC standards, and most States have not adopted the more recent standards.

We are also concerned that if this continues, you have very uneven protection for consumers. So, we recommend that if this continues that Congress consider establishing minimum Federal standards.

Thank you, Mr. Chairman. I would be happy to answer any questions.

[The prepared statement of Ms. Shikles appears in the appendix.]

Senator ROCKEFELLER. Great. Thank you, Janet Shikles, very much. Are we talking, basically, about a few bad apples here in the industry?

Ms. SHIKLES. It is hard to tell, because there is no good national data and it is proprietary information. The companies will not allow you to look at what is being sold.

In our review of 44 policies that are being sold by a diverse set of companies in eight States, we found a range. We found some very good policies, and we found some pretty terrible policies. It is hard to tell.

Senator ROCKEFELLER. Ten percent problem, 90 percent good? 40 percent problem, 60 percent good?

Ms. SHIKLES. I do not think I could make an estimate. I do know that every time we went into a State we did find policies that no one should buy. It is unlike any area that I have ever worked in. I mean, it makes Medigap look so easy.

We went through 10–15 years of abuses in Medigap, and no one understands long-term care insurance. We gave policies to our actuaries and they could not determine the difference in benefits for many of them.

You saw a price range, for example, of $1,200 to $3,000 for what looked like identical coverage. And our actuaries could not give you advice on what was the difference. You are requiring someone to

have such expertise to figure out what this policy provides and if you will get protection 10–15 years from now.

Senator ROCKEFELLER. Well, in fact, some of our industry representatives are going to assert that long-term care insurance is not like Medigap, and there is no reason, therefore, for Federal intervention.

What do you think about the so-called Federal standards, or oversight function, as compared to, let us say, Medigap?

Ms. SHIKLES. I would make the opposite argument. I did a lot of work in Medigap insurance. We found a lot of abuses. And Medigap is a pretty straightforward insurance product. Long-term care insurance is very complex, it is very expensive, and it is very risky.

In our study, we visited companies where we do not think that many agents know what they are selling. Whether it is intentional or unintentional, they are advocating that people buy a product. And the individual who is asking for advice is probably not getting good information.

So, people are buying a product they do not understand, and spending $2,000, $3,000 a year. Only two of the policies we reviewed have non-forfeiture benefits.

So, 10 years later when this lapses because you cannot keep up premium payments, you walk away with nothing, no protection. And, yet, the elderly I talked to believe that there is going to be no rate increase because that is what the agent told them.

They think it is like whole-life insurance; if they decide to drop it, they will get money back. You will find that they are totally confused about what they have bought.

Senator ROCKEFELLER. Do you think the NAIC model act is appropriate? Do you have any idea how many States have adopted their guidelines? Or what seems to be the problem?

Ms. SHIKLES. Well, NAIC has worked very hard, and we have worked extensively with former Chairman Pomeroy. NAIC's problem is that many States move aggressively and some States do not. So, as soon as NAIC upgrades its standards, you have some States that put these standards in place. And then you have other States, as I testified, that have not passed standards that NAIC enacted between 1986 and 1988.

Senator ROCKEFELLER. What are some aggressive States, what are some passive States on this, for example?

Ms. SHIKLES. Joel.

Mr. HAMILTON. All right. New York and Washington are States that have been aggressive in adopting NAIC standards and moving forward, even trying to develop some of their own standards in addition to NAIC's. So, those are a couple of States.

Senator ROCKEFELLER. What are some of the weaker ones?

Mr. HAMILTON. I can speak about some of the States we visited. Missouri is an example of a State that has been somewhat slower than others to adopt key NAIC standards.

Ms. SHIKLES. We could get you more information for the record.

Senator ROCKEFELLER. Only Missouri is failing?

Mr. HAMILTON. No. For example, most of the States that we visited had not adopted all of the key NAIC standards that we reviewed. Some States, however, had adopted more of the key standards than others. So, for the overall study, we reviewed States

across the board to determine the number of States that had adopted key NAIC standards.

Senator ROCKEFELLER. Could you send in for the record the aggressive and the passive?

Mr. HAMILTON. We will try to do that. Yes.

Senator ROCKEFELLER. Just as you have come upon it.

Ms. SHIKLES. Yes. We will get you that information.

[The information appears in the appendix.]

Senator ROCKEFELLER. Let me just run through another one or two quick ones here. Do you know of insurance companies that have internal penalties for agents who misrepresent policies, and what is the state of self-policing in the industry, in your judgment?

Ms. SHIKLES. The companies told us that they police agents, but I do not think they would show us that information. We were not able to verify that.

Senator ROCKEFELLER. Is there a reward system, in fact, that works the opposite way, as an incentive system?

Ms. SHIKLES. Yes.

Senator ROCKEFELLER. Can you describe that?

Ms. SHIKLES. Well, if you are a responsible company, I think you would worry about the bad press. But if you are not responsible, there is no incentive. The agent is out selling your policies.

And, as I told you, most companies currently expect high lapse rates. So, many people are going to drop their policies and walk away having left their investments with the company.

Senator ROCKEFELLER. Just a final one with Senator Pryor's forgiveness. In the matter of Alzheimer's, if we were to adopt standards for policies that insist that ADL's or cognitive impairment be used as eligibility criteria, would there be loopholes that would continue denial of Alzheimer's, or would that close it?

Ms. SHIKLES. I think that would begin to address the problem. In the policies we looked at, some did say you would be eligible for benefits if you met certain conditions of activities of daily living but ignored cognitive impairment. So, I think that if you included cognitive impairment——

Senator ROCKEFELLER. If you had the both.

Ms. SHIKLES. Right. As a criteria.

Senator ROCKEFELLER. That one of the other.

Ms. SHIKLES. I would think so.

Senator ROCKEFELLER. Yes. Yes. Three, two, of the ADL's.

Ms. SHIKLES. I am not an expert to comment on that.

Senator ROCKEFELLER. Yes. All right. That is fine. Senator Bumpers. Senator Pryor. I have got Arkansas in my mind.

Senator PRYOR. Senator Byrd, thank you very much. [Laughter.]

Thank you, Jay. Senator Rockefeller, I think that Senator Grassley, who has not made an opening statement, is not only here, but probably has a meeting shortly. And if I could, I would like to, at this time, yield my time to Senator Grassley. And then I will pick up after you get your second round.

Senator ROCKEFELLER. That is generous, sir. Senator Grassley.

Senator GRASSLEY. I would use my time for questions. I would insert a statement in the record.

Senator ROCKEFELLER. Of course.

[The prepared statement of Senator Grassley appears in the appendix.]

Senator GRASSLEY. And mine would be a followup of one of your questions, Mr. Chairman. You discussed the different pace at which States were adopting the NAIC standards. The extent to which they may have been slow in doing this, does that indicate that we ought to have Federal law, in your opinion, that States adopt NAIC standards?

Ms. SHIKLES. Well, we recommend that Congress consider that. And actually we found, and other studies have found, that many States would be interested in a more standardized national set of policies for long-term care insurance.

Senator GRASSLEY. But that is one of your recommendations?

Ms. SHIKLES. Yes.

Senator GRASSLEY. All right. You have also identified a problem with the varying terminologies used by insurers to describe services and facilities. Inconsistent or vague terminology can obviously create a host of problems potentially harmful to the consumer. Are you able to say how easy or difficult it would be to harmonize or give precision to the key terms for long-term care insurance?

Ms. SHIKLES. Well, I think it would take some effort, and I believe NAIC has a committee working on that and could come to agreement with the industry on what they wanted to define as the different types of services and eligibility criteria.

What we found in most policies was an indication that nursing home services were covered, but, then, in the fine print, they would have all these exclusions that most of us would not have picked up.

Some policies also required that care be medically necessary for you to be eligible for benefits, but they would not define the term "medically necessary." They would not say what they mean, including that a doctor would have to determine medical necessity.

So, a person who has such a policy might say, all right, I am now in a nursing home, and I want to have my policy pay for services. However, the company could say, oh, I am sorry, we have these criteria we did not tell you about. So, it is really setting out the criteria on paper so consumers would know that they have to have a doctor certify that long-term care is medically necessary.

Senator GRASSLEY. My question was—and you obviously spoke to it, but maybe in conclusion—do you see this as a very difficult problem in having some uniformity in these terms, or not?

Ms. SHIKLES. No. I do not see it as difficult, but I think it is something that you would want to do in conjunction with the industry, State insurance agencies, and NAIC.

Senator GRASSLEY. Were you able to discern from your research whether there is a pattern of claim denial related to this terminological lack of precision?

Ms. SHIKLES. Empirically, we found consumer complaints at the State insurance agencies that we visited where companies denied claims on the basis of eligibility. Policyholders disagreed with the companies over policy definitions and eligibility criteria.

Senator GRASSLEY. Mr. Chairman, I am done. And I think Senator Pryor for yielding to me.

Senator ROCKEFELLER. Senator Pryor.

Senator PRYOR. Thank you, Senator Rockefeller. Senator Rockefeller, I would like to, first, thank Janet Shikles. She, on many occasions over several years, for Finance Committee, Aging Committee, for all the other health committees and the other committees involved in the Senate, she has always, with her staff, done a remarkably fine job.

And I want to thank you. I want to publicly salute you and your staff for the work that you have done. This information that you provide for us is very, very good, and I have always found it to be reliable. I salute you.

Ms. SHIKLES. Thank you.

Senator PRYOR. Now, do you think that the State Insurance Commissioners out there is the reason that things are so lax in some States? Is that because of the respective commissioners out there who maybe are better in one State and more lax, or is it the Attorney General in their consumer protection division? What is the reason for sort of the break-down and the laxity, I guess you would say, in some of the States?

Ms. SHIKLES. I think it is a set of reasons. First, this is a product that is growing very rapidly. You have gone from 100,000 policies sold not too long ago to about 2 million. Each policy is different, so it is very complex.

Then you go to the States, and among State insurance agencies you find real diversity. We are doing a set of studies now in the States. They are so over-burdened and have unfilled staff positions.

Many States do not even have an actuary on staff or the money to hire an actuary as a consultant. They are worried about solvency issues. They regulate all insurance.

Long-term care insurance, which they are very worried about, is so complex and risky. It gives them all the problems they have. So, you have real diversity among the State agencies in how they regulate long-term care insurance products.

Senator PRYOR. Do you think the State Insurance Commissioners and the Attorneys General out in the State, would they like to see the Federal Government sort of move into this territory? I do not want to say turf, because Senator Rockefeller has cautioned us about turf today. Would they like to see the government preempt them in this deal and take over the regulation?

Ms. SHIKLES. No, I do not think they would. I think that they would not mind—and I know you are going to hear from those representatives—some approach where standardized minimum benefits are set that they were responsible for enforcing and updating.

This is very much a changing market and you do not want to freeze it in place. But they would like to have a product—and, I think many insurers that are doing a good job would like a product—that the consumer feels safe in buying. It would make the job of the State insurance agency easier, too, so they would not have to deal with so many complaints.

Senator PRYOR. You mentioned, in your opening statement, the enormous commissions that are paid some of these insurance agents to sell these policies. Now, that was true in the Medigap. Is that also true in the other policies? By the way, are these the same policies? Is this just an extension of the Medigap policy, or are these two separate policies?

Ms. SHIKLES. These are two separate policies. But the same problems that you found in Medigap you would find in long-term care insurance.

Senator PRYOR. All right. Are you finding the same sales person selling the same policy? Is that right?

Ms. SHIKLES. That can be the case. Yes.

Senator PRYOR. Now, I might say this to Senator Rockefeller. We had testimony by a former Medigap insurance salesman. He was testifying from his jail cell in Florida. We had him on video that day before the Aging Committee. [Laughter.]

He had made something like, I think, $400,000 the year he went to jail selling Medigap policies. And the reason they would not let him out of prison to come to Washington and testify to tell us how he got in the door—literally got his foot in the door—he was told never to leave that home without making that sale.

The reason they would not let him out is they said if he sat there on that witness stand, he would sell everybody in the Senate an insurance policy and we would probably buy it and pay for it. They said he was a great salesman.

But the pain and anguish that these types of unscrupulous people visit upon our population out there is pretty enormous. We make a little fun of it from time to time, but we are talking about the life savings of a lot of these people. We are talking about when they pay their insurance premium each month that they are probably, many of them, sacrificing food from their table in order to do that. So, this is serious business.

And that serious business is why the Federal Government, I think, is going to have to start involving itself a great deal more. I wish the States would do it, to be honest, but right now, I am afraid we are going to have to. Senator Rockefeller, I yield back to you, sir.

Senator ROCKEFELLER. Thank you very much. I might just ask a final question, Janet. Then we might send a few more along in writing. What do you think we have to do to guarantee policyholders, in terms of minimum standards, that they are going to get a good product?

Ms. SHIKLES. I really think that Congress is probably going to have to intervene and set minimum standards that are higher than what NAIC has now in place to address certain key issues. That will not totally eliminate the problems, but I think it will go far to do so, because there are a lot of companies that will offer policies according to these standards. These are standards that address non-forfeiture benefits and definitions, and some of the things that I mentioned.

And then, I think, if Congress does that and the States enforce it—which I think most States would be willing to do and could do—I would be comfortable having my mother buy a policy, or recommending one.

I think that would go a long way to make this a good product. There are a lot of good products out there now, but there are a lot of bad ones and it is very hard for the average consumer to sort that out.

Senator ROCKEFELLER. Yes. But with the number growing. It used to be 100,000, 10 years ago; it is now 2 million. Maybe it was

100,000 less than 10 years ago. It probably was. So, the number is growing. And as this issue becomes more of a conscious one to the American people, they are going to be more hungry, and, therefore, if they are not protected, more vulnerable.

Ms. SHIKLES. They are very vulnerable. Because I think the surveys have shown that the elderly are more educated now that Medicare does not provide long-term care coverage. And they are so frightened, not to protect assets, but to maintain their independence or not be a burden on their children.

So, they are buying these policies and they are very vulnerable to sales techniques that say, you will not have to call your kids and ask for help. And that is real scary, because a lot of these policies are not going to deliver on anything.

Senator ROCKEFELLER. It is human nature when somebody comes to sell you a product, an idea, or an argument, if you do not know the subject, not to argue back. Is it not?

Ms. SHIKLES. Yes, it is.

Senator ROCKEFELLER. Sometimes it is just that you do not want to appear to not know what you are talking about, so you go ahead and do yourself potentially some damage by buying something you should not.

Ms. SHIKLES. Right.

Senator ROCKEFELLER. Thank you, Janet.

Ms. SHIKLES. Thank you.

Senator ROCKEFELLER. You are always excellent, as David said.

Ms. SHIKLES. Thank you.

Senator ROCKEFELLER. Mr. William McCartney, who is director of insurance for the State of Nebraska, and president of the National Association of Insurance Commissioners.

STATEMENT OF WILLIAM H. McCARTNEY, DIRECTOR OF INSURANCE, STATE OF NEBRASKA, AND PRESIDENT, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, LINCOLN, NE

Mr. MCCARTNEY. Mr. Chairman and members of the subcommittee, thank you for this opportunity to discuss the——

Senator ROCKEFELLER. Did you want to introduce your associates?

Mr. MCCARTNEY. I will. With me is Gary Claxton, who is a Senior Policy Analyst dealing specifically in health issues at NAIC's Washington office.

Senator ROCKEFELLER. Good.

Mr. MCCARTNEY. And if there are some technical questions which are beyond the range of my knowledge, Gary, here, is here to bail me out.

Senator ROCKEFELLER. Thank you.

Mr. MCCARTNEY. Long-term care insurance is a growing market, primarily focused on sales to older consumers. Over the past 3 to 4 years, long-term care policies have improved in response to strengthened regulatory standards and increased consumer knowledge. Policies now offer broader and more flexible benefits with less severe restrictions and limitations.

State regulators have been actively involved in developing standards and practices to better protect consumers from uncertainties arising from the sale and issuance of long-term care policies.

The NAIC originally adopted a model Long-Term Care Insurance Act in 1986, and a model regulation in 1987. Both the act and regulation have been amended to affect greater regulatory scrutiny and changes in the marketplace.

The NAIC continues to closely monitor the long-term care insurance marketplace to help State regulators identify and respond to problems and new developments.

Currently, the NAIC Long-Term Care Insurance Task Force is working in several important areas including, first, the development of model standards to require non-forfeiture of benefits for long-term care insurance.

Just this month we received an extensive report from an actuarial advisory committee which contained information on several methods for providing non-forfeiture benefits. We intend to release a draft provision for comment in September and anticipate final adoption later this year.

Second, the development of standards to restrict the future premium increases that insurers may request. Several approaches, including rate increase caps and increased disclosure to consumers, are being considered. Adoption of a model standard is anticipated later this year, or early in 1993.

Third, the development of more effective standards to protect consumers against post-claims underwriting. Fourth, the development of standards to protect consumers whose policies lapse as a result of their physical or cognitive impairment.

And, finally, the development of standards to ensure that existing policyholders have an opportunity to upgrade their coverage if their insurer improves the policies it offers to the public.

In developing model standards, the NAIC has seen its role as balancing the needs of consumer protection and market development. As standards were developed, consideration was given both to consumer needs, as well as the potential effects on availability of products and their affordability to consumers.

Since consumers have no real alternatives except impoverishment, we have been concerned about pricing the product beyond the reach of moderate income consumers.

More recently, policymakers, academicians, and advocates have focused on the limitations of these products. Many would argue that all policies should provide more comprehensive coverage, including longer periods of coverage, extensive home care benefits, inflation protection, and non-forfeiture values.

They believe that more comprehensive coverage available to a more limited number of consumers is the appropriate direction for this marketplace. As this market matures, policymakers, including regulators, must make decisions about whether minimum standards should emphasize affordability or adequacy.

Standards that push insurers to develop more comprehensive products may reduce the number of people who are able to afford to purchase any protection in the private marketplace. We are pleased to see the interest of this subcommittee and other committees of Congress in this important issue.

We note that there are a number of Federal proposals, some of which favor State insurance regulators, and some of which cause us concern. We strongly believe that if Federal standards are enacted for long-term care insurance, the regulatory standards should be developed by State regulators through the NAIC and should be implemented at the State level.

We look forward to working with all interested parties as these important issues continue to be discussed at both the State and Federal levels.

[The prepared statement of Mr. McCartney appears in the appendix.]

Senator ROCKEFELLER. Thank you, Mr. McCartney. I have no idea about your politics, and I apologize if they turn out to be uncomfortable for what I am about to say.

Mr. MCCARTNEY. Mr. Chairman, I was originally appointed by a Republican and reappointed by a Democrat, so I guess I am bipolitical.

Senator ROCKEFELLER. Yes. You are amazing. [Laughter.]

There is an extraordinary news release which I just got—Senator Pryor may be interested in this—from Lynn Martin, who is the Secretary of Labor, and who told retired coal miners if they could not get their health benefits they could just go on welfare.

This official has also said that she and the President have been forever and a day trying to get us to pass emergency unemployment compensation, and to extend the benefits. She said that they worry about it all the time. It needs to be done so quickly.

Senator PRYOR. And what else is next, please?

Senator ROCKEFELLER. Yes. Well, I mean, I just find that interesting. Somebody handed that to me. I mean, we passed that. Well, she will find out.

I thought the question was whether he was going to veto it or not. He said he was going to veto it. I do not know. Well, they are all good people.

Bill, can I congratulate you, first of all, on doing good work, as your predecessor did. I mean, in other words, you have forced change. I mean, you got guidelines. Not all the States have done it, but you have forced change, you have forced thought, you have forced some things on us, which is good. So, I commend you for your work.

Now, the other side is, what can we do about the States who are not paying any attention to what you have done, and is that a matter of your agency not having enough power? I mean, is it not enough jurisdiction?

And whatever the answer to that, what is the movement of the States, how long do you think it is going to take them to react to, in some cases, your initial guidelines, much less your updates? What is the problem here, or what is the situation?

Mr. MCCARTNEY. Mr. Chairman, we have had some major movement, even since the GAO did its investigation last year. We are up to roughly 49 of the jurisdictions now have passed the NAIC's model act, or something similar.

The model regulation, or something similar, has now been adopted in roughly 38 of the States. So, even in late 1991 and 1992, we have seen a number of additional States come on board.

Early this month we had a meeting of the NAIC here in Washington, and, as part of those meetings, we have a commissioner's round table. And one of the topics that we reiterated, both Earl Pomeroy and I, was this issue of long-term care insurance.

And I can tell you that the States have really been running very hard the past couple of years to implement some new solvency policing measures. We are getting real close on those. And both Earl and I have asked the States to direct their attention to this very important issues as well.

Senator ROCKEFELLER. All right. Well, with that in mind, then, you are talking about 38 have already taken action. What is your judgment as to how long we ought to wait, if, indeed, we should at all, before we can say that the other States are not going to act, or they are not going to do it sufficiently.

I mean, I have some disagreement with some of those standards. I may not think they go far enough. But, nevertheless, you are pushing. How long do you think it is going to take before all of the States have the regulations?

Mr. MCCARTNEY. Well, first, Mr. Chairman, I would agree with you that some of those standards do not go far enough. And we are in the process of making them go farther to provide some additional consumer protections.

I do not have a magic answer for you. I was hopeful that we would have all of the States on board by now. Earl Pomeroy certainly was hopeful 2 years ago when he said, give us 2 years and we will get there. It is unfortunate that some of these States are not there yet, but we are getting closer.

Senator ROCKEFELLER. All right. Now, your 1992 revisions are in work, they are near completion?

Mr. MCCARTNEY. Yes. They will be completed by the end of this year, ready for the legislatures to act on next year.

Senator ROCKEFELLER. Have you got any sort of tips you can give us, off the record comments about what they might say?

Mr. MCCARTNEY. Well, non-forfeiture benefits is something we are looking at.

Senator ROCKEFELLER. Now, some will say later on that that is much too expensive. Your argument would be?

Mr. MCCARTNEY. My argument would be if the policies do not contain some kind of non-forfeiture benefit, people should not buy them.

Senator ROCKEFELLER. Yes. That is a clear answer. So that non-forfeiture should become a mandatory benefit, is what you are really saying?

Mr. MCCARTNEY. That is the position of the NAIC Long-Term Care Task Force that has looked at this. And now we are just trying to figure out the mechanics of going about that.

Senator ROCKEFELLER. How about the question of tax clarification for long-term care insurance, something the Pepper Commission recommended?

Now, if you support that, as the industry does, will that not target long-term care assistance to the richer elderly at the expense of the low-income elderly who are left more to fend for themselves, or am I whistling?

Mr. MCCARTNEY. Mr. Chairman, this is a matter that the NAIC really has no position on. And, frankly, I have not paid a whole lot of personal attention to it. I have been more concerned about the regulatory implications of some of the actions we are taking and not the tax aspects.

Senator ROCKEFELLER. If you have the personnel, could you try to get a written answer for me on that? I would just be interested in that, because it is an interesting question.

Do you see Federal minimum standards as significantly different from Federal standards for Medigap policies? Which, you will remember, Senator Pryor, on that evening when we acted at about 3:00 o'clock in the morning, we went ahead and approved that idea, affecting a $15 billion industry.

Senator PRYOR. You shrunk a foot and a half during that session, as I remember, Jay.

Senator ROCKEFELLER. But is it not interesting that we went right ahead and did that? And that was community rating, no less.

Senator PRYOR. We had to do that.

Senator ROCKEFELLER. Yes. Can I ask you, incidentally, have any of the Medigap companies gone out of business because of the community rating philosophy? We were told that people would just go out of business like crazy if we do community rating.

Mr. MCCARTNEY. Guaranty issue?

Senator ROCKEFELLER. Yes.

Mr. MCCARTNEY. Yes. I do not have any of that information at the tip of my tongue, but we will take a look.

Senator ROCKEFELLER. Could you get that? That would be interesting. I can find that out from other places, too. But that would be interesting. Because that was meant to be a bad thing that we did to insurance companies.

[The information appears in the appendix.]

Mr. MCCARTNEY. I can speak for the State of Nebraska. The Medicare supplement market is very viable in my State.

Senator ROCKEFELLER. All right. Well, in any event, you take the Federal minimum standards and then you take what we did for the Medigap policies. Do you see those as different?

Mr. MCCARTNEY. Well, there are some competing proposals. And the NAIC has not taken a position one way or the other on any of the bills. It would be unfair to say that we support any of them, but, at the same time, we are not on record opposed to minimum Federal standards.

Our main concern is if standards are developed, they should be delegated for development by the NAIC and then implemented and enforced by the States. That is our main concern. And if we can model something on the Medicare supplement model, which has worked well, we think we can work with that.

Senator ROCKEFELLER. Good. Thank you very much, Mr. McCartney.

Senator Pryor.

Senator PRYOR. Yes, sir. Mr. McCartney, we really appreciate you coming here today, and showing us where you are with your other commissioners and your colleagues.

My greatest concern about what you are doing now is, it seems like most of the things you are doing are prospective, it is going

to happen in the future, there is going to be a model developed, or you are going to talk to all the other States.

You know, I do not think we can wait much longer here on the Federal level. Our people are crying out to us to come help them right now, and I do not know how much longer we can wait. Do you have any suggestions?

Mr. MCCARTNEY. Senator Pryor, in my written testimony on pages 4 and 5 you will see an extensive listing of some of the things that the NAIC has already put in place for the regulation of long-term care policies.

And the things that I was talking about today in response to the questions from Senator Rockefeller are some additional enhancements. But there are a number of very meaningful consumer protections already in place in the NAIC models.

Senator PRYOR. Do you think that your colleagues, your fellow insurance commissioners, out there, do you think they feel like the time has come for the Federal Government to preempt this issue and the regulatory process and involvement?

Mr. MCCARTNEY. No.

Senator PRYOR. In other words, the States want to continue this. Is that right?

Mr. MCCARTNEY. Absolutely. Yes, for lots of reasons. In Nebraska, for example, I know that my department will pay more attention and devote more staff and resources to long-term care problems relating to Nebraska citizens than we would get if we had some different kind of regulatory structure.

Senator PRYOR. Well, in my legislation I think the intent is to have all the States meet the requirements of the NAIC act that you have outlined for us in your statement. Now, we understand that only 17 States actually have met these requirements. Is that correct?

Mr. MCCARTNEY. Well, not currently, Senator. With respect to the regulation, we are up to very close to 40 States—between 35 and 40 States, I think—which have enacted the regulation, or something similar. There have been some fairly dramatic changes in the past 12 months.

Senator PRYOR. Well, I think that—yes. Go ahead.

Mr. CLAXTON. Senator Pryor, we have a listing that was updated just as the first of this month of States which have adopted both the act and the regulation, and we will provide that to the committee.

Senator PRYOR. Mr. Chairman, I think that that might be timely to put in the record and extremely worthwhile if we would have those two tables.

Senator ROCKEFELLER. Absolutely.

[The information appears in the appendix.]

Senator PRYOR. Mr. Chairman, I think at this moment that is all the questions I have for Mr. McCartney.

Senator ROCKEFELLER. All right. Senator Pryor, thank you.

Senator PRYOR. Thank you, Mr. McCartney.

Senator ROCKEFELLER. And just before you leave, Mr. McCartney, I am not given to frequent partisan outbursts. But the reason that I unsettled my scholarly colleague, Senator Pryor, on this memo from Lynn Martin is not about whether the action is

done by a Democrat, or done by a Republican—but it's about what makes people so angry at us out there.

Senator PRYOR. Senator Rockefeller, you have been in the field of public service for a long time, and I have, too. And the older I get and the longer I am in this area of public life, the more confidence and faith I have in the wisdom of the people and the brilliance of the people, and, certainly the ability for them to discern and to decide what is political and what is right. And I think people see through things like this very easily.

Senator ROCKEFELLER. Do you not? Do you not? I apologize to the audience. That was uncalled for. But if it happened again, I would do it all over. Mr. McCartney, thank you very much.

Our next panel is Mildred McCauley, who is a member of the board of directors, the American Association of Retired Persons from Myrtle Creek, OR. Now, Myrtle Creek, that is the kind of place that we have in West Virginia.

Ms. MCCAULEY. Yes.

Senator ROCKEFELLER. I did not know that you had Myrtle Creek. You have those in Arkansas, would you not, a Myrtle Creek?

Senator PRYOR. Yes, sir.

Ms. MCCAULEY. I am sure most States have small towns.

Senator ROCKEFELLER. All right. And Gail Shearer, also, who is a manager of policy analysis for the Consumer's Union, and Josh Wiener, who is senior fellow at the Brookings Institution. We are very honored to have all of you here; a very distinguished panel. I will try my best not to misbehave.

I do not know where to start. Ms. McCauley, we will start with Myrtle Creek.

STATEMENT OF MILDRED McCAULEY, MEMBER OF THE BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS, MYRTLE CREEK, OR

Ms. MCCAULEY. You want to start with me? Very good. Thank you. Thank you, Mr. Chairman. My name is Mildred McCauley. I am from Myrtle Creek, OR. I am a member of the board of directors of AARP.

On behalf of our membership, I want to commend you for holding this very important hearing. Unfortunately, the long-term care insurance market continues to be one in which the large print giveth and the small print taketh away.

While the NAIC has worked hard to develop a model act and regulation which would set up basic standards for this market, we are deeply concerned that, according to a January report, only 13 States comply with 80 percent or more of the 15 major NAIC requirements.

In fact, 19 States still have not adopted the NAIC standards prohibiting prior hospitalization, and fully 40 States have not adopted the standards concerning home health care benefits, inflation protection, or outline of coverage.

Such findings demonstrate that the current State regulatory system is seriously inadequate and has failed to provide sufficient consumer protection throughout the nation. Too many consumers

continue to spend significant sums of money on policies providing largely illusory protection.

The current NAIC model act and regulation should be the starting point for the development of national long-term care insurance standards. But there are areas where we need to go beyond the current NAIC provisions if we are to provide even a modest assurance that consumers are receiving real protection for their premium dollar.

These areas include: mandating non-forfeiture protection for all policies; stabilizing premium rates; standardization of the definition of disability; avoiding inappropriate sales to low-income persons; strengthening home care standards; permitting consumers to upgrade policies; and improving data collection efforts. Our written statement discusses each of these issues in detail.

With regard to non-forfeiture benefits, the current marketplace provides little or no protection against circumstances under which purchasers pay thousands of dollars in premiums, but are forced by increasing premiums or decreasing income to drop coverage.

This problem is made more serious by the fact that studies have shown that the risk of coverage lapsing before the need for long-term care services arises is significant.

In addition, insurers have largely avoided risks by transferring them to policyholders in terms of unpredictable rates. Companies that incur more claims than anticipated in their initial premium offer will simply increase their rates. We, therefore, support efforts to create standards for approving initial rate filings and limiting premium increases.

Another important issue is the need to standardize the definition of disability for long-term care insurance policies. The uncertainty and ambiguity currently associated with insurance clauses is detrimental to both consumers and insurers.

There can be significant differences in how many policyholders qualify for benefits, depending upon how eligibility criteria are defined and measured. We urge development of a clear, uniform definition of functional capacity.

We are also very concerned about the implication of a recent report that about 3 in 10 purchasers have annual household incomes of less than $20,000, and about 25 percent have assets of less than $30,000.

These findings, together with reports of high-pressure sales tactics and data showing high lapse rates in the early years, raise serious concerns about the appropriateness of sales to lower incomes persons. Not enough is being done to limit these practices.

Finally, we do not believe providing new tax incentives to promote the purchase of long-term care insurance policies to be an efficient use of tax dollars.

In the absence of more comprehensive long-term care legislation, these incentives are likely to benefit only those with higher incomes and would entail revenue losses. There may be a role for new tax incentives, but, at this time, we do not support them.

In order to permit evaluation of the efficiency and equity of Tax Code incentives for long-term care, revenue estimates and distributional tables should be developed.

In conclusion, the need for strong Federal standards is clear. We must assure that all consumers receive real value and coverage in return for their premium dollar and have accurate information on which to base their decisions.

We should not permit consumers to continue to be misled into spending significant amounts of their hard-earned dollars on products that often fail to deliver on what they promise.

We commend you, Mr. Chairman, for your leadership on this issue, as well as Senator Pryor, for the introduction of S. 846, his legislation to create Federal long-term care insurance standards.

We look forward to working closely with you, Senator Pryor, and other members of the subcommittee, toward enactment of standards that will promote a long-term insurance market that assures value to the consumer. Thank you.

Senator ROCKEFELLER. Thank you, Ms. McCauley. And before I go on, which would be my habit, can you just answer me this. Do you know of anybody who has Alzheimer's and who cannot afford the care who is making it without other humans in that family being destroyed psychologically or financially?

Ms. MCCAULEY. Not personally. And for the ones who have Alzheimer's whom I know, regardless of their income, it is a very debilitating disease. It is very hard on the family. It is very difficult for them, in their lucid moments, to retain their dignity. They need all the help they can get, and they do need long-term insurance help.

[The prepared statement of Ms. McCauley appears in the appendix.]

Senator ROCKEFELLER. Ms. Shearer.

STATEMENT OF GAIL SHEARER, MANAGER, POLICY ANALYSIS, CONSUMERS UNION, WASHINGTON, DC

Ms. SHEARER. Thank you. Mr. Chairman, members of the subcommittee, Senator Pryor, Consumers Union appreciates the opportunity to present our views on the issue of overhauling the regulation of the private long-term care insurance market.

We commend Chairman Rockefeller, both for holding this important hearing, and for introducing S. 2571, the Long-Term Care Family Security Act of 1992. We also commend the leadership role that Chairman Bentsen, Majority Leader Mitchell, and Senator Pryor have played on this issue.

Consumers Union has monitored this marketplace since 1988 and we have repeatedly found that private policies are flawed. I will describe some of the major flaws in the marketplace and then comment briefly on how S. 846, S. 1693, and S. 2571 address them.

Failure to adequately protect against inflation is one of the most severe flaws in the long-term care market, a market in which benefits of a typical policy are expected many years in the future. We see no justification in allowing consumers the option to purchase protection without inflation coverage.

It is irrational for consumers to purchase a generous amount of coverage in early years when the risk of needing long-term care is relatively low, and a decreasing amount of real coverage over the years.

Unlike several bills that have been introduced both in the Senate and the House, none of the bills under consideration today assure that all policyholders have inflation protection.

One of the most serious problems in the long-term care insurance market is the fact that the majority of policyholders drop their policies before they need long-term care, and most of the policies provide no refund to these people. Policyholders who drop their policy, perhaps to buy a better policy, are typically out-of-pocket tens of thousands of dollars.

Consumers Union supports requiring all policies to include a built-in, standard, non-cash, non-forfeiture benefit protecting consumers in the event they drop the policy.

We are pleased that the NAIC is moving in the direction of requiring this type of mandatory benefit. S. 846 appropriate includes a mandatory non-forfeiture benefit, but S. 1693 and S. 2571 rely on a mandatory offer approach.

One of the key findings of the Consumer Reports——

Senator ROCKEFELLER. Can I just interrupt you there?

Ms. SHEARER. Yes.

Senator ROCKEFELLER. And this will not count against your time. Can the three of you just give me examples that you know of or have heard of about the effect of not having non-forfeiture in long-term care? I mean, give me a couple of examples of what has happened.

Ms. SHEARER. I cannot cite individual consumer examples, but I can tell you what would happen to a typical consumer. He might start a policy, say, at age 65, at, say, $1,200 a year; pay in $1,200 each year for 10 years. After 10 years, that is a $12,000.

It is a little bit like paying a whole-life insurance premium and then dropping the policy. And after 10 years, you are out that $12,000 which really meant to go to fund later-year risk when the risk increases are gone. So, you basically are out the equity that y u have invested in this policy.

Senator ROCKEFELLER. Do you know of some personal examples, Ms. McCauley?

Ms. MCCAULEY. No, I do not. I do not think that the long-term care insurance field is old enough yet.

Senator ROCKEFELLER. It is not big enough. Yes.

Ms. MCCAULEY. We do not have the data gathered yet.

Senator ROCKEFELLER. Yes. Thank you. I am sorry, Gail.

Ms. SHEARER. One of the key findings of the Consumer Report's article was that no two long-term care policies were alike, and it is virtually impossible to make a rational comparison of policies that are in the marketplace. Consumers Union supports simplification of the long-term care insurance marketplace through uniform definition of terms, improved benefit design, a standard outline of coverage, a standard gatekeeper, and standard benefit packages.

The OBRA '90 reforms of the Medicare supplement insurance market provide an excellent model for reform of the long-term care insurance market.

The bills vary in addressing the need for simplification. S. 2571 is the most comprehensive, with uniform definitions, a standard outline of coverage, professional assessment of the need for benefits, and significantly standard benefit packages.

One of the most distressing findings in our June 1991 Long-Term Care article was the poor performance of agents, whose lack of understanding of the products they are selling is alarming.

Agents misrepresent provisions and policies, fail to take into account medical histories subjecting people to post-claims underwriting, fail to provide outlines of coverage or buyer's guides, and sell policies that do not meet the long-term care needs of purchasers.

With first-year commissions of 70–80 percent of first-year premium, the agent has very little incentive to take the consumer's long-term interest into account when selling a long-term care policy.

This failure to take into account the long-term interest of the consumer is linked to the high lapse rate for early years of policy ownership. Many of these sales are inappropriate because the policyholder cannot afford to pay the premium year after year. S. 2571 restricts agent commissions appropriately.

Consumers are asked to purchase a policy without knowing the price of the protection that they are buying. This is because companies are free to increase the premium in the future. Once consumers buy a policy, they are locked into it because of the absence of non-forfeiture values.

We would like to see stronger protection against premium increases in all three bills. And, here, Senator, we are interested in seeing a non-cancelable policy, which means a fixed premium, guaranteeing that premiums would not increase over time.

Finally, unlike the other bills, S. 2571 creates a public long-term care program and allows the private market to fill in the coverage gaps for those that can afford a private policy and have substantial assets to protect.

If the private market reforms are considered separately from the public program, then we urge you not to include the tax clarification provisions in the reform bill.

Consumers Union believes that it is grossly inappropriate for Federal revenues to be spent providing a tax subsidy to relatively high-income purchasers of long-term care insurance policies. Instead, the next Federal health care dollars should be spent expanding access to acute health care services.

In summary, Consumers Union strongly supports your efforts to reform the regulation of the private long-term care insurance market. Building on the procedural and substantive Medigap reform provisions of OBRA '90 is a sound approach.

We urge you to enact strong consumer protection provisions to assure that all purchasers of long-term care insurance policies get the protection that they believe they are buying.

[The prepared statement of Ms. Shearer appears in the appendix.]

Senator ROCKEFELLER. Gail, again, a question that is out of order. Does it not interest you, and what explanation do you give to it, that long-term care legislation, which affects directly more people in this country than does access to coverage, has not hit more of a hot button, so to speak, out there, or in here, for that matter?

Ms. SHEARER. I do not know that I would agree that it affects more people. Because even if 86 percent of us have health insur-

ance now, we are all vulnerable to losing it if we lose our jobs or if we come into bad health. So, I guess I am not that surprised. The issue under consideration today is not the big long-term care picture.

Senator ROCKEFELLER. Well, that is what I am talking about.

Ms. SHEARER. All right. Well, the big long-term care issue. I guess that is difficult to explain. Because, as you recognize, we all are at risk of having major long-term care expenses.

Senator ROCKEFELLER. And every one of us can name people in our families or extended families, without exception.

Ms. SHEARER. Absolutely. Absolutely.

Senator ROCKEFELLER. It is immediate to every single person. Do you know what I think the reason is? Because, number one, the other one just arrived first because of the so-called immediate moral issue, so to speak, and the nature of being uncovered. And, secondly, it is in access that you build in the architecture of health care—cost containment and all the rest of that—that fits more comfortably in that than in long-term care. But it is puzzling to me.

Ms. SHEARER. Yes. And I think there is an incorrect perception that this is a problem that affects only older people, when many, many people under 65 certainly are at risk, as well. I am as puzzled as you are.

Senator ROCKEFELLER. Yes. Yes. It is puzzling to me substantively, and it is also puzzling politically. Josh.

Mr. WIENER. Well, if I could chime in here.

Senator ROCKEFELLER. Please.

Mr. WIENER. I think part of it is that, as inadequate as it is, we do have a safety net for long-term care. If you are in a nursing home and you do not have any money, Medicaid will pay for your care.

The problem for the health care for the uninsured is, if you do not happen to fit into the categories covered by Medicaid, you are just out of luck.

Senator ROCKEFELLER. Well, I mean, I am not so sure. You do not get to Medicaid unless you get broke, number one. And, for a middle-class person, that can be an unpleasant process.

And secondly, you could argue that the safety net for coverage is the local emergency room. I mean, I am not arguing with you, but I am just——

Mr. WIENER. Well, you are right that the local public hospital, the local emergency room is there in some areas, if you happen to have a public hospital and if your emergency room is not turning people away for something other than life-threatening problems.

Senator ROCKEFELLER. Yes.

Mr. WIENER. But, as you are well aware, the public opinion polls generally show that people are more willing to pay taxes for long-term care than they are for health care for the uninsured. So, I have argued, largely unsuccessfully, that we need to join those two issues together.

Long-term care needs health care for the uninsured to take the edge off some of the generational equity issues and health care for the uninsured needs long-term care to tap into some of the willingness to pay taxes. That willingness to pay taxes unfortunately, is not there for health care for the uninsured.

Senator ROCKEFELLER. And some have pointed out, interestingly—and this is just ruminating—that it might be long-term care, in fact, which is what single-payer advocates want within the package that forces some kind of a compromise between single payer, play-or-pay, or multi-type system.

The long-term care could become a leveraging approach to some form of compromise. That is all idle speculation. I am interrupting everything useful that you want to say. Please proceed.

STATEMENT OF JOSHUA M. WIENER, SENIOR FELLOW, THE BROOKINGS INSTITUTION, WASHINGTON, DC

Mr. WIENER. Thank you, Mr. Chairman. It is a pleasure to be here today. American society uses private insurance to protect against loss from catastrophic events such as automobile accidents, fires, and early death. Yet, insurance against the potentially devastating costs of long-term care is relatively rare.

While the role of private long-term care insurance will grow in the future, it is likely to finance only a modest proportion of nursing home and home care expenditures. But even if public programs are expanded, private long-term care insurance is likely to play a larger role than it does now. Thus, it is critical that it be properly regulated.

In my oral testimony I would like to point out a few areas where I think current policies and regulations tend to be deficient, and then state my preference for a regulatory strategy.

The first area is inflation protection. It is no secret that health care prices are increasing rapidly. According to HCFA, nursing home costs have been increasing an average of more than 3 percentage points faster than the Consumer Price Index since 1977.

The key problem is that long-term care insurance is typically bought years before services will be used. Thus, a policy that pays an adequate indemnity benefit now will be grossly inadequate in the future.

For example, assuming nursing home inflation is 5.5 percent per year, a consumer who purchases an un-indexed policy today at age 50 with an $80-per-day nursing home benefit and uses it at age 85 would have the same purchasing power as a person trying to buy nursing home care today with a $14-per-day benefit.

The difficulty is that the vast majority of existing policies have either no or highly inadequate inflation protection. Only mandating indemnity benefits be increased on a compound basis can ensure that the indemnity benefit will have real purchasing power when it is needed.

This mandate will substantially increase the price of policies, but will prevent insurance from offering an illusory benefit.

The second issue is basically non-forfeiture benefits. It is not widely appreciated by consumers that most insurance companies assume that the vast majority of people who initially buy policies will drop them well before it comes time to use services.

Premiums, which are generally high, are as low as they are because of assumed high lapse rates. The principal public policy problem is that virtually all policies have level premiums designed to build up substantial reserves in the early years for pay out in the later years.

Consumers who pay in during the early years and then decide not to renew their policies will have substantially overpaid during the period that the policy was in effect for the actuarily fair cost of the protection actually received.

Moreover, although no data is available, it seems likely that a substantial portion of the lapses may be to relatively low-income elderly who bought policies without fully realizing its financial burdens.

Despite the fact that non-forfeiture benefits are not a panacea, they should be required. If lapse rates are low, then the benefit can be added at little cost. If the lapse rates are high, then they are an essential element of consumer protection, even though they will substantially add to premiums.

Private long-term care insurance cannot be taken seriously as a mechanism for financing nursing home and home care, so long as its premium structure is built on the assumption that three-quarters or more of initial purchasers will end up without insurance coverage when it comes time to use services.

The third area is home care. Most of the improvements, which have been substantial, in private long-term care insurance over the last several years have addressed deficiencies in nursing home care rather than home care coverage.

While there have been improvements, there is still a ways to go for home care benefits. The principal problem is that it is not always clear whether the policies cover unskilled home care.

Although I do not necessarily favor mandating coverage of large amounts of home care, I do believe that regulators must do a better job of making sure that unskilled care is what is actually covered in policies that hold themselves out as providing home care.

Finally, the deficiencies in current policies and the slowness of the States in adopting the current National Association of Insurance Commissioners' regulatory standards—creates a strong case for increased Federal involvement in this issue.

My recommended strategy would be to have the Federal Government substantially strengthen the NAIC standards and then mandate them nationally. All insurers would be require to meet the standards and States could exceed the minimums if they wish.

This will surely strike many State regulators and most industry representatives as unduly intrusive, but the bulk of the necessary additions are critical to making sure that benefits are not illusory.

While consumers should have options, they should not be required to choose among policies that promise benefits they will not deliver. Thank you.

Senator ROCKEFELLER. Thank you very, very much.

[The prepared statement of Mr. Wiener appears in the appendix.]

Senator ROCKEFELLER. David, can I go on with one thing on this previous matter where I was being so petty and partisan? Remember, I said that it had been vetoed a couple of times.

Actually, the first time the UI extension was not vetoed, it was signed. But then the President refused to declare an emergency. Now, that is tricky; is it not?

In other words, you can get away with that. Because if there was not any emergency, then you could not expend the funds. I mean, this is just gamesmanship. This is not aimed at Republicans, it is

aimed at all of us in politics. That is why people hate us out there. Why they hate us. Because we play these stupid games.

Senator PRYOR. That probably amounted, really, to an impoundment of the funds the first time by the President. I think that is right.

Senator ROCKEFELLER. Yes.

Senator PRYOR. Once again, I think the people pretty well know. They will make this decision and make it wisely.

Senator ROCKEFELLER. Yes. Well, once again, I apologize to all intelligent and fair-minded listeners and observers. I do not know where to start.

Gail, let me start with you for a second. You have been watchdogging this for a long, long time and the country is in your debt for all of this. What do you think are the most important protections that we can provide in terms of really ensuring long-term care insurance consumers will get the benefits they need?

Ms. SHEARER. All right. What I would like to do is go through a list.

Senator ROCKEFELLER. All right.

Ms. SHEARER. It is not a short list, but I will keep it brief. And these are really from the table that I included in my testimony, and I think you will know what I am referring to if I just go through it quickly.

First, is mandatory non-forfeiture benefits of a non-cash type. This should be built into each policy. Second, built-in inflation protection. A policy without inflation protection is really illusory; it just does not make sense.

Third, is simplification. And this is really a broad category. It is absolutely impossible for people to make a rational comparison of policies today.

So, what we would like is uniform definition of terms; improved benefits, for example, making it clear that home care benefits include personal care services, and the bills before this committee do just that; standard outline of coverage; a standard gatekeeper with an appeal to third-party in case the claim is denied; and standard benefit packages so that people can compare apples with apples and not be totally confused by restrictions and fine print that vary from one policy to another.

The next category would be premium stability, to avoid the type of example that Senator Pryor mentioned today. It is absolutely outrageous that people are asked to buy a policy without knowing what the price of it is down the road, especially since they are locked into this policy and they lose a lot by dropping it.

Senator ROCKEFELLER. What are they told?

Ms. SHEARER. Pardon me?

Senator ROCKEFELLER. If they were to ask that question, what are they told?

Ms. SHEARER. Typically, the agent will say, oh, no, this premium will not go up. These are called "level premium policies." Now, what does level premium mean to you? To me, it means that that premium is going to stay the same. Well, that is not what the definition of level premium is.

A level premium can increase, as long as the company increases it for all policyholders in that class. So, people are very surprised

when their premium goes up just as their income is going down and they are locked into this policy.

We would like to change the whole way these policies are priced. Companies now have a very strong incentive——

Senator ROCKEFELLER. But how can somebody say that to somebody? My mother is 83 years old. I mean, how can somebody say that, that it is going to be a level premium?

Ms. SHEARER. Well, I cannot justify that.

Senator ROCKEFELLER. I mean, there is no other way that you could interpret that.

Ms. SHEARER. I cannot justify that. I am really baffled by it myself. This involves an entire change of mind set to think about changing how these policies are priced.

Now the companies have an incentive to under-price the policy to gain market share and then raise them down the road. There is a strong built-in incentive for that right now. I would like to see these premiums guaranteed.

And it is likely that companies will over-price these policies in order to protect themselves against future risk. Fine. They can do that. But then rebate a premium to consumers if they have overpriced it.

Now, you can imagine companies will not like this idea because it is going to be hard to make the initial sale. But our position is, the consumer is not the person who should be at-risk; it should be the insurance company, who is in a better position to judge what the risks down the road is.

Senator ROCKEFELLER. You know, Gail, what occurs to me—I do not know for sure, but my guess is—you are probably for a single-payer system in terms of the overall. David and I are not.

In other words, we are the people who are trying to preserve the private insurance market, whether it is long term or for whatever. And yet, you hear things like that and in the back of your mind you say, well, that is not everybody, that is just some.

But then, you know, you do not really know. I mean, people go into Logan County, McDowell County, and Wyoming County, WV, and down to Pine Buff, and Magnolia, and Circe, and some of these places in Arkansas, and sell policies. I mean, I will bet they are doing this just all over the place.

And, yet, we are the ones who are trying to say that they should exist in private. It seems to me if they want to do that they have to clean up their act. Because the only health care plan that is growing around Congress in popularity is single payer.

Ms. SHEARER. Well——

Senator ROCKEFELLER. You do not have to comment if you do not want to.

Ms. SHEARER. I would like to, for the record, say that Consumers Union is a strong advocate of a single-payer health care system. We have been working for reform of the private long-term care insurance market as long as there is this market. But I think that the issues are so similar.

The reason that the private long-term care insurance market will never solve this problem is the same reason that the acute care health care market will not be able to solve the under-65 problem.

And that is that insurance companies are here to make money, to screen risks. That is how they make more money. And it just is not consistent with universal access to either acute health care or long-term care insurance.

Senator ROCKEFELLER. Well, we have three insurance companies coming up, I believe, in the next panel. Are any of them going to be able to say to us, do you suppose, that they do not advertise or sell with level cost?

Ms. SHEARER. I cannot answer that. I can tell you that the NAIC——

Senator ROCKEFELLER. Do you think I can ask them that?

Ms. SHEARER. I think you should ask them that.

Senator ROCKEFELLER. All right. I will.

Ms. SHEARER. The NAIC considered at its meeting a week or two ago some language that would disclose to consumers exactly what level premium means. And this would be a very small step.

I mean, I think that that is useful, but it does not remove the strong incentive for companies to continue to under-price their policies initially. I do not think that just understanding that your premium can double solves the whole problem. I think that consumers need more protection than that.

Senator ROCKEFELLER. Yes. David, I have more than taken my time.

Senator PRYOR. I might make a suggestion, if I might. We have a vote.

Senator ROCKEFELLER. Oh, we do?

Senator PRYOR. It just started. We have about 12 minutes remaining on the vote. We could run over and come back. Would that be a good plan?

Senator ROCKEFELLER. Well, yes. Because I do have some questions that I want to ask. Do you mind?

Ms. SHEARER. Not at all.

Senator ROCKEFELLER. Thank you. We are in recess.

[Whereupon, the hearing was recessed at 4:10 p.m.]

AFTER RECESS

Senator ROCKEFELLER. Gail, I might resume with you. Your report details marketing and sales practices and problems therein, and it is fairly grim, what you portray. What consumer protections would be most effective in eliminating those marketing and sales abuses?

Ms. SHEARER. I think the most effective thing would probably be restricting agent commissions so that they do not benefit financially for first-year sales out of proportion with what their compensation should be for the first year.

And if the first-year commission, for example, were no more than 200 percent of the second-year commission and later year commissions, that would be an effective approach there and one that is in effect for the Medigap market.

Also, with regard to agents, there should be a special agent training and certification program for long-term care. And, as you know, our article last year, our reporter went under cover and basically heard the sales pitches of 15 agents.

And all 15 of them were flawed in one way or another and made inaccurate representations, for example, about what was in the policy and failed to give all the information that should have been provided. So, the agent problem is a major problem, and those are the key steps that we would recommend.

Senator ROCKEFELLER. Now, the next panel—at least part of it, probably—will testify that it is unfair to put a cap, so to speak, on commissions because you penalize good agents, presumably, with bad agents. Could you reply to that? And, also, could you describe how agents describe the option of inflation protection to purchasers in your report?

Ms. SHEARER. All right. There is no reason that an agent should suffer financially from restricted agent commissions, assuming that their selling policies are going to continue over several years. The commission can be structured so that they will get the same total amount of money if the policy stays in force.

So, the agents who will suffer are the agents who are selling a policy and it is lapsed after, say, 1 or 2 years. Those are the agents that would lose financially, and they should lose financially for selling inappropriate policies.

With regard to our article and our findings on inflation, our reporter found that agents discouraged people from buying inflation protection. And the assessment was made that this was probably because agents were afraid that the higher premium would cause them to lose the sale.

And it is really one of the key reasons why we are extremely skeptical of any sort of voluntary approach with regard to inflation or non-forfeiture.

We feel that you cannot trust the agent, who, in most cases, is not very well informed, to make a clear presentation to consumers of options. With regard to non-forfeiture, for example, the companies, if they can manipulate the figures and the choices for non-forfeiture, are making consumer choice an unrealistic goal here.

There should be a standard non-forfeiture benefit, standard inflation benefit, so that it removes the decision and the misinformation that the agent could provide.

Senator ROCKEFELLER. All right. Ms. McCauley, why is it that consumers allow their policies to lapse in such large disproportionate numbers?

Ms. MCCAULEY. I think that they fail to understand how expensive they are. They are probably buying policies that they could not afford in the first place, but they would like to have that policy because they need the protection. But it takes away from their income.

Senator ROCKEFELLER. So, it is a money decision.

Ms. MCCAULEY. I think it is a money decision. Sometimes it could be a careless decision. As I understand it—and I think it was mentioned here, that there have been 2 million policies sold. But, as I understand it, there are about 1 million in effect now.

Senator ROCKEFELLER. Yes.

Ms. MCCAULEY. So, that is a 50-percent drop-out rate. Probably that is one of the reasons, because it hits the vulnerable older people.

Senator ROCKEFELLER. All right. When you were talking you mentioned that there ought to be standards against inappropriate sales to low-income elderly.

Ms. MCCAULEY. Sales pitches.

Senator ROCKEFELLER. And GAO reported that there were abusive sales practices in addition to that. Can you, just reporting from the membership, talk a little bit about what that means?

Ms. MCCAULEY. Well, of course, AARP sells insurance through Prudential, and we do not have salespeople coming out to people. However, we encourage our members to think about whether——

Senator ROCKEFELLER. I am not talking about AARP.

Ms. MCCAULEY. But what I was getting to is that we do encourage people to examine the policies, to compare and buy the protection best suited for them. We try to educate them about asking the right questions, thinking about what they need. It is a matter of education of our consumers, of our members.

Senator ROCKEFELLER. No. I understand that that would help. But what form would an abusive sales pitch be?

Ms. MCCAULEY. Well, what I have seen when people have come to me or have come to my friends is high pressure, trying very hard to sell a policy, promising things that do not really exist. And people do not understand insurance policies. They do not read the fine print. They do not understand the confusing language.

So, again, it is a matter of education, trying to get people to discuss their needs with someone else, maybe their own attorney if they have one, or talk to a consumer advocate to try to determine what the policy actually offers. And I do not think the individual older person understands insurance all that well to sufficiently analyze what they are buying.

Senator ROCKEFELLER. Gail, do you know, is there a fairly high turnover in agents? I mean, can you tell me something about who they are, their education levels, turnover rates, et cetera, for insurance companies? Do we know that?

Ms. SHEARER. I cannot really contribute very much to your understanding of that. I would say, Senator Rockefeller, that one of the most important features of the bill that you introduced is a $20 million authorization to expand the counseling programs that were included in the Medigap reform bill enabling all 50 States to set up programs that train volunteers to counsel senior citizens on a one-on-one basis.

And this is a very important complement to agent restrictions. It provides senior citizens with an objective source of counsel, and this is extremely significant.

Senator ROCKEFELLER. All right. Josh, you are a guru on many things on long-term care. Let me get an idea of the scope of this issue.

In your testimony, you say that only limited segments of the elderly population have the wherewithal to purchase long-term care insurance, assuming the policy is available that will provide them with the protections that they need, at a reasonable price, and that number will only increase slightly in the future, you indicate.

What percentage of the elderly purchase it now, one? What percentage of our Nation's elderly that are in need of long-term care services can rely on long-term care now and in the future?

Mr. WIENER. Well, right now, about 3 to 5 percent of the elderly have some kind of private long-term care insurance. That number will, I think, grow significantly over the next 25 years.

But using our computer simulation model, we estimate that 25 years into the future that maybe 20–30 percent of the elderly will have some kind of private long-term care insurance.

And, because of a variety of restrictions and because those will tend to be focused on the relatively young elderly, insurance will pay for maybe somewhere between 12–16, 17 percent of nursing home care expenditures and a slightly lower percentage of home care expenditures.

So, for 25 years into the future, insurance is going to grow, but it will remain a relatively small segment of the elderly. And the really important question is, will it change the way in which we finance nursing home care and home care?

And I think its contribution there, again, over the 25-year period will be relatively modest, although it will certainly be dramatically higher than it is now where only about 1 percent of nursing home expenditures are paid for by private insurance.

Senator ROCKEFELLER. All right. Let me ask you this. How concerned should we be that this nascent long-term care market, which people tout as partial salvation, will be able to survive as times develop? Insurers still have not gained meaningful experience in paying claims.

Could we see the collapse, for example, of the number of companies that are offering long-term care insurance today? Or will that only come if policies are designed so companies will actually have to pay out benefits instead of reaping in big dollars from high lapse rates?

Mr. WIENER. Obviously, if companies never pay benefits they will not suffer any financial risk. However, the fact of the matter is that long-term care insurance is very risky, and there is not much in the way of experience. Insurance companies right now are taking in premiums, but they are not paying out much in the way of benefits.

And that is kind of an inherent problem with long-term care insurance, since you sell to people who are age 65 and then they do not use benefits until they are, say, 85 or 90.

And over that 20 to 25-year period there can be dramatic changes in mortality rates, disability rates, nursing home use rates, home care use rates, rate of return on reserves.

These changes can radically change what looks like, a very profitable policy into a very unprofitable policy. And I think that ultimately is going to limit the number of policies insurance companies will sell. They are going to look at their financial exposure and not want to take on too much risk. They are taking on some risk, but they may not want to take on an enormous amount that would really be involved in selling huge numbers of policies.

Senator ROCKEFELLER. All right.

Mr. WIENER. Now, I should add that some companies will deal with this through reinsurance, but that will add to the cost.

Senator ROCKEFELLER. All right. The next panel which I am going to get to here, we will hear that long-term care, again, is not Medigap, and should be treated differently.

Medigap was initially adopted without Federal minimum standards, and, as you know—and your co-panelists can also testify to—scandal ensued. Could you tell us what distinctions we should draw or lessons that you believe we should learn from that experience?

Mr. WIENER. Well, I think the primary lesson is to set a fairly high level of minimum standards from the beginning. Gail has laid out a very long list of things that can be added to the National Association of Insurance Commissioners' standards.

But I think what you need is a fairly substantial level of standards to start off with so that you avoid those medical problems at the beginning. This is a much more complicated product. Medigap, by comparison, is a piece of cake.

And I think we cannot afford to stay on the learning curve of piecemeal action here. We need to start off with a Federal program that has fairly substantial standards.

Senator ROCKEFELLER. All right. I have got, I discovered, just 20 minutes to conclude the hearing. And that is shameful, on my part, for dallying so much. That means, however, that I do have to go on to the next panel.

I have got a number of other questions for all three of you. If you would be kind enough to respond within 10 days, I would be very grateful. I thank you very much and apologize to you for the long wait.

The final panel consists of Robert DeCoursey, who is president of the Association of Health Insurance Agents; Ronald Hagen, who is vice president of product development and government relations, AMEX Life Assurance Co.; and Susan Van Gelder, associate director of policy development and research, Health Insurance Association of America. We welcome all of you. Mr. DeCoursey, maybe we would start with you, sir, if we can get the name plates changed.

STATEMENT OF ROBERT W. DeCOURSEY, PRESIDENT, ASSOCIATION OF HEALTH INSURANCE AGENTS, PHILADELPHIA, PA

Mr. DECOURSEY. Mr. Chairman, members of the committee, thank you for the opportunity to testify this afternoon. I will limit my testimony to 5 minutes and request that my written testimony be included in the record.

Senator ROCKEFELLER. It will be.

[The prepared statement of Mr. DeCoursey appears in the appendix.]

Mr. DECOURSEY. Thank you. My name is Robert W. DeCoursey, CLU. I am an insurance agent from Philadelphia. I currently serve as President at the Association of Health Insurance Agents, which is a conference of the National Association of Life Underwriters.

Mr. Chairman, we believe the Finance Committee is in a unique position to act on important legislation that would strengthen the level and quality of long-term care protection for Americans.

We congratulate you and your colleagues in the Senate Finance Committee for your leadership in examining the challenges of assuring an adequate, affordable, and understandable long-term care protection for the elderly.

In particular, we commend your efforts, as well as those of the Majority Leader, the Minority Leader, Senator Pryor, all the Sen-

ators on the subcommittee and the full committee, who have introduced and co-sponsored legislation that would assure appropriate regulation and necessary tax clarification of long-term care insurance. We encourage your committee to act quickly on the long-term care issue.

Agents are the essential link between the consumer and the insurance company, providing and servicing the products of the insurer, while educating the consumer on how to manage risk and how to make informed choices regarding their insurance purchases.

The commission or other compensation earned by a health insurance agent not only compensates him or her for the time and skill involved in the sale of the product, but, in addition, the professional agent provides a variety of services which are outlined more fully in my written testimony.

All agents are licensed and regulated by their State Insurance Departments. Prospective agents receive extensive training about insurance and applicable insurance law before they take a written examination to get the license.

In addition, a majority of States now require continuing education in order for an agent to maintain his or her license.

Over the past few years, there have been numerous allegations about abuses in the long-term care insurance market. Let me say categorically right up front that we do not condone the repugnant practices of those agents who would take advantage of the elderly, or of any other consumers of any group.

Quite simply, those individuals have no place in the market. In addition, they should be punished for their misdeeds. We have been strong supporters of State regulation which would put abusers out of business.

We support the National Association of Insurance Commissioner's model act and regulation, and we believe the States should enact it. To the extent that the States fail to act on these important recommendations by the NAIC, we support Federal incentives to encourage the States to enact appropriate standards.

As you may suspect, one of our concerns about S. 2571 is its restrictions on agent compensation. As you know, the bill would prohibit insurers from paying first-year commissions more than double the renewal commission. Presumably, the public policy reason for this is to prevent agents from churning policies. We agree with the goal, but we object to the specific provision.

Commission restrictions discriminate against the thousands of caring, ethical agents who would do a professional job of identifying the client's need, determining what resources the client has to meet that need, describing the resulting policy provisions that are a result of those two interacting factors, and servicing the policy after it has been sold.

The net result of these commission restrictions will be to leave the bad agents in the market and create a commission structure where the professional agent gets paid half as much for doing a good job for the consumer.

Congress and the States should work to promote tougher enforcement of existing laws and regulations that already promote fair, honest interaction between buyers and sellers of long-term care

rather than create laws which make the long-term care market less attractive to ethical, professional agents.

In lieu of restrictions on agent compensation, we suggest other alternatives, such as civil and criminal penalties similar to those in OBRA '90, continuing education requirements, written comparison of policies, and enhanced replacement requirements.

Mr. Chairman, there are many provisions in S. 2571 with which we agree. We endorse the provisions which would clarify the tax treatment of long-term care policies.

We also support the provisions which permit employers to provide long-term care to their employees on a tax-free basis, and that those long-term care benefits be paid tax free, unless received under a disability policy.

We further endorse many of the standards set forth in the bill. We understand Congressional concern about regulation of the long-term care insurance product.

We believe that many of the consumer protection standards contained in the Bentsen-Packwood bill, S. 1693, also co-sponsored by Minority Leader Dole and Senator Pryor, along with many of those in Senator Pryor's S. 836, offer workable provisions in which we can find agreement. In fact, we endorse both those bills.

As you may know, we are also members of the Long-Term Care Insurance Coalition, which has been working very hard on a package of standards to which the insurance industry can agree. We support that proposal.

Our associations strongly believe that long-term care insurance should be effectively regulated so that consumers may purchase the product with confidence. We stand ready to work with you in an effort to accomplish that goal. I would be pleased to respond to any questions you may have.

Senator ROCKEFELLER. Thank you, Mr. DeCoursey.

Mr. Hagen.

STATEMENT OF RONALD D. HAGEN, VICE PRESIDENT, PRODUCT DEVELOPMENT AND GOVERNMENT RELATIONS, AMEX LIFE ASSURANCE CO., SAN RAFAEL, CA

Mr. HAGEN. Thank you, Chairman Rockefeller. As you have noted, I am Ron Hagen. I am vice president of product development and government relations at AMEX Life Assurance Co., a subsidiary of American Express. We have been in this business for some 18 years now.

I appear before you today also in my capacity as co-chair of a group called the "Coalition on Long-Term Care Insurance Standards." This is a group of leading long-term care insurers, providers, and agent representatives and includes AMEX Life, UNUM Life, New York Life, John Hancock, the American Health Care Association, the American Association of Homes for the Aged, and, as Mr. DeCoursey mentioned, The National Association of Life Underwriters and their Association of Health Insurance Agents.

Our coalition has developed a package of consumer protection standards which address key issues and concerns in the design of private long-term care insurance products, as well as in the area of sales and marketing practices.

As a group, we advocate the immediate adoption of Federal long-term care insurance standards legislation which balances the need for uniform and consistent consumer protection standards with the need for continued product innovation and market growth.

The coalition also believes that it is essential to enact, along with these consumer protection standards, tax clarification provisions for those products similar to those proposed in S. 2571.

The coalition's vision of the goals of consumer protection and the role of the Federal Government are reflected in the guiding principles on which our package of consumer protection standards are based. These principles are, briefly:

One: The role of the Federal Government should be one of leadership and direction, not implementation. Two clearly stated goals of the Federal initiative should be the de-mystification of the marketplace and the creation of an educated consumer.

Two: The goal of consumer welfare in this market is best achieved within a market setting where consumers can make educated choices and insurers are held accountable for their actions or those of their representatives.

Three: States must maintain, and, in fact, enhance their oversight monitoring and general enforcement posture in this market.

Four: When desired outcomes can be directly tied to standards such as product features, then such features should be legislated.

Five: When outcomes pertain to procedures and operations, the Federal Government should state the goal, leaving it to the States to establish more explicit guidelines.

And, finally, the industry should be responsible for coming up with specific data so the consumers and regulators can measure their performance in making intelligent choices in the marketplace.

Our underlying belief is that well-informed individuals can make the best choice as to whether they need long-term care insurance, and, if so, what should be the level and type of protection?

Again, our detailed statement for the record has focused on the need for regulation in a number of areas, specifically claims payment practices as they relate to the insidious practice of post-claim underwriting, and the lack of information on company's claim payment practices.

Secondly, agent and company misrepresentation and alleged widespread inappropriate replacement activity, or churning of this business. Three: Premium equity and stability. Four: The lack of consistent and appropriate standards from State to State in the area of benefit eligibility and standardized terms and definitions in these policies.

In relation to two of these issues. those dealing with premium stability and equity and with benefit and eligibility standards, it is worth noting that there is a tradeoff to be made.

Since long-term care insurance is typically purchased 10–15 years before it is used, and each new benefit or enhancement of eligibility standards then requires an insurer to wait roughly this period of time before developing confidence that is necessary in the associated pricing.

The point here is, given marketplace and regulatory demand for expanded benefits and far more liberal eligibility standards, we can not at the same time also be calling for increased stability and

prices along with paid up insurance benefits and not expect reputable insurers to draw back from the market. The risk level and threat to solvency are simply too great.

In light of the reluctance or inability of many States to move to adopt necessary statutory and/or regulatory provisions, it is time for Congress to act.

We also believe that the NAIC model could be and should be strengthened in a number of key areas, while still retaining consumer choice among a variety of valuable features and benefit design options.

Clearly, the Federal Government should take a far more active role in the area of consumer education and information than it has to date. There is still widespread misunderstanding about Medicare, Medicare supplement, other group medical coverages, and what they do in the long-term care area.

In sum, while we are certainly prepared to discuss our concerns with various Senate and House bills aimed at establishing consumer protection standards for long-term care insurance, a closing comment is important at this point.

AMEX Life has serious concerns about three specific provisions in the long-term care standards portion of many of these bills. Specifically, these are: mandated non-forfeiture benefits; rate disclosure and stability provisions, i.e., movement toward non-cancelable policy forms; and agent compensation limitations.

We have included in our coalition standards package what we believe to be more effective and appropriate alternative provisions and we seek your review and comment.

We at AMEX Life and the coalition stand ready to work with you and your staff to craft appropriate Federal standards and tax clarification legislation. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you very much, Mr. Hagen.

[The prepared statement of Mr. Hagen appears in the appendix.]

Senator ROCKEFELLER. Ms. Van Gelder.

STATEMENT OF SUSAN VAN GELDER, ASSOCIATE DIRECTOR OF POLICY DEVELOPMENT AND RESEARCH, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC

Ms. VAN GELDER. Good afternoon, Chairman Rockefeller. My name is Susan Van Gelder, and I am an associate director with the Health Insurance Association of America. HIAA, as you know, is the trade association representing about 300 insurance companies that provide insurance coverage to about 95 million Americans.

To demonstrate our commitment in this area, just this past April our Board of Directors adopted a proposal for long-term care consumer protection.

The proposal is in the form of a 50-point legislative and regulatory agenda which we will actively be pursuing at the State level. I have attached to my written statement the proposal for your information.

We have serious concerns, however, that some consumer protection standards proposed in several of the Senate bills could do more harm than good. Let me explain that further.

First of all, the long-term care market is very young and growing rapidly. We have heard numbers thrown around today, and I will not repeat them.

But let me just say that in 1990, the latest year we have data, over 2 million policies were sold and 25 percent of those policies were sold in the employer market. So, there is a growing younger market that is interested in this type of coverage.

More importantly, the products themselves are changing tremendously. We have analyzed a random sample of 14,000 policies sold in 1990, representing 45 percent of the market, and people are buying very adequate protection.

For example, over half bought at least 5 years of nursing home coverage; one-third bought a lifetime benefit. The average daily nursing home payment was $72, which, at the time, was the national average nursing home rate.

Two-thirds bought a 20-day deductible period. About 40 percent bought an additional home health care benefit. The average monthly premium was $90. That is a little over $1,000 a year for this typical policy I have just described. The average purchaser was 68 and married.

In addition, this study found that both the buyers and the nonbuyers said the single most important thing government could do in this area would be to provide more information on the risk of needing long-term care, what options they face in financing it, and how to choose a good policy.

In our view, consumer protection is education. Education is key to this issue. In the employer market, the average age of the person purchasing such a product is 43.

And, for a plan my husband and I are enrolled under, we pay a combined monthly premium of $36.56. That is very affordable. That has an inflation protection provision in it.

And, although this is not the subject of the hearing today, there have been studies that indicate that tax clarifications could increase the employer market by a third. In this regard, we are very supportive of provisions in the Senate bills that address the tax clarification issues.

Today's products do provide meaningful and affordable benefits, but we are the last ones to say this is the ultimate in product design. We have an individual market; we have an employer market; we have coverage under continuing care retirement communities; we now have coverage under accelerated death benefits that cover long-term care. There are new ideas on the drawing board.

It is our concern that some set of Federal standards would inhibit further product development and prevent these new products coming aboard because there would be standards in place that would be locked in.

As our written statement indicates, there are at least 17 key and important provisions in the NAIC model act and regulation, which HIAA fully supports as meaningful consumer protection.

In addition, we have 10 equally important provisions in our own proposal that go beyond the model act and regulation.

These include: mandated premium waivers; mandated upgrade protection; mandated agent education and training; and insurance company monitoring of their agents; minimum standards for long-

term care reserves to help get at premium stability; and mandated policy reinstatement due to reduced competency on the part of the policyholder. We support all these provisions and their enactment by the States.

Several standards, however, contained in the Senate bills we do not believe are in the best interest of the consumer. Mr. Hagen has mentioned some of those: mandated non-forfeiture benefits; mandated inflation benefits; unprecedented premium approval process and limits on rates; and specific and standardized benefit eligibility criteria are some examples.

We are committed to getting our proposal adopted by the States. However, we are very concerned—and this has not been addressed today—that enforcement is key to regulation. Without enforcement, none of these regulations at the State or Federal level can be effective.

And our biggest fear is that the States and the Federal Government will continue to promote more and more regulation which will drive us into a cycle of continuing regulation, but no one backing it up with enforcement. So, we fail to see, too, how Federal standards can address that at the State level.

In conclusion, Mr. Chairman, we share your concern that consumers must be guaranteed solid protection when they purchase long-term care insurance. However, we feel several provisions in these bills could eliminate quality products from the marketplace.

And while this may be the ultimate goal of those favoring a government solution, it is doing a terrible disservice to the millions of Americans, both older consumers and employees, who are looking for viable solutions today. Thank you. I would be pleased to answer any questions you might have.

[The prepared statement of Ms. Van Gelder appears in the appendix.]

Senator ROCKEFELLER. Good. Good timing. Let me start with you, Mr. DeCoursey. You oppose restrictions on agent compensation. Do you honestly believe that a cap of 200 percent of renewal commission on first-year commissions is unreasonable? And, if you do, do you believe it would not help stop the churning of polices that has, frankly, been rather meticulously documented?

Mr. DECOURSEY. I certainly oppose the cap. I think that the presence of commissions—I would have said at 50 percent; someone earlier said 60 percent. That, in my view, is not out of line wit the amount of time that an agent spends in making a sale as compared to the amount of time that the agent spends in subsequent years on servicing an in force policy.

You get what you pay for in this world. And the companies have found that if they do not pay a first-year commission which is a substantial multiple of the renewal commission, then you do not get the sales.

Now, does it produce churning? My experience is, there are managers—and I will not say companies; one cannot tell about the company—and agents out there in my city who are churners, and they ought to be put out of the business. I call them an abuser. They were trained that way, they will continue that way. If you put the first-year commission down to 200 percent, I do not think it will change what they do.

I know that as long as I can sell life insurance, and disability insurance, and other lines of insurance to essentially the same clientele with a first-year commission, which is 50 percent of premiums, and long-term care limits that to something like 20 percent or 15 percent, I am going to lose interest in the market.

And good agents will certainly take care of their customers and sell it no matter what the commission is. That would have to be my own attitude.

But the managers are going to tell the agents to go looking for life insurance and disability sales and to leave the long-term care market alone until you are well established. And I think it is a shame if we take good agents and good managers out of the business, and I think that would be the result.

Senator ROCKEFELLER. Well, part of the testimony on previous panels say that, in fact, the insurance policies, in those you do not get what you pay for. So, you are saying that you have got to give this high commission.

Mr. DECOURSEY. There was, I think, implicit criticism of policies where the companies assume certain lapse rates so they can charge a certain premium with a certain scale of benefits.

Now, it is not fair to say that the insured got nothing if that policy lapses after 7 years because the person did get protection for 7 years, and the premium was based upon this expectation.

You cannot produce the whole scale of benefits that Consumer's Reports would like for the kinds of premiums being charged today, and those premiums are frequently criticized as being far too high. You have to make up your mind whether you are going to get stronger benefits and much higher premiums.

And let me say right off, as an agent's representative, I am for all the benefits that Consumer's Reports would like, if I thought the companies would not go bust. Because they greatly magnify the premium, and that is what my commission is based on, whether it be 200 percent, or 500 percent of renewal commissions.

Senator ROCKEFELLER. Gail, could you come to the mike and rebut that, if you can?

Ms. SHEARER. Any particular part of it?

Senator ROCKEFELLER. What he said.

Ms. SHEARER. I think one thing he said is that if you build in all the protections that we advocate, that the premium is going to go up. And let me just say, what we support is making sure that consumers get value for the premium dollars that they pay.

Senator ROCKEFELLER. Well, he is saying that it is sold on the basis of 7 year, and that is all it was sold for.

Ms. SHEARER. Oh. All right. Yes. Well, if it were like term life insurance, he would have a legitimate point. If the premium charged each year to the consumer reflected the risk for that year, then that would be the case. But that is not the case in long-term care insurance.

The early year premiums pay for later year risks. It is true to a certain extent, they have had protection for 7 years. That is why the non-forfeiture benefit would not be equal to 100 percent of the premiums that have been paid in. But the risk is relatively low in those early years, and that is why there is need for a non-forfeiture benefit.

Mr. DECOURSEY. Ms. Shearer is no actuary. Because the premiums from those folks who lapse or those non-forfeiture values that she would like to create are necessary for the people who keep the policy and get to the claim time for whom the insurance company reserves from their premiums alone would not be sufficient in the absence of the forfeitures and the lapses.

Senator ROCKEFELLER. Mr. Hagen, you are agreeing with that?

Mr. HAGEN. Yes. Basically, I am. The latest NAIC study that Commissioner McCartney referenced before showed that for a 4-year integrated plan, about 25 percent of those individuals would ultimately get paid benefits—an additional 8 percent—if we were to mandate a non-forfeiture of benefits. About 40 percent of those people probably will lapse due to death, given their age at the time of purchase of the policy.

Senator ROCKEFELLER. Forty percent?

Mr. HAGEN. Yes. Much of the lapsation, Senator Rockefeller, in this marketplace is due to upgrade and replacement activity where people move because of marketplace changes and/or regulatory changes to new and improved products. You have to count that in there, too.

We have to look at involuntary lapse outside of death or mortality in its totality. And a large portion of that is people making good decisions, perhaps, in their sense, to move to a better and more improved policy.

In fact, one of the things that we are working on very diligently with the NAIC now in the advisory committee on the task force there is a meaningful formula or upgrade program that could standardize that across the industry.

Senator ROCKEFELLER. Do you want to comment, Gail?

Ms. SHEARER. Well, I just think it is important to keep in mind that the State regulators are moving toward a mandatory non-forfeiture benefit because they have weighed the situation and they believe that it is appropriate. It protects people who have paid in for a long time and assures them some benefit. And I think that is very significant.

Ms. VAN GELDER. Could I add to Ms. Shearer's comment, please?

Senator ROCKEFELLER. Please.

Ms. VAN GELDER. What was not said by Mr. McCartney from the NAIC, is that, yes, the NAIC has been looking at whether or not they should mandate non-forfeiture now for about 2 years, and everyone thought that they would this last go-around. In fact, they did not.

And one major reason they did not was that a group of actuaries who they commissioned to do a study as to whether or not it should be mandated or not came down on the side that it should not be, that it should be optional because, in their best view as a body of experts, that the equity problem of those that do not lapse outweigh the benefits of those who did.

In other words, the premium increase could not be justified for the people who would lapse and ultimately use a non-forfeiture benefit. So, I think the NAIC was a bit perplexed about that finding and did not know what to do once these actuaries recommended it should not be mandated.

Senator ROCKEFELLER. Is Mr. McCartney still here?

Mr. HAGEN. No, I think he left.

Senator ROCKEFELLER. All right. So, I do not know how he would respond to that. Do you know how he might?

Ms. SHEARER. Well, I think that he would be surprised to hear it characterized that way. He has instructed the Actuarial Task Force to go back and do some more research one specific benefit package. It is called the shortened benefit period.

And the underlying sense of the meetings that I attended is that the NAIC intends to put out an exposure draft on the shortened benefit period at their September meeting, working toward adoption of this proposal in December. And I believe that is virtually what Mr. McCartney said today.

I think it is certainly true that this was not the first choice of the Actuarial Task Force, but, fortunately, they are not the ones setting the policy, it is the NAIC that is setting the policy here.

Senator ROCKEFELLER. Well, but, then, it was just pointed out to me that Mr. McCartney said in his testimony that it is not worthwhile having a policy unless it has non-forfeiture. Go ahead.

Mr. HAGEN. Senator Rockefeller, I co-chair the advisory committee, along with Jim Fremer, from United Seniors, and I have been very much involved in this process.

To quote Commissioner Pomeroy, who chairs that task force, in the discussion that took place at the meeting, he said, "The more we get into this issue, the more we look at the value and the price and value tradeoff's forcing everybody to have significantly higher rates, and the equity issues that exist between persisters and lapsers, the more we feel farther away from being able to make an appropriate decision that balances those interests."

Now, they could have very easily adopted an exposure draft at the June meeting here and proceeded to move on a policy issue and make that decision. They did not. They did not because the information put on the table before them raised serious questions, as Susan has stated, about the value of that kind of a mandated benefit in this marketplace.

And I frankly believe they may ultimately come to that conclusion, but at this point in time, decided they could not, given the evidence and the information that was made available.

Senator ROCKEFELLER. All right. Mr. Hagen, you are in the business also of providing long-term care insurance, and I am sure that you want to provide quality service to your customers.

With all of the risk and liabilities involved in long-term care insurance, why do you think so many new and smaller companies are entering the market?

Mr. HAGEN. Well, Senator, we have been in this market for 18 years, and in that period of time we have never increased our rates once.

Senator ROCKEFELLER. Well, that was not what I asked.

Mr. HAGEN. Well, can I continue? I will answer it. I think, certainly, that those insurers are looking at the experience of companies like ours, that perceive success of companies like ours in this market, are looking to the demographics that exist; the opportunity for limited numbers of new products that have large market growth potential; the need, frankly—I know this does not sound kosher

necessarily in the corporate environment—but there is a social consciousness that exists out there, and this is a social need product.

In many cases, most of our agents strongly and firmly believe in this product and the social good it provides. Frankly, I think a lot of that, along with the calculation given a 60 percent loss ratio standard in most States that they have to meet and the costs of marketing or selling this product, that they can make a marginal or decent rate of return, and a profit, given the risk that is involved. And there is a great market potential here.

Ms. VAN GELDER. I would like to set the record straight on that. We do an annual survey of the marketplace. In fact, there are not newer and smaller companies entering the market. The market has really stabilized over the last 2½ years. There are about 130 companies selling. And we have asked——

Senator ROCKEFELLER. But I always get into this discussion with Carl. I always say there are 1,500 companies selling insurance, and he says, no, there is only 300—by which he means only the people in his association

Ms. VAN GELDER. We are counting 130 companies who sell in the universe, in this country that we know of.

Senator ROCKEFELLER. In the universe. All right.

Ms. VAN GELDER. And 40 of those are members of HIAA.

Senator ROCKEFELLER. All right.

Ms. VAN GELDER. So, I am speaking, actually, for more than our membership here.

Senator ROCKEFELLER. All right. All right.

Ms. VAN GELDER. And, in fact, this last go-around we asked all the companies how many had ever had a rate increase, and eight companies reported that they have ever had a rate increase in the history of the time since they had begun selling. So, I would also like to insert that into the record.

Senator ROCKEFELLER. Eight members of the how many?

Ms. VAN GELDER. Eight of the 130 companies that were serving——

Senator ROCKEFELLER. Have ever had a rate increase?

Ms. VAN GELDER. That is correct.

Mr. HAGEN. In fact, Senator, last year there is some indication from studies that have been done that there were actually more rate reductions that were filed and approved than there were rate increases.

Certainly that was the case in Arizona, which had the largest number of rate filings in this product. I think GAO discovered that in their report, Senator Rockefeller.

Senator ROCKEFELLER. All right. Mr. Hagen, for you, again. Do you believe that Federal minimum standards, such as the ones that the coalition is backing and advocating or those that Congress is considering, would drastically reduce the number of companies participating in this market? And if you think the answer is yes, would that be good or bad?

Mr. HAGEN. It certainly may reduce, to some extent, the number of companies. I think that Susan has indicated that is already starting to happen. Certainly, new companies entering the market has been reduced. I think there is certainly a balancing and a weighing there.

There may be some reduction, and frankly that may be reduction in the less responsible carriers and people we would just as soon not see writing this business.

The problem we have is we go to mandating more and more benefits out of the mistaken belief that people are unable to make intelligent decisions given choices and options in the marketplace.

We may relegate those to such a situation that responsible carriers will leave the market and the only people you will be left with in this marketplace are the smaller carriers, perhaps carriers that are willing to cut corners, and perhaps take a risk, if you will, of solvency, or some other calamity.

Senator ROCKEFELLER. Can you foresee, Susan Van Gelder, any circumstances or market failures that would necessitate Federal regulation of insurance in the long-term care market? Is that just verboten forever, or could that possibly happen?

Ms. VAN GELDER. Well, forever is a long time. As far as I know into the future I can see, I can see valid reasons for not supporting it at that time. One issue I did mention, which was enforcement.

We fail to see how Federal standards will do anything about improving State enforcement. In fact, many of the problems cited today States have authority currently to address, and the problem is one of enforcement. We have to somehow fix that, no matter what we do.

Senator ROCKEFELLER. Well, that always gets back to the people. I mean, I was a Governor for 8 years. States cannot afford people in those insurance departments. They are tiny.

Ms. VAN GELDER. Well, is that going to change under Federal standards?

Senator ROCKEFELLER. Yes, it probably would.

Ms. VAN GELDER. Is there money in these bills to do that?

Senator ROCKEFELLER. They cannot tell. It would certainly bring a lot more oomph to the argument.

Ms. VAN GELDER. It did not really change under Medigap.

Senator ROCKEFELLER. When the Federal Government tells the States to do something about Medicaid, they do not provide all the money. But the States have to pay some of it. They do not like it, but they do it.

Ms. VAN GELDER. Well, it is a possibility, I suppose. Another issue, though, I come back to—I have several—is just the new and involving nature of this marketplace. Let us put ourselves back 4 years ago.

Senator ROCKEFELLER. But you are not disagreeing with me, then, when I say that the Insurance Commissioners' staffs are very small, so the question of enforcement is fairly difficult for the States.

Ms. VAN GELDER. Oh, I have complete sympathy for the insurance departments. And I sense——

Senator ROCKEFELLER. So, you are agreeing with me that they are too small, really.

Ms. VAN GELDER. I do not know how big or small each of them are. I know the recent AARP study done by Project Hope pointed to several deficiencies in some State insurance departments in terms of their staffing, expertise, knowledge, et cetera. I guess that

what I am questioning is, we need to fix that. I mean, someone has to enforce these laws.

Senator ROCKEFELLER. Well, is that what it is? Yes. Somebody does have to enforce the laws.

Ms. VAN GELDER. Regardless of whether they are Federal or State. And I was questioning how these bills addressed how well States would do in enforcement.

Senator ROCKEFELLER. Yes.

Ms. VAN GELDER. But let me make another point on this. Let us put ourselves back 4 years ago. Let us say we enacted a Federal law 4 years ago and Federal standards.

I highly doubt at the Federal level we would have had the ability to go back and amend that Federal law at least four times every year over the last 4 years to adapt to the changing marketplace.

States have greater flexibility to do that. States have actually, in that sense, I think, protected the consumer better in that the NAIC has been vigilant on this.

Senator ROCKEFELLER. All right. How would Federal mandates, in your view, against improper marketing practices—and I take it you do agree that they exist.

Ms. VAN GELDER. Improper marketing practices?

Senator ROCKEFELLER. Yes.

Ms. VAN GELDER. Well, I do not have any evidence one way or the other. But we certainly support all the provisions in the model regulation against twisting, churning, et cetera. And we have our own provisions in our proposal which would advocate insurance companies——

Senator ROCKEFELLER. But you have never heard of any abuses, or anything of that sort?

Ms. VAN GELDER. I have from other witnesses, yes. I have not seen data that support it beyond the 14 agents that I think were highlighted at the House Aging hearing last year.

Senator ROCKEFELLER. But, in your experience in working for the HIAA you have never actually heard of an example? You have never heard of one ever, ever?

Ms. VAN GELDER. No. Sorry, I have not.

Senator ROCKEFELLER. Do you try?

Ms. VAN GELDER. Well, I mean, I am open to any calls. I pick up the telephone. I talk to people. I do not walk out of the room when a conversation starts on this subject; it is my area.

Senator ROCKEFELLER. It is a rather large difference, do you not think, between the two sets of testimonies?

Ms. VAN GELDER. Well, that is another point I would like to make. A lot of policy seems to being made somewhat anecdotal. Ms. Shearer points out the 1988 Consumer Reports article and the provisions and deficiencies that were apparent there as if they still exist. This market has evolved light years from then.

I mean, we just heard the latest update from Mr. McCartney that 49 States have a version of the model, and 38 have a version of the model regulation. Well, our numbers are not up to date to that extent, and we have just finished our own analysis.

So, I do think progress is being made in 6-month slots, and we keep citing this old data as if these problems still exist.

Senator ROCKEFELLER. Gail Shearer.

Ms. SHEARER. Is progress being made? Progress is being made at such a slow pace. Unless Congress continues to hold hearings and considers legislation, you can be sure that progress will continue at an extremely slow pace.

In my view, the only reason that the NAIC is considering a mandatory non-forfeiture benefit now is really because there have been so many bills introduced into Congress and there have been a series of hearings, including this one. And that makes things move faster at the State regulatory level.

Senator ROCKEFELLER. Ms. Van Gelder, HIAA supports the offering of non-forfeiture benefits.

Ms. VAN GELDER. That is correct.

Senator ROCKEFELLER. Which implies that they must have some degree of value, in your view.

Ms. VAN GELDER. We believe they have value for those people who are willing to purchase the additional payment for them. We do not think they have value to be mandated where the vast majority of people would not benefit from paying for it.

Senator ROCKEFELLER. If a mere requirement to offer means that most people cannot receive the benefit because it is not pitched or it is too expensive, why not, for policy reasons, therefore, make it mandatory?

Ms. VAN GELDER. I think I have stated our position earlier in terms of the actuarial study done for the NAIC. In our view, it is not equitable for those who choose not to lapse or do not lapse. The additional price of that non-forfeiture benefit is not warranted.

Senator ROCKEFELLER. Well, look. I can see very clearly that I have got some work to do with the previous panels and with you folks on this subject, because there is just too much of a—I mean, you are saying everything is perfect. You are.

Ms. VAN GELDER. I am not saying everything is perfect.

Senator ROCKEFELLER. Well, you said you have never heard of any abuse.

Ms. VAN GELDER. Well, you asked me if I have ever heard of agent abuse in marketing practice, and I have not.

Senator ROCKEFELLER. Yes. I mean, Mr. DeCoursey did not go that far.

Ms. VAN GELDER. But he represents the agent groups, I represent insurers.

Senator ROCKEFELLER. Yes.

Ms. VAN GELDER. I am probably in a less likely position to hear about agents.

Mr. DECOURSEY. I am in the field, Senator. I mean, our associations get complaints about some of our members from time to time from consumers and we try to follow them up, refer them to the Insurance Commissioner, if that is appropriate. So, I am in the position where I should hear more of those things than Ms. Van Gelder.

Mr. HAGEN. Senator, could I add something there?

Senator ROCKEFELLER. Yes.

Mr. HAGEN. We have an ongoing program where we monitor our application process for clean-sheeting. We terminate agents all the time when we find that there has been any kind of problem as far as misrepresentation, or, frankly, where the agent simply did not

know enough about the product that they were selling and, in fact, during that process, misrepresented.

It is not something I would pick up the phone and call Susan and tell Susan about as my trade association representative, though. It is something that is an ongoing process, as Mr. DeCoursey mentions.

We relate and share that information with State insurance departments with the intent, obviously, of having that agent not go off and sell in that same manner for somebody else.

I think we need to get back, also, to a feature of the bill that is before this committee, and other bills, too, about training and education requirements.

This is a very difficult product to sell. And if we are talking about doing some kind of 200 percent commission limitation, we are not understanding the denial that exists in this marketplace, the lack of education and understanding about risk and need for this product, and the great difficulty it is in selling this product appropriately by well-trained agents.

And if we get to the point where we try to force maybe appropriate levels of training and education and continuing education for an agent, yet not adequately compensate that agent for the difficulty of selling that product correctly, I think it has a very, very major dampening impact on this marketplace and the willingness of carriers and agents to sell this product.

Senator ROCKEFELLER. Well, let me say this. I am in the position of having to leave, and I am slightly frustrated. Partly at myself, because too much time has lapsed between the Medigap actions of several years ago and today.

And I need to do more work, myself, on this question. And I just do. That is one of the things that is clear to me, that I have got to have more information. There is just too much distance between what is being said.

And I do not like my own position of being unable to pick out clearly what I think is right in this direction or wrong in that direction. It is a deficiency on my own part.

I am not apologizing, I am just saying what happens from time to time in these things. So, I am going to pursue this subject. I will pursue it with all of you and previous witnesses.

And this has been useful, but not useful to the extent that I would have liked it to have been. And I suspect that Josh is sitting over there probably going crazy. But we will pursue this and I may be in touch with you individually on this.

Ms. VAN GELDER. Please.

Mr. HAGEN. Please.

Senator ROCKEFELLER. Thank you all very much.

[Whereupon, the hearing was concluded at 5:23 p.m.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF ROBERT W. DECOURSEY

Mr. Chairman and members of the committee, thank you for the opportunity to testify this morning. My name is Robert W. DeCoursey, CLU. I am an insurance agent from Philadelphia and currently serve as President of the Association of Health Insurance Agents (AHIA), a conference of the National Association of Life Underwriters (NALU). AHIA represents some 7,000 professional insurance agents whose primary business involves health, disability, and long-term care insurance. Founded in 1890, NALU is a federation of nearly 1,000 state and local associations whose members include approximately 140,000 professional life and health insurance agents throughout the nation.

Mr. Chairman, we appreciate the opportunity to testify today. We believe the Finance Committee is in a unique position to act on important legislation that would strengthen the level and quality of long-term care protection for Americans. We congratulate you and your colleagues on the Senate Finance Committee for your leadership in examining the challenges of assuring adequate, affordable, understandable long-term care protection for the elderly. In particular, we commend the efforts of Majority Leader and Minority Leader, Senators Pryor, Bentsen, Packwood, and Durenberger, all of whom have introduced and/or cosponsored legislation that would assure appropriate regulation along with necessary tax clarification of long-term care insurance. We look forward to working with you and with all the members of your committee to find the best ways to meet these challenges. We enc3urage your committee to act expeditiously on the long-term care issue.

At the outset, I would like to comment on the role of the agent in the market and then address specifically our comments about long-term care insurance standards.

ROLE OF THE AGENT IN THE HEALTH CARE DELIVERY SYSTEM

Historically, the agency system has been the principal method of distribution for private life and health insurance. Agents are the essential link between the consumer and the insurance company, providing and servicing the products of the insurer while educating the consumer on how to manage risks and how to make informed choices regarding their insurance purchases.

The emergence of a growing aged population and with it, the need for affordable long-term care protection, along with dramatic increases in health care costs in the last decade have made the agent an increasingly important part of the health care equation. More than ever, individuals and small businesses rely on the advice of their agents regarding cost savings measures and coverage options.

The commission or other compensation earned by the health insurance agent not only compensates him or her for the time and skill involved in the sale of the product, but, in addition, for the following additional services performed by professional agents for the consumer:

- Professional health insurance agents work with clients to evaluate their need for health and other insurance protection. This may involve substantial research and fact finding about the client's needs, and the appropriate products or programs to meet those needs. It also frequently involves intensive counseling of elderly consumers who are both unfamiliar with and understandably apprehensive of the intricacies of long-term care needs and costs. This is an ongoing process since needs continuously change as a person's family and employment situations change.

- They educate by explaining the various health, long-term care and other insurance plans available, and provide appropriate cost indices.
- They make specific recommendations that suit the client's objectives and budget. Often a health insurance plan is designed by the agent to fit a client's special needs. Long-term care protection can be an important element of such a plan.
- They encourage the client to act in a timely fashion to assure that the proper coverages are in place when they are needed. They also see to it that accurate and complete information is provided to the insurer to make sure that the client gets the very best price or premium available.
- They keep in touch with the client and review or update coverage on a periodic basis. They suggest changes when appropriate and counsel clients on ways to reduce cost. Often they must assist their client in reviewing the need for legal and tax compliance, recommending other professional assistance when necessary.
- They assist with claims, answer questions and serve as an ombudsman in helping their clients deal with insurance companies and, often, providers of medical or long-term care services. Agents often spend a great deal of time helping clients assemble the proper documentation needed to file or follow up on a claim. This is especially true with seniors who receive Medicare benefits.
- They assist business owners in communicating benefit packages to their employees, often assisting the employee in seeing how the benefits coordinate with their personal financial programs as well as those provided by government entities.

All agents are licensed and regulated by their state insurance departments. Prospective agents receive extensive training about insurance and applicable insurance law prior to taking a written exam leading to licensure. In addition, a majority of states now require continuing education in order for an agent to maintain his or her license.

Many agents who have made health insurance a career have taken a sequence of college-level courses leading to a professional designation, such as Chartered Life Underwriter (CLU), the Registered Health Underwriter (RHU), Health Insurance Associate (HIA) or Certified Employee Benefits Specialist (CEBS), and Life Underwriter Training Council Fellow (LUTCF).

Many career agents belong to a professional association. A life or health insurance agent may belong to one of 1,000 state and local Life Underwriter Associations. Life underwriters who have specialized in health insurance may also be members of the Association of Health Insurance Agents.

These professional organizations provide seminars, workshops, annual meetings and other educational forums to increase agents' value to their clients. They also keep agents abreast of the latest insurance products and regulations through publications and special bulletins. Just as important to the consumer, they require their members to subscribe to a strict code of ethics and encourage them to aspire to a high level of service.

COMMENTS ABOUT LONG-TERM CARE INSURANCE STANDARDS

Your chairmanship of the Pepper Commission and your sponsorship of S. 2571 along Majority Leader Mitchell is an indication of your strong concerns about protecting consumers, especially those elderly' purchasers who need adequate long-term care insurance protection. We congratulate you for your fine efforts in this regard.

Mr. Chairman, over the past few years, there have been numerous allegations about abuses in the long-term care insurance market. we have seen magazine articles by consumer organizations and several reports by the General Accounting Office (GAO).

One regret is that to some extent, these reports provided only anecdotal information about alleged agent abuses instead of documenting specific cases, naming names. We believe that those individuals accused of the egregious practices, should be specifically identified, reported to the state insurance departments, and given an opportunity to explain themselves. If, after an appropriate hearing, the individuals are found to have engaged in these illegal practices, they ought to have their licenses revoked. They ought to be prosecuted to the full extent of the law. However, citation of anecdotes and publication of photographs of agents with their faces blocked out and no identification of the companies with whom they are employed helps no one.

Let me state categorically, upfront, that we do not condone the repugnant practices of those agents who would take advantage of senior citizens, or any consumers for that matter. Quite simply, those individuals have no place in the market. In ad-

dition, those individuals should receive appropriate penalties as the result of their misdeeds.

AHIA, and our parent organization, NALU, have been strong supporters of state regulation which would put the "abusers" out of business. We support the National Association of Insurance Commissioners (NAIC) Model Act and Regulation and believe the states should enact it. The NAIC, at its December, 1990 winter meeting, adopted various "consumer protection" revisions to the NAIC Long-Term Care Model Act and Regulation. The revisions are based in large part on the consumer protection amendments to the NAIC's Medicare Supplement Insurance Model Act and Regulation which were adopted in December 1989. The final revisions to the long-term care model act provide express authority for commissioners to issue regulations establishing standards for marketing practices, penalties, compensation arrangements and agent testing. The revisions are intended to provide model language for states in which the commissioner lacks statutory authority to issue regulations in these areas.

However, to the extent that the states fail to act on these important recommendations by the NAIC, we support Federal incentives to encourage the States to enact appropriate long-term care standards.

RESTRICTIONS ON AGENT COMPENSATION

As you may suspect, our chief concern about S. 2571 is its restrictions on agent compensation. As you know, the bill would prohibit insurers from paying first-year commissions which are greater than 200% of second-year or renewal commissions. Presumably, the public policy reason for this provision is to discourage agents from churning policies. While we agree with the goal, we object to the specific provision.

Commission restrictions have numerous flaws. First, the commission restrictions in S. 2571 discriminate against the thousands of caring, professional, ethical agents who do a professional job of identifying the client's needs, matching them with the client's resources and explaining the appropriate coverage and servicing the policy once it has been issued. Blanket restrictions on sales commissions penalize the agents who sell in an ethical, responsible way for the sins of those who do the exact opposite. The net result of this type of approach will leave the bad agents in the market and create a commission structure where professional agents are paid half as much for doing a good job for the consumer. Congress and the states should work to promote tougher enforcement of existing laws and regulations that promote fair, honest interaction between buyers and sellers of long-term care insurance rather than to create laws which make the long-term care market less attractive to professional agents. The job of regulators is, and should continue to be, effective enforcement of laws designed to weed out and prevent abuses. Agents are strongly in favor of tough laws designed to penalize bad actors.

Commission restrictions are anti-competitive. By restricting the commissions on agent-sold products, Congress is tacitly favoring the sale of insurance sold by direct marketers. Those firms which choose to employ the use of direct mail, television personalities, seniors organizations or associations, and 800 telephone numbers would enjoy favored treatment of their products since S. 2571 imposes no restrictions on marketing costs of these insurers. Congress should not give its tacit approval to the sale of one product over another.

Commission restrictions will adversely affect consumers. Compensation restrictions will deter agents from selling the product which will in turn decrease its availability to the public. Long-term care insurance is still relatively new. If Congress mandates broad restrictions which make the product unprofitable to sell, consumers will have to rely increasingly on 800 telephone numbers to have their products serviced, questions answered, and assistance with claims satisfied without benefit of personal service by an agent. This could prove particularly troublesome for senior citizens who might need the services provided by an agent. Given the problems senior citizens have had in dealing with questions about Medicare claims, we believe that these consumers would be similarly ill-served.

Moreover, why treat insurance agents differently from other industries? There are few industries wherein Congress or the states have sought to regulate the compensation of the sales forces in order to correct the behavior of a few salespeople. Abuses, however unfortunate, occur in virtually every occupation, both in the public and private sectors. This does not excuse such behavior when it occurs. However, to the extent it does occur, is it then generally acceptable to regulate the livelihood of an entire class of individuals? If so, why doesn't Congress restrict the compensation of other individuals in other industries?

Moreover, the questions then becomes: why shouldn't Congress impose restrictions upon the compensation of those who apparently tolerate, condone, or perhaps actively encourage the inappropriate sales practices of their subordinates?

This should not be construed as meaning that agents support regulation of the compensation of others but merely to suggest that If the argument is taken to its logical conclusion, Congress may wish to reconsider its interest in singling out the sales force of one particular industry without applying equally such standards across the board.

In lieu of restrictions on agent compensation, we suggest other alternatives. Specifically, civil and criminal penalties similar to those imposed in the Omnibus Reconciliation Act of 1990 (OBRA '90) may also be appropriate for the improper sale of long-term care insurance—imposition of a $15,000 fine and five years imprisonment, assuming there are appropriate due process safeguards to ensure the protection of honest agents.

In addition to civil and criminal penalties, we support continuing education requirements for agents selling long-term care insurance. It is our position that ripoff artists are unlikely to take the time, expense, and effort to meet these requirements for licensure.

Moreover, we support a requirement (contained in the NAIC Model regulation) that requires a replacing agent to compare, in writing, the existing policy with the proposed policy and provide this replacement comparison to the consumer.

This approach would force agents to prove why the replacement is needed. It would be a far more effective way to protect against unwarranted replacements.

Finally, we also support a provision that requires that in replacement situations, the replacing insurer notify the existing insurer of the proposed replacement. Such a provision would reduce the number of unnecessary replacements and would provide the first insurer with the opportunity to prove that the replacement was unnecessary.

NONFORFEITURE

We are concerned about the provision which requires all policies to include nonforfeiture benefits. Specifically, this provision requires all long-term care insurance policies to provide nonforfeiture benefits.

Such a provision may limit consumer choice, unnecessarily increase the cost of the product, and therefore make coverage unavailable. Insurers have indicated to us that required nonforfeiture may increase the cost of the policy substantially. We believe that nonforfeiture is an important provision which the consumer should positively consider. We have no problem with requiring that such coverage be offered. Drawing a parallel with life insurance, mandating the inclusion of nonforfeiture benefits would have the practical effect of similarly requiring consumers to purchase a whole life policy rather than being given the choice of buying term insurance. This provision limits consumer choice and cannot help but drive up the cost of the product.

DEFINITION OF LONG-TERM CARE INSURANCE

S. 2571's definition of long-term care insurance is very broad. It encompasses long-term care protection, regardless of whether it is a stand-alone policy or a rider to another policy, whether the policy or rider is attached to a life, health or disability insurance contract. However, the language is so broad that it could be construed to subject all life insurance policies to the rules governing long-term care coverage. This would be a nightmare because life insurance, because of its very different benefits and structure, cannot possibly comply with the consumer protection standards delineated in this bill. This could result in years worth of litigation, with courts deciding which standards should apply to life insurance and which were only intended to apply to long-term care insurance.

COMPLETION OF MEDICAL HISTORIES PROHIBITED

Many of the legislative initiatives on long-term care insurance standards prohibit agents from completing the medical history portion of an application. While we understand the goal of such a provision is, presumably, to stop the alleged practice known as "clean-sheeting" that allows applications to be submitted with incomplete or sometimes inaccurate medical histories, we question the alternative. This provision, in effect, removes from the agent the ability to advise clients and assist them with the reporting of information needed by the insurer to determine eligibility and pricing, for free.

DEVELOPMENT OF MINIMUM FINANCIAL STANDARDS

While we are fully cognizant of the recent GAO Report to the Chairman, Committee on Energy & Commerce, House of Representatives, entitled Long-Term Care Insurance: Better Controls Needed in Sales to People With Limited Financial Resources, we question the advisability of using minimum financial standards prior to purchasing long-term care insurance. We do agree that the product may not be for everyone. However, is it appropriate for Congress to tell some consumers: (1) their assets are too few to be protected; or (2) that they should not have the choice that other consumers enjoy, that is, to purchase a product if they so choose, and in particular, to decide which nursing home facility in which to reside (assuming that not all nursing homes have Medicaid beds available)? Alternatively, is it the intent of Congress to encourage individuals to "spend-down" their assets in order to seek admission to the Medicaid program?

We are concerned about the prospect of the government telling consumers what is or is not available for them to purchase. Our associations readily agree that such products may not be in the best interests of some consumers. In fact, we have no objection to creating financial criteria to use as suggestions for consumers. However, to prohibit consumers from purchasing such products may go too far.

SUMMARY

Mr. Chairman, there are a number of provisions in S. 2571 with which we agree. We fully endorse the provisions which would clarify the tax treatment of long-term care insurance policies. We also support the provisions which permit employers to provide long-term care coverage to their employees on a tax-free basis, and that long-term care benefits be paid tax-free (unless received under employer-paid disability-type policies). We further endorse the section which permits life insurers to pay life insurance death benefits tax-free to terminally ill policyholders who have been certified by a physician as likely to die within 12 months.

We believe in requiring the reporting of information as lapse or replacement rates. However, we would recommend that a threshold be created so that such reporting is not unduly burdensome. We support making policies guaranteed renewable. We support standardization of policy terminology and benefits. The associations support the prohibition of waiting periods such as prior hospitalization. We support the requirement that carriers and agents make available an outline of coverage, prior to sale. We have also supported counseling programs. Specifically, we supported such a concept during the Medigap reform debate in 1990. And, we support the standards relating to the prohibition on twisting, cold lead advertising, and high pressure tactics. As you can see, there are a number of other areas in which we are in substantial agreement.

We understand congressional concern about regulation of the long-term care insurance product. In fact, we believe that many of the consumer protection standards contained in the Bentsen-Packwood hill (S. 1693), also cosponsored by Minority Leader Pole and Senator Pryor, along with many of those in Senator Pryor's S. 846 offer workable provisions in which we can find agreement. In fact, we are pleased to endorse both S. 1693 and S. 846.

As you may know, we are also members of the Long-Term Care Insurance Coalition which has been working very hard to formulate a package of standards in which the insurance industry can agree. We are pleased to announce our support for that proposal.

At the outset of our testimony, I outlined the role of the agent in the health care delivery system. Professional agents are proud of their service to consumers. Recently, agents have been grouped together as rip-off or fast-buck artists who are merely seeking a commission, without regard to their client. In truth, agents are generally caring professionals; many are leaders in their community. Our association includes current and former state legislators, mayors, city council members, and other civic leaders.

AHIA and NALU strongly believe that long-term care insurance should be effectively regulated in order that consumers may purchase the product in confidence. We stand ready to work with you in an effort to accomplish this goal.

We appreciate the opportunity to testify today and we look forward to working with you, Senator Durenberger, members of your committee, as well as the Majority Leader, Minority Leader, chairman Bentsen, Senator Pryor, Chairman of the Special Committee on Aging, and other senators concerned about this product. I would be pleased to respond to any questions you might have.

PREPARED STATEMENT OF SENATOR CHARLES E. GRASSLEY

Thank you for calling this important hearing, Mr. Chairman.

For those of us who believe that private long-term care insurance must have an important role in providing protection against the cost of long-term care, the development of consumer protection standards is obviously a critically important goal.

It seems clear that the private long-term care insurance market is developing rapidly. Most observers seem to agree that great progress has been made over the last ten years in the development of better long-term care insurance policies.

At the same time, however, it seems to me that, one way or another, there needs to be more substantial protections in place for those who want to buy these policies than is the case at the present time.

The testimony to be offered today will highlight a number of the areas in which additional protections are needed, including inflation and nonforfeiture protections, consistency of key disability and benefit definitions, and premium stability.

It seems to me that achieving improvements in these areas are important to the continued growth of private long-term care insurance.

The obvious difficulty, which several of our witnesses today will stress, lies in determining how to provide appropriate consumer protections while at the same time allowing this relatively young insurance market to develop.

I hope our witnesses can help us determine how to strike the appropriate balance.

PREPARED STATEMENT OF RONALD D. HAGEN

Chairman Rockefeller and Members of the Subcommittee: I appreciate the opportunity to be with you today to provide our company's perspective on the private long-term care insurance market and products, and to comment on the appropriate role of federal and state government in regulating these products and sales practices. I believe we have some new and valuable information to share with you, particularly on the issues of product affordability and the claims payment practices of our company, which you should find of interest.

AMEX Life is a wholly owned subsidiary of American Express' Travel Related Service Co. (TRS). We are a leader in the long-term care insurance market, having been in this business 18 years. We are also the largest private long-term care insurer and are growing at a faster rate than all private insurers on an aggregate basis. This is based on a recent Health Insurance Association of America (HIAA) survey which concluded that this industry grew by 25% in 1991 with over 2,000,000 new policies sold by year's end. This same survey indicated that there are 150 insurers writing long-term care policies.

It should be noted that representatives of AMEX Life serve on a variety of advisory bodies and committees, including Co-Chair of the National Association of Insurance Commissioners (NAIC) Long-Term Care Advisory Committee, the industry task forces on long-term care, as well as several state advisory and technical committees supporting the Robert Wood Johnson Foundation's private long-term care insurance partnership programs.[1]

AMEX LIFE LONG-TERM CARE PRODUCTS

Our portfolio of long-term care products offers a variety of options for the consumer. Most of our insureds continue to prefer to purchase our nursing home insurance plan which offers indemnity benefits of up to $250 per day and coverage options ranging from two years to lifetime (unlimited) benefit periods. This plan provides three separate ways to qualify for benefits, embracing measures of medical need as well as Activities of Daily Living (ADL) or cognitive loss, and offers broader institutional alternatives to the standard nursing home benefit. The optional home health and community care benefits we offer condition such benefits on the loss of 1 ADL or cognitive impairment and pay for nurses, therapists, home health aides, adult day care, respite stays and home modifications which can delay the need for institutional placement. The home health care option allows consumers to purchase coverage ranging from one year through unlimited (lifetime) benefits. It is important to note that our cognitive impairment provision allows insureds with no ADL losses to access benefits and thereby amounts to a "true" cognitive trigger.

As the Subcommittee staff may be aware, our average customer is female and 68 years of age. They typically purchase our nursing home policy, buying on average $80 per day of benefit while selecting our lifetime or unlimited benefit period. The average customer will select a 20 day (or visit) elimination period and roughly two

[1] Specifically, we serve on advisory panels in New York, Oregon, and California.

thirds will purchase the automatic inflation protection benefit we make available. Further, approximately one third will also purchase our home and community care rider.

As we'll touch on later, we review the Attending Physician's Statement (APS) or medical records of each of our applicants in order to verify information supplied on the submitted application. This is a critical component in the completion of our underwriting process. Our agents are fully apprised of this practice and thus have very limited opportunity to engage in practices such as "clean-sheeting." Our long-term care products are sold through three primary distribution channels: (1) career agency offices, where agents exclusively represent AMEX Life's long-term care products; (2) independent agents, who may represent a number of companies; and (3) associations, as well as third-party administrators, who offer their members or customers our long-term care products, typically through direct mail solicitations. AMEX Life supports each of these distribution channels with a comprehensive training program focusing on the need for long-term care, Medicare and Medicaid coverage, as well as those key factors the consumer should consider before purchasing a long-term care insurance policy. We would be pleased to share any and all of this sales and training material with the Subcommittee.

CONSUMER PROTECTION ISSUES AND CONCERNS

The private long-term care insurance industry is still very new and growing rapidly. This growth has been fostered by the introduction and evolution of more market sensitive products. Certainly we all want this process to continue.

Some members of this Subcommittee, as well as a number of advocacy groups, have raised serious questions as to abusive sales and claims payment practices. Concerns have also been raised about the illusionary nature of some long-term care policies given the manner in which they are designed. These are legitimate concerns that both private insurers and their agents must address. In doing so, we must be sure that we do not repeat some of the same mistakes that were made in the sale of Medicare supplement insurance yet we must also understand that the sale of long-term care insurance must continue to typically take place across a kitchen table, that is by an agent calling on a potential (elderly) customer. Ultimately the best protection against agent misrepresentation and abusive sales practices is a quality product, competitively priced, with a clearly written policy and sales materials.

What are the issues then for the insurer and the agent that continue to stretch the credibility of this industry? And what should the industry be doing to police itself? First, I believe much of the concern revolves around four areas: (1) unfair claims practices, manifested through the practice of post-claim underwriting that some companies have undoubtedly engaged in, (2) cases of agent misrepresentation and abusive sales practices, (3) premium equity and stability issues, and (4) the variable and sometimes illusory nature of (home and community care) benefit design.

There is no excuse for a company doing very limited or cursory underwriting at time of application only then to engage in the wholesale contesting of claims, reunderwriting of insureds, and possibly rescission of the policy when benefits are claimed unless the insured mode significant misrepresentations during the application process. This practice must be stopped and the NAIC has recently taken important steps in this direction. Above age 75, the NAIC's Model Long-Term Care Act and Regulation now requires an attending physician statement, medical record or face-to-face assessment at time of application. Certain standard disclosures are now required in NAIC Model states on all applications, and all long-term care policy rescissions as well as lapses and replacements (at a company *and* agent level) are now reported annually to state insurance departments. Currently, the NAIC's Long-Term Care Insurance Task Force is examining the appropriateness of further standardization of the underwriting process, that would require a minimal level of underwriting at or above those ages where this product is typically purchased (65–75).

Given our 18 years of experience, AMEX Life has the most complete claims history of any company in the industry. In response to allegations that long-term care insurers are not paying legitimate claims, we regularly review our claims payment practices and payment/denial rates. We have found that consistently less than 2½% of claims received that met the policy elimination period have been denied. That is a 97.4% payment rate (see Exhibit I). The most typical reason for denial was the lack of a prior hospital stay on our old three day book of business. (Note: AMEX Life has not offered a long-term care policy requiring a prior hospital or nursing home stay for the past four years). This claims study confirms an earlier study (conducted by the accounting firm of Ernst & Young) which indicated that only 2.4%

of claims submitted that met the policy deductible period were denied. It is also significant that in 18 years we have rescinded only four policies (based upon customer misrepresentation on the application) out of over 300,000 policies issued, and that we have had no litigation associated with a long-term care claim and only one long-term care claim complaint. And finally, in a recent survey of customer satisfaction with our claims service, 99% of our long-term care claimants have indicated high levels of satisfaction with the claims service they have received.

AGENT SALES PRACTICES

AMEX Life has always been very much bare of the special responsibility we have as a company marketing health insurance products to the elderly. In particular, we believe it is our obligation not only to support appropriate regulation of agent licensing, training and continuing education but to go well beyond what's statutorily required of us. Our credibility, integrity, as well as the American Express name (franchise), are of overriding importance and value to us and as you can understand, we would never knowingly allow any of our agents to compromise what we as an insurer have worked so hard to earn. To ensure this, we have established our Office of Consumer Affairs. This unit of our company trains our agents, examines those who represent or wish to represent our long-term care products as to their knowledge of long-term care, assures that our agents abide by our Code of Ethics (Exhibit II). It also produces a variety of consumer education and information material. The Office of Consumer Affairs has responsibility for the careful oversight and discipline of all our appointed agents, working with state insurance departments to this end.

While most companies and their agents honestly and ethically sell long-term care products, there remain instances of inappropriate sales practices such as knowingly selling duplicative or overlapping coverage, "clean-sheeting" of applications, inappropriate "rolling" of long-term care policies, twisting and other high pressure sales tactics, as well as the general misrepresentation on occasion of the very nature of the long-term care benefits being provided (especially home care benefits). Without attempting to address these concerns one-by-one, let me offer some comments and potential remedies.

First, existing state laws and regulations if enforced by the states and policed by each insurer, already provide adequate remedies against agent misconduct. Yet there are additional steps insurers and their agents can and should take. "Clean-sheeting" by the agent, perhaps in cooperation with the applicant, is difficult to detect unless the insurer reviews each applicant's medical records or obtains an attending physician statement. In this regard, the NAIC Model Act and Regulation should probably go further to better protect insures against companies quickly issuing policies based on a less than comprehensive application only to attempt later to underwrite the policy or even rescind it altogether when a claim is filed. Furthermore, there is a difference between appropriate and inappropriate replacement (or "rolling") of these policies since it may often be in the interest of the consumer to consider new and improved long-term care products as they become available. Again, clear and concise sales materials, honestly-designed products, along with adequate disclosure of benefit/price differences can go a long way towards eliminating any instances of inappropriate replacement, as well as the perception of this "problem." Further, in such instances, insurers must have an effective monitoring or oversight program and be willing to work closely with state insurance regulators to discipline agents engaging in repeated misrepresentation of these products, "rolling," "clean-sheeting" or other abusive sales practices. Insurers and the states must be prepared to go beyond termination of an agent's appointment with a particular insurer.

Other suggestions for addressing misrepresentation and overselling would include:

- Educating and training agents, marketing representatives, and insurer home office personnel on key long-term issues, including the interface of private and public insurance programs.
- Requiring the general life and health licensing exam to include questions on long-term care insurance.
- Requiring a certain minimum amount of continuing education and training for agents already licensed to sell long-term care insurance.
- Establishing on-going insurer duality review programs. An essential part of monitoring our sales force has been to provide the insured their actual policy (when issued) along with a copy of their submitted application and a notice reminding the insured that this document is the basis upon which the policy has been issued. Our Office of Consumer Affairs, reporting directly to our president, has also been instrumental in educating and disciplining our agents.

- And, perhaps offering a benefit description and a suitability of insurance statement would help the insured focus on key policy differences as well as what are hopefully consensus criteria to be used in selecting a long-term care policy and insurer. Having said this, it has been difficult to develop such criteria and benefit comparisons for what is a very individual purchase decision.

It should be noted, in passing, that we oppose current initiatives to limit commissions through "levelizing rules" which would establish a relationship between first year and renewal percentages (e.g. the 200% rule). We believe that this would do little to curb practices of concern (rolling, churning, high pressure sales), and would simply serve to limit sales. More appropriate would be to establish guidelines which provide states the necessary tools to discern policy forms with overall commissions that are too large to accommodate loss ratio requirements along with operating/distribution expenses.

PREMIUM STABILITY AND EQUITY ISSUES

Much discussion at the federal, state and NAIC level recently has focused on issues of premium stability and the individual "equity" that arises from the level premium structure of this product. This has manifested itself in proposals to mandate the inclusion of nonforfeiture benefits and to limit companies' abilities to raise rates in the future should claims experience so Justify.

The difficulty with nonforfeiture provisions that have been proposed is that, though they do "give something" to insureds who lapse, and thereby address the concern over equitable treatment, they engender perverse results. Those who continue to pay premiums receive less value (they pay more money for the same thing) and the majority of lapsers (by virtue of the relatively small amount of accumulated "equity") receive paid up residuals of insurance that completely fail to protect against the risk originally insured. The only ones who benefit are those who lapse at the late durations (some time beyond the tenth policy year). In recognition of this, AMEX has proposed a series of regulatory reforms that include nonforfeiture values beginning in the tenth policy year, alongside rate stability and sales and marketing requirements that directly target the causes of early or near term lapses. Some of these suggestions are contained in the Federal LTC Insurance Standards Coalition bill that we have helped shape. Included as Exhibit III is an outline of steps we propose to deal with the perception of relatively "high" overall lapse rates.

In the area of rate stability, current NAIC proposals focus on absolute limits to the amount an insurer may raise premiums. Under discussion is a 10% annual and 100% lifetime limit. Principal among the difficulties with this proposal is the threat to solvency, the differing impact by issue age and the potential retarding of product standards and market growth. Carriers such as ourselves, by virtue of our concentration on long-term care, would be most vulnerable to potential insolvency. Since rate caps are most threatening at the younger ages (rates for 50-year-olds anticipate events 30 to 35 years into the future, while those for 75-year-olds embrace a 5 to 10 year window) and newer benefit configurations are more risky than those which have been covered for some years, a company like ours would have little choice but to retreat to a nursing home product issued to "upper ages." The proposal AMEX Life has offered would replace percentage caps currently under consideration with limits on an insurer's ability to game lapse assumptions and a return of most of the reserves (pre-funding portion of the premiums paid in) in the event of a rate increase.

LONG-TERM CARE INSURERS' PRICING AND PRODUCT DESIGN ISSUES

This Subcommittee has held several hearings on insurance company solvency. The establishment of adequate reserves and the sound financial management of those premium dollars set aside to pay future claims are also very important for long-term care insurers and policyholders.

Criticism has been directed at insurers for failing to disclose loss ratio or performance information and for questionable reserving and pricing decisions. Other concerns revolve around unusually high policy lapse assumptions which could serve to produce inadequate rates at the time a long-term care product is filed and approved, only to subsequently lead to the need for rate increases as claims experience develops. Increasingly, state insurance departments are requiring the filing and approval of accident and health insurance rates. State regulators are also requiring the submission of loss experience data and are increasingly asking insurers to re-justify their rates. In examining AMEX Life's claim experience we are confident that we will meet if not exceed required loss ratio standards on our long-term care policies. We have priced our long-term care policies based upon our relatively extensive

claims experience and the actual lapse rates experienced in the 18 years AMEX Life has been in this business.

Our company has also periodically retained independent actuarial consultants to review our pricing and reserve adequacy. They have concluded that we remain appropriately priced and reserved.

THE AFFORDABILITY OF PRIVATE LONG-TERM CARE INSURANCE

Recently, much has been written about the affordability and thus availability of private long-term care insurance for our current elderly. In response to a 1990 Families U.S.A. Foundation study which concluded that only 16% of persons 65–79 years of age could afford the average premium for a given long-term care policy, we asked the same economics consulting firm which conducted the Families U.S.A. study (Lewin/ICF, Inc.) to perform a similar affordability study utilizing AMEX Life's premium for the product rather than an industry average premium. We also asked Lewin/ICF to remove from the eligible population those persons 65–79 years of age who were Medicaid eligible since it is certainly inappropriate for these poor elderly to purchase private long-term care insurance. Interestingly, the results of our study showed that 65.4% of this non-Medicaid group could afford the same AMEX Life product used in the Families U.S.A. study (see Exhibit IV). We believe this to be a fairer representation of the affordability of this baseline nursing home policy (2 years, $80 per day/100 day deductible, with an automatic benefit increase provision or inflation protection feature). To AMEX Life, this affordability study underscores our conviction that most elderly should be seeking to protect themselves against a lengthy confinement in a nursing home, especially when they have limited premium dollars to spend on quality coverage. It is important to be aware of the fact that as the minimum benefit floor is raised through state or federal legislative mandates, quality long-term care insurance products will become less affordable to the current and future elderly.

STATE REGULATION OF LONG-TERM CARE INSURANCE

Our company has been actively involved in the development and evolution of the NAIC's Long-Term Care Model Act & Regulation. We continue to support, with a few exceptions, the adoption of this Model Act & Regulation (as amended in December 1991). To date, 40 states have adopted some version of the NAIC Model.

It is particularly important to understand that this is a dynamic model law and regulation and as such it is evolving to keep pace with the ever changing nature of the long-term care marketplace. Of particular significance are amendments that were recently adopted to address the problem of post-claim underwriting and inflation protection. Further, a standardized outline of coverage has been adopted and a long-term care insurance buyers guide is now in wide use. Other significant issues which the NAIC Task Force on Long-Term Care will address in 1992 include the nonforfeiture/cash value benefits, and home and community-based care benefit standards, rate stabilization and policy upgrade rating underwriting as well as required offering.

There is much to be said for the quasi-legislative process the NAIC has used to achieve an appropriate balance between the need for consumer protection and the desire to allow long-term care products to evolve and improve. This process has added consistency to the state regulatory process by clearly establishing a standards benchmark.

Having appropriately noted this, we must add that the NAIC should now pay particular attention to developing standards for home and community-based care benefits. Artificial gatekeepers and screens still limit, if not deny, access to these benefits. At the very least, the NAIC Model's prohibited policy provisions should be reexamined to create a more level playing field in the design and pricing of home care benefits. Specifically, an illusionary benefit structure is created by allowing prior or concurrent skilled care requirements as a condition to receiving long-term, personal care services in the home or community. The potential claims payout diminishes considerably when these types of policy designs or skilled care requirements are combined with policies that coordinate with Medicare. Provider licensing and certification requirements can further serve to diminish potential benefits and policy value.

FEDERAL GOVERNMENT ROLE

Long-term care financing problems facing American families are a national problem and clearly require a leading role be taken by the federal government. Unless the ultimate solution to these problems is a comprehensive non-means tested social insurance program, private insurance will certainly play a role. Given current budg-

etary difficulties and public attitudes toward increased taxation, it seems clear that the solution will involve a blend of public and private resources.

AMEX Life believes there are two areas where the federal government can play a significant role, with minimal expense. The first is to reform Medicaid by increasing the income and asset base that control eligibility and by curbing opportunities to "game the system." We would recommend an increase in the level of protected assets from $2,000 to $20,000 and monthly needs allowance from $25 to $100, along with a strengthening of states abilities to recover "Medicaid estates." This would provide coverage to those for whom private insurance is not an affordable option while sending a signal that those who have sufficient resources that they cannot rely on welfare.

The second key role is in the area of education. Misunderstandings about long-term care, its risks, the role of Medicare and Medicaid and about provision of care all persist on a broad scale. A government role in providing education here would be beneficial in that it could help individuals understand their situation and prepare for future needs.

AMEX Life believes that there is and should be a meaningful role for the federal government in helping to assure the public that quality private insurance plans are available that will provide value to the consumer. One approach to that federal minimum standards legislation might be the one that followed in 1991 for Medicare Supplement insurance, which would codify the NAIC Model Long-Term Care Insurance Act and serve to pre-empt individual states which do not move within a reasonable period of time (one year) to adopt that model. It also seems to us a sensible course that there be serious consideration to linking the tax policy (read "clarification") the industry desires to minimum federal standards with such an aggressive timetable.

In this regard, Congress may wish to focus on several specific areas, including home care benefit standards (avoiding mandated benefits that may render long-term care plans relatively unaffordable); disclosure requirements, especially as they concern replacement of long-term care policies; and the need for a comprehensive consumer education and communications program, spearheaded by the federal government in coordination with State agencies and the private sector. Federal recommendations should focus on or eliminate documented, abusive sales practices. At the same time, such federal legislation needs to avoid the pitfalls or empty promises of Medicare supplement regulation and deal with real problem areas in a forthright and targeted manner.

The NAIC Model Act & Regulation has already been strengthened on several occasions, most recently in December 1991. The marketing of long-term care products which meet minimally acceptable benefit, disclosure and performance standards has clearly been facilitated in states which have adopted the NAIC Model and where state regulators/legislators have been diligent in enforcement and flexible in allowing ever new and improving product designs. While there could be some inefficiencies in any dual state and federal regulation of an industry, those states that have not adopted the current NAIC Model Act should be "pushed" by the Congress to do so . . . now.

Long-Term Care Insurance Standards Coalition

The Coalition For Consumer Protection Through Quality And Affordable And Long-Term Care Insurance represents the coming together of a diverse group of researchers, leading insurance companies, provider associations and consumer purchasers committed to the goal of assuring consumer protection. This group was formed to develop strong consumer protection standards that would encourage the orderly development of a private insurance market. Without appropriate standards, the consumer would be at risk of purchasing plans that might not preserve value over time, and the specter of bad products would restrict the market innovative quality products. However, if standards are excessive the consumer would lose of quality Long-Term Care products are unavailable and or unaffordable.

We have developed standards so they can be used by legislative leaders. The Coalition supports Long-Term Care tax clarifications and believes if such tax benefits are going to be provided then they should go to insurance plans of high quality.

As you are aware, long-term care for the elderly has emerged as one of the most important health care financing issues facing the country. As a result of current financing arrangements for acute care, long-care is the catastrophic expense facing the elderly. Private insurance policies have been developed to fill this gap. Over the last five years growth in the long-term care insurance market has been significant—from less than 100,000 policy holders in 1986 to more than 2.0 million policies sold by 1992.

In contrast to many other countries, the tradition in the United States is to have the private sector perform activities that are needed to be done on a communal or shared risk basis. Social problems are not the sole province of the government. Insurance products have evolved to address the financing of long-term care on a shared risk basis or risk spreading basis. When this occurs, the government regulate the industry. Market regulations are needed to provide adequate consumer protection. Given the complexities of long-term care insurance government needs to establish product as well as sales and marketing if consumers are to be well served by private insurance. Further, the relationship between insurer and consumer, in which the purchase decision is made considerably before services are used, makes it necessary to reduce the uncertainty faced by the consumer and eliminate the risks attributable to any arbitrary insurer actions.

Given the importance of regulation, it is necessary to construct appropriate policies and know their implications. In setting standards, we must be concerned with goals. We believe the primary goal of consumer protection is to enhance consumer welfare by providing good product choices. This occurs when consumers understand the value of the products being offered, received fair value for the products they purchase, and consumers are not harmed because they take on undue or unknown risks. Proponents of setting high product requirements for long-term care insurance believe that by doing so consumer protection will be enhanced. High requirements raise the cost of policies, and reduce the options available. If consumer protection is having more people protected from risk, it is not evident all consumers can afford the very best. To the extent that the regulation are very extensive, design specific and do not differentiate among groups of consumers, the impact on the private market for long-term care insurance and their individual needs or preference is likely to be greater.

Regulatory program can enhance consumer choice or replace it with government decision. The coalition view is that the government should not replace consumer choice with it's own decision i.e., decide value, but rather should be concerned with consumers knowing the value of the plans purchased and assuring that this value is maintained. Shifting the focus of regulation to the maintenance of value implies that effective regulation of this market must also be concerned with the procedures and process of those offering products.

The coalition's vision of the goals of consumer protection and the role of the Federal Government are reflected in the guiding principles on which our package of consumer protection standards principles are:

1. The roles of the federal government should be one of leadership and direction and not of implementation. The Federal Government should establish "minimum standards" to assure that long-term care insurance products sold provide value to the consumer and this value is maintained. Two clearly stated goals of the Federal initiative should be the "demystification" of the market place and the creation of the "educated consumer."
2. The goal of consumer welfare in this market is best achieved within a market setting when consumers can make educated choices and insurers are held accountable for their actions or that of their representatives.
3. States must maintain and in fact enhance their oversight, monitoring, and general enforcement posture in this market of plans.
4. When desired outcomes can be directly tied to standards, such as product features, then such features should form part of legislation.
5. When outcomes pertain to procedures and operations, the Federal Government should state the goal, leaving it to States to establish more explicit guidelines.
6. The industry should be responsible for coming up with specific data so that consumers and regulators can measure their performance.

Our underlying belief is that well informed individuals can make the best choice, as to whether they need long-term care insurance and if so, what should be the level and type of protection. This results in our opposing measures that arbitrarily dictate the design of the policies offered. For example, we do not support mandated inflation protection and non-forfeiture provisions. Individuals at risk of needing long-term care services in the near future may be well advised to instead be purchasing increased daily coverage and not insuring against future long-term care cost increases of building a savings account of questionable value by being forced to purchase some vaguely described non-forfeiture benefit. Our approach is to mandate that these be offered, that these be clear product design and pricing standards, but that the choice of purchase be left to the consumer.

On the other hand, we strongly urge standards be established that assure that individuals know the value of what they are purchasing and that they receive value from the policies they have purchased. The coalition suggested standards are much

stronger with regard to protected value and delivering the value purchased that other proposed standards. We believe insurance plans must be understandable, fairly and appropriately priced, and clearly articulated. To assure value over time is maintained procedures are incorporated that result in appropriate product pricing, establishment of required loss reserves and financial strength of insurance companies—areas over which the consumer has little or no control. Also, standards must be established at the outset so as to assure that benefits will be paid as promised.

COMMENTS ON THE LONG-TERM CARE FAMILY SECURITY ACT OF 1992

In reviewing the above referenced bill, we find provisions in a number of areas to be very encouraging. In general we support the establishment of uniform national standards and the proposed tax treatment of long-term care insurance. In particular, we find the provisions related to education and assistance funds, agent training, claims and experience reporting, optional inflation protection and employer based plans to our liking. Of particular concern to us are the provisions related to the contestable period, agent compensation limits, rate disclosure and increase limits and non-forfeiture. In the comments that follow, we detail those items in the bill (by section number) with which we have a problem.

- 2704(C) disallows agents from helping to complete the medical history portion of an application. This provision will possibly lead to more rather that less errors in the application and will remove an avenue for pursuing misrepresentation.
- 2704(e) prohibits duplicate coverage. Since most long-term care insurance pays an indemnity benefit there is not much need for this provision. Its drawback is that it would force a lapse in the case where an individual simply wishes to purchase additional coverage.
- 2704(F)(2)(G) requires disclosure of statewide averages long-term care costs. Used in New York City, this would be misleading in that costs are more than twice the state average.
- 2705(c)(1) requires disclosure of claim denial reasons. This may run into state privacy laws. We suggest allowing insurers to inform the insured doctor where appropriate.
- 2705(d) establishes a six month contestable period. We strongly oppose this provision in that it removes a central protection to insurers, which in turn will make rates less stable. The provision also seems to limit the time period on fraud. This is in direct opposition to case law in this area.
- 2705(e)(1) duplicates certain NAIC reporting requirements. We suggest a coordination with NAIC reports.
- 2705(h)(1) establishes a "200%" commission limitation. We oppose this and offer our reasons in exhibit VI.
- 2706(b)(1)(B) would better read "limit eligibility for any benefit *solely* on the medical necessity." This allows insurers to offer medical necessity as an additional separate trigger alongside ADL and cognitive measures.
- 2706(b)(2) should read "Home and Community," not simply "Community." This is in accordance with common nomenclature.
- 2706(B)(3) references benefits under Title XXI. We reserve comments on this until we better understand this title.
- 2706(d) seem to require that benefits would have to be paid for drug addition and alcoholism. This would be a significant extension of benefits, with commensurate price impact, that would hit hardest at employer markets. We suggest restoring some limits in relation to such conditions.
- 2706(f)(1)(A)(i) calls for an independent assessor at time of claim and subjects requirements to the Social Security Act. This would be difficult at the state level and might exclude many otherwise qualified individuals. We suggest allowing states a role in determining standards.
- 2706(f)(1)(c) calls for ADLs as specified in the Social Security Act. We reserve comment until we familiarize ourselves with this list and definitions.
- 2706(h)(2) requires rate increase disclosures and limits on increases over age 75. We oppose this provision in that it engenders solvency problems and provides and avenue for "gamblers" to out-market conservative insurers. A similar situation developed in the Savings and Loan industry with regard to interest rates (the weakest institutions made the best offers), with disastrous results. Furthermore, insurers will respond to the above requirements by offering the most conservative products possible, thereby inhibiting product advancement.

We understand the need to move toward increasingly stable rates, but feel there are better avenues than this. Other alternatives would be to limit pricing vari-

ables over which insurers have control (e.g. lapses) and to provide avenues to insurers who are shut out by rate increase.

- 2706(h)(3)(i) requires nonforfeiture benefits in the form of cash and reduced paid up insurance. We comment on exhibit V.
- 311(q)(1) limits qualified plans to those which provide nursing home and community care. This forces everyone to buy comprehensive coverage, whether or not they need it. Many people with a strong informal support network or who live in rural areas would receive little value from a Community care benefit. We suggest allowing nursing home only to qualify as well.
- 311(g)(1)(A) does not allow a "medical trigger." In accordance with our earlier comment, we ask that this be included along with ADLs and cognitive impairment.
- 312(b)(4) disallows duplication of Medicare benefits. We would only ask that this provision be softened to allow for incidental overlaps. For example, plans with a 20 deductible may overlap with Medicare for nursing home stays which involve skilled care beyond the 20th day.

Attachment.

EXHIBIT I

AMEX LIFE ASSURANCE COMPANY

Summary of Denied Long Term Care Insurance Claims

Five Years Ended December 31, 1991

Denials (by reason)	Number of Claims	Denied claims as a percent of Total Claims
Elimination period not met	205	7.0%
Provider not covered	42	1.5%
Mental & Nervous Exclusion	3	0.1%
No Prior Hospital Stay	23	0.8%
Services Incurred Prior to Policy Effective Date	2	0.1%
Total denials	275	9.5%
Total claims	**2911**	**100.0%**
Total Claims Paid	2636	90.5%

Most Recent Claims Requests Which Met The Elimination Period

Total Claims Requests Meeting E.P.	2706	100.0%
Total Denials	70	2.6%
Total Claims Paid	**2636**	**97.4%**

Recissions

4 policies voided (became uninsurable prior to policy effective date)
4 recissions

CRITERIA USED IN ANALYSIS

This analysis includes claims prior to January 1, 1992 under the Long Term Care Insurance Group, Individual Nursing Home Indemnity Policies (also known as Nursing Home Facility Policy, Nursing Home Indemnity Policy and Skilled Nursing Home Benefit Policy), and Individual Home Health Care Riders issued by the Company between January 1, 1987 and December 31, 1991 (hereinafter "LTC claims"). Furthermore LTC claims included in the analysis had loss dates during the five years ended December 31, 1991 and were not pending completion of the Company's claim adjudication process at January 1, 1992.

EXHIBIT II

CODE OF ETHICAL CONDUCT

AS A REPRESENTATIVE OF AMEX LIFE ASSURANCE COMPANY, I BELIEVE IT IS MY PROFESSIONAL RESPONSIBILITY:

To thoroughly explain the benefits and limitations of the Company's policies.

To provide an honest and accurate disclosure of information essential to my customers' purchasing decisions.

To present the Company's product in a fair and highly professional manner.

To treat my customers with respect and dignity.

To command and maintain the trust and confidence of my customers by delivering the highest quality of service possible.

To improve my professional skills through continuous education and increase my knowledge of industry issues and activities.

To keep informed of new and/or adapted national and state laws and regulations affecting the practice of my profession and to observe them in my practice.

To pursue only those customers whose financial position allows them to consider purchasing long-term care insurance. I will, however, encourage those not in this position to seek information on how to qualify for Medicaid or there appropriate social programs.

To report to the proper authority any knowledge of activities which may be in violation of industry regulations or any of the principles listed above.

AMEX Life Assurance Company

EXHIBIT III

Proposed NAIC Amendments
AMEX Life

Item	Proposal	Comments
- Standardized Triggers and Definitions	• NAIC or HIAA proposal with modifications	
- Nonforfeiture	• Mandated nonforfeiture after policy year 10, or when values exceed 50%	• Deals with long-term lapses • Provides valuable benefit • Modest price increase
-Rate Stability	• Mandated lapse tables • Return of reserves upon a rate increase	• Curbs "non-environmental" mispricing • Protects mid-term lapsers forced out by rate increases
- Upgrades	• HIAA proposal plus premium credit	• Protects mid-term lapsers who wish to retain coverage

- Lapses	• Sales and market reforms
	  • Continuing education
	  • Special licensing
	  • Conservation programs
	• Upgrades and rate stability
	• Nonforfeiture
	• Alzheimer's lapse protection
		• Deals with short term lapses
		
		• Deals with mid-term lapses
		• Deals with long-term lapses
		• Deals with "accidental" lapses

EXHIBIT IV

ESTIMATES OF AFFORDABILITY OF AMEX POLICY FOR ELDERLY PERSONS AGE 65-79 IN 1990, BY AGE GROUP[a/]

	Age Group			Total
	65-69	70-74	75-79	65-79
Estimated Total Population (000's) from Current Population Survey	9,542	7,498	5,306	22,346
Estimated Non-Medicaid-Eligible Population (000's)	5,421	4,363	3,036	12,819
Non-Medicaid Population as a Percent of Total	56.8%	58.2%	57.2%	57.4%
Persons Who Can Afford Private Insurance As a Percent of Population				
Families U.S.A. Study	21.3%	14.5%	10.3%	16.3%
Families U.S.A. Study with Substitution of AMEX Life Premiums for Industry-wide Average	32.8%	25.0%	20.2%	27.2%
AMEX Life Premiums Plus Substitution of Non-Medicaid for Total Population	49.6%	40.8%	34.7%	43.1%
Above Two Changes Plus Substitution of Couples with One Purchase	63.8%	59.0%	49.6%	58.8%
Above Three Changes Plus Substitution of Alternative Asset Definition	69.3%	66.2%	57.1%	*65.4%*

a/ A person is assumed to be unable to afford long-term care insurance if the individual's premium payment plus other medical expenses would be greater than 10 percent of his or her income and annuitized assets.

SOURCE: Lewin/ICF analysis of pooled March Current Population Survey data for 1985 through 1988. (Data base excludes the five percent of the elderly population who are institutionalized).

EXHIBIT IV

-Continued-

Table 1

Minimum Asset Levels for Potential Buyers of Long-Term Care Insurance by Income Level

	By age group and asset level		
Income level	*65-74*	*75-84*	*85 and over*
<10,000	>$30,000	>$50,000	>$100,000
$10,000 - $14,999	>$20,000	>$30,000	>$ 50,000
$15,000 - $29,999	>$15,000	>$20,000	>$ 40,000
>$30,000	>$15,000	>$20,000	>$ 40,000

Source: LifePlans estimates based on insurance industry consultation.

Table 2

Eligible Elderly Market for Long-Term Care Insurance

	Percentage ineligible based on:				Total percentage qualifying
Age group	*Income & asset*	*Disabled in nursing home*	*Disabled in community*	*Total combined**	
65 to 74	46%	1%	7%	50%	50%
75 to 84	54	6	10	62	38
85 and up	82	21	24	92	8
Weighted total	52	5	10	58	42

* The total percentage ineligible reflects the overlap of those not qualifying because of income, assets, and health status

Sources: LifePlans estimates; 1982 and 1984 National Long-Term Care Surveys; 1985 National Nursing Home Survey; Income of the Population Age 55 and Over; and Survey of Income and Program Participation.

EXHIBIT V

COMMENTARY ON NONFORFEITURE

The overriding concern our company has with nonforfeiture proposals is simply that they do not benefit the majority of lapsing insureds. We indicated this at the NAIC Task Force meeting in Houston and, to date, have not received a satisfactory response from advocates or regulators favoring nonforfeiture benefits. The only response, albeit feeble, is that lapsers benefit because "at least they get something". But this simply begs the question, since the issue is whether the "something" they get is of any real use or, equally, whether it has value in relation to the extra cost.

To better understand the value of nonforfeiture benefits, it helps to consider a typical insured in today's market and the circumstances under which they lapse. This provides valuable insight as it bypasses the endless theoretical discussions that have surrounded this issue and focuses on results. Such an approach is especially attractive since it is independent of one's attitude on whether individual insureds do or do not have equity, whether nonforfeiture based policies cost too much or too little or whether nonforfeiture acts to stabilize prices. This last defense of nonforfeiture, by the way, is curious in that it amounts to observing that policies which pay benefits to everyone engage in less spreading of risk and therefore have less volatile prices.

Early Year Lapses

Two thirds of all lapses occur in the first five policy years. It is universally acknowledged that paid up insurance benefits in these years are pointless. The only other choice, therefore, is cash. Previous cost/benefit analyses of this option which we've provided (showing that lapsers get back less than the extra premium they spent) have been dismissed on the grounds that they are based on a schedule which returns cash in the amount of the policyholder's reserve (the so called "equity"). Such a line of criticism leads to the conclusion that lapsers should be paid more than their allocated reserve in order to receive "fair" treatment. Unfortunately, this has the perverse consequence of penalizing those who keep their insurance and exactly reverses the original concern. Another inadequate response to this situation has been a suggestion that early lapsers "receive a return of portion of the premium paid in". The difference between this and a cash benefit would miss most people and is obviously rather subtle.

The simple truth is that no nonforfeiture benefit redresses problems with early year lapses. The distribution, underwriting and issue costs associated with this insurance preclude it.

Middle Year Lapses

As we commented at the Seattle NAIC meeting, we believe that the substantive question with regard to nonforfeiture benefits will hinge in large part on a decision as to whether lapsers in middle policy years (years 6-10) would receive a benefit that is of any value. Since lapsers in these years begin with a reduced paid-up benefit of roughly 25% the original amount, and average daily amounts currently being issued are around $80, the question is: "what is the value of a $20 a day benefit?".

Recently, we have been informed by Consumer's Union that actuaries regard this $20 a day as a "meaningful benefit". With all due respect to actuaries, it is difficult to understand how they are in a special position to determine the value of partial insurance to seniors facing the possibility of an extended nursing home stay. A better gauge may be had by considering the reason a lapse takes place and looking at the value of a $20 benefit in such a situation.

There are three reasons for lapse that have been considered in this debate:

- o The sale was inappropriate because the coverage was not what was needed;
- o The insured could not afford, for whatever reason, to continue paying premiums;
- o The policy was dropped in order to purchase a better policy.

We take these in order.

- o Inappropriate Sale - Anyone sold insurance inappropriately would probably not keep it more than five years, but it could happen. The problem with nonforfeiture in this instance can be summed up very simply. If the insurance was inappropriate in the first place, then why is a smaller amount of exactly the same insurance any more appropriate? Certainly not because it's "free".

- o Unaffordable Premiums - This situation may arise due to a change in financial circumstances, a rate increase, or a combination of the two. In either case, continuation of a $1,000 to $2,000 premium is more than the insured can handle. Again, the problem with the 25% benefit is simple. Since 75% of the risk is not covered, the insured will have to co-pay $22,000 a year ($60 a day)

in the event of a nursing home stay. Given that the annual premium was more than they could afford, one is left to wonder how they can afford an annual expense of ten to twenty times that amount.

The situation above is exactly like that of a homeowner who purchases a $200,000 homeowner's policy with a $150,000 deductible because he can't afford complete coverage. His only hope is that his house doesn't burn down.

- Replaced Policy - If an insured lapses one policy in order to purchase another then it's questionable what good a small additional amount of the old coverage would do. Given the pace of evolution in these products, the difference in coverage across a five year span would no doubt be large and amount to an untenable situation with regard to triggers, provider choices, etc. A far better solution would be, as United Seniors' Health Cooperative suggests, a credit towards the premium on the upgraded policy.

  Our Company supports an initiative with regard to this latter option and regards it as superior to what is otherwise a meaningless residual of unwanted coverage.

Later Year Lapses

Policies lapsing after the tenth year have accumulated sufficient reserves to provide benefits at 50% or more of the original amount. Though this begins to approach an amount that actually might benefit individuals, lapsers after the tenth year typically comprise around 10% of all lapsers and 5% of initial policyholders. Though insurers would generally agree that this group might benefit from a nonforfeiture provision, their numbers are so small that most advocates of nonforfeiture would be unwilling to accept a solution which covers so few people.

The difficulty with non-forfeiture proposals is that they try to address sales and marketing problems, rate stability issues and a lack of standardized upgrade provisions by "giving something to everyone". The reason this doesn't work is twofold:

(1) The "nonforfeiture solution" fails to directly address any of the underlying problems. For example, a more appropriate solution than nonforfeiture to the problem of excessive early year lapses resulting from inappropriate sales is to help insure sales are more appropriate. This can be done through agent education and licensing requirements. Similarly with rate stability and upgrade issues, much better approaches that directly target the problems can be had.

(2) Nonforfeiture reduces the efficiency of private insurance by providing benefits to the majority of insureds. Contrary to first impressions, this broadening of the base of claimants degrades rather than enhances the insurance vehicle in that it turns it into a dollar trading mechanism. Individual insurance products that operate in this way (dental insurance, Med Supp) are generally a very bad deal in that too many people simply get back their contributions in the form of 60 cent or 65 cent dollars.

Percentage Increase in Premiums for Alternative Nonforfeiture Provisions, by Age

Nonforfeiture Provision	Issue Age 35 years	Issue Age 50 years	Issue Age 65 years	Issue Age 75 years
None	1.00	1.00	1.00	1.00
Return of Premium	---	1.36	1.36	1.36
Extended Term	2.49	1.92	1.33	1.36
Reduced Paid-Up Benefit	2.05	1.62	1.17	1.06

Sources: The Extended Term and Reduced Paid-Up estimates are based on the LifePlans , Inc. Pricing Model.

The Return of Premium is based on AMEX Life Assurance Company estimates and includes benefit payment in lapse situations due to death.

Notes:

1. Return of Premium returns a portion of total premium paid less claims paid. The percentage of premium returned starts with 10% in the 6th year increased by 5% per year to 100% in the 24th year and thereafter.

2. The extended term benefit starts in the third year. It takes the active life reserves and applies it to a net single premium under the benefit in effect to determine the period of protection.

3. The reduced paid-up benefit provides a fraction of policy benefits once premium payments have terminated. RPU benefit would be 10% at the end of year 3, grading up by 3% annually for 30 years.

EXHIBIT VI

THE CASE AGAINST AGENT COMPENSATION RESTRICTIONS IN LTC INSURANCE SALES

There has been much discussion and some legislative as well as regulatory action to limit compensation (commissions) paid to agents on their LTC insurance sales. The motivation behind this activity has been a belief or perception, founded on scarce documentation, that there are significant problems of inappropriate policy replacement activity in this industry and that compensation limitations will serve to effectively "police" or inhibit such "rolling" of the business. This proposed commission schedule is modeled after the commission schedule for Medicare supplement products as stated in the NAIC Model Regulation. Although both products are sold to senior citizens, there are different factors to consider in the process of the sale. Medicare supplement insurance is a commodity product which is highly standardized and which most seniors strongly believe they need.

Long term care insurance is a product which is continuously evolving and improving and for which need (and risk) is seldom clearly understood. It is also a very difficult product to sell. It is a product that is sold and not purchased. It is a product that requires multiple face-to-face meetings of anywhere from 2 to 3 hours in average duration and during which time clients need to be informed about a range of different issues relating to Medicare and their long term care needs, and have clearly demonstrated for them how private insurance products may or may not meet those needs. Without compensation incentives, quality agents will not continue to sell long term care insurance when they can more easily sell other less complicated or difficult product lines. For example, an agent would be better off selling Medicare Supplement, even though it has a "200% rule" (first year compensation no more than 200% of renewal compensation, and paid for a reasonable period), because it is a product "understood and pursued" by the public, i.e. there is consumer demand.

The fact is, most agents make only a modest living after business expenses under current compensation arrangements. It has been stated on a number of occasions that those agents may be better off in the "long run" with higher renewal commissions or a more level commission structure. However, few quality agents will be able to survive on such low first year commissions in order to 'reap the benefits from higher renewal commissions should the proposed compensation arrangements be implemented. As such, it is very questionable whether agents will even bother selling long term care coverage under such highly restricted commission arrangements.

Most agents incur significant expenses and invest substantial time in order to secure an application. In fact, our agents end up submitting an application on less than half of the people that they present the product. While some established agents may have sufficient "other" (non-LTC) business on their books to be able to finance such deficits, it would be virtually impossible for anyone new that is fully committed and focused on selling quality long term care coverage in a highly ethical and responsible fashion to enter this field.

If, in fact, agents are forced to move into other lines of insurance in to order to meet their expenses and provide an adequate living, they may be less able and less willing to take the time to develop or maintain their expertise in the long term care area. What would likely result is a "volume driven" operation where the agent becomes much less willing to spend time with the client and more eager to seek out potential clients who have already made the decision to purchase a long term care plan and who already more fully understand the risk and need for this product. In other words, much more significant potential may develop for the churning of this business or "cherrypicking" current long term care insureds and replacing their coverage.

As stated, our industry has been criticized because of a perception of significant inappropriate replacement activity. Furthermore, it is believed that compensation limitations will serve to effectively "police" or inhibit such "rolling" of the business.

However, a "200% standard," or something akin to this, is counterproductive — it prevents agents from spending the time to properly sell this catastrophic, long term care insurance product to new, first time buyers. Although many consumers of Medicare supplement insurance and long term care insurance are Medicare beneficiaries, the products are not sold in the same manner and do not need the same compensation structures to address replacement activities.

Other states that considered this rule, dropped it. One state's Insurance Department recently rejected the "200 % rule" as a tool in dealing with the perception of inappropriate replacement. In addition, another state previously proposed a "200% rule," but increased the first year limit from 200% to 400%, realizing the educational process and time spent by the agents soliciting this product and time necessary along with difficulty in properly selling this product.

The National Association of Insurance Commissioner's (NAIC) has recognized that the majority of the replacement activity in this marketplace is appropriate and required because of the new products on the market and the frequent changes to state long term care insurance laws and regulations. In the NAIC's drafting note to the optional provision contained in their Model Long Term Care Regulation, the NAIC indicated clearly that they recognize that long term care insurance is in an evolutionary state. The product needs to be able to develop in order to be responsive to the needs of consumers and to provide meaningful consumer choices in long term care products. The NAIC also stated that long term care insurance laws and regulations are constantly changing and states should consider the fact that not all replacements are inappropriate. Note that the NAIC considered and rejected the 200% rule as part of the Model Regulation and in lieu thereof, adopted other standards As part of the Model Regulation, the NAIC adopted other standards to deal with inappropriate replacement, such as: 1) requiring disclosure (within five days of application being submitted) of the original writing company that their policy/coverage is about to lapse, 2)specific reporting by company and agents of replacement as well as lapse activity, as a proportion of total applications submitted and policies issued, and 3)establishing severe penalties for agents and companies dealing with inappropriate replacement activity.

By making it much more difficult to put a highly trained, highly competent agent in the individual client's home selling this very important insurance product, we believe the adoption of these standards will only serve to *increase* whatever limited instances of inappropriate replacement activity that are taking place. Agents will be severely constrained in their ability to sell long-term care insurance since most have a range of other products to sell; we have already been told this will be the case by some of our agents. Given the nature of this product most of the work effort is at time of sale and application. Simply stated, the compensation is not going to adequately reflect the substantial work and effort that goes into appropriately selling to new customers this new and significant long term care product.

Agent compensation restrictions will be very unfortunate and significantly limit the growth of quality companies selling quality products. We at AMEX Life counsel very strongly against such action. We have seen a significant drop in business in the one state that has adopted a 200% rule. As evidenced, production in the one state that has adopted such a rule has dropped by 50% over the last year. Again, we also believe that this requirement will encourage agents to "cherry pick" or seek to replace good business already on the books. The sale of a replacement policy takes less time since the insured already understands the need for the product. We also believe companies and agents will move to other product lines to sell.

In summary, compensation limitations will make it very difficult if not impossible for the long term care insurance industry to attract quality and reputable agents that can focus their resources and expertise on further developing the market. Our future ability to write any long term care products (industry-wide), and the growth of quality companies selling quality products *in general*, would be (significantly) adversely impacted.

PREPARED STATEMENT OF WILLIAM H. MCCARTNEY

INTRODUCTION

Mr. Chairman and Members of Subcommittee, thank you for this opportunity to discuss the important topic of long-term care insurance.

My name is William H. McCartney and I am Director of Insurance in the State of Nebraska. I also am the president of the National Association of Insurance Commissioners ("NAIC"), on whose behalf I am testifying today. The NAIC is a nonprofit association whose members are the insurance officials of each state, the District of Columbia, and four U.S. Territories.

The purpose of this testimony is to briefly discuss the regulatory challenges presented by the growth of the long-term care insurance market and to outline the measures that regulators, through the NAIC, have taken to meet those challenges. I will also comment on federal legislation to address long-term care insurance.

THE LONG-TERM CARE INSURANCE MARKET

Long-term care insurance is a growing market primarily focused on sales to older consumers, although employers are beginning to show interest in sponsoring long-term care insurance plans for their employees and their families. In addition, some insurers have begun exploring different types of insurance products, including long-term care disability products and advance payments of life insurance benefits for long-term care.

Over the past three to four years, long-term care policies have improved in response to strengthened regulatory standards and increased consumer knowledge. Policies now offer broader and more flexible benefits with less severe restrictions and limitations. For example, policies offered today usually provide coverage for longer periods in a wider variety of settings than those offered just a few years ago. Prior hospitalization and prior nursing home-stay requirements also have been eliminated as benefit triggers in most instances. Many policies also now offer options to protect against inflation and a few insurers are offering benefits (although limited) in cases of policy forfeiture.

Despite these improvements, policies still have important limitations, leaving consumers with uncertainty about product performance. The indemnity-type benefits offered in most policies may not meet the cost or duration of service needs of policyholders. Further, the types of inflation protection offered by insurers may fail to keep pace with actual increases in the costs of services. Difficulties in assessing chronic disability and defining appropriate care settings can leave consumers with questions about whether services received in certain circumstances or settings will be covered by the policy.

Another potential problem for consumers is that insurers may seek to raise premium rates if adverse experience develops. Because of the many unknowns associated with these products—such as limited data about utilization of long-term care services, limited actual claim experience from an insured environment, and the changing nature of the long-term care delivery system—the utilization assumptions and premium calculations made by insurers are less certain than with more traditional health insurance products. For the same reasons, regulators have a more limited basis upon which to evaluate initial rate filings of insurers to ensure that the initial rates requested are adequate.

State regulators have been and continue to be actively involved in developing standards and practices to better protect consumers from these uncertainties. The NAIC Long-Term Care Insurance (B) Task Force has ongoing projects to address the issues discussed above. The current NAIC standards for long-term care insurance and the Task Force agenda for 1992 are discussed below.

DEVELOPMENT OF MODEL STANDARDS

NAIC Model Standards

The NAIC Long-Term Care Insurance Model Act was originally adopted in December 1986, and a Model Regulation was adopted in December 1987. Both the Model Act and Regulation ("Model Standards") have been amended to reflect greater regulatory scrutiny and changes in the marketplace.

In developing Model Standards for these products, the NAIC has attempted to balance the need for strong consumer protection with the need for innovation and flexibility in product development. The lack of adequate public protection for long-term care has motivated state and federal policymakers to encourage the development of private options to protect individuals against the potential financial ruin

often caused when families members need long-term care services. The Model Act's stated purpose is

> . . . to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance . . . from unfair or deceptive enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.
>
> Long-Term Care Model Act, *Model Laws regulations and Guidelines, Vol. I, No. 132.*

The NAIC Model Standards afford a number of protections to consumers. These provisions, and the Model Standards in general, reflect input which the NAIC and the states solicited from regulators, consumer organizations, and members of the insurance industry.

- Preexisting condition exclusion periods of longer than six months are prohibited.
- Purchasers have a 30-day free-look period during which they may return the policy for a full refund.
- Policies may not exclude coverage for Alzheimer's Disease.
- Policies may not limit coverage to skilled nursing care nor provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.
- Prior hospitalization requirements are prohibited.
- Conditioning eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care ("step-down") is prohibited.
- Significant minimum provisions for home health care benefits are prescribed, including prohibitions against tying benefits for home care to the need for skilled nursing, covering only services by registered or licensed practical nurses, or limiting coverage to services provided by Medicare-certified agencies or providers.
- Individual policies must be guaranteed renewable and group products must provide for continuation or conversion of coverage.
- Purchasers must be offered the opportunity to purchase a product with inflation protection with compounded annual benefit increases of at least 5 percent.
- Insurers must graphically demonstrate, at the time of sale, the projected effects of inflation on policy benefits. A recent change requires that
- insurers provide compounded inflation protection unless the consumer signs a statement rejecting such protection.
- Insurers are prohibited from denying benefits or canceling policies based on post-claims underwriting and are required to keep records of policy rescissions and report them to insurance commissioners.
- Individual policies must meet a 60% loss ratio.
- Insurers must establish auditable standards for marketing, including:
  - —fair and accurate comparisons of policies;
  - —assurance that excessive insurance will not be sold;
  - —notification to applicants of limitations of coverage;
  - —identification of existing coverage; and
  - —notification of the availability of a senior counseling program if one exists in the policyholder's state of residence.
- Twisting, high pressure sales tactics and cold-lead advertising are prohibited.
- Agents must determine the appropriateness of a recommended purchase prior to sale.
- A detailed outline of coverage must be delivered to all prospective applicants for long-term care insurance at the time of initial solicitation.
- Delivery of a buyer's guide is required prior to sale. The NAIC adopted a long-term care buyer's guide for use by the states in 1990.
- An optional limitation on agent compensation is included which prohibits payment of first-year commissions which are substantially greater than renewal commissions.

In addition, the NAIC has added a separate long-term care insurance experience reporting form to the annual statement filed by all insurers. The form, which was filed for the first time in 1992, gathers information on a policy form basis about premiums, claims, reserves, and number of insured individuals on both a cumulative and durational basis. These reports will permit regulators in each state to compare a policy's expected and actual experience as it unfolds and should allow earlier intervention if pricing assumptions are inaccurate.

Current Activities

The NAIC continues to closely monitor the long-term care insurance marketplace so that state regulators can identify and respond to problems and new developments. To enhance our efforts, in 1991 the NAIC established a formal consumer participation program and set aside $50,000 to support consumer attendance and participation at NAIC meetings in 1992. We believe that this action enhances our already strong commitment to assuring consumer representation in the NAIC model legislation process.

The NAIC Long-Term Care Insurance Task Force currently is working in several important areas. Perhaps the most important project underway is the development of model standards for nonforfeiture benefits. For almost two years, the Task Force, with the assistance of an actuarial advisory committee composed of regulatory, consulting and industry actuaries, has analyzed the benefit and price effects of including nonforfeiture values in long-term care insurance policies. This month the Task Force received a final report and recommendations from the actuarial advisory committee.

After hearing the report and discussing it with interested parties, the Task Force indicated a preference for a mandatory nonforfeiture benefit based on a shortened benefit period approach. Under the shortened benefit approach, long-term care insurance policyholders become vested for increasingly longer periods of long-term care services as they pay premiums. If the policy lapses, instead of losing all his or her equity in the policy, the policyholder is eligible to receive a portion of benefits provided by the policy if he or she ever needs long-term care services. For example, if a policy provided five years of nursing home benefits and a consumer paid premiums for ten years and then lapsed the policy, the nonforfeiture benefit might provide the policyholder with two years of nursing home coverage (at the full level of benefit provided under the policy).

Before making its final determination on nonforfeiture, the Task Force asked the actuarial advisory group to provide cost estimates of several different variations of a shortened benefit period nonforfeiture benefit. The Task Force intends to adopt final standards later this year.

Another major area of focus for the Task Force is development of standards on premium stabilization. As we discussed above, the information available to insurers to support pricing decisions is limited, leaving consumers exposed to the risk of future rate increases. To limit this risk, the Task Force is considering methods of restricting the future premium increases that insurers may request. Exposure of a model standard is anticipated in September or December of this year with final adoption early next year.

At its recent meeting, the Task Force also exposed for public comment several proposed modifications to the NAIC Model Standards. The proposed provisions would (1) establish standards for associations endorsing long-term care insurance policies; (2) require insurers to reinstate policies that are allowed to lapse because of the cognitive or mental impairment of the policyholder; (3) permit policyholders to designate alternate beneficiaries that must receive notice from their insurer prior to termination of a policy for nonpayment of premium; (4) require insurers to notify policyholders that premiums may increase and (5) prohibit insurers from using the term "level premium" unless the policy in noncancellable (i.e., rates are guaranteed not to increase).

Other items on the Task Force agenda for 1992 include:

- Strengthening the model provisions against post claims underwriting;
- Developing model standards to assure that existing policyholders have an opportunity to "upgrade" their coverage;
- Developing model standards to require more consistency in insurer methods of determining benefit eligibility;
- Evaluating the effectiveness of the NAIC long-term care loss ratio reporting form;
- Considering increased regulatory standards for certain group long-term care insurance policies; and
- Updating the NAIC's long-term care insurance buyer's guide.

ASSURING CONSUMER PROTECTION

Need for Public Policy

Designing appropriate standards for long-term care insurance products is made more difficult for regulators by the absence of an articulated public policy about how society should meet the long-term care needs of its citizens. The long-term care insurance market began in earnest with much fanfare about seven to eight years ago.

Medicaid, a welfare program, was and is the only public response to long-term care needs. Public policymakers and consumers alike viewed long-term care insurance as an alternative to impoverishment and a potential new financing source. Many also saw expansion of private coverage as producing potential savings for Medicaid.

More recently, policymakers, academicians, and advocates have focused on the limitations of these products. Many would argue that all policies should provide more comprehensive coverage, including longer periods of coverage, extensive home care benefits, inflation protection, and nonforfeiture values. They believe that more comprehensive coverage, available to a more limited number of consumers, is the appropriate direction for this marketplace.

In developing Model Standards, the NAIC has seen its role as balancing the needs of consumer protection and market development. As standards were developed, consideration has been given both to consumer needs as well as to potential effects on availability of products and their affordability to consumers. Since consumers have no real alternatives (except impoverishment), we have been concerned about pricing the product beyond the reach of moderate-income consumers. As this market matures, however, policymakers (including regulators) must make decisions about whether minimum standards should emphasize affordability or should push insurers to develop much more comprehensive, but less affordable, products.

Federal Legislation

Several bills to create federal standards for long-term care insurance have been introduced in the Senate, including S. 846, introduced by Senator Pryor, S. 1693, introduced by Senator Bentsen and S. 2141, introduced by Senator Kennedy. Standards for private insurance also are included in several more comprehensive long-term care bills, including S. 1668, introduced by Senator Packwood and S. 2571, introduced by Senator Mitchell.

Each of these bills would establish important consumer protections for long-term care insurance purchasers, albeit in some cases at the cost of higher premiums. In most instances, the standards contained in the bills reflect the current NAIC Model Standards or address areas, such as nonforfeiture benefits, being considered by the NAIC. The NAIC applauds the fact that in most cases these bills would call on state regulators to implement and enforce the standards created. The NAIC also applauds the provisions in these bills that look to state regulators, through the NAIC, to develop the model regulatory provisions to implement the standards contained in these bills. This recognizes, we believe, the experience and commitment that state regulators have demonstrated in developing meaningful standards for this product as it has evolved.

The NAIC has several concerns, however, about some of the provisions in the bills that have been introduced. Our first concern relates to the "look behind" authority that would be granted to the Secretary of Health and Human Services in several of the bills and the dual regulatory structure that would result. These provisions permit the Secretary to directly regulate long-term care insurance policies even in states with approved regulatory programs for long-term care insurance regulation. This type of dual regulation would confuse jurisdiction over enforcement of long-term care insurance standards and leave consumers with questions about where to go for assistance. It also could lead to confusion about interpretation and application of legal standards, making it difficult for consumers and insurers to rely on the decisions of state regulators and courts. We would recommend that the "look behind" provisions be deleted. These bills already provide the Secretary with sufficient authority to ensure enforcement of long-term care insurance provisions through oversight of state regulatory programs.

We also are concerned that one bill, S. 2141, would establish an independent federal commission to develop the regulatory standards to implement the bill. We believe that the development and implementation of insurance standards must be left to experienced state insurance regulators. As we demonstrated with the standards for Medicare supplement insurance developed by the NAIC pursuant to OBRA 1990, state regulators are willing and able to construct and implement a complicated regulatory framework in a fast and efficient manner through an open and participatory process. Equally important, the experience of state regulators ensures that the regulatory provisions developed will be both meaningful and realistic. In addition, we believe that states and state regulators will be much more wiling to accept and implement regulatory standards that they have developed. For these reasons, we would urge that S. 2141 be amended to give state regulators, through the NAIC, a greater role in establishing the regulatory standards to implement the bill.

An additional concern relates to the administrative burdens on state insurance departments that could be caused by some of the reporting and disclosure requirements contained in the bills. While we understand that enhancing standards for

long-term care insurance will necessitate that more resources be devoted to the task, some of the requirements may be overly burdensome. For example, several bills would require states to report to the Secretary about any enforcement issues not resolved within thirty days. State insurance departments, like all government agencies, have limited resources, and staff devoted to reporting must be drawn from direct enforcement and other consumer protection functions. If these bills move forward, we look forward to working with members of the Subcommittee in designing reasonable reporting requirements that permit an appropriate level of oversight without unduly burdening state insurance departments

Finally, we also have several technical comments regarding provisions of these bills. We will happy to discuss these with you and your staff when appropriate.

CONCLUSION

The appropriate role of long-term care insurance in meeting the financial needs of consumers must continue to be a topic for discussion and debate at both the state and federal levels. For its part, the NAIC will continue to closely monitor this market and move to address new issues or problems as they arise.

Thank you for inviting me to present the NAIC's regulatory approach to long-term care insurance.

Attachments.

RESPONSES OF MR. MCCARTNEY TO QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER

Question No. 1. Does the NAIC support tax incentives for long-term care insurance? Would such incentives target long-term care assistance to the richer elderly at the expense of the low-income elderly who are left to fend for themselves?

Answer. The NAIC has no position on tax incentives for long-term care insurance and has not considered the implications and distributional effects of providing such subsidies. Given that long-term care insurance is primarily an asset protection product at this time, it would appear that any subsidies would primarily benefit individuals with assets to protect.

Question No. 2. Have any insurers offering Medicare supplemental insurance gone out of business because of the changes adopted by congress as part of the Omnibus budget Reconciliation Act of 1990?

Answer. We have no indication that any Medicare supplement insurers have gone out of business due to these changes. We believe that a few insurers may have stopped offering Medicare supplemental insurance, but there appears to be a viable market for this coverage in each of the states.

We must point out, however, that consumers and insurers continue to face several difficulties related to Medicare supplemental insurance because of Congressional failure to pass technical corrections for the Omnibus Budget Reconciliation Act of 1990. Perhaps most serious is the overly restrictive non-duplication of coverage provision enacted as part of OBRA 1990. The revised non-duplication provision not only effectively bars the sale of more than one Medicare supplement policy to a consumer, but also prohibits the sale of any new health insurance policy to a Medicare beneficiary if the sale would result in duplication of any other health insurance benefits. As strictly construed, this provision prohibits the sale of a Medicare supplement policy to a beneficiary with a long-term care insurance policy or with retiree health benefits, no matter how minor or incidental the resulting duplication of benefits might be. Some consumers have had difficulty purchasing the Medicare supplemental coverage because of this problem. There are other technical problems with OBRA 1990 as well, including the effective date of premium refunds. H.R. 1555, passed by the House last December, would address these problems and we would urge its consideration by the Senate as soon as possible.

During the hearing, we also offered to provide detailed charts which describe the progress states have made in enacting the NAIC Model Long-Term Care Insurance Act and Regulation. Those charts are attached.

NAIC

STATE ADOPTIONS OF LONG-TERM CARE INSURANCE ACT PROVISIONS

	ALABAMA	ALASKA	ARIZONA	ARKANSAS
Cite	Regulation 91 (1990)	§§ 21.53.010 to 21.53.200 (1990)	§§ 20-1691 to 20-1691.07 (1987/1991)	§§ 27-97-201 to 27-97-213 (1989)
Based on Model?	Yes	Yes	Yes	Yes
Definition of Long-Term Care Insurance	Current model language; cover at least 12 mo.	Current model language; cover at least 12 mo.	Must cover for at least 24 mo.	Current model language; cover at least 12 mo.
Specific Provision for Life Insurance Riders?	Yes	Yes	Yes	No
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?	Yes	Yes	Yes	Yes
Preexisting Condition Provision	6 mo.; may not use exclusion or waiver	6 mo.; may not use exclusion or waiver	6 mo.; does not include waiver language	6 mo., may not use exclusion or waiver
Can Condition Coverage on Prior Hospitalization?	Prohibited	Prohibited	Prohibited after after July 1, 1990	Prohibited after March 17, 1990
Uniform 30 Day "Free Look"	Yes	Yes	Yes	Yes
Requires Outline of Coverage	Yes	Current model language	Same as original model	Current model language
Policy Summary for Life Products	Yes	Yes	Yes	No provision
Report of Accelerated Death Benefits Required?	Yes	Yes	No	No
Miscellaneous				

STATE ADOPTIONS OF LONG-TERM CARE INSURANCE ACT PROVISIONS

	CALIFORNIA	COLORADO	CONNECTICUT	DELAWARE
Cite	§§ 10230 to 10235.22 (1989/1992)	§§ 10-19-101 to 10-19-115 (1990)	Admin. Code tit. 38a §§ 501-1 to 501-7 (1986); Stat. § 38a-501 (1991)	tit. 18 §§ 7101 to 7107 (1990/1991)
Based on Model?	Yes	Yes	No	Yes
Definition of Long-Term Care Insurance	Some of current model language; removed 12 mo. criterion	Cover at least 12 mo.; model language	Cover at least 1 yr.	Current model language; cover at least 12 mo.
Specific Provision for Life Insurance Riders?	Yes, in life insurance laws	Yes	No	No
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?	Yes	Yes	No provision	Yes
Preexisting Provision	6 mo., may not use exclusion or waiver unless approved by Commissioner	6 mo., may not use exclusion or waiver	6 mo., may not use exclusion or waivers	6 mo., may not use exclusion or waiver
Can Condition Coverage on Prior Hospitalization?	Prohibited after January 1 1990	Prohibited after 7-1-91	May if offer policy without prior hospitalization requirement	Prohibited
Uniform 30 Day "Free Look"	Yes	Yes	10 to 30 days for individual policies, 30 days for direct response	Yes
Requires Outline of Coverage	Original model with additions	Current model language	No provision	Current model language
Policy Summary for Life Products	No	Yes in regulation	No provision	Yes
Report of Accelerated Death Benefits Required?	No	No	No	Yes
Miscellaneous	Includes amendments effective 1-1-93			

STATE ADOPTIONS OF LONG-TERM CARE INSURANCE ACT PROVISIONS

	DISTRICT OF COLUMBIA	FLORIDA	GEORGIA	HAWAII
Cite	No action to date	§§ 627.9401 to 627.9408 (1988/1992)	§§ 33-42-1 to 33-42-7 (1988/1989)	§§ 431:10A-521 to 431:10A-531 (1989/1991)
Based on Model?		Yes	Yes	Yes
Definition of Long-Term Care Insurance		Not less than 24 mo. of coverage; part of model definition	Not less than 24 mo. of coverage; similar to model but varies in some respects	At least 12 mo., current model language
Specific Provision for Life Insurance Riders?		No	Yes	Yes
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?		Yes	Yes; may not provide coverage for lower levels which is not "unreasonably lower" than that for skilled care	Yes
Preexisting Condition Provision		6 mo.; may not use exclusion or waiver	6 mo.; may not use exclusion or waiver	6 mo.; may not use exclusion or waiver
Can Condition Coverage on Prior Hospitalization?		Prohibited after 10-1-92	Allowed if also offer policy without prior hospitalization requirement	Prohibited after 12-1-91
Uniform 30 Day "Free Look"		Yes	Yes	Yes
Requires Outline of Coverage		Original model language	Original model language	Model language
Policy Summary for Life Products		No provision	No provision	Yes
Report of Accelerated Death Benefits Required?		No	No	No
Miscellaneous		Must offer nonforfeiture protection provision		

STATE ADOPTIONS OF LONG-TERM CARE INSURANCE ACT PROVISIONS

	IDAHO	ILLINOIS	INDIANA	IOWA
Cite	§§ 41-4601 to 41-4606 (1988/1991)	Ch.I.C. §§ 351A-1 to 351A-11 (1989/1991)	§§ 27-8-12-1 to 27-8-12-16 (1987/1991)	§§ 514D.1 to 514D.10 (1987/1991)
Based on Model?	Yes	Yes	Yes	Yes
Definition of Long-Term Care Insurance	Not less than 12 mo. most of current definition	Not less than 12 mo. most of current definition	At least 12 mo., most of definition	Not less than 12 mo. most of model language
Specific Provision for Life Insurance Riders?	Yes, in regulation	Yes	Yes	No
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?	Yes	Yes	Yes	Yes
Preexisting Condition Provision	6 mo.; may not use exclusion or waiver	6 mo.; may not use exclusion or waiver	6 mo.; may not use exclusion or waiver	6/24 as in original model
Can Condition Coverage on Prior Hospitalization?	Prohibited	Prohibited	No provisions	Prohibited; if holder of policy issued before prohibited must be offered rider waiving requirement
Uniform 30 Day "Free Look"	Yes	Yes	Yes	10/30 as in original model
Requires Outline of Coverage	Current model language	Model language	Model language	As in original model
Policy Summary for Life Products	Yes	Yes	Yes	Yes, in regulation
Report of Accelerated Death Benefits Required?	Yes	Yes	Yes	Yes, in regulation
Miscellaneous	Additional consumer protection provisions	Amendments pending HB 2528, HB 1864		

STATE ADOPTIONS OF LONG-TERM CARE INSURANCE ACT PROVISIONS

	KANSAS	KENTUCKY	LOUISIANA	MAINE
Cite	§§ 40-2225 to 40-2228 (1988/1989)	SB 217 (1992); § 304.14.560 (1990)	§§ 22:1731 to 22:1737 (1989)	tit. 24-A §§ 5051 to 5056 (1986/1991)
Based on Model?	Yes	Yes	Yes	No
Definition of Long-Term Care Insurance	Not less than 12 mo., most of model language	Not less than 12 mo., model language	Not less than 12 mo., most of model language	Not less than 12 mo., most of model language
Specific Provision for Life Insurance Riders?	In life insurance statutes	Yes	No	No
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?	Must also provide coverage for intermediate care by regulation	Yes	Yes	Cannot limit to skilled care only, custodial care benefits must be at least 50% of skilled care benefits
Preexisting Condition Provision	6/24 as in original model; may not use exclusion or waiver	6 mo., may not use exclusion or waiver	6 mo., may not use exclusion or waiver	Regulation provides 6 mo. before, 6/24 after covered depending on age, no waivers or exclusions
Can Condition Coverage on Prior Hospitalization?	Prohibited	Prohibited	Prohibited after Sept. 1, 1990	Prohibited
Uniform 30 Day "Free Look"	Yes, in regulation	Yes	10/30 as in original model	Yes
Requires Outline of Coverage	As in original model	Current model language	As in original model	No provision
Policy Summary for Life Products	No provision	Yes	No provision	No provision
Report of Accelerated Death Benefits Required?	No	Yes	No	No
Miscellaneous				Tax incentives, innovative policy designs encouraged

STATE ADOPTIONS OF LONG-TERM CARE INSURANCE ACT PROVISIONS

	MARYLAND	MASSACHUSETTS	MICHIGAN	MINNESOTA
Cite	art. 48A §§ 642 to 649 (1989)	211 Code of Mass. Regs. 65:01 to 65:16 (1989)	§§ 500.3901 to 500.3955 (1992)	§§ 62A.46 to 62A.56 (1986/1990)
Based on Model?	Yes	Partially	Yes	No
Definition of Long-Term Care Insurance	Not less than 24 mo., last sentence of model definition included	Most of model language, no time specified	Not less than 12 mo., most of model language	No specified length of policy, none of model language
Specific Provision for Life Insurance Riders?	No	No	Yes	No
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?	Yes	No provision	Yes	No provision
Preexisting Condition Provision	9 mo. instead of 6, may not contain exclusion or waiver	6 mo	6 mo., may not contain exclusion or waiver	90 days
Can Condition Coverage on Prior Hospitalization?	Prohibited after 7-1-90	Prohibited	Prohibited	Prohibited
Uniform 30 Day "Free Look"	Yes	No provision	Yes	Yes
Requires Outline of Coverage	Same as original model	No provision	Yes, mostly model	Requires an outline, no contents specified
Policy Summary for Life Products	No provision	No provision	Yes	No provision
Report of Accelerated Death Benefits Required?	No	No	Yes	No
Miscellaneous				Requires offering of two policies with different levels of coverage; must specify another person who will get notice of cancellation for nonpayment of premiums

STATE ADOPTIONS OF LONG-TERM CARE INSURANCE ACT PROVISIONS

	MISSISSIPPI	MISSOURI	MONTANA	NEBRASKA
Cite	Reg. 90-102 (1990)	§§ 376.951 to 376.958 (1990)	§§ 33-22-1101 to 33-22-1121 (1989/1991) §§ 33-20-127 to 33-20-128 (1991)	§§ 44-4501 to 44-4517 (1987/1992)
Based on Model?	Yes	Yes	Yes	Yes
Definition of Long-Term Care Insurance	Not less than 12 mo.; model language	Not less than 12 mo., model language	Not less than 12 mo., model language	Not less than 12 mo. most of model language
Specific Provision for Life Insurance Riders?	Yes	Yes	Yes	Yes
Provision that Does Not Limit to Skilled Care or Give Significantly More Coverage?	Yes	Yes	Yes	Yes
Preexisting Condition Provision	6 mo., may not contain exclusion or waiver	6 mo., may not contain exclusion or waiver	6 mo., may not contain exclusion or waiver	6 mo., may not contain exclusion or waiver
Can Condition Coverage on Prior Hospitalization?	Prohibited	Prohibited	Prohibited	Prohibited after 8-25-90
Uniform 30 Day "Free Look"	Yes	Yes	10/30 as in original model	Yes
Requires Outline of Coverage	Current model language	Current model language	Current model language	Current model language
Policy Summary for Life Products	Yes	Yes	Yes	Yes
Report of Accelerated Death Benefits Required?	Yes	Yes	Yes	Yes
Miscellaneous				

STATE ADOPTIONS OF LONG-TERM CARE INSURANCE ACT PROVISIONS

	NEVADA	NEW HAMPSHIRE	NEW JERSEY	NEW MEXICO
Cite	Regulation §§ 687B.010 to 687B.135 (1988/1991)	§§ 415-D:1 to 415-D:11 (1990)	Admin. Code §§ 11.4-34.1 to 11.4-34.13 (1989)	§§ 59A-23A-1 to 59A-23A-8 (1989)
Based on Model?	Yes	Yes	Yes	Yes
Definition of Long-Term Care Insurance	Not less than 24 mo., most of model language	Not less than 24 mo.; most of model language	Not less than 24 mo., most of model language	At least 6 mo. coverage, most of model language
Specific Provision for Life Insurance Riders?	No	No	No	No
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?	Yes	Yes	Yes	Yes
Preexisting Condition Provision	6 mo., may not contain exclusion or waiver	6 mo., may not use exclusion or waiver	6 mo., may not use exclusion or waiver	6 mo., may not use exclusion or waiver
Can Condition Coverage on Prior Hospitalization?	Prohibited after 1-11-91	Prohibited	Prohibited	Permitted if also offer a policy without such requirement
Uniform 30 Day "Free Look"	10/30 as in original model	Yes	Yes	Yes
Requires Outline of Coverage	Same as original model	Requires outline, more brief than current model	No provision	Outline of coverage as in original model
Policy Summary for Life Products	No provision	No provision	No provision	No provision
Report of Accelerated Death Benefits Required?	No	No	No	No
Miscellaneous			AB 317 pending	

STATE ADOPTIONS OF LONG-TERM CARE INSURANCE ACT PROVISIONS

	NEW YORK	NORTH CAROLINA	NORTH DAKOTA	OHIO
Cite	§ 1117 (1986); Reg. 62 (1991)	§§ 58-55-1 to 58-55-35 (1987/1991)	§§ 26.1-45-01 to 26.1-45-12 (1987/1991)	§§ 3923.41 to 3923.48 (1988/1992)
Based on Model?	Statute: no, Reg. contains some of model act	Yes	Yes	Yes
Definition of Long-Term Care Insurance	Not less than 24 mo.	Not less than 12 mo., most of model language	Not less than 1 yr., model language	Not less than 1 yr.; model language
Specific Provision for Life Insurance Riders?	No	No	Yes	Yes
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?	All options provide coverage for all levels of care	Yes	Yes	Yes
Preexisting Condition Provision	6 mo.	6 mo. no provision regarding exclusions or waivers	6 mo. with specific exception; no waivers or exclusions	6 mo.
Can Condition Coverage on Prior Hospitalization?	Prohibited	Prohibited after 10-1-88	Prohibited after 7-12-90	Prohibited after 8-14-92
Uniform 30 Day "Free Look"	No provision	Yes	Yes	Yes
Requires Outline of Coverage	Provisions in regulation like model	Outline of coverage, as in original model	Current model language	Current model language
Policy Summary for Life Products	No provision	No provision	Yes	Yes
Report of Accelerated Death Benefits Required?	No	No	Yes	Yes
Miscellaneous	Contains criteria commissioner may use for policy approval			

STATE ADOPTIONS OF LONG-TERM CARE INSURANCE ACT PROVISIONS

	OKLAHOMA	OREGON	PENNSYLVANIA	RHODE ISLAND
Cite	tit. 36 §§ 4421 to 4427 (1987/1989)	§§ 743.650 743.656 (1989)	HB 506 pending	§§ 27-34.2-1 to 27-34.2-12 (1988/1992)
Based on Model?	Yes	Yes	Yes	Yes
Definition of Long-Term Care Insurance	Not less than 12 mo., model language	Not less than 24 mo., most of model language		Not less than 12 mo., most of model language
Specific Provision for Life Insurance Riders?	Yes	No		Yes
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?	No provision	Yes, evaluation based on aggregate days of care covered for lower levels of care, when compared to days of care covered for skilled care		Yes, evaluation based on aggregate days of care covered for lower levels of care when compared to days of care covered for skilled care
Preexisting Condition Provision	12 mo. if 65 or older, 24 mo. if under 65; no language regarding exclusions or waivers	6 mo., may not use exclusions or waivers		6 mo., may not use exclusions or waivers
Can Condition Coverage on Prior Hospitalization?	Allowed	Prohibited		Prohibited
Uniform 30 Day "Free Look"	10/30 as in original model	Yes		10/30 as in original model
Requires Outline of Coverage	Outline of coverage similar to original model	Current model language		Current model language
Policy Summary for Life Products	Yes, in regulation	No provision		Yes
Report of Accelerated Death Benefits Required?	No	No		Yes
Miscellaneous				Policy provisions to be based on Uniform Policy Provision Law

STATE ADOPTIONS OF LONG-TERM CARE INSURANCE ACT PROVISIONS

	SOUTH CAROLINA	SOUTH DAKOTA	TENNESSEE	TEXAS
Cite	§§ 38-72-10 to 38-72-100 (1988/1991)	§§ 58-17B-1 to 58-17B-15 (1989/1991)	§§ 56-42-101 to 56-42-106 (1988/1991)	art. 3.70-12 (1991); Regulation 3.3801 to 3.3838 (1990)
Based on Model?	Yes	Yes	Yes	Yes
Definition of Long-Term Care Insurance	Not less than 12 mo., model language	Not less than 24 mo., most of model language	Not less than 12 mo., most of model language	Not less than 12 mo., model language
Specific Provision for Life Insurance Riders?	Yes	Yes, in regulation	No	No
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?	Yes	Yes	Yes, evaluation based on aggregate days of care covered for lower levels of care when compared to days of care covered for skilled care	Yes, in regulation
Preexisting Condition Provision	6 mo., no language on exclusions or waivers	6 mo., may not use exclusions or waivers	6 mo., may not use waivers or riders to limit or reduce benefits	6 mo., may not use exclusion or waiver
Can Condition Coverage on Prior Hospitalization?	Prohibited	Prohibited after 7-1-91	Prohibited after 7-1-91	Prohibited in regulation
Uniform 30 Day "Free Look"	Yes	Yes	Yes	Yes
Requires Outline of Coverage	Current model language	Outline of coverage as in original model	Current model language	Outline of coverage in regulation
Policy Summary for Life Products	Yes	No provision	No provision	No provision
Report of Accelerated Death Benefits Required?	Yes	No	No	No
Miscellaneous				Commissioner authorized to adopt regulations no less favorable than model

STATE ADOPTIONS OF LONG-TERM CARE INSURANCE ACT PROVISIONS

	UTAH	VERMONT	VIRGINIA	WASHINGTON
Cite	§§ 31A-22-1401 to 31A-22-1410 (1991)	tit. 8 §§ 8051 to 8063 (1989)	§§ 38.2-5200 to 38.2-5208 (1987/1990)	§§ 48.84.010 to 48.84.910 (1988)
Based on Model?	Yes	Yes	Yes	No
Definition of Long-Term Care Insurance	Not less than 12 mo., model language	Not less than 12 mo., most of model language	Not less than 12 mo., model language	Definition does not contain minimum period of coverage; disability rule says "prolonged period of time"
Specific Provision for Life Insurance Riders?	Yes	No	Yes	No
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?	Yes	Yes	Yes	Yes, can't differentiate benefits on basis of level of care
Preexisting Condition Provision	6 mo., may not use waiver or riders to limit or reduce benefits	6 mo., may not use waiver or riders to limit or reduce benefits	6 mo., no waiver or exclusion allowed	Sought treatment 1 year before or 6 mo. after effective date, definition similar to model
Can Condition Coverage on Prior Hospitalization?	Prohibited	Prohibited	Prohibited	Reg. says if require prior hospitalization or skilled care, must also offer policy without requirement
Uniform 30 Day "Free Look"	Yes	Yes	Yes	30 days for individual policies, 60 for direct response
Requires Outline of Coverage	Current model language	Outline of coverage as in original model plus buyer's guide	Current model language	No provision
Policy Summary for Life Products	Yes	No provision	Requires consumer's guide and policy summary	
Report of Accelerated Death Benefits Required?	Yes	No	Provision for accel benefits	No
Miscellaneous			HB 477 would amend, carried over to 1993 session	Agent may not complete medical history portion of application

STATE ADOPTIONS OF LONG-TERM CARE INSURANCE ACT PROVISIONS

	WEST VIRGINIA	WISCONSIN	WYOMING	TOTALS
Cite	§§ 33-15A-1 to 33-15A-7 (1989)	§§ 632.71 to 632.84, 600.03, 625.16 (1989/1990); Reg. INS. 3.46 (1991)	§§ 26-38-101 to 26-38-106 (1988/1991)	
Based on Model?	Yes	No	Yes	42 - based on model 5 - not based on model 2 - partially
Definition of Long-Term Care Insurance	Not less than 24 mo., most of model language	Not less than 365 days	Not less than 12 mo., model language	33 - 12 mo. 11 - 24 mo. 7 - Other
Specific Provision for Life Insurance Riders?	No	Yes	Yes	27 - with specific provisions
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?	Yes	In regulation	Yes	44 - can't limit
Preexisting Condition Provision	6 mo., may not contain waiver or exclusion	6 mo., no waiver or exclusion language	6 months, no waiver or exclusive language	40 - 6 mo. provision 2 - 6/24 mo. provision 6 - Other
Can Condition Coverage on Prior Hospitalization?	Prohibited after 7-1-90	Regulation prohibits after 6-1-91	Prohibited after 7-1-91	43 - Prohibit 0 - Allow 5 - Other
Uniform 30 Day "Free Look"	10/30 as in original model	Yes	Yes	37 - 30 day free look 5 - 10/30 1 - Other
Requires Outline of Coverage	Current model language on outline	In regulation, not model	As in original model	45 - Require Outline of Coverage
Policy Summary for Life Products	No provision	Yes, in regulation	No provision	24 - Require Summary
Report of Accelerated Death Benefits Required?	No	No	No	18 - Require Report

Miscellaneous

Every effort has been made to make this information as correct and complete as possible. For questions about specific state laws, you should consult the statutes.

NAIC
10/15/92

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NAIC
STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	Alabama	Alaska
Cite	Reg. 91 (1990)	Drafting
Based on Model?	Yes	
Adopted Model Law?	Most of Act combined with regulation	Yes
Individual Policies are Guaranteed Renewable	Model language	
Provision for Continuation and Conversion	Model language	
Provision for Discontinuance and Replacement	No provision	
Prohibition of Attained Age or Duration Rating	No provision	
Prohibit Post-Claims Underwriting	Model language	
Rescission Reporting Requirement	No provision	
Standards for Home Health Care	Model language	
Offer of Inflation Protection	Most of model language	
Requirement for Application Forms and Replacement Notices	Model language before 1990 amendments	
Reporting of Lapse Rates	No provision	
Agents Licensing Requirements	No provision	
Reserve Standards for Accelerated Life Products	Model language	
Loss Ratios	At least 60% loss ratio for individual and group, use model criteria for evaluation	
Filing Requirement for Out-of-State Group Policy	Yes	
Filing Requirement for Advertising	No provision	
Standards for Marketing	No provision	
Agent Shall Make Effort to Determine Appropriateness	No provision	
Replacement Policies Must Not Have Preexisting Condition Limit	No provision	
Standard Format for Outline of Coverage	Model format	
Shopper's Guide	Yes, requirement to deliver NAIC Shopper's Guide	
Penalty Provision	No provision	
Limits on Compensation of Agents	No provision	
Miscellaneous	Consumer protection amendments pending	Using NAIC model in preparing, expect draft in November

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STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	Arizona	Arkansas
Cite	Reg. 4-14-1001 to 4-14-1016 (1992)	Rule 13 (1990/1992)
Based on Model?	Yes	Yes
Adopted Model Law?	Yes	Yes
Individual Policies are Guaranteed Renewable	Yes	Yes
Provision for Continuation and Conversion	Model language	Model language
Provision for Discontinuance and Replacement	Model language	Model language
Prohibition of Attained Age or Duration Rating	No provision	No provision
Prohibits Post-Claims Underwriting	Model language	Model language
Rescission Reporting Requirement	Model language	Model language
Standards for Home Health Care	Model language	Most of model language
Offer of Inflation Protection	Model language	Most of model language
Requirement for Application Forms and Replacement Notices	Model language	Model language
Reporting of Lapse Rates	Model language	Model language
Agents Licensing Requirements	No provision	No provision
Reserve Standards for Accelerated Life Products	Model language	Model language
Loss Ratios	At least 60% loss ratio for individual policies, use model criteria for evaluation	At least 60% loss ratio for individual policies, use model criteria for evaluation
Filing Requirement for Out-of-State Group Policy	Yes	Yes
Filing Requirement for Advertising	Model language	Model language
Standards for Marketing	Model language	Model language
Agent Shall Make Effort to Determine Appropriateness	No provision	Model language
Replacement Policies Must Not Have Preexisting Condition Limit	No provision	Model language
Standard Format for Outline of Coverage	Model format	Model format
Shopper's Guide	Yes, requirement to deliver NAIC Shopper's Guide	Yes, requirement to deliver NAIC Shopper's Guide
Penalty Provision	No provision	Model language
Limits on Compensation of Agents	No provision	No provision
Miscellaneous		

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NAIC
STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	California	Colorado
Cite	Ins. Code §§ 10230 to 10237.2 (1988/1992)	Reg. 4-4-1 (1991)
Based on Model?	Yes	Yes
Adopted Model Law?	Yes	Yes
Individual Policies are Guaranteed Renewable	Yes	Yes
Provision for Continuation and Conversion	Model language	Model language
Provision for Discontinuance and Replacement	Yes, not model language	Uses health insurance provision in statute
Prohibition of Attained Age or Duration Rating	No provision	No provision
Prohibits Post-Claims Underwriting	Model language	Model language
Rescission Reporting Requirement	Model language	Model language
Standards for Home Health Care	Model language and more on ADLs	Model language
Offer of Inflation Protection	Most of model language	Most of model language
Requirement for Application Forms and Replacement Notices	Model language before 1990 amendments	Model language before 1990 amendments
Reporting of Lapse Rates	No provision	No provision
Agents Licensing Requirements	No provision	No provision
Reserve Standards for Accelerated Life Products	No provision	No provision
Loss Ratios	Loss ratio of 60% for individual policies, use model criteria for evaluation	Loss ratio of 60% for all policies, use model criteria for evaluation
Filing Requirement for Out-of-State Group Policy	Yes	Yes
Filing Requirement for Advertising	Yes, not model language	No provision
Standards for Marketing	Model language	No provision
Agent Shall Make Effort to Determine Appropriateness	Model language	No provision
Replacement Policies Must Not Have Preexisting Condition Limit	Model language	No provision
Standard Format for Outline of Coverage	Model format	Model format
Shopper's Guide	No provision	Yes, in form approved by commissioner
Penalty Provision	Yes, not model language	Yes, not model language
Limits on Compensation of Agents	File commission structure with department	No provision
Miscellaneous	Enhanced definition of senile dementia, which must be covered; includes amendments effective 1-1-93	

NAIC
STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	Connecticut	Delaware
Cite	ch. 38a §§ 501-1 to 501-7 (1986); §§ 475-1 to 475-6 (1991)	Reg. 63 (1990)
Based on Model?	No	Yes
Adopted Model Law?	No	Yes
Individual Policies are Guaranteed Renewable	No provision	Model language
Provision for Continuation and Conversion	Includes provision consistent with model	Model language
Provision for Discontinuance and Replacement	No provision	No provision
Prohibition of Attained Age or Duration Rating	No provision	No provision
Prohibits Post-Claims Underwriting	No provision	Model language
Rescission Reporting Requirement	No provision	Model language
Standards for Home Health Care	Statute requires coverage; no specific standards except for precertified policies	Model language
Offer of Inflation Protection	No provision except for precertified policies	Most of model language
Requirement for Application Forms and Replacement Notices	Model language before 1990 amendments	Model language before 1990 amendments
Reporting of Lapse Rates	No provision	File information on lapses with annual statement
Agents Licensing Requirements	No provision	No provision
Reserve Standards for Accelerated Life Products	No provision	Model language
Loss Ratios	Loss ratio of at least 60% for individual policies	Loss ratio of at least 60% for individual policies and groups under 250, use model criteria for evaluation
Filing Requirement for Out-of-State Group Policy	Prior approval of all policies required by statute	Yes
Filing Requirement for Advertising	No provision	No provision
Standards for Marketing	No provision	No provision
Agent Shall Make Effort to Determine Appropriateness	No provision	No provision
Replacement Policies Must Not Have Preexisting Condition Limit	No provision	No provision
Standard Format for Outline of Coverage	No provision	Model format
Shopper's Guide	No provision	No provision
Penalty Provision	No provision	No provision
Limits on Compensation of Agents	No provision	No provision
Miscellaneous	Includes provisions for certification for CT Partnership for Long-Term Care	Cost disclosure provision, pending amendments include recent NAIC changes

NAIC
STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	District of Columbia	Florida
Cite	No action to date	§§ 4-81.001 to 4-81.022 (1989)
Based on Model?		Yes
Adopted Model Law?	No	Yes
Individual Policies are Guaranteed Renewable		Yes
Provision for Continuation and Conversion		Model language
Provision for Discontinuance and Replacement		No provision
Prohibition of Attained Age or Duration Rating		No provision
Prohibits Post-Claims Underwriting		No provision
Rescission Reporting Requirement		No provision
Standards for Home Health Care		Most of model language in statute
Offer of Inflation Protection		No provision
Requirement for Application Forms and Replacement Notices		Model language before 1990 amendments
Reporting of Lapse Rates		No provision
Agents Licensing Requirements		No provision
Reserve Standards for Accelerated Life Products		No provision
Loss Ratios		Loss ratio of at least 60% for all policies, use model criteria for evaluation
Filing Requirement for Out-of-State Group Policy		Yes
Filing Requirement for Advertising		Yes, in statute, not model language
Standards for Marketing		No provision
Agent Shall Make Effort to Determine Appropriateness		No provision
Replacement Policies Must Not Have Preexisting Condition Limit		Only if replacement policy from same insurer
Standard Format for Outline of Coverage		No provision
Shopper's Guide		No provision
Penalty Provision		No provision
Limits on Compensation of Agents		No provision
Miscellaneous		Nonduplication provision

NAIC
STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	Georgia	Hawaii
Cite	Ch. 120-2-16 (1989)	Drafting
Based on Model?	Yes	
Adopted Model Law?	Yes	Yes
Individual Policies are Guaranteed Renewable	Model language	
Provision for Continuation and Conversion	Model language	
Provision for Discontinuance and Replacement	No provision	
Prohibition of Attained Age or Duration Rating	No provision	
Prohibits Post-Claims Underwriting	No provision	
Rescission Reporting Requirement	No provision	
Standards for Home Health Care	No provision	
Offer of Inflation Protection	Yes	
Requirement for Application Forms and Replacement Notices	Model language before 1990 amendments	
Reporting of Lapse Rates	No provision	
Agents Licensing Requirements	No provision	
Reserve Standards for Accelerated Life Products	No provision	
Loss Ratios	Loss ratio of at least 60% for all policies, use model criteria for evaluation	
Filing Requirement for Out-of-State Group Policy	Yes	
Filing Requirement for Advertising	Prior approval of all advertising	
Standards for Marketing	No provision	
Agent Shall Make Effort to Determine Appropriateness	No provision	
Replacement Policies Must Not Have Preexisting Condition Limit	No provision	
Standard Format for Outline of Coverage	Model format	
Shopper's Guide	Must deliver Buyer's Guide attached to regulation	
Penalty Provision	No provision	
Limits on Compensation of Agents	No provision	
Miscellaneous		Expect draft late this year

NAIC
STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	Idaho	Illinois
Cite	Regulation 60 (1990)	tit. 50 §§ 2012.10 to 2012.110 (1990)
Based on Model?	Yes	Yes
Adopted Model Law?	Yes	Yes
Individual Policies are Guaranteed Renewable	Model language	Model language
Provision for Continuation and Conversion	Model language	Model language
Provision for Discontinuance and Replacement	No provision	No provision
Prohibition of Attained Age or Duration Rating	No provision	No provision
Prohibits Post-Claims Underwriting	Model language	No provision
Rescission Reporting Requirement	Model language	No provision
Standards for Home Health Care	Model language	Model language
Offer of Inflation Protection	Most of model language	Most of model language
Requirement for Application Forms and Replacement Notices	Model language before 1990 amendments	Model language before 1990 amendments
Reporting of Lapse Rates	No provision	No provision
Agents Licensing Requirements	No provision	No provision
Reserve Standards for Accelerated Life Products	Model language	Model language
Loss Ratios	At least 60% for individual policies, loss ratio, use model criteria for evaluation	At least 60% loss ratio for individual and all direct response policies ; use some model criteria for evaluation
Filing Requirement for Out-of-State Group Policy	Yes	Yes
Filing Requirement for Advertising	No provision	No provision
Standards for Marketing	No provision	Statutory authority to adopt regulation
Agent Shall Make Effort to Determine Appropriateness	No provision	No provision
Replacement Policies Must Not Have Preexisting Condition Limit	No provision	No provision
Standard Format for Outline of Coverage	Model format	Model format
Shopper's Guide	No provision	No provision
Penalty Provision	No provision	No provision
Limits on Compensation of Agents	No provision	No provision
Miscellaneous		

NAIC
STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	Indiana	Iowa
Cite	tit. 760 R-1-43-1 to 1-43-11 (1989)	§§ 191-39.1 to 191-39.10 (1988/1992)
Based on Model?	Yes	Yes
Adopted Model Law?	Yes	Yes
Individual Policies are Guaranteed Renewable	Model language	Model language
Provision for Continuation and Conversion	Must provide, but no standards specified	Model language
Provision for Discontinuance and Replacement	No provision	Model language
Prohibition of Attained Age or Duration Rating	No provision	No provision
Prohibits Post-Claims Underwriting	No provision	Model language
Rescission Reporting Requirement	No provision	Model language
Standards for Home Health Care	No provision	Model language
Offer of Inflation Protection	No provision	Most of model language
Requirement for Application Forms and Replacement Notices	Model language before 1990 amendments	Model language
Reporting of Lapse Rates	Statutory authority to adopt regulation	No provision
Agents Licensing Requirements	No provision	No provision
Reserve Standards for Accelerated Life Products	No provision	Model language
Loss Ratios	At least 60% loss ratio for individual policies, use model criteria for evaluation	At least 60% loss ratio for individual policies, use model criteria for evaluation
Filing Requirement for Out-of-State Group Policy	Yes	Yes
Filing Requirement for Advertising	No provision	No provision
Standards for Marketing	Statutory authority to adopt regulation	Model language
Agent Shall Make Effort to Determine Appropriateness	No provision	Model language
Replacement Policies Must Not Have Preexisting Condition Limit	No provision	Model language
Standard Format for Outline of Coverage	No provision	Model format
Shopper's Guide	No provision	Model shopper's guide or others specified
Penalty Provision	Close to model language in statute	No provision
Limits on Compensation of Agents	First year compensation no more than 200% second and succeeding years by statute	No provision
Miscellaneous		Return of premium provision

NAIC
STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	Kansas	Kentucky
Cite	§ 40-4-37 (1988/1992)	Reg. 17:080 (1987); Code §§ 304.17-312 to 304.17-313 (1980)
Based on Model?	Partially	No
Adopted Model Law?	Yes	Yes, in 1992
Individual Policies are Guaranteed Renewable	Earlier version of model language, more brief	No
Provision for Continuation and Conversion	No provision	Use health insurance provision in statute
Provision for Discontinuance and Replacement	No provision	No provision
Prohibition of Attained Age or Duration Rating	No provision	No provision
Prohibits Post-Claims Underwriting	No provision	No provision
Rescission Reporting Requirement	No provision	No provision
Standards for Home Health Care	No provision	Statute requires offering home health care policies and contains requirements
Offer of Inflation Protection	No provision	No provision
Requirement for Application Forms and Replacement Notices	Similar to model language	Use rules for health insurance replacement in 12:060
Reporting of Lapse Rates	No provision	No provision
Agents Licensing Requirements	No provision	No provision
Reserve Standards for Accelerated Life Products	No provision	No provision
Loss Ratios	Loss ratio of at least 55% for individual policies, 80% for group policies	Anticipated loss ratios of at least 50% for individual policies
Filing Requirement for Out-of-State Group Policy	Prior approval of all policies required by statute	Prior approval of all policies required by statute
Filing Requirement for Advertising	No provision	No provision
Standards for Marketing	No provision	No provision
Agent Shall Make Effort to Determine Appropriateness	No provision	No provision
Replacement Policies Must Not Have Preexisting Condition Limit	Yes, if replacing same company's policy	No provision
Standard Format for Outline of Coverage	No provision	Not based on NAIC model
Shopper's Guide	No provision	Statute requires Commissioner to prepare and update annually
Penalty Provision	No provision	No provision
Limits on Compensation of Agents	No provision	No provision
Miscellaneous		Must advertise availability of coverage yearly, NAIC current regulation will be promulgated

NAIC

STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	Louisiana	Maine
Cite	Drafting	Ch. 420 §§ 1 to 12 (1988/1991)
Based on Model?		Partially
Adopted Model Law?	Yes	No
Individual Policies are Guaranteed Renewable		All policies must be guaranteed renewable for life
Provision for Continuation and Conversion		Must provide, not based on model
Provision for Discontinuance and Replacement		No provision
Prohibition of Attained Age or Duration Rating		No provision
Prohibits Post-Claims Underwriting		Model language
Rescission Reporting Requirement		Model language
Standards for Home Health Care		Yes, not based on model
Offer of Inflation Protection		Most of model language
Requirement for Application Forms and Replacement Notices		Model language
Reporting of Lapse Rates		No provision
Agents Licensing Requirements		No provision
Reserve Standards for Accelerated Life Products		No provision
Loss Ratios		At least 60% loss ratios for all policies, use model criteria for evaluation
Filing Requirement for Out-of-State Group Policy		Prior approval of all policies required by statute
Filing Requirement for Advertising		No provision
Standards for Marketing		Standards not based on model
Agent Shall Make Effort to Determine Appropriateness		No provision
Replacement Policies Must Not Have Preexisting Condition Limit		Model language
Standard Format for Outline of Coverage		Format not based on NAIC model
Shopper's Guide		Regulation contains guide not based on model
Penalty Provision		No provision
Limits on Compensation of Agents		Authority to adopt regulation in statute
Miscellaneous	Using NAIC model as form for draft	Encourage innovative policy designs, contains tax incentives, requires reporting of multiple policies

NAIC
STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	Maryland	Massachusetts
Cite	**§ 09.30.08 pending (1992)**	**211 Code of Mass. Regs. 65:01 to 65:16 (1989)**
Based on Model?	**Yes**	**Partially**
Adopted Model Law?	**Yes**	**Parts of model act included in regulation**
Individual Policies are Guaranteed Renewable		**Yes**
Provision for Continuation and Conversion		**Contains continuation provision**
Provision for Discontinuance and Replacement		**No provision**
Prohibition of Attained Age or Duration Rating		**No provision**
Prohibits Post-Claims Underwriting		**No provision**
Rescission Reporting Requirement		**No provision**
Standards for Home Health Care		**Must provide home health care benefits**
Offer of Inflation Protection		Yes, not model language
Requirement for Application Forms and Replacement Notices		Model language before 1990 amendments
Reporting of Lapse Rates		No provision
Agents Licensing Requirements		No provision
Reserve Standards for Accelerated Life Pr s		No provision
Loss Ratios		Loss ratios of 60% for individual policies, 80% for group
Filing Requirement for Out-of-State Group Policy		Yes, extensive form and rate filing requirements for all policies
Filing Requirement for Advertising		No provision
Standards for Marketing		No provision
Agent Shall Make Effort to Determine Appropriateness		No provision
Replacement Policies Must Not Have Preexisting Condition Lims		No provision
Standard Format for Outline of Coverage		Requires "disclosure statement" not based on model format
Shopper's Guide		No provision
Penalty Provision		No provision
Limits on Compensation of Agents		No provision
Miscellaneous	Hearing 9/9/92, open comment period follows	May not exclude mental and nervous conditions

NAIC
STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	Michigan	Minnesota
Cite	§§ 500.3901 to 500.3955 (1992)	§§ 62A.46 to 62A.56 (1986/1990)
Based on Model?	Yes	No
Adopted Model Law?	Model act and regulation both in statute	No
Individual Policies are Guaranteed Renewable	Model language	Yes; not model language
Provision for Continuation and Conversion	Model language	No provision
Provision for Discontinuance and Replacement	Model language	No provision
Prohibition of Attained Age or Duration Rating	Model language	No provision
Prohibits Post-Claims Underwriting	Model language	Similar provision
Rescission Reporting Requirement	Model language	No provision
Standards for Home Health Care	Model language	Yes
Offer of Inflation Protection	Model language	No provision
Requirement for Application Forms and Replacement Notices	Model language	No provision
Reporting of Lapse Rates	Model language	No provision
Agents Licensing Requirements	No provision	No provision
Reserve Standards for Accelerated Life Products	Model language	No provision
Loss Ratios	At least 60% loss ratio for individual policies; use model criteria for evaluation	60% individual, 65% group loss ratio
Filing Requirement for Out-of-State Group Policy	Yes	Yes
Filing Requirement for Advertising	No provision	No provision
Standards for Marketing	Model language	Yes, not model
Agent Shall Make Effort to Determine Appropriateness	No provision	No provision
Replacement Policies Must Not Have Preexisting Condition Limit	Model language	No provision
Standard Format for Outline of Coverage	Model format	Yes; not model format
Shopper's Guide	NAIC Shopper's Guide required	No provision
Penalty Provision	No provision	No provision
Limits on Compensation of Agents	Three year level commissions on policies sold to persons 65 and older	Four year level commissions
Miscellaneous		Regulation defines ADL and cognitive impairment assessments

NAIC
STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	Mississippi	Missouri
Cite	Regulation 90-102 (1990)	tit. 20 ch. 400-4.100 (1991)
Based on Model?	Yes	Yes
Adopted Model Law?	Most of model act combined with regulation	Yes
Individual Policies are Guaranteed Renewable	Model language	Model language
Provision for Continuation and Conversion	Model language	Model language
Provision for Discontinuance and Replacement	No provision	Model language
Prohibition of Attained Age or Duration Rating	No provision	No provision
Prohibits Post-Claims Underwriting	Model language	Model language
Rescission Reporting Requirement	Model language	Model language
Standards for Home Health Care	Model language	Model language
Offer of Inflation Protection	Most of model language	Most of model language
Requirement for Application Forms and Replacement Notices	Model language	Model language
Reporting of Lapse Rates	No provision	Model language
Agents Licensing Requirements	No provision	Yes, not model language
Reserve Standards for Accelerated Life Products	Model language	Model language
Loss Ratios	At least 60% loss ratio for individual policies, use model criteria for evaluation	At least 60% loss ratio for individual policies, use model criteria for evaluation
Filing Requirement for Out-of-State Group Policy	Yes	Yes
Filing Requirement for Advertising	No provision	No, but insurer should retain for 3 years
Standards for Marketing	No provision	Model language
Agent Shall Make Effort to Determine Appropriateness	No provision	Model language
Replacement Policies Must Not Have Preexisting Condition Limit	No provision	Model language
Standard Format for Outline of Coverage	Model format	Model format
Shopper's Guide	Requires delivery of NAIC Shopper's Guide	Requires delivery of NAIC Shopper's Guide
Penalty Provision	No provision	No provision
Limits on Compensation of Agents	No provision	No provision
Miscellaneous		

NAIC
STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

Cite	Montana Reg. 6.6.3101 to 6.6.3116 (1991)	Nebraska tit. 210 ch. 46 (1989/1992), Bulletin CB-76 (1991)
Based on Model?	Yes	Yes
Adopted Model Law?	Yes	Yes
Individual Policies are Guaranteed Renewable	Model language	Model language
Provision for Continuation and Conversion	Model language	Model language
Provision for Discontinuance and Replacement	No provision	Model language
Prohibition of Attained Age or Duration Rating	No provision	No provision
Prohibits Post-Claims Underwriting	Model language	Model language
Rescission Reporting Requirement	Model language	Model language
Standards for Home Health Care	Model language	Model language
Offer of Inflation Protection	Most of model language	Most of model language
Requirement for Application Forms and Replacement Notices	Model language before 1990 amendments	Model language
Reporting of Lapse Rates	No provision	Model language
Agents Licensing Requirements	No provision	Model language
Reserve Standards for Accelerated Life Products	Model language	Model language
Loss Ratios	At least 60% loss ratio for individual policies, uses model criteria for evaluation	At least 60% loss ratio for individual policies, uses model criteria for evaluation
Filing Requirement for Out-of-State Group Policy	Yes	Yes
Filing Requirement for Advertising	No provision	Model language
Standards for Marketing	No provision	Model language
Agent Shall Make Effort to Determine Appropriateness	No provision	Model language
Replacement Policies Must Not Have Preexisting Condition Limit	No provision	Model language
Standard Format for Outline of Coverage	Model format	Model format
Shopper's Guide	Requires delivery of NAIC Shopper's Guide	Requires delivery of NAIC Shopper's Guide
Penalty Provision	No provision	Model language
Limits on Compensation of Agents	No provision	No provision
Miscellaneous		Amendments pending

NAIC

STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	Nevada	New Hampshire
Cite	§§ 687B.005 to 687B.135 (1988/1991)	Model pending
Based on Model?	Yes	
Adopted Model Law?	Model law provisions incorporated into regulation	Yes
Individual Policies are Guaranteed Renewable	Model language	
Provision for Continuation and Conversion	Must provide, no specifics	
Provision for Discontinuance and Replacement	No provision	
Prohibition of Attained Age or Duration Rating	No provision	
Prohibits Post-Claims Underwriting	No provision	
Rescission Reporting Requirement	No provision	
Standards for Home Health Care	No provision	
Offer of Inflation Protection	No provision	
Requirement for Application Forms and Replacement Notices	Model language before 1990 amendments	
Reporting of Lapse Rates	No provision	
Agents Licensing Requirements	No provision	
Reserve Standards for Accelerated Life Products	No provision	
Loss Ratios	At least 60% loss ratio for individual policies, uses model criteria for evaluation	
Filing Requirement for Out-of-State Group Policy	Yes	All policies must be filed before used, by statute
Filing Requirement for Advertising	No provision	
Standards for Marketing	No provision	
Agent Shall Make Effort to Determine Appropriateness	No provision	
Replacement Policies Must Not Have Preexisting Condition Limit	No provision	
Standard Format for Outline of Coverage	Model act outline	
Shopper's Guide	Use guide approved by commissioner or NAIC Shopper's Guide	
Penalty Provision	No provision	
Limits on Compensation of Agents	No provision	
Miscellaneous		Hearing 9/14/92

NAIC
STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	New Jersey	New Mexico
Cite	§§ 11.4-34.1 to 11.4-34.13 (1989)	Planning to draft
Based on Model?	Yes	
Adopted Model Law?	Some of model law included in regulation	Yes
Individual Policies are Guaranteed Renewable	Model language	Required by statute, not model language
Provision for Continuation and Conversion	Model language	
Provision for Discontinuance and Replacement	No provision	
Prohibition of Attained Age or Duration Rating	No provision	
Prohibits Post-Claims Underwriting	No provision	
Rescission Reporting Requirement	No provision	
Standards for Home Health Care	No provision	
Offer of Inflation Protection	No provision	
Requirement for Application Forms and Replacement Notices	Model language before 1990 amendments	
Reporting of Lapse Rates	No provision	
Agents Licensing Requirements	No provision	
Reserve Standards for Accelerated Life Products	Yes; use standards for individual health policies	
Loss Ratios	Guaranteed renewable 55%, noncancellable 50%	
Filing Requirement for Out-of-State Group Policy	Yes	Yes, in statute
Filing Requirement for Advertising	No provision	
Standards for Marketing	No provision	
Agent Shall Make Effort to Determine Appropriateness	No provision	
Replacement Policies Must Not Have Preexisting Condition Limit	No provision	
Standard Format for Outline of Coverage	Model format	
Shopper's Guide	No provision	
Penalty Provision	No provision	
Limits on Compensation of Agents	No provision	
Miscellaneous		

NAIC
STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	New York	North Carolina
Cite	Reg. 62 (1992)	Ch. 12 §§ 1001 to 1016 (1990/1991); § 0555 (1989/1992)
Based on Model?	Partially	Yes
Adopted Model Law?	No	Yes
Individual Policies are Guaranteed Renewable	Must be guaranteed renewable	Model language
Provision for Continuation and Conversion	Yes, not model language	Model language
Provision for Discontinuance and Replacement	No provision	No provision
Prohibition of Attained Age or Duration Rating	No provision	No provision
Prohibits Post-Claims Underwriting	Mostly model language	Model language
Rescission Reporting Requirement	Model language	Model language
Standards for Home Health Care	Yes, not model language	Model language
Offer of Inflation Protection	Most of model language	Most of model language
Requirement for Application Forms and Replacement Notices	Model language	Model language before 1990 amendments
Reporting of Lapse Rates	No provision	No provision
Agents Licensing Requirements	No provision	License for Medicare Supplement and Long-Term Care in licensing statute
Reserve Standards for Accelerated Life Products	No provision	Model language
Loss Ratios	60% loss ratio ages 64 and below, 65% loss ratio ages 65 and above for all policies	At least 60% loss ratios for individual policies, 75% for group, use model criteria for evaluation
Filing Requirement for Out-of-State Group Policy	Prior approval of all policies required by statute	Yes
Filing Requirement for Advertising	No provision	No provision
Standards for Marketing	No provision	No provision
Agent Shall Make Effort to Determine Appropriateness	No provision	No provision
Replacement Policies Must Not Have Preexisting Condition Limit	No provision	No provision
Standard Format for Outline of Coverage	Model format	Model format
Shopper's Guide	No provision	No provision
Penalty Provision	No provision	No provision
Limits on Compensation of Agents	First year and renewal commissions subject to approval, renewal commissions must be even for reasonable number of years	Replacement policy may pay only renewal commissions unless benefits better
Miscellaneous	Provisions for long-term care nursing home, and home care insurance, includes non-forfeiture provision	Coordination of benefits permitted between true group LTC policies only

NAIC
STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	North Dakota	Ohio
Cite	§§ 45-06-05-01 to 45-06-05-09 (1988/1990)	Model pending
Based on Model?	Yes	Yes
Adopted Model Law?	Yes	Yes
Individual Policies are Guaranteed Renewable	Model language	
Provision for Continuation and Conversion	Model language	
Provision for Discontinuance and Replacement	No provision	
Prohibition of Attained Age or Duration Rating	No provision	
Prohibits Post-Claims Underwriting	Model language	
Rescission Reporting Requirement	Model language	
Standards for Home Health Care	Model language	
Offer of Inflation Protection	Most of model language	
Requirement for Application Forms and Replacement Notices	Model language before 1990 amendments	
Reporting of Lapse Rates	No provision	
Agents Licensing Requirements	No provision	
Reserve Standards for Accelerated Life Products	No provision	
Loss Ratios	At least 60% loss ratios for individual policies, use model criteria for evaluation	
Filing Requirement for Out-of-State Group Policy	Yes	Prior approval of all policies required by statute
Filing Requirement for Advertising	No provision	
Standards for Marketing	No provision	
Agent Shall Make Effort to Determine Appropriateness	No provision	
Replacement Policies Must Not Have Preexisting Condition Limit	No provision	
Standard Format for Outline of Coverage	Model format	
Shopper's Guide	No provision	
Penalty Provision	No provision	
Limits on Compensation of Agents	No provision	
Miscellaneous		Regulation pending is current NAIC model

NAIC
STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	Oklahoma	Oregon
Cite	Reg. 365:10-5-40 (1989/1992)	Reg. 836-52-500 to 836-52-645 (1991/1992)
Based on Model?	Yes	Partially
Adopted Model Law?	Yes	Yes
Individual Policies are Guaranteed Renewable	Model language	No provision
Provision for Continuation and Conversion	Model language	No provision
Provision for Discontinuance and Replacement	Model language	No provision
Prohibition of Attained Age or Duration Rating	No provision	No provision
Prohibits Post-Claims Underwriting	Model language	Model language
Rescission Reporting Requirement	Model language	Model language
Standards for Home Health Care	Model language	Model language
Offer of Inflation Protection	Model language	No provision
Requirement for Application Forms and Replacement Notices	Model language	Model language before 1990 amendments
Reporting of Lapse Rates	Model language	No provision
Agents Licensing Requirements	No provision	No provision
Reserve Standards for Accelerated Life Products	Model language	Most of model language
Loss Ratios	At least 60% loss ratio for individual policies, use model criteria for evaluation	At least 60% loss ratio for individual policies, use model criteria for evaluation
Filing Requirement for Out-of-State Group Policy	Prior approval of all forms	Statute requires prior approval of all forms
Filing Requirement for Advertising	Model language	No provision
Standards for Marketing	Model language	Model language
Agent Shall Make Effort to Determine Appropriateness	Model language	No provision
Replacement Policies Must Not Have Preexisting Condition Limit	No provision	Model language
Standard Format for Outline of Coverage	Model format	Model format allowed; Oregon designed own format
Shopper's Guide	Requirement to deliver NAIC Shopper's Guide	Deliver guide approved by commissioner
Penalty Provision	Penalties in statute	No provision
Limits on Compensation of Agents	No provision	No provision
Miscellaneous	Includes provisions in emergency regs that will expire July 15, 1993 unless approved by the legislature prior to that date	Standards for ADL; rules for rate filings with actuarial memorandum; experience records

NAIC
STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	Pennsylvania	Rhode Island
Cite	No action to date	Reg. XLIV (1989/1990)
Based on Model?		Yes
Adopted Model Law?	No	Yes
Individual Policies are Guaranteed Renewable		Model language
Provision for Continuation and Conversion		No provision
Provision for Discontinuance and Replacement		No provision
Prohibition of Attained Age or Duration Rating		No provision
Prohibits Post-Claims Underwriting		Model language
Rescission Reporting Requirement		Model language
Standards for Home Health Care		Model language
Offer of Inflation Protection		Most of model language
Requirement for Application Forms and Replacement Notices		Model language before 1990 amendments
Reporting of Lapse Rates		No provision
Agents Licensing Requirements		No provision
Reserve Standards for Accelerated Life Products		Model language
Loss Ratios		At least 60% loss ratio for individual policies, use model criteria for evaluation
Filing Requirement for Out-of-State Group Policy		Yes; if other state's laws not substantially similar, policy approval required
Filing Requirement for Advertising		No provision
Standards for Marketing		No provision
Agent Shall Make Effort to Determine Appropriateness		No provision
Replacement Policies Must Not Have Preexisting Condition Limit		No provision
Standard Format for Outline of Coverage		Model format
Shopper's Guide		No provision
Penalty Provision		No provision
Limits on Compensation of Agents		No provision
Miscellaneous		

NAIC
STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	South Carolina	South Dakota
Cite	Reg. 69-44 (1989)	§§ 20:06:21:01 to 20:06:21:09 (1990)
Based on Model?	Yes	No
Adopted Model Law?	Yes	Yes
Individual Policies are Guaranteed Renewable	Model language	Yes, by statute; regulation provides for conditionally renewable policies
Provision for Continuation and Conversion	Model language	No provision
Provision for Discontinuance and Replacement	No provision	No provision
Prohibition of Attained Age or Duration Rating	No provision	No provision
Prohibits Post-Claims Underwriting	No provision	No provision
Rescission Reporting Requirement	No provision	No provision
Standards for Home Health Care	Provides for home care, statute includes option to pay nursing home benefs for home care	No provision
Offer of Inflation Protection	Yes	Yes
Requirement for Application Forms and Replacement Notices	References regulation controlling health insurance	No provision
Reporting of Lapse Rates	No provision	No provision
Agents Licensing Requirements	No provision	No provision
Reserve Standards for Accelerated Life Products	No provision	No provision
Loss Ratios	At least 60% loss ratio for individual policies, use model criteria for evaluation	Individual policy 60%, group 75% loss ratio
Filing Requirement for Out-of-State Group Policy	Yes	Prior approval of all policies required by statute
Filing Requirement for Advertising	No provision	No provision
Standards for Marketing	No provision	No provision
Agent Shall Make Effort to Determine Appropriateness	No provision	No provision
Replacement Policies Must Not Have Preexisting Condition Limit	No provision	No provision
Standard Format for Outline of Coverage	Model format	No provision
Shopper's Guide	No provision	No provision
Penalty Provision	No provision	No provision
Limits on Compensation of Agents	No provision	No provision
Miscellaneous		

NAIC
STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	Tennessee	Texas
Cite	Ch. 0780-1-61 (1991)	§§ 3.3801 to 3.850 (1990/1992)
Based on Model?	Yes	Yes
Adopted Model Law?	Yes	Some of model act included in regulation
Individual Policies are Guaranteed Renewable	Model language	Yes
Provision for Continuation and Conversion	Model language	Model language
Provision for Discontinuance and Replacement	No provision	Model language
Prohibition of Attained Age or Duration Rating	No provision	No provision
Prohibits Post-Claims Underwriting	Model language	Model language
Rescission Reporting Requirement	Model language	Model language
Standards for Home Health Care	Model language	Model language
Offer of Inflation Protection	Most of model language	Yes
Requirement for Application Forms and Replacement Notices	Model language before 1990 amendments	Model language
Reporting of Lapse Rates	No provision	Model language
Agents Licensing Requirements	No provision	No provision
Reserve Standards for Accelerated Life Products	Model language	Reserves required according to method acceptance to Board
Loss Ratios	At least 60% loss ratio for individual policies, use model criteria for evaluation	At least 60% loss ratio for all policies, use model criteria for evaluation, requires actuarial memorandum
Filing Requirement for Out-of-State Group Policy	Yes	Yes, all forms filed for approval
Filing Requirement for Advertising	No provision	Yes, file 60 days before use
Standards for Marketing	No provision	Model language
Agent Shall Make Effort to Determine Appropriateness	No provision	No provision
Replacement Policies Must Not Have Preexisting Condition Limit	No provision	Model language
Standard Format for Outline of Coverage	Model format	Model format
Shopper's Guide	No provision	NAIC Shopper's Guide required until one developed by dept
Penalty Provision	No provision	No provision
Limits on Compensation of Agents	No provision	No provision
Miscellaneous		Contains readability standards

NAIC
STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	Utah	Vermont
Cite	Reg. R540-148 (1992)	Regulation 91-1 (1991)
Based on Model?	Yes	Yes
Adopted Model Law?	Yes	Yes
Individual Policies are Guaranteed Renewable	Model language	Model language
Provision for Continuation and Conversion	Model language	Model language
Provision for Discontinuance and Replacement	Model language	Model language
Prohibition of Attained Age or Duration Rating	Model language	No provision
Prohibits Post-Claims Underwriting	Model language	Model language
Rescission Reporting Requirement	Model language	Model language
Standards for Home Health Care	Model language	Model language
Offer of Inflation Protection	Model language	Most of model language
Requirement for Application Forms and Replacement Notices	Model language	Model language
Reporting of Lapse Rates	Model language	No provision
Agents Licensing Requirements	No provision	No provision
Reserve Standards for Accelerated Life Products	Model language	Model language
Loss Ratios	At least 60% loss ratio for individual policies, use model criteria for evaluation	At least 60% loss ratio for individual policies, use model criteria for evaluation
Filing Requirement for Out-of-State Group Policy	Yes, in statute	File for prior approval
Filing Requirement for Advertising	Model language	Model language
Standards for Marketing	Model language	Model language
Agent Shall Make Effort to Determine Appropriateness	Model language	Model language
Replacement Policies Must Not Have Preexisting Condition Limit	Model language	Model language
Standard Format for Outline of Coverage	Model format	Format available from department
Shopper's Guide	Yes, requirement to deliver NAIC shopper's guide	Delivery of guide approved by commissioner; commissioner has approved NAIC model guide
Penalty Provision	Model language	Yes, in statute
Limits on Compensation of Agents	No provision	No provision
Miscellaneous	Effective 11/1/92	

NAIC
STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	Virginia	Washington
Cite	Regulation 40 (1992) Admin. Letter 1990-23	§§ 284-54-010 to 284-54-900 (1989)
Based on Model?	Yes	No
Adopted Model Law?	Yes	No
Individual Policies are Guaranteed Renewable	Model language	All policies are guaranteed renewable
Provision for Continuation and Conversion	Model language	No provision
Provision for Discontinuance and Replacement	Model language	No provision
Prohibition of Attained Age or Duration Rating	No provision	No provision
Prohibits Post-Claims Underwriting	Model language	No provision
Rescission Reporting Requirement	No provision	No provision
Standards for Home Health Care	Model language	No provision
Offer of Inflation Protection	Most of model language	No provision
Requirement for Application Forms and Replacement Notices	Model language	Use notice for accident and sickness insurance
Reporting of Lapse Rates	Model language	No provision
Agents Licensing Requirements	No provision	No provision
Reserve Standards for Accelerated Life Products	Model language	No provision
Loss Ratios	At least 60% loss ratio for individual policies, use model criteria for evaluation; statute requires actuarial certification	Loss ratios adopted by reference, at least 60% for individual policies, group ratio varies by size of group
Filing Requirement for Out-of-State Group Policy	Prior approval of all policies	Prior approval requirement in general disability statutes
Filing Requirement for Advertising	Model language	No, but follow standards of health advertising regulation
Standards for Marketing	Model language	No provision
Agent Shall Make Effort to Determine Appropriateness	Model language	No provision
Replacement Policies Must Not Have Preexisting Condition Limit	Model language	No provision
Standard Format for Outline of Coverage	Model format	Disclosure form, not based on NAIC format
Shopper's Guide	Delivery of guide approved by commissioner, commissioner has approved NAIC model guide	No provision
Penalty Provision	No provision	No provision
Limits on Compensation of Agents	No provision	No provision
Miscellaneous		List of unfair or deceptive acts, no exclusions for mental or nervous condition permitted

NAIC
STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	West Virginia	Wisconsin
Cite	§§ 114-32-1 to 114-32-24 pending (1992)	§ INS. 3.46 (1991) § INS. 3.455 (1991)
Based on Model?	Yes	Partially
Adopted Model Law?	Yes	No
Individual Policies are Guaranteed Renewable		Yes
Provision for Continuation and Conversion		Yes, not model language
Provision for Discontinuance and Replacement		Yes
Prohibition of Attained Age or Duration Rating		No provision
Prohibits Post-Claims Underwriting		Similar to model language
Rescission Reporting Requirement		Yes
Standards for Home Health Care		Yes
Offer of Inflation Protection		Similar to model language
Requirement for Application Forms and Replacement Notices		Required, but no format specified
Reporting of Lapse Rates		Yes
Agents Licensing Requirements		No provision
Reserve Standards for Accelerated Life Products		Model language
Loss Ratios		At least 65% for individual policies and group mail order, 75% for the group, actuarial certification required
Filing Requirement for Out-of-State Group Policy	Yes, in statute	Yes, in statute
Filing Requirement for Advertising		No provision
Standards for Marketing		Similar to model language
Agent Shall Make Effort to Determine Appropriateness		Mode. language
Replacement Policies Must Not Have Preexisting Condition Limit		Model language
Standard Format for Outline of Coverage		Prescribe format not based on NAIC model
Shopper's Guide		Shopper's Guide required, not NAIC model
Penalty Provision		No provision
Limits on Compensation of Agents		First year commission limited to 400% of second and succeeding years
Miscellaneous	Comment period ends 9/11/92	

NAIC
STATE ADOPTIONS OF LONG-TERM CARE INSURANCE REGULATION PROVISIONS

	Wyoming	TOTALS
Cite	Ch. XXXVII (1990)	
Based on Model?	Yes	30 - Based on model 6 - Partially 5 - Other
Adopted Model Law?	Yes	
Individual Policies are Guaranteed Renewable	Model language	38 - Guaranteed Renewable
Provision for Continuation and Conversion	No provision	34 - Continuation and Conversion Provision
Provision for Discontinuance and Replacement	No provision	14 - Discontinuance and Replacement
Prohibition of Attained Age or Duration Rating	No provision	2 - Contain Provision
Prohibits Post-Claims Underwriting	Model language	28 - Prohibit
Rescission Reporting Requirement	Model language	25 - Reporting Requirements
Standards for Home Health Care	Model language	32 - Home Care Standards 2 - Require but no Standards
Offer of Inflation Protection	Most of model language	31 - Requires Offer of Inflation Protection
Requirement for Application Forms and Replacement Notices	Model language before 1990 amendments	37 - Replacement Notices Included
Reporting of Lapse Rates	No provision	11 - Reporting Requirements
Agents Licensing Requirements	No provision	3 - Licensing Requirements
Reserve Standards for Accelerated Life Products	No provision	23 - Reserve Standards
Loss Ratios	At least 60% loss ratio for individual policies, use model criteria for evaluation	30 - 60% Loss Ratio 10 - Other Specified Ratio
Filing Requirement for Out-of-State Group Policy	Yes	45 - Filing Requirement
Filing Requirement for Advertising	No provision	11 - Filing Requirements
Standards for Marketing	No provision	16 - Standards for Marketing
Agent Shall Make Effort to Determine Appropriateness	No provision	10 - Contain Requirement
Replacement Policies Must Not Have Preexisting Condition Limit	No provision	13 - Prohibit Preexisting Condition Limit 2 - Prohibit if Same Company
Standard Format for Outline of Coverage	Model format	28 - Model Outline 8 - Other Format Specified
Shopper's Guide	NAIC Shopper's Guide required	22 - Require a Shopper's Guide
Penalty Provision	No provision	8 - Penalty Provision
Limits on Compensation of Agents	No provision	6 - Limit Commissions
Miscellaneous		

Every effort has been made to make this information as correct and complete as possible. For questions about specific state law, please consult the regulations cited.

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RESPONSES OF MR. MCCARTNEY TO QUESTIONS SUBMITTED BY SENATOR GRASSLEY

Question 1. You noted in your testimony that long-term care insurance is a new product for which experience is still developing. Assuming that this market is able to continue to grow, how long do you think it will be before this market is out of this uncertain phase and into a more mature phase?

Answer. The long-term care insurance market will not actually mature until insurers are able to review the actual claims experience for some of the more comprehensive policies that have been sold in the past few years. Since the lifetime for these policies is at least ten or more years (e.g., some policies marketed to younger consumers will be in force for thirty or more years), it may be that long before insurers are more secure in their pricing for these products.

Question No. 2. Both you and the GAO witness noted that at least five percent inflation increase annually would be necessary to provide inflation protection. To me five percent doesn't seem like a very large annual increase, given that health care costs in general have been rising faster. What has the inflation rate been like over the last ten years in the long-term care area?

Answer. We are not aware of any good indices for gauging the general increase in costs for long-term care services. We understand that, over the past decade, nursing home costs have increased by a little over 9% per year.

The five percent figure, which is used in the NAIC Model Long-Term Care Insurance Regulation, was chosen as a conservative estimate for future cost increases ad represents the minimum level of inflation protection that an insurer must offer to consumers. The estimate is consistent with Social Security Administration estimates for wage increases over the next several decades and, given that labor is the primary component of non-skilled long-term care services, this appears to be one reasonable indicator of future increases in costs. Insurers are permitted to offer higher levels of inflation protection if consumers wish to purchase it.

Question No. 3. The GAO testimony stressed the lack of clear definitions of services and facilities. You mentioned this at one point in your testimony, but did not dwell on it.

(A) Isn't this a very serious limitation of such policies? If key terms remain ambiguous, then the insurer can basically decide at the time a claim is made whether or not they want to reimburse for the service claimed, whether or not a claim "fits" the definitions in the policy.

Answer. The lack of uniformity in definitions ad terms can make comparison of policies difficult for consumers and can lead to ambiguities about whether services are covered in certain settings. The NAIC agrees that developing greater uniformity would increase consumer understanding and protection For these reasons, the NAIC Long-Term Care Insurance Task Force has been charged with developing uniform definitions for this product.

(B) Second, how difficult would it be to develop terminological consistency?

Answer. The fact that states have differing licensure requirements and definitions for long-term care providers ad services makes developing uniform definitions and terminology for use by long-term care insurers more difficult. However, it should be possible to develop clear generic definitions that would enable consumers and insurers to determine whether particular facilities or services are covered by a policy.

(C) And third, what about a grievance procedure as a method of dealing with potentially inappropriate use of discretion by an insurer? Would establishment of such a procedure be a good idea in your view?

Answer. The NAIC has not considered this issue with respect to long-term care insurance. Personally, I believe the idea may have merit and will forward the suggestion to the NAIC Task Force for consideration.

Question No. 4. You noted that one of the proposed modifications to the NAIC model standards would establish standards for associations endorsing long-term care insurance policies. Can you tell us more about this modification? What are the problems it is trying to address?

Answer. Concerns have been expressed that some associations do not adequately review and evaluate the long-term care insurance products that they endorse to their members. Since associations may receive a fee for endorsing a long-term care insurance product, there is concern that some associations are more motivated by their financial interest than their responsibility to find the best product to fit their members' needs. The NAIC is considering model standards to require due diligence by associations endorsing particular long-term care insurance products.

PREPARED STATEMENT OF MILDRED MCCAULEY

My name is Mildred McCauley and I am a member of the Board of Directors of the American Association of Retired Persons (AARP). On behalf of our membership, I want to commend you for holding this hearing on the need for federal consumer protection standards for the sale of private long-term care insurance policies.

Two years ago the Congress laid the groundwork for significant improvement in consumer protections for purchasers of Medicare Supplemental Insurance policies. This year, we believe it to be equally important to address similar serious problems that exist in long-term care insurance products.

The development of the private long-term care insurance market over the past several years demonstrates that private insurance can help some people, but that its potential for meeting the nation's long-term care needs is limited. While private sector initiatives have expanded over the past several years, it is clear that neither these efforts alone nor tax-subsidized strategies by the private sector can fully address the uncertain risk of long-term care. AARP believes that for a majority of Americans, new and innovative mechanisms for long-term care service delivery and reimbursement developed by the private sector should be encouraged. However, we also believe that a comprehensive public long-term care program based on the principles of social insurance and shared risk is the only way we can address this problem for all Americans, particularly that vast majority of older Americans with moderate and lower incomes. Under such a social insurance system, the federal government would play a much stronger role in financing long-term care. Similarly, AARP believes that private sector approaches can and should supplement the public system by covering copayments, deductibles and extra services.

There are a number of reasons why private long-term care insurance will not and cannot be a viable solution for most people. Long-term care insurance premiums tend to be steep—especially for policies with meaningful benefits which keep pace with inflation. In addition, underwriting restrictions leave persons with disabilities or a poor medical history unable to attain coverage. Particularly for those at greatest risk of needing care and protection—those 75 and over—coverage restrictions and/or very high premiums usually make insurance purchase unlikely or unwise.

The limited nature of the policies available—in part caused by insurers' lack of experience—also limits this market's potential. Even with the improvements of the past several years, most of the policies on the market today have restrictions and exclusions that limit their effectiveness. For example, many available plans are not indexed for inflation and hence will fail to keep up with escalating costs of care. The vast majority also lack premium guarantees or nonforfeiture benefits, increasing the risk that policies will be dropped and substantial built-up equity lost. Home and community-based benefits also are generally limited. Unfortunately, these and other shortcomings have an even greater impact on purchasers because they often fail to understand the significance of these restrictions until after care is needed.

AARP believes that the current National Association of Insurance Commissioners (NAIC) Model Act and Regulation should be the starting point for the development of uniform national long-term care insurance standards. At a minimum, every state should be required to adopt the NAIC standards promulgated through December, 1991. On certain issues, we believe these standards are sufficient. On the issue of inflation protection, for example, we are generally supportive of the approach taken by the NAIC. In our view, until the long-term care insurance market is more fully developed, a mandatory *offer* of inflation protection, together with strong disclosure standards, is appropriate so as not to make policies unaffordable. There are, however, a number of areas which would go beyond the current NAIC standards and which deserve greater attention now. After discussing why we need *federal* long-term care insurance standards, our testimony will articulate some of the areas beyond those in the NAIC standards that AARP believes should be included in federal legislation. These include: (1) nonforfeiture values; (2) rate stabilization; (3) standard definition of disability; (4) avoiding inappropriate sales; (5) home care standards; (6) policy upgrades; and (7) data collection. We will also provide comments on the tax treatment of long-term care insurance policies.

THE NEED FOR FEDERAL STANDARDS

Unfortunately, the long-term care insurance market continues to be one in which the large print giveth and the small print taketh away. It is clear that regulation and enforcement of long-term care insurance policies can no longer be left to the states alone, many of whom have not adopted some of the critically important standards suggested in the NAIC Model Act and Regulation. We were extremely troubled, for example, to see the U.S. General Accounting Office (GAO) report that 19 states *still* have not adopted NAIC standards prohibiting prior hospitalization, that 40

states have not adopted the standards concerning home health care benefits, inflation protection, outline of coverage or post-claims underwriting. Although some claim that companies are meeting the standards despite states' lack of regulatory action, the GAO found that only one of the 34 actual policies it reviewed met the NAIC standard on a mandatory offer of inflation protection.[1] This lack of action hardly inspires confidence.

A recent report conducted by Project HOPE for AARP[2] confirms the persistence of these problems. Among its principle findings:

- Only 13 states complied with 80 percent or more of the 15 major NAIC requirements;
- 27 states and D.C. complied with less than 60 percent of these standards;
- Over half the states could not assemble information on the number of long term care policies filed and approved in 1990; and
- 13 states and D.C. have neither an actuary on staff nor available on a consultant basis.

Such findings demonstrate that the current state regulatory system has failed to provide sufficient consumer protection throughout the nation and is clearly inadequate. Too many consumers continue to spend significant sums of money on policies providing largely illusory protection. AARP, therefore, supports the enactment of legislation which would create federal minimum standards that build on, but go beyond, the current NAIC Model Act and Regulation. All Americans must have at least some minimum protection against those policies that fail to provide meaningful benefits. Such minimum standards would accrue to the benefit not only of consumers but to the companies offering good policies who desire stability and are being placed at disadvantage for lack of a level playing field vis-a-vis unscrupulous industry members.

NONFORFEITURE BENEFITS

We strongly object to circumstances under which consumers purchase policies and pay premiums for a period of time expecting to receive some protection, but when their need arises years later, no protection is available. Therefore, AARP firmly believes that the inclusion of nonforfeiture benefits should be *mandated* in *all* long-term care insurance policies. Consumers, at the time of purchase, often do not understand that there is a significant risk that their policy will lapse. This conclusion is supported by the three major sets of available data on lapse rates:

- According to the Health Insurance Association of America: "Fifteen companies, representing about one-third of the market, reported an average first year lapse rate of 18 percent and an overall lapse rate, including the first year, of 16 percent. (These figures excluded lapses due to death except in two cases.)"[3]
- According to the U.S. General Accounting Office: "On average, insurers we reviewed [20 policies] expected that 60 percent or more of their original policyholders would allow their policies to lapse within 10 years; one insurer expected an 89 percent lapse rate."[4]
- A 1990 survey by the House Energy and Commerce Committee of 24 companies with 979,941 total policies issued found that 36.7 percent, or 359,638 policies, had already lapsed.[5]

Although independently each of these findings may be subject to some criticism on methodology, the overall trend is quite apparent. Taken together, these reports clearly indicate that the risk of coverage lapsing before the need for long-term care services arises is significant. The risk is much greater for younger purchasers. According to Gordon Trapnell, President of the Actuarial Research Corporation:

> "At issue age 55, with a 5 percent annual lapse rate (which . . . is the lowest I have seen in the actuarial memoranda other than my own) the insurer is assuming that of those who are actually confined to a nursing home, less than one in five will keep the policy long enough to be insured when they are admitted. [emphasis in original] The proportions are better

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[1] *Long-Term Care Insurance: Risks to Consumers Should be Reduced,* December 1991, HRD-92-14.

[2] *State Variation in the Regulation of Long Term Care Insurance Products,* January 1992.

[3] *Long-Term Care Insurance: A Market Update,* January 1991 (Page 29).

[4] Supra, note 1 (page 13).

[5] Released at a Hearing before the Subcommittee on Oversight and Investigations, May 2, 1990.

at later issue ages; 28 percent at issue age 65 and 37 percent at issue age 75."[6]

If we could be assured that prospective purchasers truly understood the actual risk of lapsation, the age at which they would likely need long-term care services, and the probability of their insurer increasing premiums in the future, we might be more comfortable with only a mandatory offer of nonforfeiture. However, because of (1) the complexity of the choices which already face consumers—which would be made even more complex by the inclusion of a nonforfeiture offer; (2) the poor track record of agents accurately disclosing relevant information to prospective purchasers (according to investigations by Consumers Union, NBC News and the House Select Committee on Aging); and (3) the possibility that many companies will increase premiums in the future (given the difficulty actuaries have in pricing products accurately and the fact that most long-term care insurance products are quite new and few policyholders have filed claims to date), we believe that nonforfeiture protection should be mandatory for all policies.

It is also important to note that mandatory nonforfeiture values, if properly constructed, need not make insurance policies prohibitively expensive. A major factor in keeping premium costs down is the type of nonforfeiture benefit provided. Clearly, as the NAIC Nonforfeiture Benefits Ad Hoc Actuarial Group study indicates, cash benefits typically are much more expensive than services benefits.[7] AARP does not support including cash surrender values or return of premiums as mandatory nonforfeiture options for two additional reasons: (1) we do not want to encourage consumers to use long-term care insurance as a cash investment; and (2) a cash return would undoubtedly prompt tax policy issues at the state and federal levels.

It appears that, among the options available, nonforfeiture in the form of a Shortened Benefit Period (SBP) would be most helpful to consumers. SBP provides the full daily benefit regardless of when a qualified claim occurs after premiums cease, but the maximum benefit period is shorter than that provided if the policy had not lapsed.[8] We support the work currently being conducted by the NAIC Actuarial Group to price such a product and to develop tables to assist in structuring an affordable, meaningful benefit. This work likely will be incorporated by the NAIC into an exposure draft next September.

Although opinions differ as to how long a policy must be held to become eligible for nonforfeiture protection, we believe that somewhere in the range of three to seven years—not unlike private pension practices—is a reasonable starting point for analysis and discussion.

We are also concerned about the prospect of premium increases causing lapses and are fearful that certain companies may pursue marketing strategies that exacerbate this problem. These and other concerns regarding rate stabilization are discussed below.

PREMIUM STABILIZATION

A primary question that must be resolved is how much risk should be shared between the insurer and insured. Who is in the best position to take risks involved in the long-term care insurance business—policy holders or insurance companies? In our view, the answer is obvious. Unlike typical medical insurance policies, most long-term care insurance policies pay a fixed indemnity amount; therefore, premium increases cannot be justified by increases in health costs. Unfortunately, in the current regulatory environment, insurers have largely avoided risks, such as increased utilization, by transferring them to policy holders in terms of unpredictable rates. Companies that incur more claims than expected will simply increase their premiums. The need to stabilize premiums is clear.

Since this market is still developing, pricing is difficult and little data on premium increases exists. Evidence recently obtained by the General Accounting Office, however, is not encouraging:

> In the three states from which we were able to obtain data, we identified 13 insurer requests for price increases, resulting in 12 approvals. Arizona had 11 of the 13 requests for price increases, ranging from 15 to 54 percent.

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[6] Testimony presented before the House Energy and Commerce Committee, Subcommittee on Oversight and Investigations, May 2, 1990 (Page 4).

[7] Final Report to the NAIC Long-Term Care Insurance Task Force from the NAIC Long-Term Care Insurance Nonforfeiture Benefits Ad Hoc Actuarial Group (June 2, 1992).

[8] Much of the development of the SBP form of nonforfeiture is based on work conducted through AARP's Public Policy Institute. See *Inflation Protection and Nonforfeiture Benefits in Long-Term Care Insurance Policies: New Data for Decision Making,* William M. Mercer, Inc. (June 1992).

These requests were quite recent. Between 1988 and 1990, the state allowed increases for all 11 policies.[9]

Federal legislation needs to address two problems: underpricing initial rate filings (which can be used to justify future increases) and subsequent unreasonable premium increases. Several approaches can be taken to address these issues. First, standards should be established for prior approval of initial rate filings and subsequent rate increases. Second, special rate stabilization measures should be adopted for older policy holders, when incomes are generally not increasing and the risk of needing care is greatest. Third, if approved rate increases are found to have resulted in lapse rates above a specified percentage (indicating an initially underpriced product), the financial gains should be rechanneled back to those whose policies have lapsed, in the form of increased nonforfeiture benefits. At the same time, consideration should be given to developing limits on permissible increases, subject to exceptions for circumstances beyond the control of the insurer. Legislation should provide specific direction to the NAIC to develop standards on these issues for federal application.

DEFINING DISABILITY

Another issue that needs to be addressed is standardizing the *definition* of disability for long-term care insurance policies. The uncertainty and ambiguity currently associated with insuring clauses is detrimental to both consumers and insurers. Lack of clarity and specificity can unfairly mislead purchasers and trigger expanded court review. There can be significant differences in how many policy holders qualify for benefits depending on how eligibility criteria are defined and measured. Lack of standards also makes it virtually impossible for consumers to accurately compare coverage among policies.

GAO found continuing problems in the marketplace in this area. Specifically, 6 of the 30 policies reviewed that used "medical necessity" criteria left the term completely undefined, while the definition varied in the other policies. Of the 27 policies that used criteria based on Activities of Daily Living (ADLs), 17 did not even specify or describe those ADLs used to determine benefit eligibility.[10]

The Association would like to see a clear, uniform definition of functional capacity that can be interpreted consistently. ADLs are the most appropriate measure for determining physical disability since strictly "medical necessity" coverage criteria do not generally apply to custodial care. Few physicians are familiar with the needs of frail elderly patients. Measures should also be developed for determining cognitive impairment, most likely relating to the need for supervision.

It might be most appropriate for the Office of Technology Assessment or the NAIC to be charged with forming a task force, with broad representation from consumers, industry and assessment experts, to refine a set of definitions for use by all insurance companies. This effort can rely heavily on the work of experts that is already underway. In our view, the Uniform Needs Assessment instrument, mandated in OBRA '86, which has been reviewed by numerous experts and is intended to be used by providers across the country, can provide the starting point for such discussions.

AVOIDING INAPPROPRIATE SALES

We are very concerned about the implications of recent reports on the numbers of relatively poor persons purchasing long-term care insurance policies. According to a study conducted by Lifeplans, Inc. for HIAA: "About three in ten purchasers have annual household incomes of less than $20,000, and about 25 percent have assets of less than $30,000."[11] The study goes on to state that 61 percent of purchasers use their liquid assets to pay their insurance premiums.

These findings, together with reports of high pressure sales tactics and data showing surprisingly high lapse rates in the first and second years (20 to 30 percent) raise serious concerns about the appropriateness of sales to lower income persons. Although most company representatives readily admit that lower income individuals should not be targeted for sales, very little is being done to limit such practices.

The GAO recently reported that companies were failing to take appropriate steps to avoid inappropriate sales to low-income individuals. Specifically, they found:

> The companies we reviewed do little to avoid selling long-term care insurance to low-income people. The companies generally do not (1) have clearly established financial criteria for determining or advising who should not

[9] Supra, note 1 (page 12).
[10] Supra, note 1 (pages 8–9).
[11] Who Buys Long-Term Care Insurance?, 1992 (page 19).

buy insurance, (2) obtain information regarding the income or assets of applicants, (3) provide training material instructing agents to consider the financial condition of potential buyers and to avoid sales to low-income people, (4) monitor whether agents sell to such people, or (5) distribute marketing material informing low-income people that long-term care insurance might not be appropriate for them.[12]

In our view, companies should be required to take these types of actions. Consumers also need good information to help them make informed purchase decisions. We have a continuing interest in the development of a standard form to assist consumers in determining the appropriateness of their purchase decision.

HOME CARE STANDARDS

Last December, the NAIC adopted improved standards for home care coverage in long-term care policies. In our view, federal standards should go further. AARP's three primary concerns are: strengthening minimum coverage requirements; requiring coverage of homemaker services; and, the need to provide a mandatory offer of home care coverage.

In order to provide meaningful protection, policies should cover at least one year of home care—the equivalent of 365 visits over a lifetime. Any amount less than this is illusory. This would help address the current institutional bias in most products and provide for a standard roughly equivalent to the minimum NAIC requirement for nursing home benefits.

Policies also should be required to include coverage of homemaker services once the eligibility criteria are met. These services, which are included in the list of Medicare covered services—a restrictive, skilled care oriented benefit—are critical to allowing insureds to remain in their homes. Any potential overutilization concerns should be addressed in the eligibility process, not by unreasonably restricting the scope of services available in the community setting.

Finally, we support a mandatory offer of home care coverage. If it is true, as some allege, that virtually all companies currently are making such an offer, then this requirement will not be burdensome. Consumers, however, will benefit from having this desirable option available to them whenever they are considering purchase of a long-term care policy.

POLICY UPGRADES

Current policy holders, particularly those with earlier-generation policies containing restrictive provisions such as prior hospitalization, must be given the opportunity to improve the benefits in their policies. Currently, persons who wish to upgrade their policies generally must meet the same medical underwriting and preexisting criteria as first-time buyers. They also must pay higher premiums commensurate with their attained, as opposed to purchase, age. In our view, standards must be developed to permit policy holders to upgrade under more favorable conditions.

For example, if current policy holders purchase a different, improved policy from the same company, they should receive some "credit" toward the new premium in recognition of the amount of premiums paid on their previous coverage. Underwriting criteria for upgrades is a complex issue, because of the possibility that policy holders who know they will be needing benefits could select adversely to take advantage of the option. This could be alleviated somewhat by offering upgrades every few years (e.g. three), rather than annually or on demand. We are working with the NAIC to address these issues and hope this work will assist in the development of federal standards.

DATA COLLECTION

Adequate consumer protection and the development of better insurance policies in the long-term care market will depend heavily upon the compilation of useful national information regarding various aspects of long-term care insurance from both insurers and state insurance departments. Since this is a new product, the financial and utilization assumptions supporting the rates are often more the result of estimated best judgment than of experience.

Federal data collection, possibly through state insurance departments, would greatly help both buyers and sellers by providing necessary information upon which to base and compare prices. A comprehensives federal information system also is necessary to provide state and federal authorities with the information they need

[12] *Long-Term Care Insurance: Better Controls Needed in Sales to People With Limited Financial Resources*, March 1992, HRD–92–66 (page 12).

to assure that buyers receive a fair return on their insurance investment, that rates are adequate to preserve insurer solvency, and to assist consumers in evaluating products and companies.

A federal role also would provide needed coordination. Centralized collection and uniform data standards would greatly increase understanding over time about use of services, number of insurance purchasers, availability and affordability of coverage, and administrative costs. The effects of private insurance on the cost and utilization of public programs (primarily Medicaid) also could be studied. We believe that an adequately funded and staffed task force should be set up to review data needs and develop an action plan.

Although the NAIC has initiated some data collection efforts, it appears that little is being done with the information. Much more can and should be done. For example, there is a clear need to standardize and aggregate state data on consumer complaints and to require that such information be collected to isolate long-term care concerns. Other examples include information on market trends, utilization, lapses and replacements, claims experience, premium adjustments, current expenses, reserves and profits, and provider payment arrangements.

TAX TREATMENT OF PRIVATE LONG-TERM CARE INSURANCE POLICIES

A number of the proposed tax incentives to encourage individuals to purchase long-term care insurance policies would help only a limited number of persons. For the most part, the benefits would be far more available and worth more for higher income individuals. One proposal would clarify that long-term care expenses and premium payments for long-term care insurance policies are medical expenses eligible for the medical deduction for those who itemize their income tax return. As with any itemized deduction, only about one-third of taxpayers—generally higher income individuals—are eligible for the medical deduction. Because of the 7.5 percent threshold on these deductions, even fewer actually use them. In addition, those in the higher tax brackets will receive the greatest tax benefit.

Another proposed clarification would treat benefits received under long-term care insurance policies similarly to benefits from accident or health insurance contracts. Benefits under such policies would be excluded from the gross income of the recipient. However, AARP is concerned that such policies are expensive and are less likely to be affordable by lower and middle-income persons. In addition, an exclusion from income—as with any exclusion—provides the greatest tax benefit to persons in the highest income brackets.

Proposals to permit employer-provided long-term care insurance and services to qualify as an employee tax-free fringe benefit would be of value only to those few employees who are covered by such a plan. In fact, this opportunity exists only very rarely because employers are struggling to fund benefits currently offered.

The Association believes that it may be appropriate to consider including tax change options as discussed above in an overall, *comprehensive* long-term care financing package. However, it is premature to enact tax changes now that would result in lost revenues and which, by their nature, are directed primarily to a limited number of individuals who tend to be towards the higher end of the income scale.

Before taking any action on specific private sector tax proposals, revenue estimates and distribution tables detailing the extent and distribution of proposed tax changes should be developed. Such tables will permit evaluation of the efficiency and equity of tax code incentives for long-term care.

CONCLUSION

AARP appreciates the opportunity to submit our views on this important issue. The need for strong federal standards is clear. Without action on the issues discussed above, consumers across the nation will continue to be misled into spending significant amounts of their hard-earned dollars on products that often fail to deliver on what they promise.

We are particularly pleased, Mr. Chairman that your long-term care financing legislation, S. 2571, includes federal standards for private insurance policies and that Senator Pryor has also introduced a very well developed free-standing standards bill, S. 846. We commend you both for your interest and leadership on these matters. We look forward to working closely with this committee toward enactment of federal legislation to address the concerns that purchasers of private long-term care insurance must face.

RESPONSES OF MS. MCCAULEY TO QUESTIONS SUBMITTED BY SENATOR GRASSLEY

Question No. 1. Does AARP offer long-term care insurance at this time to its members? Do the AARP policies conform to the standards you are urging in your testimony?

Answer. AARP has been offering long-term care insurance to our members through Prudential Insurance since 1986. Each year, we have made improvements in the policies offered and we continue to actively pursue benefit improvements. Although, initially, we had enrollment periods of only several months per year, we now enroll policy holders throughout the entire year. The policies we offer meet all the current NAIC requirements. Despite the fact that the current long-term care insurance market often places insurers which employ strong consumer protection standards at a disadvantage, the policies offered through Prudential have also made significant strides toward addressing the other concerns we raised in our testimony. The following outlines the manner in which we have attempted to address these issues:

- *Nonforfeiture Benefits*—We currently offer a policy with an "extended term" form of nonforfeiture, which would continue full benefits for several years after a policy is dropped. This does not fully conform with the standards urged in our testimony because we also offer three policies that do not include nonforfeiture benefits.
- *Premium Stabilization*—We have never increased premiums and have priced the product conservatively so that we never hope to have to. In 3 of our policies, level premiums are guaranteed for the first 5 years. In the other policy, level premiums are guaranteed for 10 years.
- *Defining Disability*—Eligibility for home health care benefits is based on either a certification that the policyholder would require an inpatient stay in a nursing home if the home health care were not provided or on the inability to perform, without direct assistance, 2 or more activities of daily living (ADLs—bathing, dressing, toileting, transferring and eating). This conforms with the standards urged in our testimony.
- *Inappropriate Sales*—The policies are sold through the mail, without the use of agents. When the information is available, our mailings screen-out low-income persons. Question and answer materials included in the information packet we provide to prospective purchasers include the suggestion that it would probably be inappropriate for people with less than $30,000 in assets to purchase long-term care insurance (see attached).
- *Home Care Coverage*—Each of the policies includes a home health benefit with a lifetime maximum of 730 visits, without the limitations we expressed concerns about in our testimony. Coverage of Adult Day Care services is also included.
- Policy Upgrades—The option to upgrade indemnity amounts to account for inflation is offered every four years. Additionally, while the Association initially sold policies that included a prior hospitalization requirement and a two year benefit period, these policies have all been upgraded at no cost to the policy holders. In general, however, upgrades on demand of specific coverages within the plan are not permitted.

Question No. 2. You mentioned the Uniform Needs Assessment instrument mandated by OBRA '86. Can you tell us a bit more about that? Is that study being undertaken by the Health Care Financing Administration, and what is its status?

Answer. The Health Care Financing Administration (HCFA) informs us that the report they conducted on this instrument has been cleared by the Department of Health and Human Services but, thus far, has been distributed only to the offices of Vice President Quayle and House Speaker Foley. Additional copies are in the process of being printed and should be available in approximately two months. Serious questions remain regarding whether sufficient funds will be available to field test and evaluate the study.

It is our hope that the report will shed light on the development of uniform definitions of terms used for eligibility purposes as well as an instrument for determining whether an individual needs long-term care services.

Question No. 3. Do you consider a five percent compounded inflation protection sufficient? And, just for the record, do you know what the annual increase in, for instance, the average nursing home care is?

Answer. At this time, we believe that five percent compounded inflation is sufficient, although not ideal, protection. Clearly, it is superior to simple inflation which, over time, will fall far short of keeping pace with the cost of care.

Although the annual increase nursing home revenues per patient day has averaged 10 percent since 1965, there is little reason to believe that future trends will be identical to these historical ones. Providing inflation protection much above five

percent would have a significant impact on premiums. Our hope is to strike an appropriate balance between providing meaningful protection and making policies available that are affordable to consumers.

QUESTIONS & ANSWERS

Q. *Who is eligible to apply for this Plan?*

A. AARP Members (and their spouses) age 50-79 residing in an eligible state may apply for the AARP Long Term Care Plan. However, in order to keep the monthly rate affordable for as many members as possible, only those who can answer "No" to each of the Health Statements on the Application form will be accepted under the Plan.

Q. *Who should not consider the AARP Long Term Care Plan?*

A. Individuals who might qualify for state provided Medicaid or Medicaid-type benefits do not need this Plan and should not apply. This is because the government will pay for most of the benefits provided by this Plan at little or no cost. In addition, individuals should base their ability to pay for the Plan on their projected retirement income. Because this Plan can help to protect your assets, participation in this Plan is recommended only for people with assets of $30,000.00 or more (excluding houses).

To help prevent the possibility of members becoming over-insured, no member may be enrolled in more than one Plan of this type or in more than three Plans at the same time under the AARP Group Health Insurance Program.

Q. *What kind of coverage does Plan FN provide?*

A. AARP's Long Term Care Plan (FN) provides three types of coverage. Plus, a valuable Extended Protection feature. First, when professional home health care would keep you out of a nursing home, it pays benefits for covered home visits by nurses (RN or LPN), qualified therapists, and qualified home health aides of up to $50.00 to $70.00 per visit. Second, this Plan also pays up to $60.00 per visit for care in an adult day care center. Third, it pays up to $100.00 a day for covered stays in a nursing home -- up to 4 years or a lifetime maximum of 1,460 days. Perhaps the most valuable feature of Plan FN is Extended Protection. This feature guarantees that you will receive coverage for FULL benefit amounts, for a specified time, if you should cancel the Plan **(see the enclosed Brochure for full details)**

Q. *Will benefits be paid for a stay in any kind of nursing home?*

A. Most state-licensed nursing facilities -- including skilled nursing facilities, intermediate care facilities, and custodial care facilities -- qualify under the Plan. However, stays in government-owned or operated nursing homes, nursing homes outside the United States, homes where there is no charge to you, or homes that primarily provide domiciliary, residential, or retirement care are not covered. See the definitions, limitations and exclusions in the enclosed brochure for details.

Q. *Is a hospital stay required before nursing home benefits are payable?*

A. NO. Another important feature of the AARP Long Term Care Plan is that no preceding hospital stay is required. You're eligible for benefits whether you enter a nursing home from your home or you enter after a hospital stay. It doesn't matter.

PREPARED STATEMENT OF GAIL SHEARER

Mr. Chairman and Members of the Subcommittee, Consumers Union [1] appreciates the opportunity to present our views on the issue of overhauling the regulation of the private long-term care insurance market. We commend Chairman Rockefeller both for holding this important hearing and for introducing S. 2571, the Long-Term Care Family Security Act of 1992. S. 2571 recognizes that the private market can not solve the nation's growing long-term care crisis. It provides for universal coverage of long-term care for people of all ages, providing both home and community-based care and short-term nursing home care. It also provides a floor of income and

[1] Consumers Union is a nonprofit membership organization, chartered in 1936 under the laws of the State of New York to provide information, education, and counsel about consumer goods and services and the management of family income. Consumers Union's income is derived solely from the sale of Consumer Reports, its other publications and films. Expenses of occasional public service efforts may be met, in part, by nonrestrictive, noncommercial contributions, grants, and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports, with approximately 5.1 million paid circulation, regularly carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

asset protection for long stays in nursing facilities, greatly reducing the financial devastation faced by couples when one of them must enter a nursing home. S. 2571 also improves the regulation of the private long-term care insurance market—insurance that would be sold to wrap-around the new public program. In my testimony I plan to outline the flaws in the private long-term care market as it exists today and to comment on some of the consumer protection provisions of S. 2571 (introduced by Senators Mitchell, Rockefeller et al.) S. 846 (introduced by Senator Pryor), and S. 1693 (introduced by Senator Bentsen). We value the leadership that Chairman Rockefeller, Chairman Bentsen, Majority Leader Mitchell and Senator Pryor have brought to this issue.

Consumers Union has monitored this marketplace since 1988, and we have repeatedly found that the private policies are flawed. We have devoted considerable efforts to improving the marketplace, by supporting regulatory measures such as built-in inflation protection, mandatory nonforfeiture benefits, and simplification of the marketplace. But we would be remiss if we failed to point out that even if Congress (or the states) enacted the ideal reform package, the private market would be unable to solve the country's long-term care crisis. This is because the private market will never protect people with existing health conditions (who would not qualify for a policy), the many millions of middle-income and low-income consumers who can not afford to buy a policy, and young people who are the victims of an illness or accident before they would even consider buying a policy. S. 2571 recognizes the limits of the private market. Consumers Union supports a national health care program that protects all Americans against the devastating costs of both acute health care and long-term care health care. Notwithstanding this support for a public program, we will continue to work to improve the performance of the private long-term care insurance market, as long as these products are sold.

CONSUMERS UNION'S EXPERIENCE WITH LONG-TERM CARE INSURANCE

Monitoring the private long-term care insurance market has been a high priority for Consumers Union for the past four years. In May 1988 and again in June 1991, **Consumer Reports** published in-depth analyses of many of the policies on the market. Some of the findings of the recent article were: (1) our reporter heard 15 agents' sales pitches, all of which misrepresented some aspects of the policies, the financial condition of the insurers, or the quality of a competitor's product. No agent properly explained the benefits, restrictions, and policy limitations; (2) only one policy offered any protection from the unpredictable premium increases; premiums are not guaranteed over the life of the policy. We found that some companies set low initial premiums to attract customers, with the likelihood that these "lowball" premiums will be inadequate in the future; (3) fine print and loopholes restrict coverage and result in rejected claims down the road; (4) benefits, terminology and definitions vary so greatly from policy to policy that consumers cannot make informed purchasing decisions; (5) consumers are unable to predict future financial stability of insurers, and are subject to premium increases if their company is taken over by another carrier; (6) few policies build in inflation coverage, with the result that "protection" could be virtually worthless by the time it is needed. (7) many companies expect a high proportion of their policyholders to drop coverage before collecting a penny of benefits, but make no provision to provide nonforfeiture benefits.

In addition to the Consumer Reports articles, Consumers Union has been active in the long-term care insurance public policy arena. Our Insurance Counsel, Mary Griffin, serves on the National Association of Insurance Commissioner's Long-Term Care Advisory Committee. Our office has recently released two reports, "Analysis of Long-Term Care Insurance Proposals" and "The Case for Nonforfeiture: Refuting the Myths," summaries of which are attached to our statement. In addition, we prepared a report in 1989, "Long-Term Care: Analysis of Public Policy Options."

FLAWS IN THE LONG-TERM CARE INSURANCE MARKETPLACE

Before commenting on provisions in S. 846, S. 1693, and S. 2571, I will describe some of the major problems that exist today in the private long-term care insurance market.

Inflation. Failure to adequately protect against inflation is one of the most severe flaws of the long-term care market, a market in which benefits of a typical policy are expected to be paid (if at all) many years in the future. Without any inflation protection, a long-term care policy provides only illusory protection. With no inflation provision, a $50/day policy today (which covers just 40 of the cost of a nursing home in D.C. in 1991), would cover only 20 of the cost of a nursing home day in D.C. in 15 years.

But when it comes to inflation coverage, the choice consumers face is much more complicated than whether or not to buy inflation coverage. Policies vary in how they define inflation coverage. Some offer automatic benefit increases using a simple rate of increase. Benefits calculated with a simple rate are far less than benefits calculated with a compound rate. Therefore, a policy's benefits will erode since the benefits do not keep up with the actual increase in long-term care costs.

Other policies use an option to purchase additional benefit amounts. But this option requires affirmative action on the part of consumers and, in the end, costs more than building inflation protection in from the start. Other variations (in both types of inflation riders) include limiting the inflation rider to people under a certain age (e.g., 80 years old), or limiting the inflation adjustment to a certain time period (e.g., 10 years or until the policyholder reaches a certain age). If people buy a policy at a younger age, say 50, a 10-year or 20-year limit on inflation protection freezes the benefit at an inadequate level. The net result is a great deal of confusion on the part of consumers about which—if any—inflation option best meets their needs.

We see no justification in allowing consumers the option to purchase protection without inflation coverage. It is irrational for consumers to purchase a generous amount of coverage in early years, when the risk of needing long-term care is relatively low, and a decreasing amount of real coverage over the years. The argument that consumers should be free to choose policies without inflation coverage is weak at best. Based on Consumers Union's findings, agents do not make selection of the inflation rider a viable option. We repeatedly saw agents discourage the purchase of inflation protection. Agents are concerned that the cost of inflation protection will kill the sale; they can not be trusted to present the options fairly.

True, even partial inflation protection (5 percent per year, compound) increases the cost of a policy—by about 69 percent at age 70.[2] In return for the higher premium, policyholders will have a better value product; without the inflation protection, the "protection" is illusory. We believe that people who can not afford the higher premium for a policy with inflation protection are the very people most likely to lapse their policies as time goes on. If affordability is a major concern at the time of sale, then it is likely that the sale is inappropriate in the first place. Better consumers not purchase a policy at all than buy one that must be dropped within a few years. A recent report from the General Accounting Office highlights the need for Congress to be concerned with the fact that too many low income people are drawn into the long-term care insurance market inappropriately; higher initial premiums could play the role of deterring some of these inappropriate sales.[3]

Consumers Union believes that inflation protection should not be an option, but should be built-in to all long-term care insurance policies.

High lapse rates/Nonforfeiture Benefits. One of the most serious problems in the long-term care insurance market is the fact that most policies provide nothing in the event the policyholder discontinues the policy. (In insurance parlance, the provision of some refund or benefits in the event of lapsation is referred to as "nonforfeiture value.") Policyholders who drop their policy, perhaps to buy a better policy, are typically out of luck. While most people who are considering buying a policy probably believe that they are unlikely to let the policy lapse, most policyholders do eventually drop their policy (for a variety of reasons.) Most companies build assumed "lapse rates" of 5 to 20 percent per year into their actuarial calculations. Even using low lapse rate assumptions, only 33 percent of purchasers can expect to have a policy in force when they need long-term care services. In its report, the General Accounting Office (GAO) found that on average, "insurers we reviewed expected that 60 percent or more of their original policyholders would allow their policies to lapse within 10 years; one insurer expected an 89 percent lapse rate."[4]

Not only are "lapsed" policyholders prevalent, but the stakes can be very high. Based on the 44 policies GAO reviewed, a consumer who purchases at age 65 and lapses at age 75 would, on average, lose approximately $20,000 in premiums. After paying long-term care premiums for 25 years, a 90-year-old policyholder could have as much as $60,000 of equity in his/her long-term care policy. As the GAO stated, "[n]onforfeiture benefits would significantly enhance the value of policies."

Requiring nonforfeiture values provides companies with an incentive to market their policies with the long-range interests of consumers in mind. The requirement

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[2] Final Report to NAIC Long-Term Care Insurance Task Force" from NAIC Long-Term Care Insurance Nonforfeiture Benefits Ad Hoc Actuarial Group, June 2, 1992.

[3] Long-Term Care Insurance: Better Controls Needed in Sales to People With Limited Financial Resources," General Accounting Office Report to the Chairman, Committee on Energy and Commerce, House of Representatives, March 1992.

[4] "Long-Term Care Insurance: Risks to Consumers Should be Reduced," General Accounting Office, December 1991, p. 13.

is likely to lead to more realistic pricing of policies, since companies would be discouraged from underpricing these policies initially, hoping to recoup later on. If actual lapse rates turn out to be high, then the need for nonforfeiture benefits, to protect consumers who lapse, is great. On the other hand, if lapse rates are low, then the extra premium that must be passed through to consumers as a result of this requirement will be relatively low. Therefore consumers benefit from mandatory nonforfeiture whether lapse rates are high or low.

Consumers Union supports requiring all policies to include a built-in standard nonforfeiture benefit, protecting consumers in the event they drop the policy. The nonforfeiture benefit should be non-cash, since non-cash benefits are less expensive than cash benefits, maintains the long-term care nature of the product (i.e., avoiding converting it into an "investment"), and are likely to lead to lower lapse rates.

Marketplace Confusion: Need for Simplification. One of the key findings of the **Consumer Reports** article was that no two long-term care policies were alike, and it is virtually impossible to make a rational comparison of policies that are in the marketplace. The definitions of terms—"skilled nursing facility," "licensed nursing facility," "custodial care," "medically necessary," "home health care benefit," "inflation benefit," "nonforfeiture benefit" vary from policy to policy. Terms like "inflation benefit" and "nonforfeiture benefit" can have dramatically different values because of subtle differences in assumptions made by actuaries. These figures can easily be manipulated and are very difficult for consumers to understand. It is virtually impossible for consumers to make a comparison of **similar** long-term care insurance policies because the terms—and indeed the implications of the fine print in the definitions—vary so widely.

Consumers Union supports simplification of the long-term care insurance marketplace through: uniform definition of terms, improved benefit design, a standard outline-of-coverage, a standard gatekeeper, and standard benefit packages.

Agents. One of the most distressing findings in our June 1991 long-term care article (found also in the GAO investigation and in the investigation by subcommittees of the House Select Committee on Aging and Committee on Small Business) was the poor performance of agents, whose lack of understanding of the products they are selling is alarming. Agents misrepresent provisions in policies, fail to take into account medical histories, subjecting people to post-claims underwriting; fail to provide outlines-of-coverage or buyers guides; and sell policies that do not meet the long-term care needs of the purchasers.

Commission structures presently reward agents generously, with commissions of 70 to 80 percent of the first year premium, for making the sale. The agent therefore has very little incentive to take the consumer's long-term interest into account when selling a long-term care policy. This failure to take into account the long-term interest of the consumer is linked to the high lapse rate for early years of policy ownership—many of these sales are inappropriate, because the policyholder can not afford to pay the premium year-after-year.

Several steps are needed to address this problem—steps such as expanded agent training, agent certification, increased monitoring of complaint records and lapses by agents, increased scrutiny of replacement and duplicative sales, and increased prosecution of unfair marketing practices. In addition, agent commission schedules should be restructured. Agent commissions should be level for the first four years or so (or a few more if commissions continue), or the first year commission should be no more than 200 percent of later year commissions.

Consumers need an objective source of information and advice about health insurance, and senior citizen health insurance counseling programs have proven to be an effective means to deliver this advice.

Policy Upgrades. Purchasers of early-generation long-term care policies are often treated poorly when their company upgrades its long-term care benefits in newly-sold policies. In many cases, they are forced to lose the equity in their policies if they want to purchase more comprehensive coverage. Consumer Reports found that few companies offered upgrades on favorable terms. The GAO found that policyholders who want to upgrade must meet the same requirements and terms as new purchasers (if allowed to at all). Existing policyholders should be able to upgrade their policy (whenever their company improves its policy) for a fair premium; the reserves built up in the original policy should be taken into account when upgrading a policy. With premiums more than doubling between the ages of 65 and 75, policyholders should not be forced to purchase a new policy, sacrificing the equity that they have in their existing policy.

Premium Stability. Consumers are asked to purchase a policy **without knowing the price of the protection they are buying.** This is because companies (despite selling what are called "level premium" policies) are free to increase the premium in the future (sometimes with the need for approval for the rate increase from

the state insurance commissioner.) Once consumers buy a policy, they are locked into it because of the absence of nonforfeiture values. The **Consumer Reports** survey indicated that many companies are underpricing their policies (presumably in an attempt to gain market share). The National Underwriter recently reported that there are "a lot of amateurs out there" setting prices for long-term care insurance, often overstating lapse assumptions (hence underpricing the policies).[5] Consumers should not be at risk because insurance companies are not pricing policies with sufficient care.

Premium increases are especially burdensome to senior citizens who live on fixed incomes. If premiums increase dramatically, forcing policyholders to drop their policies just as their risk of needing long-term care increases, then the market will not be serving consumers well.

Requiring noncancellable policies (i.e., policies whose premium can not increase in the future) is one option, and one that would be relatively desirable if there were a satisfactory guarantee system in place. By requiring policies to be noncancellable, insurers would be forced to carefully assess risk, rather than shift the risk to the consumer. Instead of having a strong incentive to underprice policies, companies would have an incentive to come closer to the correct price, and possibly to overprice the policy. In order to assure that consumers do not pay more money than they should, policies should be "participating." In other words, insurers would refund to the consumer money, to the extent that premiums were higher than needed to cover true cost of the policy.

S. 846, S. 1693, AND S. 2571: ANALYSIS OF CONSUMER PROTECTION PROVISIONS

This section summarizes how the three bills under consideration at this hearing address Consumers Union's consumer protection concerns. A table "Long-Term Care Insurance Proposals" at the end of my written statement summarizes provisions of the three bills, the NAIC model regulation, and Consumers Union's position on 16 key provisions. I should point out that the private market provisions of S. 2571 serve a different function than the provisions of the other bills, since the private long-term care insurance market under S. 2571 wraps around a public program, similar to the role that medigap policies play vis-a-vis Medicare. At the end of this section, I point out further implications of this role.

Inflation. Unlike several bills that call for built-in inflation protection (e.g., S. 2141, H.R. 2378, H.R. 3830, H.R. 1916, and H.R. 4848), none of the three bills under consideration today assure that all policyholders will have inflation protection. S.846 requires a mandatory **offer** of 5 percent compound inflation protection; S. 1693 requires a mandatory annual offer, and S. 2571 requires an offer at the time of sale of inflation protection indexed to costs of long-term care. S. 2571 also requires an inflation option (to adjust for actual inflation) be offered at the time of each annual renewal. We believe that inflation protection should be built-in to all long-term care policies, just as minimum safety standards are required of other consumer products. We basically view long-term care policies that do not keep up with inflation to be a defective product, providing illusory benefits.

High lapse rates/nonforfeiture. S. 846 includes a mandatory nonforfeiture benefit (either a reduced paid-up or up to 2 additional benefit designs). S. 1693 and S. 2571 have only a mandatory **offer** approach for nonforfeiture benefits with S. 1693 requiring the NAIC to develop a requirement for a mandatory nonforfeiture **offer** and S.2571 requiring the optional benefit to be reduced paid up or cash after 5 years of policy ownership. In light of the significant losses incurred by people who drop their long-term care policies, Consumers Union supports a built-in (mandatory) standard nonforfeiture benefit. We are pleased that the NAIC is working toward including such a benefit in its model regulation.

A new idea for nonforfeiture benefit design has surfaced recently in proceedings before the National Association of Insurance Commissioners; it is referred to as "shortened benefit period." The NAIC is considering including a shortened benefit period, mandatory nonforfeiture benefit in its model regulation. In the event of lapse, a former policyholder would receive long-term care benefits; the duration of benefits would be a proportion of benefits covered by the policy. For example, a person lapsing after ten years, with a policy that would have covered four years of nursing home care, might be eligible for one year of coverage. We, and other consumer representatives, believe that this new benefit design is preferable to both reduced-paid-up and cash benefits, and we recommend that you consider it. "Cash benefits" are particularly undesirable since they are extremely expensive and would turn long-term care insurance policies into a combination of an insurance policy and

[5] "Are LTC Insurers Pricing in the Dark?" **National Underwriter,** June 8, 1992, p. 3.

investment vehicle. "Reduced-paid up" and "shortened benefit period" benefits preserve the insurance function of these policies. We also recommend that you consider some sort of protection for people who lapse after one or two years, perhaps a partial refund-of-premium would be appropriate.

Simplification. S. 846 requires uniform definitions and a standard outline of coverage. It improves benefits for home care by requiring personal care services to be included in all home care policies and prohibits policies from restricting covered nursing home care beyond state nursing home licensing regulations. It also requires, for home health care only, a standard gatekeeper through professional assessment of the need for benefits and the use of standard functional impairment limitations. S. 1693 requires uniform definitions and improves benefits for home care and nursing home care. S. 2571 requires uniform definitions, improved nursing home and home care benefits, a standard outline of coverage, a standard gatekeeper (through functional assessments, with denials appealable to a third party), and, significantly, standard benefit packages. Hence, while all three bills contain some important provisions, S. 2571 is the only bill under consideration today that offers consumers the possibility of comparing "apples to apples" in this complicated marketplace.

Agents. Neither S. 846 nor S. 1693 restrict agent commissions or require strengthened training or certification. Like several other bills that have been introduced (S. 2141, H.R. 3830, H.R. 1916, and H.R. 4848), S. 2571 restricts first year agent commissions to 200 percent of the commission in the second or subsequent years. In addition, S. 2571 requires that all agents who sell long-term care policies be certified as having received training with respect to such policies in accordance with the standards. Consumers Union believes that restrictions on agent commissions are essential in order to give agents a financial incentive to consider the long-range interests of purchasers.

Policy Upgrades. Neither S. 846 nor S. 1693 has a policy upgrade provision. S. 2571 requires companies that issue policies after the standards go into effect to permit each policyholder to purchase a policy that meets all of the applicable standards. The insurer would be allowed underwriting restrictions only for benefits not included in the previously issued policy. In addition, S. 2571 limits the premium that can be charged for an upgraded policy (the premium for the upgraded policy must be consistent with premium that would be charged if the individual had purchased the upgraded policy at the time of issuance of the original policy.) Consumers Union supports including a policy upgrade provision with appropriate premium restrictions.

Premium Structure. S. 846 requires public hearings for consideration of premium increases. Proposed premium increases must be accompanied by an actuarial memorandum which supports the increase. In addition, the bill requires that each policy specify a limit on the percentage increase in premiums for a policy that can be made in any one year. S. 1693 does not have any provisions with regard to premium stability. S. 2571 requires disclosure of the (self-imposed) limit on the annual percentage increase in premiums offered by an insurer. In addition, it specifies a 5 percent maximum annual premium increase for policyholders who are 75 years old or older.

While disclosure of maximum premium increases, a public review process, and limits on increases for people over age 75 can be helpful, Consumers Union urges you to consider a stronger approach that will shift the risk from consumers to insurers. This can be done by requiring fixed premiums ("noncancellable policies"). By making policies "participating," companies can make refunds to consumers if experience shows that they over-priced the policy. Not only does this shift the risk to the most appropriate party of the transaction, but this policy is administratively simple and frees state insurance regulators from the onerous and time-consuming task of determining whether increases are actuarially justified. A useful model for this pricing structure is disability insurance, where consumers can shop for a policy whose premium will remain fixed. This pricing structure would eliminate strategic pricing manipulation by companies. Of course this approach must go hand-in-hand with comprehensive reform (and nationwide availability) of a guarantee system that protects consumers against insurance company insolvency.

Senior Citizen Counseling. S. 846 and S. 2571 authorize $20 million for FY 1993, 1994, and 1995 to provide information, counseling and assistance relating to the purchase of long-term care insurance, expanding on the program established in OBRA–90 medigap reform legislation. State counseling programs in the few states that have them have proven to be extremely effective in providing senior citizens with an objective source of information and advice, freeing many senior citizens from total reliance on the insurance agent. S. 1693 has no provision for senior citizen counseling programs.

S. 2571: **Wrap-Around Public Program.** The private market reforms in S. 2571 serve a somewhat different function than the reforms in the other two bills. This is because S. 2571 appropriately creates a public program to protect all Americans against the devastating costs of long-term care, and then allows the private market to fill in the gaps for certain people. There are a few points that should be kept in mind:

If a public long-term care program were to be adopted, the Congress has a special responsibility to assure a properly functioning private market. Nobody wants a repeat of the medigap experience, where it took 25 years to get set tough federal standards for policies that fill the gaps in Medicare. With a federal long-term care public program, Congress must set up federal standards for the private market from the start. S. 2571 should be strengthened to **require** inflation protection and a nonforfeiture benefit. The standards should be comprehensive, correcting all of the flaws in the marketplace, so that purchasers can be assured that the policy provides real protection.

The existence of the comprehensive public coverage means that fewer people should consider private insurance than should consider it absent a public program. S. 2571 protects assets of $60,000 per couple, and increases protected income, making long-term care insurance less attractive for people who are close to these protected levels. Therefore, S. 2571 should direct the NAIC or the Secretary to develop guidelines about income/asset profiles who should, or should not, consider the purchase of a policy. Indeed, whether considered separately or as part of a public program, regulators should address how to prevent the inappropriate sale of long-term care policies to people who can not afford them. The General Accounting Office recently found (in a Report to the House Energy and Commerce Committee) that companies provide agents with limited training on how to assess the financial condition of potential buyers or avoid sales to people with low incomes.[6] It is no wonder that 29 percent of people buying long-term care policies had annual incomes below $20,000.[7]

If the private market reforms are considered separately from the program, then we urge you NOT to include the "tax clarification" provisions in the reform bill. Consumers Union believes that it is grossly inappropriate for federal revenues to be spent providing a tax subsidy to relatively high income purchasers of long-term care insurance policies. Instead, the next federal health care dollar should be spent expanding access to acute health care services.

In sum, Consumers Union strongly supports your efforts to reform the regulation of the private long-term care insurance market. Building on the procedural and substantive medigap reform provisions of OBRA–90 is a sound approach. We urge you to enact strong consumer protection measures in order to assure that all purchasers of long-term care policies get the protection that they believe they are buying.

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[6] General Accounting Office, p. 13.

[7] "Who Buys Long-Term Care Insurance," by LifePlans for Health Insurance Association of America, 1992, p. 14.

LONG-TERM CARE INSURANCE PROPOSALS					
	NAIC 12/91 MODEL REGULATION	PRYOR S. 846	BENTSEN[1] S. 1695	MITCHELL, ROCKEFELLER, ET AL S. 2571	CU RECOMMENDATIONS
NONFORFEITURE	-	mandatory NF, RPU or up to 2 additional designs	mandatory offer	mandatory offer RPU or cash after 5 years	mandatory RPU
INFLATION	mandatory offer 5% compound	mandatory offer 5% compound	mandatory annual offer	mandatory offer inflation	mandatory 5% compound (or more)
SIMPLIFICATION					
• uniform definitions	—	yes	yes	yes	yes
• improved benefits	—	homecare: personal care N.H. care: all licensed	homecare: personal care N.H. care: all licensed	community care, homemaker care personal care respite, hospice care adult day care N.H. care: all licensed	homecare: homemaker, personal care adult day care respite care N.H. care: all licensed
• standard outline of coverage	yes (by state)	yes	-	yes	yes
• standard gatekeeper	—	yes professional assessment for home care services.		yes. functional assessment. appealable to 3rd party.	yes. professional assessment. uniform eligibility criteria
• standard benefit packages	—	-	-	yes	yes
PREMIUM STABILITY	—	public hearings disclose maximum	-	Maximum 5% increase per year if over 75. Discloses maximum increase	fixed premiums (non-cancelable)
AGENTS	optional 200 $/100 $	-	-	200 $/100 $ training and certification	200 $/100 $ training and certif. exam
SOLVENCY	—	report	-	report	-improved regulation -report
UPGRADES	—	-	-	yes premium restrictions	yes
CLAIMS REVIEW	—	yes. Impartial. appeals process also.	-	yes. insurers must have appeal process with fair hearing. Process must meet standards.	yes. impartial appeal process
WHO SETS POLICY	NAIC/STATES	NAIC/[DHHS]	NAIC/[DHHS]	NAIC/[DHHS]	Commission, Secretary or NAIC
WHO REGULATES	STATES	STATES/[DHHS]	STATES/[DHHS]	States/Secretary	States/Secretary
COUNSELING	—	$20 MILLION	-	$20 MILLION	$20 MILLION
ACCESS TO COMPLAINTS	—	yes	-	yes	yes
REPORTS	lapse reports	several	-	several	several
SALES PRACTICES	some restrictions	several prohibitions	no sale to medicaid; agents/medicaid battery	several prohibitions	several prohibitions
PENALTIES	up to $10,000	$25,000	$5,000 tax	$25,000	$25,000, 5 years in jail
GROUP POLICIES	continuation/conversion	continuation/conversion	-	continuation/conversion	continuation/conversion

[1] Primarily a tax bill

LONG-TERM CARE INSURANCE PROPOSALS		
	PRYOR S 646	BRUCE H R 2378
NONFORFEITURE	mandatory NF, RPU or up to 2 additional dowgas	mandatory RPU after 5 years
INFLATION	mandatory offer 5% compound	mandatory 5% compound
SIMPLIFICATION		
•uniform definitions	yes	no, just "simple language"
•improved benefits	homecare personal care N H care all licensed	1 yr homecare homemaker and respite
•standard outline of coverage	yes	
•standard guidelines	yes professional assessment	yes professional assessment
•standard benefit packages		
PREMIUM STABILITY	public hearings disclose maximum	requires public comment
AGENTS		
SOLVENCY	report	
UPGRADES		
CLAIMS REVIEW	yes Impartial appeals process also	yes for review of grievances
WHO SETS POLICY	NAIC/DHHS	Secretary
WHO REGULATES	STATES/DHHS	STATES/DHHS
COUNSELING	$20 MILLION	
ACCESS TO COMPLAINTS	yes	yes
REPORTS	several	
SALES PRACTICES	several prohibitions	restricts sale of duplicative
PENALTIES	$25,000	$25,000
GROUP POLICIES	continuation/conversion	

LONG-TERM CARE INSURANCE PROPOSALS			
	NAIC 12/91 MODEL REGULATION	BENTSEN[1] S 1693	KENNEDY S 2141
NONFORFEITURE	-	mandatory offer	mandatory NF benefit, defined by commission
INFLATION	mandatory offer 5% compound	mandatory annual offer	mandatory compound inflation adjustment based on $ or $ wage index
SIMPLIFICATION			
• uniform definitions	—	yes	yes
• improved benefits	—	homecare personal care N H care all licensed	homecare homemaker, personal care adult day care respite care N H care all licensed
• standard outline of coverage	yes (by state)	-	yes
• standard guidelines	—		yes professional assessment
• standard benefit packages	—	-	yes
PREMIUM STABILITY	—	-	public hearings discloses maximum 10% max if > 75 years
AGENTS	optional 200 h/100 h	-	training and certification 200 h/100 h
SOLVENCY	—		report
UPGRADES	—		yes
CLAIMS REVIEW	—	-	yes independent annual review uniform guidelines
WHO SETS POLICY	NAIC/STATES	NAIC/(DHHS)	LTC insurance standards commission
WHO REGULATES	STATES	STATES/(DHHS)	Commissioner/States/(DHHS)
COUNSELING	—	-	$10 MILLION
ACCESS TO COMPLAINTS	—	-	yes
REPORTS	lapse reports		several
SALES PRACTICES	some restrictions	no sale to uninsured, agents/medical history	several prohibitions
PENALTIES	up to $10,000	$5,000 tax	$25,000, 5 years in jail
GROUP POLICIES	continuation/conversion	-	continuation/conversion

[1] Primarily a tax bill

	STARK H.R. 3830	WYDEN H.R. 1916	CU RECOMMENDATIONS
NONFORFEITURE	mandatory NF, either RPU or E.T. or mandatory RPU or ET	mandatory NF, RPU or up to 2 additional designs	mandatory RPU
INFLATION	mandatory at least 5% compound	mandatory 5% compound	mandatory 5% compound (or more)
SIMPLIFICATION			
•uniform definitions	yes	yes	yes
• improved benefits	homecare: not just RN, RPN N.H. care: all licensed	homecare: personal care N.H. care: all licensed	homecare: homemaker, personal care adult day care respite care N.H. care: all licensed
•standard options of coverage	yes	yes	yes
•standard gatekeeper	yes, uniform eligibility criteria	yes, professional assessment	yes, professional assessment, uniform eligibility criteria
•standard benefit packages	-	-	yes
PREMIUM STABILITY	no increase if >75 years	public hearings disclose maximum	fixed premiums (non-cancelable)
AGENTS	200%/100%	200% / 100%	200%/100% training and certification
SOLVENCY	-	report	-improved regulation -report
UPGRADES	yes	yes	yes
CLAIMS REVIEW	must disclose process	yes, impartial appeal process also	yes, impartial appeal process
WHO SETS POLICY	Secretary	NAIC/[DHHS]	Commission, Secretary or NAIC
WHO REGULATES	Secretary/States	STATES/[DHHS]	States/Secretary
COUNSELING	-	$20 MILLION	$20 MILLION
ACCESS TO COMPLAINTS	-	yes	yes
REPORTS	Secretary; insurers	several	several
SALES PRACTICES	several prohibitions	several prohibitions	several prohibitions
PENALTIES	50% of premium tax; $25,000	$25,000; 5 years jail	$25,000; 5 years in jail
GROUP POLICIES	continuation/conversion	continuation/ conversions	continuation/conversion

SUMMARY OF CONSUMERS UNION RECOMMENDATIONS

This section summarizes Consumers Union's positions on the key consumer protection issues that should be addressed by federal long-term care insurance legislation.

NONFORFEITURE

Long-term care insurance policies should be required to have a built-in standard nonforfeiture benefit, protecting consumers in the event they drop the policy. The benefit should begin after one or two years of policy ownership (possibly with a return-of-premium type of benefit), and after five or so years should convert to a reduced-paid-up type of benefit. There should be no more than two standard non-cash benefits, each with the same actuarial value.

INFLATION

All long-term care policies should build in inflation protection through a standard compound inflation formula. One option would be to build in (at least) a five percent inflation increase (compound) to continue for the life of the policy. Another option would be to index benefit levels to a health-care related inflation index. (One disadvantage of the first option is that with health care costs increasing at the annual rate of about 15 percent, there is a very good chance that actual inflation could greatly exceed the fixed percent; the key advantage is the relatively low cost of this amount of inflation protection and the certainty/predictability of a fixed index, making pricing easier for insurance companies.) Inflation protection should continue while a policy is "in claim."

SIMPLIFICATION/MEANINGFUL BENEFITS

The long-term care marketplace should be improved and simplified through uniform definition of terms, improved benefit design, a standard outline-of-coverage, standard gatekeepers, and standard benefit packages.

PREMIUM STABILITY

Companies should be required to write noncancelable policies, i.e., policies whose premiums are guaranteed for life. (This change should be enacted in conjunction with an overhaul of the system to protect consumers in the event of company insolvency.)

Refuting the Myths -- Summary

Myth One -- Nonforfeiture will not address the problems of high lapse rates and underpricing.

Fact -- Mandatory nonforfeiture benefits will both provide a long-term care benefit to the many policyholders who lapse AND provide incentives for companies to accurately price their products.

Myth Two -- Mandating nonforfeiture benefits will drive the price of the product up so high that the market will be destroyed, taking consumers' choices away from them.

Fact -- Mandating nonforfeiture benefits may increase the price of long-term care insurance products somewhat. Any increase in price is offset by the enhanced value of the product; there is no dispute that nonforfeiture is an improvement. The level of increase in price, however, is dependent upon the type of nonforfeiture value provided -- noncash benefits are less expensive than cash value benefits.

Myth Three -- Mandatory nonforfeiture benefits cannot be developed because long-term care insurance is a relatively new product and the experience is not yet available. Therefore the market should be allowed flexibility to determine what benefits policies should offer.

Fact -- Several different kinds of nonforfeiture benefit structures have already been offered by insurers, proving that they are in fact feasible. In addition, there is now extensive data concerning the utilization rates for the most expensive service, nursing home care, that is available to all insurers that actuaries can rely on, and that allows actuaries to assess and address the risks posed by possible changes in the future. While the NAIC should take into account the need for some flexibility, the consumer should not bear the entire risk of loss.

Myth Four -- Nonforfeiture will do nothing for those who lapse since most lapses occur within the first two years and any benefit at that time would be illusory.

Fact -- The majority of lapses occur in later years. A nonforfeiture benefit structured to begin after an initial period of 3 to 5 years will provide a meaningful level of benefits. For those who lapse in the first few years, often a result of inappropriate sales, they should receive a return of a portion of the premium paid in.

Myth Five -- Nonforfeiture is a "simple singular solution," offered as a "broad panacea" to a complex problem and, as such, is illusory.

Fact -- Nonforfeiture is one of several regulatory reforms proposed to improve the long-term care market to adequately protect the long-term care interests of consumers.

Myth Six -- If nonforfeiture is required, insurers must have the option of offering cash based benefit.

Fact -- Cash nonforfeiture benefits do not have to be offered as an option. From a public policy viewpoint, noncash benefits are preferable to cash benefits. In addition, not only is there no dispute that cash nonforfeiture benefits cost substantially more than noncash benefits, but the mere offering of the option of cash benefits increases the cost of providing nonforfeiture benefit and will have the perverse affect of encouraging lapsation.

Myth Seven -- There is no need for the nonforfeiture benefit for those policyholders over a certain age, i.e. 75, because the cost is not worth the benefit.

Fact -- Older policyholders need protection against lapsation: (1) because of limited incomes, they are at great risk of having to lapse when premiums increase; (2) initial premiums increase with age (at application), subjecting older people to greater equity loss; and (3) the longer the policy has been owned, the larger the amount of equity at risk, subjecting older policyholders to great risk.

Myth Eight -- The issue of nonforfeiture has not been studied sufficiently enough for the NAIC to act. NAIC should not act until price implications of action are understood.

Fact -- The issue of nonforfeiture has received more study and analysis than any other long-term care insurance issue recently before the NAIC. Whether or not nonforfeiture benefits should be mandated is a policy matter; it should not be delayed by scare tactics employed by the industry.

Myth Nine -- Mandating Offer of Nonforfeiture sufficiently protects policyholders.

Fact -- An "offer" approach is inadequate: (1) new policyholders do not expect that they will lapse; (2) the nonforfeiture choices are complex and the figures easily manipulated by companies; and (3) agents are likely to distort the choice.

Myth Ten -- Those who advocate for mandatory nonforfeiture do not know what they are doing.

Fact -- Knowledgeable representatives, actuaries, public policy analysts, health care specialists, economists, and well-known consumer advocates have studied the issue and believe that mandatory nonforfeiture enhances the value of long-term care policies and is well worth the modest premium increases.

Summary of Consumers Union Recommendations

AGENTS

Agent commission should be leveled either to totally level commissions or a limit of first-year commissions to 200% of later year commissions. Alternatives to an agent-based distribution system should be explored. In addition, agent training and certification should be expanded and state enforcement efforts strengthened.

SOLVENCY

Consumers need improved protection against the risk that their company becomes insolvent. They need assurance that they will receive full benefits in the event of insolvency, and they need protection against the risk of premium increases that can result from takeover of their company. Reserve requirements should be reviewed. The performance of state guaranty associations should be subject to intense public scrutiny and should be accountable to the public with public representation on any boards. Sound financial regulations (reserve requirements, outside audits when necessary, actuarial certification of loss ratios, early warning systems, uniform and consistent reporting requirements, centralized information system to allow states to share information, intense market conduct examinations) should reduce insolvencies.

POLICY UPGRADES

Existing policyholders should be able to upgrade their policy (whenever their company improves its policy) for a fair premium. They should not be forced to purchase a new policy, sacrificing the equity that they have in their existing policy.

THIRD PARTY CLAIMS REVIEW

Consumers should have the automatic right of appeal to an objective third party whenever a long-term care claim is denied by the insurer.

WHO SETS POLICY/REGULATES

Regardless of what structure is used to set policy and enforce the regulations, there should be the opportunity for considerable input from consumer representatives and state counseling programs. If necessary to ensure participation, there should be funding for travel expenditures and compensation (for otherwise uncompensated time) for consumer representatives.

SENIOR CITIZEN COUNSELING

Congress should increase the amount of money authorized and appropriated to encourage states to establish senior citizen counseling programs from $10 million per year by an additional $20 million per year.

CONSUMER ACCESS TO COMPLAINT INFORMATION

Consumers should have access to complaint information about insurers.

REPORTING REQUIREMENTS

DHHS and/or NAIC should be required to report to the Congress on subjects such as: lapse rates; agent abuses; claim denials; premiums; methods to conduct assessments of functional ability; insurer solvency; standard measure of value for long-term care insurance policies.

REGULATION OF SALES PRACTICES

Abusive sales practices (such as twisting, high pressure sales tactics, cold lead advertising that fails to disclose that the method of marketing is solicitation of insurance) should be prohibited. Agents should be prohibited from completing the medical history portion of applications. The sale of a policy to a person who is eligible for medical assistance should be prohibited. The sale of duplicative service benefit policies should be prohibited.

PENALTIES

Penalties for failure to comply with regulations or engaging in prohibited practices should be stiff, including civil money penalties (e.g., $25,000 per violation) and jail terms of up to five years.

GROUP POLICIES

Group policies should provide a basis for continuation or conversion in the event that group coverage is terminated for any reason.

RESPONSES OF GAIL SHEARER TO QUESTIONS SUBMITTED BY SENATOR GRASSLEY

Question No. 1. Do you consider a five percent compounded inflation protection sufficient? And, just for the record, do you know what the annual increase in, for instance, the average nursing home cost is?

Anwer. We consider a five percent compound inflation protection provision to be an acceptable compromise between full protection against inflation and a mere option of inflation protection. Without any inflation protection, a long-term care policy provides only illusory coverage. With 5% inflation, a policy worth $100 in 1992 would be worth only $36 in 20 years, covering an insignificant portion of anticipated long-term care costs. If long-term care cost inflation averaged 10% per year, the $100 face value policy would pay the equivalent of just $12 per year in 20 years.

According to an AARP study, nursing home costs increased (on a compound, basis) an average of 10.0 percent per year between 1965 and 1990.* If historical trends continue, 5% inflation protection should be considered a **modest** amount of protection against the devastating erosion of benefit value.

Question 2. You called in your statement for a "standard gatekeeper." You also listed in your summary "impartial claims review," "functional assessment by professionals," and a "third party appeals process." Can you elaborate on what these functions are designed to accomplish and how you would organize them' so as to insure objectivity and impartiality?

Answer. There are two goals addressed in this question: First, consumers must be assured that in order to qualify for benefits of various policies, the same criteria of disability are applied. In other words, fine print and company practice should not keep policyholders **with identical levels of disability** from qualifying for benefits that appear to be identical. Second, consumers should be assured that the claims consideration is not influenced by anything other than objective criteria that are applied consistently and can be understood by the consumer at the time of purchase of the policy. There have been concerns with gatekeepers (e.g., medical necessity) that are now used: if claims of one policy increase over time, the company might well restrict claims approval and tighten up its definition of "medical necessity.

A standard gatekeeper, using for example standard ADL (activity of daily living) measures, including cognitive impairment, is a key component of long-term care reform. Impartial claims review can be achieved through the combination of "functional assessment by professionals" (e.g., uniformly applying the standard gatekeeper requirements by trained professionals) and by a third party appeals process. The appeals process could be conducted by an outside party with no ties to the insurance companies. Through such a process, consumers could be assured of fair, uniform consideration of their claim and of their appeal if necessary. Without such a process, companies might be overly restrictive in their consideration of claims, especially since many policyholders making a claim are in no condition to argue their own case in favor of benefits.

PREPARED STATEMENT OF JANET L. SHIKLES

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] The other study reviewed company practices regarding the sales of long-term care insurance to people with limited financial resources.[2] 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.

**Inflation Protection and Nonforfeiture Benefits in Long-Term Care Insurance Policies: New Data for Decision Making,* Prepared by William M. Mercer, Inc. for American Association of Retired Persons, June 1992, p. ix.

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

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

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.

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.[3] 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.[4] 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 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.

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[3] 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.

[4] 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.

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.[5]

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.

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

[5] 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.

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).[6] 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.

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

[6] 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.

lapse within 10 years; one company expected an 89 percent lapse rate after 10 years.[7] 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 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.[8] 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 would become eligible for Medicaid soon after they incur nursing home expenses.

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

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

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.[9]

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.

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 toe 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.[10]

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;
- 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.

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

[10] LifePlans, Inc., 1992.

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.

RESPONSES OF DIRECTOR SHIKLES TO QUESTIONS SUBMITTED BY SENATOR GRASSLEY

Question No. 1. Are you able to say whether states that have adopted NAIC standards have done a good job of enforcing the standards that they adopted?

Answer. We did not study how states have enforced NAIC standards. But enforcement of NAIC standards is as important as the adoption of the standards themselves in regulating long-term care insurance. We also know from visits with officials of eight state insurance agencies that they face a considerable task in enforcing long-term care insurance standards, particularly in light of limited staff and other resources.

Question No. 2. The Insurance Commissioners' testimony, which followed yours, notes very pointedly that they have tried, in their recommendations, to strike a balance between consumer protection and the need to let a new product and market develop. May I just have your general comment on this tension? And can you tell us whether you believe that your recommendations strike this balance?

Answer. Although the NAIC standards are not mandatory, they suggest the minimum standards states should adopt in regulating long-term care insurance. The standards do provide consumer protection while offering insurance companies flexibility to experiment with different products in a competitive, emerging market. The additional standards we proposed would likely increase premiums. However, we believe that they would significantly improve consumer protection. Further, adding these standards to existing NAIC standards is still consistent with an approach of incrementally strengthening standards while giving insurers the flexibility to continue to experiment with and improve their products.

Question No. 3. (A) Can you tell us what a formal grievance procedure should look like? (B) And do you believe that we could establish one that is simple and will not bog down both the consumer and insurers with endless litigation? (C) Is there a current model in use of an appropriate grievance procedure? (D) Finally, is a grievance procedure going to be enough to protect the consumer?

Answer. A grievance procedure allows policyholders to formally contest insurers decisions about their eligibility. A grievance procedure alone will not provide effective consumer protection and should be considered with other standards to regulate long-term care insurance. At minimum, a grievance procedure could help to resolve different interpretations of contractual obligations between policyholders and insurers in a forum other than a legal one.

Of the 44 policies we reviewed, 10 offered some type of simple grievance procedure. Each of the 10 policies stipulated that the insurer would reconsider a claim and review any supporting materials after the policyholder submitted a reconsideration request in writing. Seven of the 10 policies obligated the insurer to respond to the grievance, in writing, within a specific period (30 or 60 days). Provisions stipulating an insurer's time limit give policyholders a safeguard against inordinate delays.

Question No. 4. You discussed the importance of nonforfeiture requirements for long-term care insurance policies. Do you have any thoughts on how those should be structured? Would you contemplate a cash surrender value or forfeiture value or some sort of service or benefit value? What about the length of time a policy should be held before the nonforfeiture protection kicks in?

Answer. It was most important that we emphasize consumers vulnerability to financial loss absent nonforfeiture benefits. We did not evaluate specific options or types of nonforfeiture benefits. In principle, however, reduced paid-up benefits should have a more limited impact on premiums than cash surrender benefits.

U.S GENERAL ACCOUNTING OFFICE,
Washington, DC, November 30, 1992.

Hon. JOHN D. ROCKEFELLER IV, *Chairman,*
Subcommittee on Medicare and Long Term Care,
Committee on Finance,
U.S. Senate.

This letter is in response to the additional information you requested to be included in the June 23, 1992 hearing record. It concerns the status of states in adopt-

ing key NAIC standards for regulating long-term care insurance. To review state standards, we compared each state's applicable laws and regulations with key NAIC standards. Compliance with NAIC standards was based on states' long-term care insurance acts and regulations as of January 1991. Almost all states had adopted some of the NAIC standards we reviewed. However, only a few states, including Alabama and Mississippi, met all the standards that we reviewed. In contrast, a few states or jurisdictions, including the District of Columbia, Ohio, Pennsylvania, and Utah, did not meet any of the standards we reviewed. The enclosed chart indicates the number of states that had enacted key NAIC standards at the time of our study.

Should you or your staff have any additional questions about our study, we would be happy to discuss them.

JANET SHIKLES, *Director, Health Financing and Policy Issues.*

Enclosure.

State Enactment of Key NAIC Provisions

NAIC provision[a,b]	Consumer protection: Equal to or more than model	Consumer protection: Less than model	No provision
Requires guaranteed renewability	28	2	21
Prohibits prior hospitalization	32	8	11
Prohibits Alzheimer's disease exclusions	32	2	17
Standards for home health care	11	1	39
Meets inflation protection standard[c]	11	6[d]	34
Application disclosure requirements to prevent post-claims underwriting	11	0	40
Prohibits stepdown provisions[e]	28	1	22
Cannot limit to skilled care or give significantly more coverage for skilled care than other care	35	4	12
Has preexisting condition limits[f]	23	23	5
Requires outline of coverage	21	25	5
Standard format and content for outline of coverage	21	4	26
Requires uniform 30-day free look[g]	29	12	10
Standards for loss ratios	26	6	19

[a]Compliance with NAIC standards was based on states' long-term care insurance acts and regulations as of January 1991. Data were provided by NAIC.

[b]Includes the District of Columbia; thus, states add to 51.

[c]We compared states to a standard requiring that inflation protection be compounded annually.

[d]One state sets minimum caps on inflation protection but does not require compounding.

[e]Stepdown provisions require policyholders to obtain higher levels of care before they become eligible for lower levels. This would, for example, require that skilled nursing care be received before custodial care would be covered.

[f]Preexisting condition is one for which medical advice or treatment was recommended by or received from a health care provider within 6 months before the effective date of coverage. A policy cannot deny coverage of such a condition after 6 months of effective coverage.

[g]We evaluated standards for individual policies only; ranking would differ for some states if group policy standards were included.

PREPARED STATEMENT OF SUSAN VAN GELDER

Good afternoon Mr. Chairman and Members of the Subcommittee. My name is Susan Van Gelder, Associate Director of the Health Insurance Association of America (HIAA). I am pleased to testify today on behalf of the HIAA which represents 300 private health insurance companies providing health insurance for 95 million Americans.

HIAA welcomes the opportunity to testify today on the status of the private long-term care insurance market and the consideration of proposals to establish federal consumer protection standards for such products.

To emphasize the need for unique consumer protection requirements in the area of long-term care, on April 26, 1992, the HIAA Board of Directors adopted a Proposal for Long-Term Care Consumer Protection which states the Goals of Long-Term Care Insurance Consumer Protection Regulation and proposes a Consumer "Bill of Rights" which identifies fundamental consumer rights for the purchase of long-term care insurance. To back up the Bill of Rights, the proposal recommends a series of specific provisions in the areas of company, agent, and consumer education, disclosure, marketing practices, and policy benefit provisions. The HIAA Proposal for Long-Term Care Consumer Protection is in the form of a legislative and regulatory agenda which HIAA is actively pursuing at the state level. See Attachment A.

HIAA and its members share the objectives of policy makers and consumers—strong consumer protection laws and their full enforcement are needed for long-term care insurance. The market will not survive without them. However, HIAA has serious concerns that some consumer protection standards being considered by state and federal policy makers will do more harm to consumers than good. Lot me discuss these reasons in more detail.

I. THE LANG-TERM CARE INSURANCE MARKET IS GROWING RAPIDLY, OFFERING CONSUMERS MEANINGFUL AND AFFORDABLE PROTECTION

Market Growth

Prior to 1985, only 24 companies sold a long-term care insurance policy. Today, over 130 companies are selling long-term care insurance. Many diverse products are being offered—consumers may buy coverage on an individual basis; through their employer; as part of their membership in a continuing care retirement community; or as part of their life insurance policy.

The number of people who have purchased long-term care insurance has more than doubled since 1987. An HIAA survey shows that, as of the end of 1990, 1,928,000 policies had been sold.

Although the market is still dominated by products sold individually to an older population, newer vehicles, such as employer-sponsored arrangements and coverage under life insurance plans, have grown rapidly since their recent introduction. One quarter of all policies sold in 1990 were in the employer market.

Other-types of products are also developing. For example, between 1987 and mid-1990, the number of people purchasing coverage as part of a life insurance contract increased from about 1,000 to more than 14,000. Clearly this market is young and just beginning to demonstrate its potential, especially among the nonelderly population.

Meaningful Protection

More importantly, the products themselves have undergone tremendous changes in benefit features and design in response to consumer demand and market and regulatory pressures. Our analysis of about 14,000 individual long-term care policies purchased in 1990 indicates that individuals are purchasing long benefit periods, reasonable daily benefit amounts, and short elimination periods. For example,

- The benefit durations of policies sold in 1990 were quite long. Almost all policies covered at least two years of nursing home care (96%) and slightly more than half had durations greater than five years; 35 percent were lifetime policies.
- The average daily nursing home benefit was $72.
- Most policies sold had elimination periods of 20 days or less (65%).
- About 37 percent of policies had home health care protection.
- About 40 percent of purchasers over age 55 chose to include inflation protection in their policy. Purchasing inflation protection is highly correlated with age. While about half of purchasers age 55 to 64 chose inflation protection, only 17 percent of individuals over age 75 chose the coverage. In addition, the percentage of purchasers opting for inflation protection does not increase for those with

incomes above $35,000; suggesting that above a certain income level, individuals self-insure for the risk of inflation costs.
- While the average premium across all individual buyers of all ages and including those with and without inflation was $1,072 a year or about $90 per month, the average premium:
- at age 65 without inflation was $776 a year,
- at age 65 with inflation it was $900 a year.
- at age 79, without inflation was $1,786 a year,
- at 79 with inflation it was $2,466.

Although the market is quite young, it is clear that good products are widely available across the country. Furthermore, newer products, although a smaller percentage of the market, tend to offer newer benefits. For example, most newer policies condition benefit eligibility upon becoming disabled in a number of activities of daily living rather than physician certification of need. Some policies offer case management services. A few policies determine eligibility for noninstitutional care based on disability alone; they are eligible for benefits while receiving care from family or other informal caregivers.

Company Experience

In 1989, HIAA conducted a survey of 27 member companies selling long-term care insurance to determine what their market experience had been to date. The following information was reported:

- Most companies required an attending physician statement for all applications or under certain conditions such as age or the presence of a specific health condition. Additionally, 15 companies conducted follow-up phone interviews with every applicant. Across companies representing 40 percent of the market, an average of 76 percent of all applicants were approved for coverage.
- All companies using an agent force provided a copy of the policy's outline of coverage at point of sale.
- Across companies representing 40 percent of the market, an average of 10 percent of all policies were returned within the 30-day free-look period for a premium refund and cancellation of the policy.
- Although very few companies had enough experience to report claims information, for those companies with at least 25 filed claims, the median percentage of claims approved for payment was 88 percent. The most frequent reasons for denial were failing to meet the preexisting condition requirement, failing to meet the deductible period, and misrepresentation or fraud on the application.
- Across companies representing one-third of the market, the average first year agent commission rate was 36 percent. The average second year commission rate was 11 percent. After 5 years, the average was 7 percent. Independent agents generally do not receive the entire commission, however, because it is also used to help pay overhead such as office space, management and support staff.

Affordable Products

HIAA believes that long-term care insurance can offer meaningful and affordable long-term care protection for millions of Americans. In the employer market, where the average age of a long-term care buyer has been 43, the average yearly premium is $200 for a plan offering an $80 a day nursing home benefit, 5 years of coverage and providing a 90-day deductible period.

A recent *Fortune* survey of 500 executives indicates that long-term care is the most likely type of employee health benefit to be added over the next 5 years. It is estimated that clarification of the tax treatment for employer-sponsored plans could increase this market by 35 percent. In addition, such legislation is important for recognizing the unique nature of certain long-term care products—such as those using life insurance or those that provide benefits based upon a level of disability rather than upon the receipt of formal services.

Who is Buying Long-Term Care Insurance and Why

While the market has grown rapidly and the products have improved substantially over the past few years, very little had been known about who is actually buying long-term care policies, why they are buying and what kind of policies are being bought—information which is critical assessing the extent to which private insurance is a viable financing vehicle for long-term care and if so, for whom.

HIAA recently released findings from a survey conducted by Life-Plans Inc. of a sample of buyers and non-buyers of both individual and employer group long-term care insurance during 1990. In addition to who is buying what products and why, the survey produced findings related to people's attitudes about the government's

role which may help policy makers in developing consumer education and protection needs in this area.

With respect to *individual* long-term care insurance policies, six companies, that together represented 45 percent of total individual long-term care insurance sales in 1990, contributed a sample of purchasers and non-purchasers over age 55 to the study. The response rate for purchasers and non-purchasers was 61 percent and 43 percent respectively. Major study findings include:

- Purchasers are wealthier and younger than their counterparts in the general population age 55 and over; they are also more likely to be female, married and college educated.
- Compared to non-purchasers, purchasers view planning for the future as very important, have a more positive attitude toward the products provided by the insurance industry, and are less likely to view government as a major payor of long-term care costs than are non-purchasers. Purchasers are also more likely to believe that they are at a higher risk for needing nursing home care than non-purchasers. However, there still exists a great need for education about long-term care and how to pay for it by both groups.
- There are a variety of important reasons behind the decision to purchase long-term care insurance. However, one-half of the purchasers cited the most important reasons were preserving their independence and being able to afford needed care. Protecting assets was cited by only 14 percent as the most important reason for purchasing.
- In addition, there were a variety of reasons why individuals chose not to purchase policies. Three reasons related to cost were cited by 43 percent of non-purchasers. Many non-purchasers, 17 percent, were waiting for better policies.
- Providing information about long-term care risks, costs, and private insurance is considered by purchasers to be the single most important action that government should take in this area.

With respect to *employer group* long-term care insurance, two companies which represented 16 percent of all policies sold in the employer market in 1990 contributed a sample of employee purchasers and non-purchasers. The response rate among employees who purchased a policy was 63 percent, while the response rate of non-purchasing employees was 46 percent.

Most of the employers who agreed to participate in the survey were insurance-related organizations. Given the small sample size and the unique nature of the employers, data from this sample offer only a "first look" at the demographic profile and attitudes of a subset of purchasing and non-purchasing employees. Major study findings include:

- The employees in the survey differ substantially from their counterparts in the general population. Sampled employees are between seven and eight times more likely to have incomes in excess of $50,000 than are individuals in the general population. They are also more likely than those in the general population to hold financial assets of great value.
- Employee purchasers are somewhat older, more likely to be male, and more likely to have completed some college education than are employee non-purchasers. Moreover, about 80 percent of purchasers have incomes of over $35,000, compared with only 69 percent of non-purchasers.
- Both insurance companies offered plans with nursing home and home health care protection, inflation coverage, elimination periods of 90 days, and minimum benefits of at least $73,000. Employees could choose daily benefit amounts, lifetime maximums, and whether or not they wanted inflation protection.

  Although one employer offered a $1 million lifetime maximum, the lifetime maximum offered by the other five employers ranged from $73,000 to $390,000.

  The average daily nursing home benefits was $80. The average home health care benefit was half that of nursing home benefits. Chosen daily benefits did not vary with age or income.

  When offered the choice of inflation protection 90 percent of purchasers chose it. Two options were available—an opportunity to increase daily benefits on a periodic basis and an annual 5 percent compounded increase to the daily benefit.

- compared to non-purchasing employees, employee purchasers view planning for the future as very important, worry more about how they will pay for care if they need it, believe their risk of needing nursing home and home care is higher and are less likely to view government as a major payor of long-term care costs than are non-purchasers.

- Like individual buyers, the most important reason employees bought long-term care insurance related to preserving independence and the desire to guarantee the affordability of services.
- Reasons related to cost were the most frequently cited (46 percent) for not purchasing long-term care insurance among employees. About 17 percent of respondents felt they were too young to consider long-term care.
- A comparison across markets indicates that employees' reasons for non-purchase were more focused on the product and its cost whereas older individuals' concerns were focused more on the insurance company itself.
- Employees were uncertain about the desirability of establishing a new government program for long-term care financing. They were, however, 1.7 times more likely than are their counterparts in the individual market to oppose a new government program.
- As in the individual market, purchasers expressed an interest in having the government assist individuals in understanding the risks they face, the financing options for long-term care, and how to choose a policy. Providing this information was cited as the most important action that government should take.

The attitudes of these purchasers and non-purchasers provide both the public and private sector better information about this market place. For example, *both insurers and the government have a critically important role to play in the area of consumer education.* Information about the future risks, and the conditions under which government coverage is available is especially important. Education is the key to consumer protection.

II. FEDERAL STANDARDS MAY INHIBIT NEW PRODUCT INNOVATION

While today's products provide meaningful benefits, we are not at all certain that they represent the ultimate in product design. Given its brief history, we do not know yet where the products will go in terms of what funding mechanisms may be used to pay for them or what benefits such products might finally provide. The employer market and life insurance products, which accelerate death benefits for such needs as long-term care, have only been recently introduced.

A recently issued report by the Washington Business Group on Health also found that employers are showing a growing interest in sponsoring group long-term care insurance plans. According to the WBGH report, which is based on a study of 136 Fortune 500 firms, approximately 10 percent of large employers have sponsored a long-term care insurance plan. And 75 percent of those employers who responded to the study plan to sponsor a long-term bare insurance plan by 1996. The study also found that these employers believe the most critical federal government involvement in the financing of long-term care is to ensure favorable tax incentives. The employer and individual market, as well as continuing care retirement communities and long-term care insurance riders to life policies each respond to different needs and each bring with it different consumer concerns. We have seen these markets undergoing refinements on a regular basis. A single set of federal standards would have a chilling effect and could well result in inhibiting such product innovation, just when it is needed most.

Federal Legislative Proposals

Several bills which would impose certain federal standards for long-term care insurance have been introduced and referred to this subcommittee and are the subject of this hearing. S. 2571, introduced by the Chairman and Senator Mitchell, would set up a publicly funded long-term care program along the lines of the Pepper Commission proposal, in addition to establishing private insurance standards and clarifying the tax status of long-term care insurance. S. 846, introduced by Senator Pryor, would establish federal standards for private long-term care insurance. S. 1693, introduced by Senator Bentsen would clarify the tax treatment of long-term care insurance and accelerated death benefit riders as well as establish certain minimum standards for qualified long-term care policies by definition. Senator Packwood's Secure Choice Legislation (S. 1668) would establish certain minimum standards for qualified long-term care policies, in addition to creating a public program for low income individuals and clarifying the tax treatment of long-term care. In addition, S. 2141 introduced by Senator Kennedy, although not referred to this Committee, would create a Long-Term Care Commission to develop long-term care standards.

Many of the provisions in these bills have been adopted by the NAIC in either the Long-Term Care Insurance Model Act or Regulation and we support their enactment by the states. On the other hand, many provisions in these bills are currently

being discussed with the NAIC, the industry, and consumer organizations and there is no consensus as to whether these provisions truly protect the consumer.

With respect to provisions currently in the Long-Term Care Model Act and Regulation, there are multiple provisions which HIAA firmly supports as appropriate consumer protection. These include:

—Prohibition against prior-hospitalization.
—Required 30 Day Free Look Period.
—Penalties on agents and insurers equal to three times the commission rate, or $10,000 whichever is greater.
—Required delivery of detailed outline of coverage.
—Required coverage of Alzheimers.
—Prohibition of preexisting condition exclusion period of longer than 6 months.
—Minimum standards for Home Care, including prohibitions against tying benefits for home care to need for skilled nursing care, covering only services by registered or licensed practical nurse, or limiting coverage to services provided by Medicare-certified agencies or providers.
—Prohibition against conditioning eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care.
—Requirement that individual policies be guaranteed renewable.
—Requirement that group policies provide for continuation and conversion.
—Required offer of inflation protection.
—Prohibition against post-claims underwriting.
—Loss ratio requirements of at least 60% for individual policies.
—Requirement that insurers establish auditable marketing standards, for fair and accurate comparisons of
—Policies, notification of limitations of coverage, and notification of availability of senior counseling programs if one exists in the state.
—Prohibition against twisting, high pressure sales tactics and cold lead advertising.
—Requirement that agent determine appropriateness of a recommended purchase prior to sale.
—Required delivery of buyers guide prior to sale.

In addition, there are several provisions in the HIAA Consumer Protect ion Framework which go beyond the current NAIC Long-Term Care Model Act and Regulation. They include:

Require agents to provide the address and phone number of the state insurance department and the name and phone number of an insurer home office contact.

Require insurers to establish and implement long-term care education and training programs and materials for their marketing representatives and appropriate home office staff.

Require insurers to establish procedures for monitoring the sales practices of their agents. Measures of agent conduct include lapse rates, replacement rates, rescission rates, and application denial rates. Such agent specific data shall not be required until it reaches a credible level.

If states have continuing education requirements, require agents licensed as accident and health agents to earn long-term care insurance credits.

Require policies to waive premiums while the insured is receiving nursing home benefits.

Require insurers to establish and maintain a meaningful update protection program offering policyholders new policy forms, improvements and coverages currently marketed by the insurer.

Require insurers to base benefit eligibility criteria upon clinically-based empirical research in the area of disability and long-term care. Insurers shall include in their contracts at least one of the following criteria:

- Insureds are determined to be disabled due to an inability to perform an appropriate number of activities of daily living (ADLs), or
- Insureds have a similar level of disability such as one measured in terms of medical necessity, or
- Insureds have a similar level of disability due to cognitive impairment.

Require insurers to provide a clear and thorough written definition of the benefit eligibility criteria at the point sale.

Insure must inform an applicant whether he/she is accepted for coverage within 60 days after receiving a completed application and all necessary supporting documentation requested by the insurer.

Require insurers to establish a thorough claims process which will be explained clearly in written form at the time a claim is filed.

Reguire insurers to either:

- provide at least a three-month guaranteed reinstatement period for policyholders who miss a payment because of reduced competence, or
- offer at the time of application the opportunity for the insured to designate an alternative individual to be notified if a premium is not received by the premium due date.

Require state insurance departments and the NAIC to develop and specify minimum standards for establishing long-term care reserves.

The NAIC, working with insurers, should develop criteria for evaluating insurer reporting data.

Require states to report the finally adjudicated violations of a state's long-term care insurance laws or regulations.

HIAA opposes federal regulation of private long-term care insurance. However, in considering federal legislation, lawmakers should be mindful that the most immediate federal government role should be the clarification of the tax status of long-term care insurance so that it is treated as accident and health insurance. Senator Mitchell and Senator Rockefeller's legislation (S. 2571), Senator Bentsen's legislation (S. 1693) and Senator Packwood's Secure Choice legislation (S. 1668) all provide for the tax clarification of long-term care insurance. HIAA looks forward to our continuing efforts with the Committee to enact legislation in this area.

Although HIAA has made it clear that the industry does not support the adoption of federal standards for long-term care insurance, HIAA has been asked today to comment on specific provisions of the above referenced bills:

1. Mandatory Non-Forfeiture Benefit

HIAA supports the concept that insurers must be required to *offer* all prospective policyholders, including group policyholders, a nonforfeiture benefit in the event of non-payment of premium which bears a reasonably consistent relationship by issue age and duration. We do not support mandated nonforfeiture benefits in policies. Examples of non-forfeiture benefit options include, but are not limited to, a reduced paid-up benefit, extended term insurance, a return of premium and a cash surrender value.

A mandatory non-forfeiture benefit presents serious equity problems by substantially increasing the premium for the majority of policyholders. In fact, according to an HIAA analysis of several of its member company long-term care products, a reduced paid-up nonforfeiture benefit increased the average annual premium for a 55 year old by 30 percent, and 20 percent for a 60 year old. A non-forfeiture benefit which returns premium upon lapse raised the average annual premium for all ages by roughly 40 percent. **[Mitchell/Rockefeller (S. 2571) mandates non-forfeiture with a minimum requirement of RPU at time of purchase. Pryor (S. 546) mandates at least RPU with NAIC to specify no more than two other types of benefit. Bentsen (S. 1693) requires offer with NAIC to promulgate. Kennedy (S. 2141) mandates non-forfeiture to be specified by a Commission. Packwood (S. 1668) Secure Choice requires offer of RPU non-forfeiture benefit.]**

2. Mandatory Inflation Protection Benefit

Affordability would be severely affected by mandating the purchase of inflation protection. According to the same HIAA analysis, a lifetime 5 percent compounded inflation benefit increases the average annual premium for a 55 year old by 123 percent, 101 percent for a 60 year old and 64 percent for a 70 year old. HIAA strongly believes consumers should be allowed to choose inflation protection if they decide they want it; it should not be forced upon them. As our survey of buyers indicates, people are selecting inflation options based on their age and income in a logical manner. In fact, for those with incomes about $35,000, the percentage opting for inflation does not increase regardless of income levels. For them, purchasing higher daily benefit amounts and self-funding the inflation risk makes more sense. We concur with the NAIC in having this benefit remain optional. **[Mitchell/Rockefeller (S. 2571) mandates offer of compounded IP with rate of increase at least the average annual percentage increase for payment rates under the Act. Pryor (S. 846) mandates offer of 5 percent compounded IP. Bentsen (S. 1693) mandates offer using NAIC standard. Kennedy (S. 2141) mandates compounded IP at rate of increase of the average wage index. Packwood (S. 1668) Secure Choice mandates 5 percent compounded IP.]**

3. Daily Benefit of 80 Percent of Statewide Average Nursing Home

Most long-term care policies on the market offer a range of daily benefit amounts, from $40 per day to $200 per day. As indicated from our buyer survey, most individuals are purchasing adequate daily nursing home benefits. The average daily benefit purchased by individual buyers was $72 per day and the average daily benefit purchased by employees was $80 per day. In comparison, the 1990 national average of nursing home costs was $70–80 per day, according to the Department of Health and Human Services. Requiring that the average daily benefit be a percent of the statewide average nursing home rate in the year of sale is both unnecessary and, at this point in time, infeasible—information on state wide nursing home rates is non-existent or unreliable at best. Also, an individual may purchase in one state but plan on using services in another. **[Mitchell/Rockefeller (S. 2571) has this provision. Packwood (S. 1668) Secure Choice has similar a provision for qualified policies.]**

4. Premium Approval Process/Rate Controls

States currently have some form of rate regulation or review with an inherent right to act upon rate increases which they deem to be unfair, discriminatory or unreasonable in relationship to the benefits. Furthermore, because insurers are obligated to meet loss ratio requirements, changes in premiums must be justified to the state; they cannot be arbitrarily determined by insurers. Subjecting long-term care premium increases to public comment, i.e., hearings, is unfair and unproductive. Unlike utilities which provide services to all consumers, long-term care insurance is not a product used by a vast majority of citizens. Subjecting premium increases to public hearings attended by people who do not own policies, or in states where the distribution of business is too small to administer credibly, would be overly complex and expensive. Even allowing only those who own policies to attend would be Confusing to the consumer and unfair to the insurer and insured in the long run. Lastly, we believe the new NAIC loss ratio reporting form will more effectively assist regulators in overseeing premium changes.

Finally, such a proposal would be particularly problematic in employer group market whereby each employer's plan experience may be used as a rate basis. Employers typically use benefit managers, independent actuarial consultants and a competitive bid process to maintain rate oversight.

We share the concerns of the committee that consumers be protected from large rate increases. To that end, we believe the most effective protections are state measures which assure that initial premiums, and potential increases, are determined appropriately. Setting arbitrary limits on premium increases does not achieve the goal of ensuring that rates are set correctly in the first place. It also could potentially threaten insurers' abilities to pay future claims which is certainly not in the best interest of the consumer. Currently, the NAIC is grappling with this issue and the results of their deliberations should be considered. **[Mitchell/Rockefeller (S. 2571) requires state approval process with public input on rate increases to be taken into consideration. Pryor (S. 846) requires public hearing before premium increases. Bentsen (S. 1693) has no specific provision. Mitchell/Rockefeller (S. 2571) caps premium increases at 5 percent for ages 75 and over. For all others, policy must state minimum annual increase. Kennedy (S. 2141) has similar provision but would cap increases at 10 percent for ages 75 and older.]**

5. 6-Month Contestability Period

Although the vast majority of insureds honestly complete the application, there are some consumers who will choose to disregard the request that applications be completed truthfully. In accordance with existing law, standard practice is to allow insurers 1 or 2 years to determine "fraudulent" policies. The purpose of this provision is not to give insurers adequate time to research and challenge those who give misinformation. Rather, the purpose is to assure that after some period of time, all individuals can be assured that their insurance will not be challenged. Neither the insurer nor the consumer benefits from insurance issued on the basis of false information. Abuses will only result in higher premiums for everyone.

Insurers are fully prepared to pay valid claims regardless of when they occur. Insurers are merely requesting protection against instances of fraud or negligent misrepresentation. Such a request will not affect truthful policy holders, but instead allows insurers to underwrite coverage based on known facts and keep their rates competitive. **[Mitchell/Rockefeller (S. 2571), Pryor (S. 846), and Kennedy (S. 2141) all limit contestability period to six months.]**

6. Limitation on Agent Commissions/Limits on Agent Practices

HID does not support the use of agent compensation restrictions as the vehicle to get at bad agents. HIAA believes that problems with regard to lapse rates and replacement rates should be dealt with more directly by regulating agent sales and marketing practices and extensive agent training and education. Caps on commissions will not remove incentives for unwarranted initial sales or ill-advised replacements. Blanket restrictions on sales commissions do not distinguish between agents selling in an ethical, responsible way and those who do not. The job of regulators is, and should continue to be, the effective enforcement of laws designed to weed out and prevent abuses—not the creation of laws which indiscriminately restrict competition across the board.

HIAA believes that commission restrictions may deter good agents from selling long-term care insurance thereby decreasing the availability of good products to consumers. **[Mitchell/Rockefeller (S. 2571) and Kennedy (S. 2141) limit agent compensation to 200 percent of second year commission. Pryor (S. 846) and Bentsen (S. 1693) have no similar provision.]**

7. Benefit Eligibility Criteria

HIAA supports the concept that insurers base benefit eligibility criteria upon clinically-based empirical research in the area of disability and long-term care. Insurers should be allowed to include in their contracts at least one of the following criteria: the inability to perform a specific number of activities of daily living (ADLs), or insured have a similar level of disability, such as one measured in terms of medical necessity, or have a similar level of disability due to cognitive impairment. In addition, we support full disclosure of the benefit eligibility criteria at time of sale. Such information should be provided in clear and thorough written form in the marketing materials and the policy.

Secondly, HIAA has strong objections to a public agency determining benefit eligibility under private policies. While we advocate that there be a strong and simple appeals process, the insurer, or an organization affiliated with the insurer, is contractually obligated to manage an individual's long-term care needs so that the best care can be delivered most efficiently. Most importantly, transferring the claim adjudication function to an outside party could expose the insurer to unintended claim liabilities. **[Mitchell/Rockefeller (S. 2571) requires eligibility to be based on inability to perform an appropriate number of ADLs, cognitive impairment and/or dangerous behavior. Insurer flexibility is limited to criteria specified under the social insurance program of the bill where moderately or severely disabled is defined as (1) needing substantial assistance or supervision from another individual with at least 3 of 5 ADLs (bathing, dressing, transferring, toileting, and eating), (2) needing substantial supervision due to cognitive or mental impairment needs substantial assistance or supervision with at least 1 ADL or in complying with a daily drug regimen or (3) needs substantial supervision due to behavior dangerous (to themselves or others) disruptive or difficult to manage. Pryor (S. 846) requires policies to specify levels of functional impairment required to obtain benefits. Bentsen (S. 1693) requires 3 ADLs for nursing home and 2 ADLs for home care or cognitive impairment. ADLs are: bathing and dressing, toileting, mobility, transferring and eating.]**

8. Independent Third Party Assessment For Benefits

HIAA strongly objects to an independent third party determining eligibility under private policies. Who would pay for it? While we advocate that there be a strong and simple appeals process, the insurer, or an organization affiliated with the insurer, is contractually obligated to manage and individual's long-term care needs so that the best care can be delivered most efficiently. Transferring the claim adjudication function to an outside party could expose the insurer to unintended claim liabilities. **[Mitchell/Rockefeller (S. 2571) and Kennedy (S. 2141) require professional assessment conducted by independent person or agency. Pryor (S. 846) requires professional assessment. Bentsen (S. 1693) uses NAIC Standard.]**

9. Stipulation Of Income And Asset Criteria For The Purchase Of Long-Term Care Insurance

HIAA objects to a Commission developing minimum financial standards including both income and asset criteria that individuals must meet to be eligible to purchase a long-term care policy. While HIAA agrees that discretion should be exercised in selling to low income individuals, we are concerned that such standards would be

paternalistic and unprecedented, leaving many who would prefer to purchase a long-term care policy with no option but Medicaid spend-down. [Kennedy (S. 2141) only.]

10. Uniform Policy Definitions

HIAA recognizes that in order to provide meaningful benefits, policies must have clearly understood and well defined long-term care benefits. Several policy benefits, however, cannot be uniformly defined at this time. States vary widely in their definitions of licensed long-term care providers. Many types of noninstitutional services are evolving and there is no clear, much less uniform, definition yet developed. Beneficiaries could be harmed if definitions are "locked in" prematurely. However, HIAA recommends that if the following terms are included in a policy, they must be appropriately and clearly defined: skilled, intermediate and custodial nursing home care; nursing home; home health care; adult day care; elimination period; waiting period; and maximum benefit period. **[Mitchell/Rockefeller (S. 2571), Pryor (S. 846), and Kennedy (S. 2141) require uniform language and definitions.]**

11. HIAA Supports Policy Upgrades For Current Policyholders

HIAA supports the establishment and maintenance of a meaningful upgrade protection program for improvements currently being marketed to the same class of purchasers, without subjecting the insured to new preexisting conditions or other limits on existing coverage. However, underwriting is necessary and should be employed as long as it is not more restrictive than for new issues. If underwriting were not allowed, people on claim payout would be eligible making the premium unnecessarily costly for those not on claim. **[Kennedy (S. 2141) does not allow for underwriting.]**

III. THE STATES HAVE REACTED RESPONSIBLY IN REGULATING LONG-TERM CARE INSURANCE

NAIC Long-Term Care Model Act and Regulation

Long-term care insurance is an evolving product. It is critical that the regulatory environment allow for the development of new and different products while protecting consumer interests. HIAA believes this dual regulatory objective is best met at the state level.

In December 1986, the NAIC first adopted model legislation which successfully balanced the needs of both the industry and consumers. A model regulation was adopted shortly thereafter. Since then, the Model Act and Regulation have been amended several times to better meet consumer needs.

To date, 43 states have passed legislation or adopted regulation based on *some version of* the Model Act or Regulation. Additionally, six states have implemented some other form of long-term care insurance regulation. Only two jurisdictions—Pennsylvania and the District of Columbia—have not yet passed legislation or adopted a regulation specifically for long-term care insurance. The product, however, is not unregulated in these jurisdictions, but rather falls under the numerous laws of general applicability for group and individual health insurance. Moreover, in states with specific long-term care insurance laws, long-term care insurance is also subject to all state health insurance laws.[1]

These and a number of state laws exist to protect consumers of long-term care insurance, making it one of the most regulated insurance products on the market. Given this vast state regulatory process, structure, and expertise, HIAA strongly believes that the states are better able than the federal government to regulate an evolving product which requires equal consideration of consumer needs and product development. Federal standards would create a burdensome dual state and federal

[1] Although the NAIC Long-Term Care Insurance Model Act and Regulation are important, they comprise only one of several state regulatory initiatives applicable to long-term care insurance and consumer protection. Specifically, long-term care insurance is subject to the NAIC Unfair Trade Practices Model Act, supported by the HIAA and applicable in all the states, which provides consumers with the broadest range of protection against inaccurate product descriptions, fraud, misrepresentation as well as improper denial of benefits. Long-term care insurance is also subject to the NAIC Uniform Individual Accident and Sickness Policy Provision Law, again supported by HIAA and applicable in all states, which specifies a variety of consumer protection provisions regarding such items as the policy form, specific policy provisions and policy applications.

In addition, long-term care insurance may be subject to the NAIC Model Rules Governing Advertisements of Accident and Sickness Insurance, adopted in a majority states (all but 6), which provides guidelines for truthful and accurate disclosure of health insurance advertising as well as the NAIC Life and Health Policy Language Simplification Model Act, adopted in a significant number of states (30), which requires policies to be written in simple language and large print.

regulatory environment producing inevitable competition between state and federal legislators to "out-legislate" the other. This could result in a set of standards so costly to the consumer that private long-term care insurance is no longer an option to Medicaid spend-down.

HIAA recognizes that not all states have adopted the most recent version of the NAIC Model Act and Regulation which was adopted by the NAIC less than a year ago. However, as found in a study conducted for AARP, companies selling long-term care insurance on a nationwide basis have been voluntarily updating their policies to comply with updated versions of the Model Act and Regulation as they have been amended several times over the last few years. These policies are widely available in states that have not kept pace with the NAIC amendments.

Because HIAA is concerned about the lag time between NAIC amendments to the models and individual state adoption of the amendments, its Board of Directors recently made this issue a number one priority. HIAA and its member companies are committed to working through this year to seek state adoption of the most recent and critical provisions of the model act and regulation in the states.

As an industry, we understand more than anyone that the potential for consumer abuses must be eliminated if we are to sustain a viable market. Therefore, HIAA remains committed to working actively to have all states adopt the models and update their existing laws. Although state adoption of the Model laws is essential, equally critical is the enforcement of those laws. HIAA strongly supports the adoption and enforcement of all state health insurance laws, not just those pertaining to long-term care, to prohibit illegal or unscrupulous practices. Without strong enforcement, the laws themselves are meaningless.

IV. LONG-TERM CARE IS NOT MEDIGAP

Although long-term care insurance and Medigap insurance are primarily purchased by elderly individuals, it is important to note that they are very different products. Medigap insurance is purchased to fill the gaps not covered by Medicare, the government sponsored insurance program which covers acute care for the elderly and disabled. Moreover, the acute care provider network is well established, whereas the long-term care provider network is still evolving. Long-term care insurance is intended for catastrophic long-term nursing home or home health care and is not necessarily an appropriate purchase for all elderly.

The federal government's role in regulating policies to supplement a federal entitlement program such as Medicare is different than with long-term care where no appreciable government overlap exists with private sector policies. As a result, there is no standard set of gaps for this product to fill. In addition, because long-term care delivery systems and insurance are still evolving, federal standards could result in severe restrictions in the market's development.

Unlike Medigap, long-term care insurance is being provided increasingly through the employer setting to younger individuals who are able to purchase policies at more affordable prices long before they need the benefits. These sales are not typically solicited through agents but are marketed as part of the employer's overall employee welfare benefit package. The average age of such enrollees is 43.

Finally, budget considerations make it highly unlikely that a government sponsored program for long-term care such as the one proposed in H.R. 4848, will be enacted any time soon. Cost estimates for publicly funded programs have been prohibitively expensive. Preliminary CBO estimates of new federal costs for the Public Program in H.R. 4848 is $45 billion for the first full year of implementation. Given such costs, it would seem much better to encourage the purchase of private long-term care insurance today to minimize the number of people who will be candidates for public long-term care financing tomorrow.

CONCLUDING COMMENTS

In conclusion, Mr. Chairman, we share your concern that consumers must be able to purchase solid protection for long-term care insurance. HIAA believes, however, that many of the provisions in federal proposals would not actually benefit the consumer. This market only began in the mid-1980's. For the product to survive and grow financially healthy, it must take measured and deliberate steps. Several provisions in these bills will discourage, if not eliminate, many products from the marketplace. While this may be the ultimate agenda for those favoring a total government solution, it does a terrible disservice for the many hundred of thousands of persons facing potential financial ruin who are looking for viable solutions today.

Lastly, we believe it is the duty of both the private and public sectors to educate the public about their potential long-term care needs. The private sector has taken

a lead in this area and we look to the state and federal government to share in this responsibility. The key to consumer protection is education.

Thank you for this opportunity to express the views of HIAA.

RESPONSES OF SUSAN VAN GELDER TO QUESTIONS SUBMITTED BY SENATOR GRASSLEY

Question No. 1. You oppose mandatory nonforfeiture benefits on the grounds that such a requirement would substantially raise the cost of premiums for remaining policyholders. But earlier witnesses point out that very substantial sums can be lost by an individual through forfeiture. Doesn't this present a substantial inequity? It almost seems that reasonable premiums are achieved through the losses sustained by those who can't afford to maintain their policies. Can you comment?

Answer. HIAA does not support mandated nonforfeiture benefits for two separate, but related, reasons. First, many types of nonforfeiture benefits add significantly to the premium. Second, these costs are borne by all purchasers, including the majority of policyholders who will not lapse their policy. Therefore, mandated nonforfeiture benefits are inequitable for the majority of policyholders—they are forced to pay an additional, perhaps substantial, amount for a benefit they will not use. We concur with the conclusions drawn by the actuarial study commissioned by the NAIC to study this issue—the additional cost of nonforfeiture is not equal to the benefits derived and therefore, nonforfeiture benefits should be a mandated offer.

In addition, it should be pointed out that most voluntary lapses (i.e., lapses not due to death), occur shortly after purchase. These individuals would not be eligible for a nonforfeiture benefit as currently envisioned by the NAIC.

Question No. 2. Can you comment on the General Accounting Office's observation that there is no definitional consistency among currently offered long-term care insurance policies and that this creates some obvious problems with respect to ultimate receipt of benefits? Do you agree with the GAO's recommendation to the effect that key definitions should be standardized.

Answer. It is very easy to talk about the need for standardization in long-term care. It is quite another task for the industry, or any other entity—policy makers, providers, or consumers—to reach agreement as to an appropriate and accurate definition for many terms used in the delivery and payment of long-term care services. Insurers are at the forefront in attempting to define a long-term care "system" that has yet to be defined.

For example, in the area of Activities of Daily Living, (ADLs), there is no consensus as to how to define ADLs, which type of ADLs should be used, or how many ADLs should trigger benefit eligibility. Three separate bills on long-term care financing reform, introduced last year in the

Congress, used different numbers and types of ADLs and illustrate the lack of consensus on this issue. (The three bills were introduced by Senators Packwood/Dole/Bentsen, Mitchell and Congressman Gradison.)

Another example is definition of adult day care. The NAIC has incorporated one definition in the model regulation which is very different than the definition proposed by the National Institute on Adult Daycare or the working definition employed by the Health Care Financing Administration.

My point is that many of these terms are evolving and there has yet to be defined one "right" definition that everyone agrees is the correct one. We believe that all key provisions in long-term care policies should be well-defined and written in an easily understood manner, but that consumers and the market will not be well-served by standardized definitions in many areas.

Question No. 3. A related question has to do with gatekeepers mentioned in the testimony of the Consumers' Union. May I have your thoughts on the use of standard gatekeepers, impartial claims review and functional assessments by professionals, and a third party appeal process?

Answer. Standard gatekeepers: I believe I partially answered this question in my answer above—it is premature to choose one uniform set of ADL measures when there is so little agreement as to what that should be. In addition, empirical work is currently being done on cognitive assessment tools which should improve insurers' ability to determine benefit eligibility based on cognitive impairment alone. I do not believe any expert is in the position of recommending one way to measure cognitive impairment at this time.

Impartial claims review and functional assessments by professionals: HIAA is in full support of an impartial claims review process and the implementation of a claims adjudication process which is thoroughly conveyed in writing to every policyholder at the time a claim is filed. HIAA supports the use of experts in conducting functional assessments, however, we do not support the use of expert opinion which operates independently from the contract between the insurer and the policyholder.

Third party appeal process: Such an appeals process [illegible]s now. Virtually all states have adopted the NAIC Unfair Claims Practices model act which specifies acceptable and unacceptable practices for settling claims. All state insurance departments have the authority to enforce violations of this act. Policyholders can also sue insurers for violation of contract in civil court.

Question No. 4. some of our prior witnesses do not believe that the states have been particularly quick to adopt some of the hey recent NAIC standards. Furthermore, they do not believe that the NAIC standards go far enough to protect the consumer. Thus, they call for federal standards. Why should we wait for the states to move on these standards given that they do not seem to be moving very quickly to adopt some of the main recent standards?

Answer. The states are, in fact, moving to adopt the NAIC standards. As the witness from the NAIC indicated, 48 states have a version of the model act and 39 states have a version of the model regulation. It is a top priority of HIAA to seek state adoption of the most recently adopted provisions in the model act and regulation. It should be pointed out, however, that studies by GAO and Project Hope for the AARP have found that more insurers comply with the most recent versions of the model act and regulation that do states. In other words, consumers have access to these policies even if a state does not have the most recent version of the model act and regulation.

In addition, federal regulation does nothing to address enforcement. Many problems addressed in federal proposals are within the realm of current state authority to fix. The problem is one of enforcing current law.

The long-term care market is young and still evolving. It is highly doubtful that had federal standards been implemented four years ago, these standards would have been amended four times in every proceeding year as they have been by the NAIC. The states are in a more flexible position to continue to address changing consumer protection needs as products develop.

ATTACHMENT A

HIAA PROPOSAL FOR LONG-TERM CARE INSURANCE CONSUMER PROTECTION
(Adopted by the HIAA Board of Directors, April 26, 1992)
(Amended by LTC Task Force, 5/21/92)

The Health Insurance Association of America (HIAA), the trade association of the nation's leading commercial insurance carriers that provide health insurance for approximately 95 million Americans, strongly believes that the insurance industry can play a vital role in financing the nation's long-term care bill. The nature and cost of long-term care make reliance on the private sector both appropriate and practical.

In order to develop and grow successfully, however, insurers must provide long-term care insurance products which provide meaningful and affordable protection to their policyholders. Policies must also be marketed and sold by educated and trained individuals. HIAA recognizes that in order to reach its full potential, there is an exceptional need to protect consumers who purchase this type of private insurance product. This particular need is unique to long-term care insurance products and should in no way be considered appropriate for other types of health insurance.

To strengthen consumer protection regulation, the purpose of this proposal is to recommend specific regulatory measures for adoption by the states, through enforcement of existing laws, or where current authority is inadequate, through enactment of new laws or adoption of additional insurance department regulations. More specifically, this proposal sets forth the following:

I. The goals of meaningful consumer protection regulation;

II. The fundamental tenets, or rights, that long-term care insurance consumers should be guaranteed; and

III. Specific consumer protection provisions, or standards, which are aimed at guaranteeing that these basic consumer protection rights are achieved.

The specific consumer protection provisions supported under Section III were considered primarily with the individual market in mind. This section includes a discussion, however, of additional consumer protection provisions which are necessary in group long-term care insurance markets. Lastly, the proposal discusses the equally critical need for effective enforcement mechanisms to ensure that consumers are protected by the very laws designed to do so.

Taken together, HIAA believes that this proposal offers a sound approach to protecting purchasers of long-term care insurance policies, creates an appropriate state regulatory framework for effectively regulating the market, and recognizes the critical role that enforcement must play to ensure a successful regulatory process.

I. GOALS OF LONG-TERM CARE INSURANCE CONSUMER PROTECTION REGULATION

HIAA believes that the cumulative effect of government regulation should be to create a regulatory environment where the benefits of regulation outweigh their costs for consumers, the private sector and government. Based on this overall objective, HIAA believes that the following goals form the basis for developing meaningful consumer protection regulation.

1. Increase consumers' knowledge about long-term care and financing options available to them.

2. Provide consumers, regardless of where they live in the U.S., access to long-term care policies which provide meaningful benefits at a reasonable price.

3. Recognize the need to maintain strong consumer protection while encouraging insurers to develop fair and innovative benefits in an evolving marketplace.

4. Link regulatory standards to appropriate enforcement mechanisms to ensure their effectiveness.

II. FUNDAMENTAL LONG-TERM CARE INSURANCE CONSUMER RIGHTS

In developing a consumer "Bill of Rights", HIAA was guided by the overriding concern that consumers be guaranteed a "good value" when they purchase a long-term care insurance policy. Although this term has yet to be defined adequately by regulation or otherwise, we believe that we have taken a solid first step in this direction by identifying fundamental consumer rights and the specific provisions which must be implemented in order to ensure these rights. These fundamental rights are:

1. Consumers have the right to accurate, complete and clearly written information about long-term care and long-term care insurance policies.

2. Consumers have the right to trained and educated agents who respect their clients' trust and would never do anything which would betray that trust or confidence.

3. Consumers have the right to policies which provide meaningful long-term care benefits.

4. Consumers have the right to a fair and thorough explanation, in written form, of all the requirements they must meet to qualify for benefits.

5. Consumers have the right to a fair and understandable application process and once insured, they have the right to a fair and equitable claims payment process which is communicated clearly in written form.

6. Consumers have the right to policies which are at least guaranteed renewable.

7. Consumers have the right to reasonable and justifiable premiums over the life of their policies and the right to expect an insurer will have the financial capacity to meet all future claim obligations.

8. Consumers have the right to effective state enforcement of laws created to achieve these consumer protection rights.

III. APPROPRIATE CONSUMER PROTECTION PROVISIONS

To ensure that the fundamental consumer protection rights are achieved, HIAA identifies below specific regulatory standards which should be adopted by state legislatures or regulators. We have also made recommendations for states to improve their data collection, monitoring and enforcement relating to the long-term care insurance market. Irrespective of the specifics of legislation regulating long-term care insurance, HIAA believes that the principles discussed below represent a comprehensive regulatory approach to ensuring that the public's best interests are protected in this marketplace.

1. **Consumer Right: Accurate and Thorough Disclosure**

   A. Require insurers to provide consumers a uniform description of the policy that will allow them to clearly understand benefits, limitations, and other plan provisions and will facilitate comparison among different policies. The policy description must include all significant benefits and limitations of the policy including types of care covered, deductible periods, maximum benefit periods, preexisting condition exclusions, noneligible providers and types of care, inflation protection options, renewability, coverage of Alzheimer's Disease, and premiums.

   B. Require insurers to provide consumers with a state-approved long-term care insurance consumer guide.

   C. If such a program exists, require agents to provide consumers with the name, address and phone number of a state-approved senior insurance counseling program at time of policy solicitation.

   D. Require agents to provide the address and phone number of the state insurance department and the name and phone number of an insurer home office contact.

2. **Consumer Right: Appropriate Insurer and Agent Sales and Marketing Practices**

   A. Require insurers to establish and implement long-term care education and training programs and materials for their marketing representatives and appropriate home office staff.

   B. Require insurers to establish marketing procedures which ensure that if any comparison of policies is made by agents, that the comparison be a fair, complete and accurate one.

   C. Prohibit insurers and their agents from the marketing practices of "twisting", high pressure sales tactics, and "cold lead" advertising.

      "Twisting" refers to knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer.

      High pressure sales tactics refers to employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

      "Cold lead" advertising refers to making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

   D. Require insurers to establish criteria for agents to follow in making reasonable efforts to determine the appropriateness of new, additional or replacement policies.

E. Require insurers to establish procedures for monitoring the sales practices of their agents. Measures of agent conduct include lapse rates, replacement rates, rescission rates, and application denial rates. Such agent specific data shall not be required until it reaches a credible level.

F. Require insurers to establish auditable procedures for verifying compliance with marketing and sales practices and training and education programs.

G. Require states to include testing on long-term care insurance as part of the general health and life licensure process.

H. If states have continuing education requirements, require agents licensed as accident and health agents to earn long-term care insurance credits.

I. Depending on a state's existing advertising requirements, require insurers to retain a copy of any long-term care insurance advertisement intended for use whether through written, radio or television medium for at least three years from the date the advertisement was first used. Such advertisement shall be available for review by the state insurance department upon request.

Or, require insurers to provide a copy of any long-term care insurance advertisement to the state insurance department for review or approval to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer for at least three years from the date the advertisement was first used.

J. Require insurers to give insureds an opportunity to return their policy for any reason and receive a full refund for up to 30 days after receiving their policy.

K. If a policy is returned during the 30-day free-look period, require insurers to refund premiums promptly and in accordance with state law.

3. **Consumer Right: Policies Must Provide Meaningful Benefits**

For purposes of this section, a long-term care insurance policy is defined as:

> Any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve consecutive months for each covered person on an expense incurred, indemnity, prepaid or other bases; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. With regard to life insurance, this term includes those policies which accelerate the death benefit specifically for the receipt of long-term care.

Specifically:

A. Policies must provide at least one year of long-term care benefits.

B. Policies may offer home health care and other noninstitutional benefits. To support the insured's desire to remain at home, at a minimum, home health benefits cannot:

Be conditioned upon the receipt of nursing and/or therapeutic services before other home health care benefits are covered; limit services to those provided by R.N.s or L.P.N.s or require R.N.s or L.P.N.s to provide services that other appropriate personnel could provide; require that benefits be based on an acute condition or be provided only in lieu of skilled nursing home care; and limit providers to those certified by Medicare.

C. Policies must cover all levels of nursing home care -- skilled, intermediate and custodial -- if nursing home benefits are provided in the policy.

D. Policies cannot exclude coverage for insureds who develop Alzheimer's Disease and other related organically-based dementias.

E. Policies cannot employ preexisting condition limits which are more stringent than:

A condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of the policy. Coverage for a loss or confinement which is the result of a preexisting condition cannot be excluded from coverage unless such loss or confinement begins within six months following the effective date of the policy.

F. Policies must waive premiums while the insured is receiving nursing home benefits after a period of receiving such benefits not to exceed 90 consecutive days. (Not applicable to policyholders residing in CCRCs.)

G. Insurers must establish and maintain a meaningful update protection program. Insurers issuing long-term care insurance on or after the date of enactment shall offer policyholders, including group policyholders, new policy forms, improvements, and coverages currently marketed by the insurer to the same class of policyholders.

A meaningful update program shall offer every policyholder, including group policyholders, policy improvements currently being marketed to the same class which have not previously been offered to that policyholder. The frequency of the offering to any class shall be at least every 5 years. The offer must be made without subjecting the insureds to new preexisting conditions or other limitations on existing coverage. Rates and underwriting shall not be more restrictive than for new issues. No update protection offer need be made to any person receiving benefits and/or not pay premiums.

Policy improvements that must be offered: removal of exclusions for coverage of Alzheimer's and related dementias; removal of prior institutionalization requirements; adding nonforfeiture protection; adding inflation protection; adding or expanding home care coverage; changing the policy to guaranteed renewability; and eliminating restrictions for payment of only certain levels of care.

HIAA recognizes that in order to provide meaningful benefits, polices must have clearly understood and well-defined long-term care benefits. Several policy benefits, however, cannot be uniformly defined at this time. States vary widely in their definitions of licensed long-term care providers. Many types of noninstitutional services are evolving and there is no clear, much less uniform, definition yet developed. As a result, insurers have struggled to provide a comprehensive description of a heretofore undefined and evolving delivery system. In defining policy benefits, insurers have attempted to address consumer concerns of provider quality as well as insurer concerns that expected utilization be reasonable in relation to premiums. To further improve this situation, HIAA recommends that:

H. If policies include the following terms, they must be appropriately and clearly defined: skilled, intermediate and custodial nursing home care; nursing home; home health care; adult day care; elimination period; waiting period; and maximum benefit period.

I. Insurers must offer all prospective policyholders, including any group policyholder, optional inflation protection features. At least one inflation option offered must increase the daily benefit 5 percent annually on a compounded basis over the lifetime of the policy, including any period of time the insured is on claim. If insurers only offer policies with inflation protection features, they need not also offer ones without them.

J. Insurers must offer all prospective policyholders, including a group policyholder, a nonforfeiture benefit in the event of nonpayment of premium. The nonforfeiture benefit must maintain a reasonably consistent relationship by issue age and duration. The insurer must disclose the amount of the nonforfeiture benefit for each policy or certificate anniversary to the state insurance department. Examples of nonforfeiture benefits include, but are not limited to, a reduced paid-up benefit, extended term insurance, a return of premium and a cash surrender value. If insurers only offer policies with nonforfeiture benefits, they do not have to offer a policy without such a benefit.*

4. Consumer Right: Appropriate and Understandable Benefit Eligibility Criteria

A. Require insurers to base benefit eligibility criteria upon clinically-based empirical research in the area of disability and long-term care. Insurers shall include in their contracts at least one of the following criteria:

- Insureds are determined to be disabled due to an inability to perform an appropriate number of activities of daily living (ADLs), or
- Insureds have a similar level of disability based on the medical care required, or
- Insureds have a similar level of disability due to cognitive impairment.

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*This provision does not apply to policies where each policy year's attained age premium is expected to provide for that policy year's morbidity risk.

B. Require insurers to provide a clear and thorough explanation of their benefit eligibility criteria in the policy contract. All significant terms, such as ADLs, the need for assistance in ADLs, medical necessity, and cognitive impairment must be defined.

C. Require insurers to provide a clear and adequate written definition of the benefit eligibility process at the point of sale.

D. Prohibit insurers from conditioning long-term care benefit eligibility upon prior hospitalization or prior nursing home confinements. In addition, prohibit insurers from conditioning the use of non-skilled nursing home or noninstitutional benefits upon the prior use of skilled level benefits.

5. **Consumer Right: Fair and Understandable Application Process; Fair and Equitable Claims Payment Process**

A. Require insurers to develop clear and unambiguous questions on the application form designed to ascertain the health condition of the applicant.

B. If the application form asks about prescribed drug use, the insurer must also ask the applicant to list the medications prescribed. Insurers are prohibited from later rescinding the policy if the listed medications are related to medical conditions that would have resulted in disapproving the applicant for coverage.

C. Insurers must inform the applicant in clearly written form that incorrect or untrue responses on the application form may lead to denial of benefits or rescission of the policy.

D. Insurers must collect further medical history information, such as a report of a physical exam, an assessment of functional capacity, an attending physician's statement, or copies of medical records, for all applicants age 80 and over.

E. Insurers must return the completed application form to the insured no later than when the policy is delivered.

F. Insurers must inform an applicant whether he/she is accepted for coverage within 60 days after receiving a completed application and all necessary supporting documentation requested by the insurer.

G. Require insurers to establish a thorough claims process which will be explained clearly in written form at the time a claim is filed.

H. Require insurers to report well-defined and meaningful claims experience data to each state annually.

6. **Consumer Right: Guaranteed Renewable Policies**

A. Require insurers to guarantee that long-term care policies cannot be canceled unless the policyholder terminates the contract by nonpayment of premiums.

B. Require insurers to either:

- provide at least a three-month guaranteed reinstatement period for policyholders who miss a payment because of reduced competence, or

- offer at the time of application the opportunity for the insured to designate an alternative individual to be notified if a premium is not received by the premium due date.

7. **Consumer Right: Reasonable and Justifiable Premiums; Long-Term Care Obligations Will be Met**

A. Prohibit insurers from selling policies with premium schedules based on attained age rating and durational rating. Such a prohibition however, should not limit insurers' rights with regard to rate adjustments under guaranteed renewable contracts. Nor should such a prohibition limit the ability of insurers to develop plan designs, especially in the employer market, which base premiums on some structure other than entry age level premiums.

B. Require insurers to report their total long-term care premiums earned, claims incurred and loss ratios by state and in total to each state annually.

C. Require state insurance departments and the NAIC to develop and specify minimum standards for establishing long-term care reserves.

D. Require insurers to meet an expected loss ratio of at least 60 percent. The NAIC, working with the industry, should determine the effects of lapse rates and underwriting practices on the pattern of loss ratios.

8. **Consumer Right: Effective Enforcement**

A. Insurer Data Collection, Reporting and Monitoring

1. Require insurers to report the following information to each state annually: agent and insurer replacement, lapse and rescission rates; and the number of policies sold and in-force. Data reported are subject to all applicable privacy laws. Such agent specific data shall not be required until it reaches a credible level.

2. The NAIC, working with insurers, should develop criteria for evaluating insurer reporting data.

3. To the extent current law permits, consumers have the right to receive reporting information required in this section from the states upon request.

B. State Enforcement

1. Require states to establish specific monetary penalties on agents and insurers for violations of sales and marketing laws. These penalties shall be in the form of a fine of up to three times the amount of any commission paid for each policy involved in a violation, or up to $10,000, whichever is greater.

2. Require states to report the finally adjudicated violations of a state's long-term care insurance laws or regulations.

Consumer Protection Unique to Some Long-Term Care Markets

The consumer protection provisions described in the previous pages of section III were developed primarily for the individual long-term care insurance market. While this market constitutes the bulk of the market today, other types of products are

developing rapidly. For example, about 25 percent of all individuals who became insured in 1990 were in the employer market. Group association policies available to members of continuing care retirement communities are also growing.

In addition, there are several recently developed life insurance products which will advance the policy's death benefit based on certain triggering events, including long-term care. While the latter are primarily life insurance products, to the extent they specifically provide long-term care insurance protection, they are subject to this proposal.

Because of important differences from the individual market, there are several consumer protection provisions which should be adopted for group long-term care policies. For purposes of this proposal, a group refers to the four different groups defined in the NAIC model act, Section 4E. Special consumer protections which state governments should adopt include:

1. **A Continuation and Conversion Requirement**

   Group policies are designed to provide similar protections to guaranteed renewable individual policies. This is achieved by the insurer offering individuals the right to have their group coverage continued or by issuing a conversion policy whenever coverage would otherwise terminate -- including discontinuance of the master group policy.

   Insurers selling group long-term care insurance policies should follow the continuation and conversion requirements as specified in the NAIC model act and regulation to guarantee that individuals purchasing long-term care policies under group arrangements have protections similar to those provided by a guaranteed renewable individual policy.

2. **Extraterritorial Jurisdiction for Discretionary Groups**
   Group long-term care coverage may be made available to individuals who are members of groups which are approved by state insurance departments because these groups result in economies of scale, the benefits are reasonable in relation to the premiums charged, and formation of the group is not contrary to the best interest of the public (i.e., Section 4E (4) of the model act).

   To adequately protect consumers purchasing policies under this group arrangement, insurers should be required to abide by the requirements of Section 5 of the NAIC model act. This provision provides that no long-term care coverage may be offered to a resident of a state under a group policy issued in another state to a "discretionary" group unless the former state (or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in the former state), has made a determination that such requirements have been met.

3. **Agent Sales and Marketing Practices**

   When an insurer uses licensed agents to sell a group product, then all the consumer protection provisions in Section III addressing agent sales and marketing practices in the individual market should apply to insurers selling these products as well.

There are some unique consumer protection provisions which should be considered specifically for the employer-sponsored group market. Historically, employers have secured health care benefits for employees and their dependents based on what they

believe is in their employees' best interests. This has resulted in insurer, employer, and often employee negotiations that affect policy design, benefits, and premiums.

Employers typically use actuarial consultants, benefit managers and a competitive bid process (often required of government employers), to help design the policy's benefits and to evaluate initial and renewal rates. Employer-sponsored group plans are also subject to separate state laws regarding initial rate filings. They are typically class rated or experience rated based upon the employer's actual claims experience and they are subject to financial accounting and group rating laws.

Because of these differences, some provisions recommended for the individual market should be modified to strengthen their intent and effect in the employer-sponsored group market. For purposes of the following provisions, employer-sponsored group policies refer to those policies issued to a group as defined in Section 4E (1) of the model act. These provisions include:

1. **Consumer Disclosure Requirements**

   As stated above, employers and organized labor have traditionally selected and determined welfare benefits for both employees and their dependents. As a result, many of the consumer disclosure requirements in the individual market take on a different format and process in the employer group market.

   For example, a description of the policy's benefits, limitations, and other provisions are usually determined by the employer, rather than the insurer. Similarly, employers often determine the format of how information is provided to their employees. This may or may not include the use of a specific consumer guide. Requiring that a state-approved consumer guide be provided to every employee, as specified for the individual market, is not necessarily effective or efficient.

   However, to assure that employees and their dependents receive similar information to that received by persons buying policies in the individual market, insurers should provide employers information which is equivalent to that provided in a state-approved consumer guide. Moreover, because the specific provisions required in the outline of coverage for individual policies are not entirely adequate or accurate for persons purchasing policies in the market, insurers should provide the following disclosure information to be included in the enrollment material:

   - Description of long-term care.
   - Why long-term care insurance is being offered.
   - Cost of long-term care.
   - Need for long-term care.
   - Current methods for paying for long-term care.
   - A notice that eligible employee, retiree or family members may be eligible for coverage from other sources, such as an employer medical plan, Medicare, or Medicaid.
   - Description of principal plan features, including:
     - Coverage of family members
     - Covered conditions and exclusions
     - Benefit eligibility
     - Waiting periods/deductibles
     - Evidence of insurance requirements
     - Inflation provisions
     - Preexisting conditions
     - Continuation and conversion coverage
     - Cost of coverage

   In addition, certificates issued under the group contract should include:

- Description of principal benefits and coverages
- Statement of exclusions, reductions and limitations
- Statement that the group master policy determines governing contractual provisions.

In addition to these written materials, employers generally hold meetings and other educational forums during the enrollment period so that employees have the opportunity to learn about a long-term care benefit. Recognizing these employer activities, this proposal supports the NAIC model act, Section 6F, which excludes employer groups from having to provide a 30-day free-look period after the enrollment process.

Lastly, because employers are responsible for the creation of all written, radio, television, and other materials about their long-term care insurance product, insurers should not be required to file such materials with state insurance departments for approval, (if a state has such a requirement for the sale of individual health insurance products).

2. Preexisting Condition Limits

To date, most employer-sponsored group plans have provided policies to active employees with no underwriting or knowledge of the employee's medical history. Under these conditions different preexisting condition limits are necessary to take the place of medical underwriting and to avoid using a high premium rate that is otherwise necessary to cover uninsurable conditions. Recognizing this difference in the employer group market, this proposal supports the NAIC model act, Section 6C, which excludes employer groups from the preexisting condition requirements established for other long-term care insurance products.

IV. State Enforcement of Laws is Equally Critical

HIAA recognizes the unique market that long-term care insurance products serve and believes that state enforcement of all health insurance laws is particularly critical for this product. Long-term care insurance is subject to a host of state health insurance laws which affect product design, advertising, and sales and marketing practices. These laws, combined with the additional provisions we recommend in this paper, should all be used to protect consumers of long-term care products. Equally important are the states' commitment to effective monitoring and enforcement.

The company data reporting requirements, state imposition of monetary penalties, and state reporting of violations recommended in section III(8) of this proposal will significantly enhance current state enforcement activities. These provisions require that a number of key data elements be reported to the states and that insurers and states work together to develop criteria to evaluate such data. We believe this approach encourages "good" companies to stay in the market and provides states the additional information they need to monitor the market and effectively protect consumers.

HIAA continues to support more punitive enforcement measures as well. Monetary fines specifically for insurers and agents selling long-term care products should be implemented and states should make public those entities found in violation of a state's long-term care insurance laws or regulations.

In the absence of a systematic approach to improving the current enforcement process, regulators will act on anecdotal stories, not solid evidence, to require more standards and impose more penalties when current standards and penalties are still not enforced. Clearly, this process can only be half effective in securing effective consumer protection.

PREPARED STATEMENT OF JOSHUA M. WIENER

HIGH QUALITY PRIVATE LONG-TERM CARE INSURANCE: CAN WE GET THERE FROM HERE?

American society uses private insurance to protect against loss from catastrophic events such as hospitalization, automobile accidents, home fires, theft, and early death. Insurance against the potentially devastating costs of long-term care, however, is relatively rare. Nonetheless, private long-term care insurance is a growing and rapidly changing market. A survey conducted by the Health Insurance Association of America (HIAA) found that the number of companies selling long-term care insurance increased from 15 in 1987 to 130 in 1991 (Van Gelder, personal communication, May 15, 1992). Moreover, the number of insurance policies ever sold increased from 815,000 in 1987 to 1,920,000 at the end of 1991.

While private long-term care insurance can play a much larger role than it does now, it is not a panacea. Private insurance will not prevent public expenditures for long-term care from increasing substantially over the next 30 years, nor will it provide financial protection for the great majority of elderly. Nonetheless, because it is likely to play a larger role in the future even if public programs are expanded, it is critical that private long-term care insurance be properly regulated.

The Limits of Private Insurance

The rapid growth in sales has led some policymakers to promote private insurance as the best way to finance protection against the catastrophic costs of long-term care at a time of government austerity. But studies done at The Brookings Institution, the Employee Benefit Research Institute, Families USA, the Urban Institute, and Brandeis University all conclude that only a minority of the current elderly can afford private long-term care insurance (Rivlin and Wiener, 1988; Friedland, 1990; Families USA, 1990; Zedlewski et al., 1990; Crown et al., forthcoming). Even with optimistic assumptions, projections using the Brookings-ICF Long-Term Care Financing Model suggest that only limited segments of the population will be covered by private insurance. By 2018 insurance sold to those 65 and older may be affordable to 20–32 percent of the elderly, may finance 12–19 percent of nursing home expenditures, and may reduce Medicaid nursing home expenditures by 2–5 percent (author's unpublished estimates).

Why will private insurance have only a modest role in financing nursing home and home care? First, private insurance is so expensive that most older people cannot afford it. The Health Insurance Association of America reports that the average annual premium for 15 of the better policies is $1,395 if purchased at age 65, rising to $4,199 if purchased at age 79 (Van Gelder and Johnson, 1991).

Second, although coverage has improved substantially over the last few years, financial protection is still limited. As will be discussed below, benefits are rarely fully indexed for inflation, home care is highly restricted, and nonforfeiture benefits are very uncommon.

Third, private long-term care insurance is a very risky business. Insurers are worried because the long interval between initial purchase of insurance and ultimate use of nursing home and home care involve great uncertainty. A policy bought by a woman at age 65 may not be used until she is 85, a full 20 years later. During those 20 years, unforseen changes in disability or mortality rates, nursing home and home care utilization patterns, inflation in service costs, or the rate of return on financial reserves can dramatically transform a profitable policy into an unprofitable one. Such uncertainty will likely lead insurers to ultimately limit the number of policies they sell.

What Are Long-Term Care Policies Like?

Over the past several years, long-term care insurance has changed dramatically. Faced with great uncertainties and lacking actual experience with an insured population, companies initially tried to protect themselves against financial loss by imposing severe restrictions and limitations on what services they covered.

The net effect of these restrictions was to substantially lessen the probability that a person who used nursing home or home care would receive insurance benefits (Wilson & Weissert, 1989). These so-called "first generation" private long-term care insurance policies were roundly criticized by Consumers Union, United Seniors Health Cooperative, the American Association of Retired Persons, and the author (U.S. House of Representatives, 1989; U.S. House of Representatives, 1990).

Over time, policies have improved substantially, although not as much as some in the insurance industry would claim. While the average policy still has many restrictions, new policies provide significantly better coverage (Stone et al., 1992). In particular, among newer policies, prior hospitalization requirements have been eliminated, policies are guaranteed renewable, Alzheimer's Disease is explicitly cov-

ered, all levels of nursing home care are covered, a bit more home care is covered, and indemnity levels are at least partly indexed for inflation. It is important to note that these changes were largely in response to strengthened state regulatory requirements and market demand. Insurers still have not gained meaningful experience in paying claims.

State Insurance Regulation

Historically, the insurance industry has been regulated by the states. When the federal government does intervene, the issues often involve market imperfections unresolvable at the state level. For example, the federal government now plays a role in regulating flood, mail-order and Medicare supplemental ("Medigap") insurance (Meier, 1988).

The National Association for Insurance Commissioners (NAIC) plays a prominent regulatory role. The NAIC provides state regulators with a variety of support services, including standardization of administrative functions, research, and the development of model legislation and regulations. The influence of the NAIC depends largely on the financial resources available to state regulators and the regulatory climate particular to each state. As the private long-term care insurance market has grown, so has regulatory activity, most of it revolving around the NAIC model act and regulation on private long-term care insurance Over the last few years, the NAIC has considerably strengthened its regulatory requirements.

State insurance regulators must strike a balance between protecting consumers and nurturing the development of a new product. Proponents of strict regulation fear that without tough regulations, consumers will not be protected against inferior products and fraudulent sales practices. They recall the scandals that resulted from the failure to set minimum standards for Medigap policies. Opponents of strict regulation argue that the government has neither enough information or experience to regulate intelligently nor the flexibility that is needed to prevent financial losses that discourage the development of a viable market.

Consumer Protection Issues

Despite these advances, there are several additional issues that deserve more regulatory attention. These include:

The Vanishing Benefit: The Need for Adequate Inflation Protection

It is no secret that health care prices are increasing rapidly. According to the Health Care Financing Administration (HCFA), nursing home revenue per day—a rough proxy for price—increased by an average of more than three percentage points above the consumer price index between 1977 and 1990 (HCFA, 1992). Unlike acute care health insurance, which links benefits to services or charges, almost all private long-term care insurance provides fixed indemnity benefits (e.g., $60 per day in a nursing home). Without adequate inflation adjustment, policyholders may find that the benefits provided by the policy are not sufficient to cover long-term care costs without depleting assets or relying on Medicaid.[1] As of 1990, most new policies and virtually all older policies lack any, let alone adequate, inflation protection (LifePlans, Inc., 1992). Although the National Association of Insurance Commissioners (NAIC) adopted model regulations on inflation protection in December 1990 and December 1991, the issue remains inadequately regulated.

Insurers typically deal with the inflation issue in one of four ways. First, some companies tell consumers that if they want to buy additional coverage in the future, then they can do so, but only if they provide evidence of good health status.

Second, many companies offer policies where the insured can periodically purchase increased indemnity benefits—called attained age pieces—without medical underwriting. This additional coverage is purchased, however, at the new attained age and will cost more—perhaps dramatically more—than if the coverage was bought when the insured was younger. For example, if a person buys a policy at age 62 that pays $60 a day in a nursing home and if there is 33 percent inflation over the next five years, then the insured can buy an additional $20 per day of coverage but at the price charged 67 year olds, not 62 year olds. In order to retain purchasing power, I estimate (without adjusting for inflation) that the premiums at age 82 may be approximately *ten times* what they would be at age 62. Even after adjusting for

[1] As important as inflation adjustments are to the elderly, they are absolutely essential for policies sold to active workers, where there could easily be 30 to 40 years between the initial purchase and use of long-term care services. Assuming that nursing home and home care costs rise at 5.5 percent per year, a consumer who purchases an unindexed policy today at age 50 with an $80-per-day nursing home benefit and uses it at age 85 would have the same purchasing power as a person trying to buy long-term care today with a $14-a-day benefit.

general inflation, premiums at age 82 are likely to be over *four times* what they were when the insured was age 62.[2]

While the premiums will skyrocket, the incomes of the elderly will not. Income and assets of the elderly tend to decline as they age, partly because private pensions are not indexed for inflation, surviving spouses do not usually receive full pension benefits after the pension-earning spouse dies, and because the elderly slowly use up their savings as they age. Thus, with this method of inflation protection, the elderly will have to use an sharply higher percentage of their fixed incomes in order to maintain the policy's purchasing power. This "attained age piece" approach is especially deceptive because it makes an adequate benefit appear far less expensive than it actually will be.

Third, some companies offer "simple" inflation adjustments, where the benefit level increases by a fixed amount each year, usually 5 percent of the initial indemnity value for some period of time, often 20 years. For example, a policy that initially pays $60 per day in a nursing home will increase by $3 per year, a declining percentage increase with every passing year.

Although many consumers undoubtedly confuse simple adjustments with increases that are compounded annually, the benefits are dramatically different. For a person who purchases a policy at age 55, a simple inflation adjustment of 5 percent for 20 years will increase the benefit level by only 100 percent by age 85. In contrast, if the price of long-term care services increases at a compounding rate of 5 percent per year, the price of long-term care would have increased by 327 percent over the 30 years. Thus, policies that use simple inflation adjustments do not adequately adjust for the rising cost of nursing home or home care.

Fourth and finally, insurers are beginning to offer compound inflation adjustments. The NAIC model regulation now requires that insurers offer consumers either an inflation adjustment compounded at a minimum of 5 percent annually or the right to increase the policy's indemnity level by an amount comparable to the compound adjustment (NAIC, 1990). Importantly, the revised model regulation requires only that compound adjustments be available as optional features. Insurers are not prohibited from selling unindexed or simple-indexed policies. In order to lessen the price impact of compound adjustments on premiums, some insurers have put limits on the number of years of indexing or discontinue indexing once a policyholder reaches a given age.

There is little doubt that few consumers understand how devastating inflation is to the policy's purchasing power. Anecdotal evidence suggests that consumers want very high initial indemnity values but are reluctant to pay for inflation protection. Insurers are reluctant to offer policies that increase benefits at a fixed percentage compounded annually, because doing so dramatically increases the premiums, thus reducing the potential market. For example, Wiener et al. estimate that a four-year, unindexed policy covering both home and nursing home care would cost $1,103 when purchased at age 65–69 (Wiener et al., 1990). A similar policy with indemnity benefits compounded at 5.5 percent per year for the life of the policyholder would cost $2,607. Despite the substantial increase in cost, the dramatic effects of rises in nursing home and home care costs makes inflation protection the single most important benefit that should be mandated by regulators.

These high costs can be somewhat offset by reducing the minimum benefit level. For elderly with good incomes and substantial assets, it makes little sense to buy insurance that covers the full cost of nursing home care. Indemnity levels set at the full cost of care will only result in the insured who ends up in a nursing home saving virtually all of their Social Security and pension income, thus "making money" on being in a nursing home. This makes little sense from anyone's perspective.

The Vanishing Insured: High Lapse Rates and Nonforfeiture Benefits

If long-term care insurance is purchased at age 65, premiums may have to be paid for 20 years or more until death. If purchased at younger ages, the insured may have to pay premiums for 40 years or longer. For a variety of reasons, not all persons who initially purchase a policy will make premium payments until death. Although not much data is available, it is commonly assumed in the insurance industry that, exclusive of the impact of mortality, approximately half of all insureds will drop their policies within the first five years of purchase and approximately 70 percent will drop their policies within 15 years of purchase. In pricing their premiums,

[2] For active workers, this approach requires the insured to actively monitor nursing home and home care prices and consciously decide every few years to buy additional coverage. In order to retain purchasing power, I estimate that premiums at age 82 (after adjusting for inflation) are likely to be approximately ten times what they were when the insured was age 42. Almost all employer-sponsored plans use this approach to inflation adjustment.

many companies assume substantially higher lapse rates. It is unknown what proportion of these lapses represent decisions by insureds to switch to better policies with fewer restrictions.

The public policy problem is that virtually all policies have level premiums, designed to build up substantial reserves in the early years for payout in the later years. Consumers who pay in during the early years and then decide not to renew their policies will have overpaid during the period that the policy was in effect for the actuarially fair cost of the protection actually received.

In addition, some actuaries have argued that some companies are substantially underpricing their policies to gain a larger market share and that premiums will be raised in the future, creating a high lapse rate (Trapnell, 1990; Richmond, 1989). The higher the insurer's lapse rate assumptions, the lower the premiums will be because fewer benefit payments will be made on behalf of purchasers. Since insurers will receive premium payments without ever having to pay claims, the premiums paid by the policyholders who lapse can subsidize the premiums of the policyholders who do not lapse. While policies sold on a level premium basis do not have scheduled premium increases, the insurance companies universally reserve the right to raise premiums for all persons in a class, if necessary, sometime in the future. Under these circumstances, companies could make windfall profits and the insured would be left both overcharged and without coverage.

Finally, although no data is available, it seems likely that a substantial portion of the lapses may be to moderate and low-income elderly who bought policies without fully realizing the financial burdens. In a recent study for the Health Insurance Association of America, LifePlans, Inc. found that nearly a fifth of private long-term care insurance purchasers in 1990 had annual incomes of less than $15,000 (LifePlans, Inc., 1992). Moreover, the General Accounting Office has found that insurance agents do not make much of an effort to ensure that prospective policyholders will be able to make payments over the long run (U.S. General Accounting Office, 1992).

Lapse rates would be a less significant consumer protection issue if insurance policies had nonforfeiture benefits. Nonforfeiture benefits allow policyholders who drop their policies to finance a residual benefit with a portion of their accumulated reserves. While nonforfeiture benefits are required in pre-funded life insurance products, few long-term care insurance products have them.

It is important, however, to distinguish between short-term and long-term lapses. To date, most of the adverse publicity concerns lapses within the first five years after purchase. Short-term lapses are better addressed by changing agent incentives to avoid churning and by establishing higher overall standards so that policies are not being constantly changed by insurers, thus enticing consumers to drop old policies and buy new ones. Nonforfeiture benefits are most appropriate for people who have paid premiums for a substantial period of time, perhaps five to ten years. Only at that point will consumers have built up enough reserves to finance a meaningful nonforfeiture benefit.

Despite the fact that nonforfeiture benefits are not a panacea, they should be required. If lapse rates are low, then the benefit can be added at little cost. If lapse rates are high, then they are an essential element of consumer protection, even though they may add substantially to premiums. Private long-term care insurance cannot be taken seriously as a mechanism for financing nursing home and home care if three-quarters or more of initial purchasers end up without coverage when it comes time to use services.

Getting in the Door: Variations in Measures of Activities of Daily Living (ADLs)

Every insurance policy, public or private, must have criteria to determine who qualifies for benefits. Some insurance policies now use inability to perform the activities of daily living (such as bathing, dressing and eating) as a trigger for benefits, especially home care. This approach has substantially replaced the older criteria of prior hospitalization, needing skilled care, or a doctor's certification of medical necessity. While generally a positive development, policies generally do not use a standard set of ADL elements nor do they generally describe how they will assess ADLs. For example, some companies omit bathing or combine it with another activity; others include continence or ability to take medications. This is a serious problem because there can be great differences in how many people qualify for benefits depending on how ADLs are defined and measured (Wiener et al., 1990). A key assessment issue is whether a person is considered to be disabled only if they require "active human assistance" or whether "supervision or stand-by" help (providing cues and reminders) and mechanical assistance are included. Using the more restrictive

definition of disability can reduce the number of elderly qualifying for benefits by 41 percent (Kennell et al., 1989).

Moreover, although policies specifically claim to cover people with Alzheimer's Disease, many consumers erroneously believe that individuals with the disease automatically qualify for benefits. That is not the case. Persons with Alzheimer's Disease must meet the disability screens just like everyone else. However, a substantial proportion of severely demented persons do not have serious ADL limitations, especially if narrowly defined to include only persons needing active human assistance. Nearly 40 percent of the elderly with moderate to severe cognitive impairment received no active human assistance in any of five ADLs (Wiener et al. 1990). Indeed, in some cases, it is Alzheimer's patients' very mobility and wandering behavior that makes them difficult to care for.

As a result of the complexity of measuring disability, regulators should establish standards for how activities of daily living should be measured and what elements should be included. The rationale for this standardization is not that there is "one true" measure and that regulators know what it is. Rather, the rationale is that without standardization there is no conceivable way for a layman to compare across policies. Without a computer and a set of large national surveys, it is impossible to know whether a policy that provides benefits when the insured has deficiencies in four of seven activities of daily living is a stricter or more generous policy than a one that provides benefits when an individual has deficiencies in two of five activities of daily living.

An Underdeveloped Benefit: Home Care

Most of the improvements in private long-term care policies over the last several years addressed deficiencies in nursing home coverage rather than home care. Home care coverage, for the most part, remains relatively skimpy. To a large extent, this reflects uncertainty on the part of insurers as to whether home care is an insurable risk. In particular, insurers worry that home care usage will be large and uncontrollable under insurance (Fama and Kennell, 1990). They note that the number of people who might "medically qualify" for home care far exceeds the number currently receiving it. For example, even among persons with two or more problems with five activities of daily living, only a third currently use home care (Hanley and Wiener, 1991). Moreover, the inherent desirability of low-skill home care services, such as homemaker and chore services, means that their use is likely to increase substantially if covered by insurance.

In order to minimize insurers potential risk, home care benefits tend to be skilled-care oriented, to have benefit eligibility criteria that leave considerable discretion to the insurer as to whether to provide benefits at all, and to provide coverage for a shorter period of time than nursing home care. In addition, some home care benefits require a prior nursing home or hospital stay.

These benefits are of limited value to the chronically disabled elderly for three reasons. First, many of the disabled elderly do not require skilled services. Instead, they need unskilled services, such as assistance with the activities of daily living, house cleaning and meal preparation, which are not covered by many policies. Second, in the event that the insured requires post-acute care, many of the services provided by home-care policies are already covered by the Medicare home health benefit and some Medigap policies. Third, many people who need home care do not first require nursing home or hospital care.

Responding to the elderly who want to purchase meaningful home care benefits, and to pressure from some insurance regulators, newer policies tend to have better coverage. Increasingly, policies pay benefits for personal care, although usually only if provided through a home health agency. Furthermore, some insurers are liberalizing their coverage of respite and adult day care services. Employer-sponsored policies, in particular, tend to provide better coverage than individual plans.

Under the NAIC's model statute and regulation, regulation of home care is fairly minimal. All that is required is that long-term care insurance policies cover some home care as well as some nursing home care and that "long-term care" benefits not require a prior nursing home or hospital stay. Recuperative benefits may, however, have a prior institutional requirement. In order to reduce confusion, regulatory standards should be strengthened to make sure that home care benefits, when included, cover an array of nonskilled services.

Other Issues: Financial Status of Companies and Policy Upgrades

Two-other issues that deserve mention are the financial status of insurance companies and the availability of insurance policy upgrades. Selling long-term care insurance is a financially risky venture, with the potential for losses that may be substantial and not apparent for many years into the future. While most of the major

insurance companies have entered the market, a nontrivial number of the policies are sold by relatively small, regional companies. It is not known to what extent these smaller companies use reinsurance mechanisms to lessen their financial risk. Moreover, the recent financial problems of the insurance industry as a whole cast some doubt on whether even well established insurers could easily weather the financial strain if their claims experience turned sour after selling a large number of policies. While financial solvency is a general concern of state insurance commissioners, regulations that specifically address long-term care insurance are usually lacking.

As noted, long-term care insurance policies are changing rapidly, mostly for the better. Some people have replaced their policies, searching for the one with the least restrictions. A significant issue is how to protect consumers who bought policies with restrictions that are—now or will be outmoded in the future. While some companies offer policyholders the chance to upgrade policies without further medical underwriting, regulators have not yet addressed whether consumers should have the right to upgrade to a better policy.

Federal Regulation of Long-Term Care Insurance

Should the federal government regulate long-term care insurance? There are arguments on both sides of the issue. On one hand, the federal government may be able to improve upon existing NAIC standards and reduce variation in state regulation. Despite the progress that has been made, the current NAIC model sets forth only minimal standards. As a result, there is no guarantee that even policies that meet the NAIC standards are of high quality. In addition, there is no uniformity in the speed with which state legislatures address even these minimal NAIC standards and in the stringency of their enforcement. Proponents of federal regulation also argue that it is inefficient for insurers to modify these policies to meet individual state requirements. Long-term care insurance is mostly provided by large companies who cross state boundaries. One suspects that the insurance industry's preference for state involvement reflects a divide and conquer approach to regulation. Finally, the regulation of Medigap policies sets a precedent for federal regulation of insurance products marketed to the elderly. There have already been reports of fraudulent sales practices of the type that led Congress to pass the Baucus Amendment setting minimal standards for Medicare supplemental insurance policies (Consumers Union 1991; U.S. House of Representatives 1990).

On the other hand, federal intervention may create some of its own problems. The federal government may prove more rigid than the NAIC in adapting to inevitable changes in regulatory issues. For example, lapse rates and ADL measures were barely perceived as serious problems just a few years ago. Further, the development of federal standards does not guarantee that more adequate resources for enforcement will be made available at either the state or federal level. The result of federal intervention may be a set of impressive standards with uneven compliance and enforcement.

Despite possible drawbacks, federal regulation of long-term care insurance is probably desirable, if for no other reason than there are some states that will never adopt even minimally acceptable standards without a federal mandate. As of April 1991, Stone et al. found only 13 states that were in 80 percent or more compliance with the NAIC model statute and regulations (Stone et al., 1992).

There are three broad options for federal involvement. First, the federal government could adopt a voluntary, Medigap-like certification strategy with minimal standards much like the current NAIC long-term care model statute and regulation. This would be much like the old Medigap regulatory strategy that was established by the Baucus Amendment. This incremental strategy would not impose substantial new requirements since many existing policies already meet these standards (Stone et al., 1992). The advantage of this approach is that some states would upgrade their requirements and some insurers might upgrade their policies to meet these higher standards, improving the average product. It would also establish the principle of federal involvement and open the door to raising the minimum standards in the future. However, this approach could mislead consumers into thinking that policies with the "government stamp of approval" were high quality policies. In addition, as more states adopt the NAIC model statute and regulation and as the NAIC improves its standards over time, this intervention may not add a great deal to what would have occurred under the current regulatory system without any federal standard.

Second, the federal government could adopt a voluntary certification strategy that set such stringent standards that few policies currently on the market would meet them. Under this scenario, policies not meeting this standard could still be sold so long as they met state regulatory standards, but they could not claim to deserve a

"government seal of approval." The advantage of this approach is that any policies that met the standards would truly deserve recognition as high quality policies. The standards would send a strong message to consumers and insurers on what constitutes a good policy. However, the voluntary standards may be set so high as to be considered irrelevant by insurers and, therefore, not an important influence on policy design.

Third, and our recommended strategy, the federal government could substantially strengthen the NAIC standards and then mandate them nationally. All insurers would be required to meet the standards. States could exceed these minimum standards if they wished. This is similar to the Medigap regulatory strategy embodied in the Omnibus Budget Reconciliation Act of 1990. The advantage of this approach is that it ensures that all policies will be of high quality. This will strike some in the insurance industry as unduly intrusive, but the bulk of the necessary additions are critical to making sure that benefits are not illusory. The risk of this approach is that insurers might decide that the compliance costs are too high and drop out of the market. Additional problems may arise if a mechanism is not provided for modifying the regulations over time as new issues arise.

Conclusion

Private insurance is a major new initiative in the reform of long-term scare financing. Companies who write these policies and the state insurance regulators who regulate them are handicapped by lack of experience with how the insured and the long-term care delivery system will respond to insurance. Both companies and regulators face a trade-off between protecting consumer interests and encouraging a financially risky new product.

Over the last five years, there has been a marked improvement in the quality of private long-term care insurance policies on the market and in the stringency of state regulation of these policies. Unfortunately, many states have failed to upgrade their regulations to protect consumers. The private long-term care insurance market is now mature enough so that more than minimum national standards should be adopted. These standards should build on the current NAIC model regulations, but considerably exceed them, especially in the areas of inflation protection, nonforfeiture benefits, and standardizing benefit triggers. Proper resolution of almost all of the regulatory issues discussed above are essential to ensuring that consumers actually get the benefits they think they are purchasing. While consumers should have options and choices, they should not be required to negotiate among policies that promise benefits they will not provide.

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