

**Regulation of Private Long-Term  
Care Insurance:**

**Implementation Experience  
and Key Issues**

*Prepared by*

**Stephanie Lewis, J.D.**

**Georgetown University Institute for  
Health Care Research and Policy**

**John Wilkin**

**Actuarial Research Corporation**

**Mark Merlis**

*Prepared for*

**The Kaiser Family Foundation**

**The Kaiser Family Foundation** is an independent, national health philanthropy dedicated to providing information and analysis on health issues to policymakers, the media, and the general public. The Foundation is not associated with Kaiser Permanente or Kaiser Industries.

# **Regulation of Private Long-Term Care Insurance: Implementation Experience and Key Issues**

Stephanie Lewis, J.D., Georgetown University  
Institute for Health Care Research and Policy

John Wilkin, Actuarial Research Corporation

Mark Merlis

**March 2003**

The Henry J. Kaiser Family Foundation commissioned the Institute for Health Policy Solutions to conduct this research. The views presented here are those of the authors and should not be attributed to the Foundation or the Institute or their directors, officers, or staff. The authors are grateful for comments and suggestions from Patricia Neuman and Michelle Kitchman of the Kaiser Family Foundation.

## Table of Contents

Executive Summary .....	iii
Introduction .....	1
Background.....	2
Overview of Long-Term Care Insurance.....	2
Regulation of LTCI.....	4
State regulation.....	5
HIPAA requirements .....	8
Consumer Protection in Practice.....	9
Methodology.....	9
Suitability .....	10
Choosing a policy .....	12
Education Initiatives .....	13
Standardization of Policies .....	14
Replacement.....	15
Benefit triggers and other coverage issues.....	17
Eligibility determination.....	20
Care management plans .....	20
Benefit trigger definitions .....	21
Post-Claims Underwriting.....	22
Premium Rates .....	24
How premiums are developed .....	26
Persistency.....	26
Utilization.....	28
Potential variation in premiums .....	29
The New NAIC Model Rules .....	31
Conclusions .....	35
References .....	38
Appendix A. State Reporting Requirements .....	41
Appendix B. Complaint Data, Florida and Illinois .....	44

## Tables

Table ES-1. Key Events in the Evolution of Private Long-Term Care Insurance Regulation.....	iv
Table ES-2. State Adoption of Select Private Long-Term Care Insurance Consumer Protections, July 2001.....	xi
Table 1. Evolution of NAIC Long-Term Care Insurance Model Law and Regulations.....	6
Table 2. State Adoption of Key Standards, 2001.....	7
Table 3. Year of Adoption of Key Consumer Protections, Study States .....	9

Table 4. Benefit Triggers under NAIC Model Regulation and HIPAA.....	18
Table 5. Illustration of Premium Variation Using Optimistic and Conservative Pricing Assumptions .....	30
Table 6. Distribution of Benefits and Administrative Load, Original Premium of \$1,000 and Later Increases .....	35
Table 7. Selected State Filing and Reporting Requirements .....	41
Table 8. Complaints on Long-Term Care/Home Health Care Coverage, Florida Department of Insurance, January 1, 2000-December 31, 2000 .....	44
Table 9. Long-Term Care Complaints, Illinois Department of Insurance, January 1, 2000-December 31, 2000 .....	45

## Executive Summary

While private long-term care insurance (LTCI) has been available since the mid-1970s, its popularity has grown rapidly in recent years, and Congress is considering proposals that would further encourage LTCI purchase through expanded tax subsidies. Yet there has been little independent examination of just how well LTCI works and how much security it really provides. This report focuses on consumer protections for individuals buying LTCI in the current market. It begins with a brief description of how LTCI works and how it is regulated. It then examines how well existing federal and state regulatory mechanisms address issues in several key areas.

### Overview of Long-Term Care Insurance

A private LTCI policy provides payment towards the cost of necessary long-term care services, such as nursing home care or home care. Typically the policy makes fixed dollar payments for each day of care, regardless of the actual cost of the service. LTCI generally pays benefits only for a fixed period—e.g., two years of nursing home care, three years, and so on; the longer the coverage, the more costly the policy. (Some policies have a dollar limit instead of a time limit.) To receive benefits, a policyholder must not only obtain the covered service, but must also meet a “benefit trigger.” For example, he or she requires assistance in performing any two out of a list of “activities of daily living” (ADLs), such as bathing, eating, or dressing. Or the policyholder requires supervision because of a cognitive impairment, such as Alzheimer’s disease.

Most purchasers of LTCI do not expect to need long-term care services until some time in the future; they pay premiums over a period of some years in return for a promise of future protection. Because the cost of long-term care services will likely rise over time, a per diem coverage amount that might be adequate today could be inadequate by the time services are needed. As a result, most policies offer inflation protection for an additional charge: for example, the policy may provide that the allowable per diem payment will increase 5 percent per year. Many policies provide a “nonforfeiture” option, which allows a policyholder who stops making premium payments to recover some of the accrued value of the policy. For example, the policyholder who has stopped making payments may retain an LTCI policy that provides lifetime coverage but with reduced benefits.

Although LTCI may seem to resemble health insurance for acute care, its premiums are set very differently. The premiums paid for a health insurance policy during a year cover average expected claims costs for the purchasers

during that same year. In contrast, premiums for LTCI policies are set with the assumption that most buyers will pay premiums for some years before requiring services. A 50-year-old who buys LTCI may not need care until she is 80 – or never. The rates are set on the assumption that she will go on paying premiums throughout the intervening years, thus building up a pot of money that will be available as the need for long-term care becomes more likely. So LTCI works much as life insurance does, by relying on the long-range accumulation and investment of premiums to meet a distant future cost. This long-range investment component means that LTCI presents some regulatory issues very different from those presented by health insurance.

Like other forms of insurance, LTCI is regulated by states. Most states have adopted at least some consumer protections for LTCI purchasers, often using model standards promulgated by the National Association of Insurance Commissioners (NAIC). The first NAIC model act on long-term care insurance was developed in 1987 and was followed by a model regulation in 1988. The model act and regulation have been altered regularly, with the most recent amendments completed in 2000 (Table ES-1). In addition, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) included provisions meant to clarify when premiums paid for LTCI were tax deductible and when benefits paid out by an LTCI policy could be excluded from taxable income. These provisions specify some consumer protections that must be provided if a policy is to be “tax-qualified” – eligible for favorable tax treatment.

**Table ES-1. Key Events in the Evolution of Private Long-Term Care Insurance Regulation**

1987	First NAIC model act
1989	Prohibition of post-claims underwriting
1990	Regulation of replacement policies
1990	Requirement to assess suitability
1995	Specification of minimum benefit triggers
1996	HIPAA clarifies tax deductibility of premiums and exclusion of benefits as taxable income
2000	NAIC amendments revise rules for state approval of initial rate filings and rate increases

## Method

To learn more about actual experience in enforcing of long-term care insurance consumer protections, we conducted interviews in 2001 with state insurance department officials in four states, California, Colorado, Florida, and Illinois. These states were identified as leaders in LTCI regulation, and should not be considered as nationally representative. In addition to regulators, we spoke with representatives of consumer advocacy and counseling groups and with agents who currently or recently specialized in the sale of private LTCI. Interviews focused on several key areas: suitability and other issues in choosing a policy, policy replacement, benefit triggers and other coverage issues, and post-claims underwriting.

## Consumer Protections in Practice

**Suitability.** LTCI can be costly, especially for purchasers who wait until late in life to buy coverage or who buy very comprehensive policies. Purchasers may buy more coverage than they can really afford. If they eventually cannot afford to continue paying premiums, they can lose everything they have invested. The NAIC model includes suitability standards, under which the insurer or agent must obtain financial and other information from applicants and notify applicants for whom the purchase of LTCI appears to be inappropriate, using income thresholds or other standards developed by the insurer itself. The insurer *may* reject the application, or it may complete the sale after obtaining documentation that the applicant still wishes to proceed.

While 30 states had suitability standards as of January 2001, monitoring and enforcement may be difficult. Because the rules do not actually specify financial thresholds, regulators can only evaluate whether insurers are following their own standards. There is evidence that there are fewer very low-income purchasers of long-term care insurance than there were in the early 1990s (HIAA, 2000), and there has been a steady decline in voluntarily terminations (Society of Actuaries, 2000) –suggesting that fewer purchasers are having trouble paying renewal premiums. However, there may still be some purchasers who are overextending themselves to buy LTCI. For example, many buyers, especially those with low incomes, are liquidating assets to pay premiums.

**Choosing a policy.** LTCI is available from many different companies, and any one company may offer many different coverage options –varying by benefit amount and duration, inflation protection, and other features. Consumers may not be able to assess what policy is most appropriate for them. While agents can help, some may focus on providing as much in benefits as buyers can afford without helping them assess the trade-offs involved.

Consumers' choices may also be affected by the different incentives placed on agents: some may offer the products of only one company and may be rewarded for steering customers toward particular policy designs.

Many states have developed information materials to help consumers understand their choices, the key questions they should consider, and the implications of their decision. Perhaps the most ambitious information initiative has been undertaken in California, which publishes a rate guide providing comparison of policies and premium history for all insurers operating in the state. All states also have State Health Insurance Assistance Programs (SHIPs), funded by the Centers for Medicare and Medicaid Services and sponsored by state aging units or insurance departments. SHIPs are staffed mainly by volunteer counselors who must deal with a wide range of issues, such as Medicare billing problems and Medicare+Choice concerns. While they receive some training on LTCI issues, their ability to provide expert advice is necessarily limited.

In an effort to minimize consumer confusion and provide benchmarks for comparison, Colorado requires each LTCI insurer to offer two standardized LTCI policies: a "basic" plan for people with moderate incomes, and a "standard" plan meant for higher-income buyers. Insurers or agents remain free to offer other policies, and it appears that few are encouraging consumers to purchase the standardized plans.

**Replacement.** A key problem that emerged as the LTCI industry grew was a high degree of replacement of existing policies with new policies that were not markedly different from the coverage they replaced. Agents had strong incentives to encourage inappropriate replacement, because the commission paid to an agent during the first year of a policy is often much higher than the commission for renewal years. Meanwhile, because LTCI premiums are based on the buyer's age at the time a policy is first issued, a buyer who replaces an older policy with a similar new policy will pay more for the same benefits.

Nearly all states have adopted rules to discourage unjustified replacement of existing policies (47 states). Insurers or agents must identify applicants who are replacing an existing policy and notify the applicant of the implications of buying replacement coverage; in addition, if the applicant chooses to proceed, the existing insurer must be notified. A few states have also addressed one of the underlying causes of replacement by regulating agent commission structures. Most of the regulators interviewed believe that the incidence of inappropriate replacement has been reduced. HIAA survey data indicate that 11 percent of policies sold in 2000 replaced an existing policy; it is not known how many of these replacements represented significant improvements in coverage.

**Benefit triggers and other coverage issues.** Benefit triggers govern when the policyholder becomes eligible to receive benefits. Early LTCI policies often left unclear exactly what circumstances would make a policyholder eligible. In 1995, the NAIC adopted minimum benefit triggers to help standardize the approach used by insurers. Only a minority of states have adopted these or similar standards (18 states). However, most policies now sold conform to the HIPAA requirements for tax-qualified policies. Under HIPAA, a policy must pay benefits if the policyholder (a) is expected to need “substantial” assistance for at least 90 days with any 2 of a list of any 5 ADLs to be specified by the insurer, or (b) has a cognitive disability and needs “substantial” supervision to protect himself or herself. While consumer assistance representatives believe that benefit trigger standards have greatly clarified when an insured is eligible for benefits, there remain some concerns about triggers and about approval of services.

First, some consumers with serious disabilities may be unable to receive benefits. For example, an insurer may provide coverage only if the policyholder requires “hands-on” as opposed to “standby” assistance. Others may delay eligibility by using a list of ADLs that excludes bathing--often the first ADL with which an individual needs help. Second, it is not always clear whether the policyholder has the right to an assessment performed by an independent clinician, rather than one selected by the insurer. Third, growing numbers of insurers are using coordinators to assist policyholders in locating care settings or home care providers and develop plans for care management. So far, only a handful limit benefits to services approved by the care management coordinator, but plans may become more restrictive as more policies are purchased and claims are filed.

While states generally require that policies specify some process for resolving disputes, regulators lack the authority to impose any particular requirements for this process, nor are states requiring external review of insurers’ eligibility and coverage decisions.

## **Premium Rates**

Most people buy long-term care insurance many years before they are likely to require services. Because prices are much lower for younger purchasers, buying coverage earlier in life and paying premiums for a longer period can be a sensible investment—*if* the premiums stay at the same level over time. Under most state laws, the insurer cannot increase the premium for an individual because he or she grows older or develops health problems after buying the coverage. However, the insurer may impose a general rate increase

applicable to an entire class of purchasers if it can show regulators that more revenue is needed to cover current or future costs.

While insurers are supposed to set their initial premium rates at levels sufficient to cover their ultimate projected costs, this is difficult because LTCI is a fairly new product. Until recently, insurers lacked sufficient experience to accurately estimate revenue requirements. Some less scrupulous insurers have deliberately “low-balled” – offered unrealistically low initial premiums to gain market share, knowing that they might have to raise rates later on. Other insurers have made a business of acquiring under-priced policies from other companies and then raising the rates.

Stronger regulation and the threat of policyholder suits may have discouraged some abusive practices, and insurers today have more experience to work from. Still, pricing of LTCI policies remains subject to considerable uncertainty. For example, while there is a growing body of data on actual utilization by policyholders, the data may not have kept pace with the evolution of LTCI. Insurers know a lot about nursing home use, but less about likely use of home care or the disability-based cash payments now available from some insurers. Reliability of past data may also be affected by subsequent changes in benefit triggers and underwriting standards. Numerous other factors affect the reliability of premium calculations, including expected returns on invested reserves and estimates of the proportion of policyholders who will “lapse” – die or drop coverage before needing care. As a result, two insurers pricing the same policy can come up with very different rates. One using very optimistic assumptions might charge half as much as a more conservative insurer, with the risk of needing rate increases later on.

When LTCI was first introduced, state insurance departments had no principles for regulating it and tended to treat it as analogous to health insurance. They accepted the likelihood that rates could increase over time, just as they do under health insurance, and rate review focused on assuring that benefits were reasonable in relation to premiums. Until recently, regulation of LTCI pricing specified minimum loss ratios – the proportion of premiums that had to be spent on benefits. In effect, regulators focused on making sure premiums were not too high. There was no examination to assure that premiums were not too low; on the contrary, insurers were discouraged from including any margin for error.

In response to some huge rate increases (e.g., one North Dakota insurer allegedly raised rates by an average of 700 percent over a 7-year period) the NAIC drastically changed its model regulations in 2000. The new rules place greater responsibility on insurers to make initial premiums adequate, rather than

relying on experience after policies are sold to make corrections in the premiums. A qualified actuary must now certify that proposed premiums are sufficient to cover anticipated costs under “moderately adverse” experience and are reasonably expected to be sustained over the life of the product with no future premium increases anticipated. Insurers will still be able to ask for rate increases later on if they can show that their premiums are inadequate. Projected loss ratios, which under the new model are no longer considered in approving the initial rates, will be considered at this point. Regulators may take further steps if an insurer raises rates repeatedly for a particular group of policyholders, and insurers who consistently file inadequate initial rates may be barred from selling new LTCI policies.

As of September 2002, 14 states had adopted the new rating provisions, and another 17 were in the process of doing so. Even if all states implement the standards, they do not guarantee that policyholders will never see substantial rate increases. Instead, they seek to discourage deliberate underpricing and assure that any rate increases are justified. There are some additional concerns about the new rules. First, the regulation leaves significant leeway for rate increases by companies that acquire a block of business from another company. Second, if a company must raise its rates because of underestimates of utilization or other factors, it is allowed to devote part of the increase to administration and profit. Third, the new rules afford no protection to current policyholders. Finally, adequate enforcement of the new rules would require greater resources than many states may be willing to devote to this comparatively minor line of insurance business.

## **Conclusion**

In states – such as those selected--with strong regulation of LTCI, there has been real progress in addressing some of the most troublesome practices that emerged in the early years of the long-term care insurance market. Fewer people who cannot afford coverage appear to be buying it, and there may be fewer inappropriate sales of replacement coverage. However, as table ES-2 shows, not all states have adopted key NAIC standards. Those that have may not have been as active as the study states in overseeing LTCI, and there are some areas, such as handling of claims and claim disputes, in which it is too early to assess how regulators are performing. Moreover, states have made little progress in data collection; many may not be in a position to document patterns of complaints and identify new challenges as they emerge.

The NAIC has recently proposed an Interstate Compact, under which states could choose to participate in a uniform system of standards and regulation for a variety of products, including LTCI. It remains to be seen how

many states will join the compact; moreover, since the compact specifically provides that states can join for other products but opt out for LTCI, it might not result in greater uniformity of consumer protections. Only federal action, such as stronger standards for tax-qualified products, could assure full uniformity.

Even if every state adopted and enforced every part of the NAIC model law and rules, there remain some issues that are not fully addressed in the model and that may require renewed attention as the market develops further.

- Consumers still need more assistance in determining whether LTCI is right for them and in choosing from among available plans.
- While state laws now require insurers to have a process for policyholders to seek review of an insurer's eligibility and coverage decisions, they do not give regulators the ability to ensure that those procedures are effective, and external review is not available.
- State laws do not address whether the policyholder must comply with the insurer's care management plan in order to receive benefits.
- Finally, even under the new NAIC rate-setting rules, purchasers of LTCI still face a real possibility that their premiums may rise substantially in the future.

**Table ES-2. State Adoption of Select Private Long-Term Care Insurance  
Consumer Protections, July 2001**

	Replacement	Suitability	Prohibition against post- claims underwriting	Benefit triggers	Rate stabilization (as of September 2002)
Alabama	x	x	x	x	
Alaska					
Arizona	x		x		
Arkansas	x	+	x		
California	x <sup>a</sup>	x	x	x	x
Colorado	x <sup>a</sup>	x	x	x	
Connecticut	x	+	x		
Delaware	x	x	x	x	
District of Columbia					
Florida	x	b	x	x	
Georgia	+ <sup>a</sup>				
Hawaii	+ <sup>a</sup>	x	x	x	
Idaho	x		x		x
Illinois	x	x	x	x	x
Indiana	x	+			
Iowa	x	+	x		x
Kansas	x		x	+	
Kentucky	+	+	x		x
Louisiana	x	x	x	x	
Maine	x		x		
Maryland	+	+	x		x
Massachusetts	+ <sup>a</sup>		x	+	
Michigan	x		x		
Minnesota	x	+	x	+	x
Mississippi	x		x		
Missouri	x	+	x		
Montana	x	x	x	x	
Nebraska	x	x	x		
Nevada	x <sup>a</sup>		x		
New Hampshire	+ <sup>a</sup>				
New Jersey	+ <sup>a</sup>				
New Mexico	x	x	x	x	
New York	x		x		
North Carolina	+ <sup>a</sup>	+	+	+	x

	Replacement	Suitability	Prohibition against post-claims underwriting	Benefit triggers	Rate stabilization (as of September 2002)
North Dakota	x	+	x		
Ohio	x	+	x		x
Oklahoma	x	x	x		x
Oregon	x		x	+	
Pennsylvania	x	+	x		x
Rhode Island	+ <sup>a</sup>	x	x		
South Carolina					
South Dakota	x	+		+	x
Tennessee	+ <sup>a</sup>		x		
Texas	x		x	+	x
Utah	x	x	x		
Vermont	x	x	x		
Virginia		+			
Washington				x	
West Virginia	x	+	x		
Wisconsin	x	x	x	x	x
Wyoming	+ <sup>a</sup>		x		
Total	47	30	42	18	14

Sources: NAIC 2001; updated for study states through telephone interviews.

x State law is identical or similar to NAIC model language

+ State law uses language other than the NAIC model

<sup>a</sup>Model language before 1990 amendments; earlier standards were less specific about the types of questions that must be asked to determine whether replacement is appropriate.

<sup>b</sup>Adopted in 2002.

## Introduction

People who live long enough have a high risk of eventually requiring some form of long-term care. For example, of people turning 65 in the year 2000, an estimated 44 percent will at some point enter a nursing home (Spillman and Lubitz 2002). The costs can be devastating. A one-year stay in a nursing home costs an average of \$55,000, and may reach almost twice this amount in high-cost areas such as New York City.<sup>1</sup> Because neither Medicare nor private health insurance covers most of these costs, and because few people have sufficient retirement income or savings to meet them on their own, many people requiring long-term care ultimately become destitute and turn to Medicaid. An alternative that is receiving increasing attention is private long-term care insurance (LTCI). In return for a fixed annual premium, the insurer agrees to pay specified amounts for the buyer's future nursing home and home care costs for a fixed period or up to a fixed dollar amount.

While private LTCI has been available since the mid-1970s, its popularity has increased rapidly in recent years. The cumulative number of policies sold grew from fewer than 1 million in 1987 to almost 7 million by 1999 (HIAA 2002). Perhaps about 4 million of these policies were still in force as of 2000 (Merlis 2002). An increasing number of employers, now including the federal government, are offering LTCI to their employees, and a recent study found that a majority of financial planners are now recommending LTCI as an important part of their clients' planning for retirement (ACLI 1999). Congress is considering proposals that would further encourage LTCI purchase through expanded tax subsidies.

The aging of the baby boom generation will almost certainly mean a dramatic increase in the need for long-term care services in the coming decades. While there is an ongoing debate about how best to meet the nation's future financing burden for long-term care, it is possible that private LTCI will play an ever more important role. Yet there has been little independent examination of just how well LTCI works. How much security does it really provide? Is it a sensible investment, either for people already in retirement or for younger purchasers? How could it be made to work better?

---

<sup>1</sup> Based on a nursing home survey by GE Long Term Care Insurance; press release at [http://www.csfbdirect.com/cgi/inet/qndigest.trn?research\\_cde=BSW&key\\_nmb=BW2088&trn\\_key\\_nmb=BSW020304000164&symbol=GE&topic=misc&selection=all\\_news\\_sources](http://www.csfbdirect.com/cgi/inet/qndigest.trn?research_cde=BSW&key_nmb=BW2088&trn_key_nmb=BSW020304000164&symbol=GE&topic=misc&selection=all_news_sources), accessed Mar. 12, 2002.

This report, the first in a two-part study, focuses on consumer protections for individuals buying LTCI in the current market. It begins with a brief description of how LTCI works and how it is regulated. It then examines how well existing federal and state regulatory mechanisms address issues in three key areas: marketing and consumer education, benefit payment and appeals, and pricing of policies.

The second paper, *Private Long-Term Care Insurance: Who Should Buy It and What Should They Buy?*, looks at the product itself. How does LTCI fit into people's general financial planning? Are the types of LTCI policies commonly sold today likely to meet consumers' needs--in the short term or, for younger purchasers, many years in the future? Are there ways in which LTCI policies could be improved?

## **Background**

### **Overview of Long-Term Care Insurance**

A private LTCI policy provides payment towards the cost of necessary long-term care services, such as nursing home care, care in an alternative setting such as an assisted living facility, and/or home care.

#### **Benefits**

The coverage provided under most LTCI policies is indemnity coverage in the traditional sense. That is, the policy makes fixed dollar payments for each unit of service (such as a day of nursing home care or a day of home care) obtained, regardless of the actual cost of the service.<sup>2</sup> One can buy a policy that will pay \$75 per day of nursing home care or—for a higher premium—\$100 a day, and so on. The per diem allowance often differs for care in different settings. For example, a policy that pays \$100 per day of nursing home care might pay \$50 per day of home care. LTCI generally pays benefits only for a fixed period—e.g., two years of nursing home care, three years, and so on; the longer the coverage, the more costly the policy. Some policies have a dollar limit (often referred to as a pool of money) instead of a time limit; they may provide longer coverage for less costly home care than for nursing home care. Other policies offer lifetime benefits, at considerably higher cost.

---

<sup>2</sup> Many policies will pay the lesser of the actual cost of services or the stated maximum daily benefit. However, given the expected inflation in the costs of services and the typical amounts of daily maximum benefits purchased, for all practical purposes these policies can be viewed as paying a fixed amount per day regardless of the cost of services.

To receive benefits, a policyholder must not only obtain the covered service, but must also meet a “benefit trigger.” Most policies sold today provide benefits in either of two circumstances. The policyholder has a specified degree of functional disability; for example, he or she requires assistance in performing any two out of a list of “activities of daily living” (ADLs), such as bathing, eating, or dressing. Or the policyholder requires supervision because of a cognitive impairment, such as Alzheimer’s disease. Some policies use “medical necessity” – certification by a physician that the policyholder needs long-term care – as a benefit trigger; this trigger is becoming rare, for reasons discussed below. Most policies also require an “elimination period”: coverage does not begin until the policyholder has met the benefit trigger (and, under most policies, received care) for some fixed period, such as 30 days or 90 days. This prevents pay-outs for very short periods of disability.

Some policies provide fixed daily payments to a policyholder who meets a benefit trigger (for example, two ADLs), whether or not the policyholder uses any particular services.

### **Inflation and nonforfeiture protections**

Most purchasers of LTCI do not expect to need long-term care services until some time in the future; they pay premiums over a period of some years in return for a promise of future protection.

Because the cost of long-term care services will likely rise over time, a per diem coverage amount that might be adequate today could be inadequate by the time services are needed. As a result, most policies offer inflation protection for an additional charge: for example, the policy may provide that the allowable per diem payment will increase 5 percent per year. Some policies offer only simple inflation protection; they calculate each year’s increase on the basis of the original coverage amount purchased. Thus a policy that paid \$100 a day at the time of purchase would pay \$150 a day ten years later. Others compound the inflation protection, so that a policy allowing a 5 percent increase would go from \$100 a day at purchase to about \$163 ten years after purchase. Alternatively, the policy may provide that the policyholder can buy additional coverage at some future date. However, the policyholder would then pay a higher premium reflecting his or her age at the time of the additional purchase.

Many policies provide a “nonforfeiture” option, which allows a policyholder who stops making premium payments to recover some of the accrued value of the policy. For example, the policyholder who has stopped making payments may retain an LTCI policy that provides lifetime coverage but

with reduced benefits. This provides some protection to those who may not be able to continue payments if their income decreases or premiums rise. It may also reassure some buyers who are concerned about paying for a policy for years and getting nothing in return.

## **Pricing**

Although LTCI may seem to resemble health insurance for acute care, its premiums are set very differently. The premiums paid for a health insurance policy during a year cover average expected claims costs for the purchasers *during that same year*. The premium charged to a 40-year-old reflects annual average costs for 40-year-olds; the premium for a 50-year-old reflects average costs for 50-year-olds; and so on. In contrast, premiums for LTCI policies are set with the assumption that most buyers will pay premiums for some years before requiring services. A 50-year-old who buys LTCI may not need care until she is 80—or never. The rates are set on the assumption that she will go on paying premiums throughout the intervening years, thus building up a pot of money that will be available as the need for long-term care becomes more likely. So LTCI works much as life insurance does, by relying on the long-range accumulation and investment of premiums to meet a distant future cost. Also as with life insurance, the cost of the LTCI policy depends on how early in life one obtains it— younger people can be expected to pay into the pool for a longer period and their likelihood of needing services in the near future is low. Thus, a policy that might cost a 40 year-old \$600 a year would cost an 80-year-old nearly \$6,000 a year.<sup>3</sup>

In theory, the premium for LTCI is expected to be fixed for the life of the policy. Under most state laws, the insurer cannot increase the premium for an individual because he or she grows older or develops health problems after buying the coverage. However, the insurer may impose a general rate increase applicable to an entire class of purchasers—for example, because the insurer initially underestimated future utilization and costs for the class.

## **Regulation of LTCI**

Like other forms of insurance, LTCI is regulated by states. Most states have adopted at least some consumer protections for LTCI purchasers. In addition, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) included provisions meant to clarify when premiums paid for LTCI

---

<sup>3</sup>Average 1997 premiums for a comprehensive policy with compound inflation protection (HIAA 2000).

were tax deductible and when benefits paid out by an LTCI policy could be excluded from taxable income. These provisions specify some consumer protections that must be provided if a policy is to be “tax-qualified” – eligible for favorable tax treatment.

## **State regulation**

LTCI was first offered in 1974 and began to be widely marketed in the 1980s. Its early history was marked with reports of marketing abuses and other practices that weakened its value to consumers. Very low-income consumers were sold policies with premiums they would not be able to afford over time. Some agents convinced policyholders to replace an existing LTCI policy with a new policy, not because the change was appropriate but because the agent could earn another commission. Some insurers, who failed to look into an applicant’s health status before issuing a policy, were canceling those policies once a policyholder brought a claim, on the grounds that the insurer was unaware of a pre-existing condition. And policyholders were provided insufficient information to understand when they would actually be eligible for benefits.

Through the National Association of Insurance Commissioners (NAIC), an organization of state insurance regulators, the states developed standards to help address these and other concerns.<sup>4</sup> The first NAIC model act on long-term care insurance was developed in 1987 and was followed by a model regulation in 1988. As table 1 shows, the model act and regulation have been altered regularly, with the most recent amendments completed in 2000.

---

<sup>4</sup> The models developed by the NAIC are the product of deliberations by committees of state regulators with extensive input from industry and consumer representatives. Consequently, they are seen as consensus documents that reflect the concerns of a very broad array of interested parties. While the models provide guidance, the individual states decide whether they will adopt the NAIC model, in whole or in part, or will pursue another course of action.

**Table 1. Evolution of NAIC Long-Term Care Insurance Model Law and Regulations**

1987	First NAIC model act
1989	Prohibition of post-claims underwriting
1990	Regulation of replacement policies
1990	Requirement to assess suitability
1995	Specification of minimum benefit triggers
2000	Revised rules for approval of initial rate filings and rate increases

Every state and the District of Columbia now has some laws governing long-term care insurance. While many states’ laws reflect the guidance in the NAIC models, others have adopted only some of the major consumer protections provided. Some have moved beyond the NAIC standards in specific areas. For example, California has more stringent rules for enrollee appeals, while Colorado requires standardized benefit offerings (see below).

Table 2, based on the NAIC’s Compendium of State Laws on Insurance Topics, shows the number of states that have standards in four key areas. (Table ES-2, above, gives information by state.)

- *Suitability:* These standards require insurers to help applicants decide whether a policy is affordable and appropriate, given their resources and expectations;
- *Replacement:* These standards require insurers or agents to help applicants who already have an LTCI policy assess whether they should replace an old policy with a new one;
- *Prohibition against post-claims underwriting:* These standards prevent insurers from performing underwriting after a policy has been purchased and a claim has been filed.
- *Benefit trigger.* These standards specify uniform minimum benefit triggers.

These consumer protections were chosen because the practices they were designed to address received prominent attention from regulators, consumer advocates, and industry representatives. There has also been sufficient time for

regulators to have gained some experience implementing and enforcing these protections.

**Table 2. State Adoption of Key Standards, 2001**

	Number of states
Any standard for:	
Replacement	47
Suitability	30
Post-claims underwriting	42
Benefit triggers	18
Of the four areas, number for which the state has standards	
Zero	3
One	5
Two	10
Three	21
Four	12

Source: NAIC; updated for study states through telephone interviews.

The NAIC models also include standards for state approval of initial premium rates and rate increases for LTCI policies. These standards, which were extensively revised in 2000, are reviewed later in this report. As of September 2002, 14 states had adopted the revised standards and another 17 had reported to the NAIC that they were in the process of doing so.

In December 2002, the NAIC adopted an Interstate Insurance Product Regulation Compact. States choosing to participate in the compact would agree to a uniform set of standards and processes for regulatory approval of insurance products, including life insurance, annuities, disability income and long-term care products. If enough states adopt the compact, insurers will be better able to market products nationally without facing duplicative or conflicting reviews. Consumers may also benefit if the standards adopted under the compact are stronger than those already in effect in their state. The compact specifically provides that standards for LTCI will be at least as stringent as those included in the LTCI model law and regulation. However, it also provides that states may participate in the compact for all the other kinds of insurance products but opt out for LTCI. Whether the compact will actually promote greater uniformity in LTCI consumer protections remains to be seen.

## HIPAA requirements

Under HIPAA, tax-qualified policies receive favorable treatment in a number of respects. Benefits paid under these policies, up to certain limits, are not taxable as income. LTCI premiums paid by individuals may be counted towards the medical expense deduction.<sup>5</sup> LTCI premiums paid by an employer, or long-term care benefits furnished directly by an employer, are deductible for the employer and are not taxable income for the employee.

A policy is treated as tax-qualified if it is in compliance with specified 1993 NAIC model standards, including the suitability and replacement standards and the prohibition of post-claims underwriting cited earlier. The insurer must offer (though the consumer need not accept) inflation protection and nonforfeiture benefits. In addition, the law specifies the benefit triggers that must be included in policies.

Insurers may continue to sell policies that are not tax-qualified, provided that those policies comply with any applicable state requirements.<sup>6</sup> (Under a grandfather rule, policies sold before the 1997 effective date of the Act are treated as tax-qualified even if they do not meet the HIPAA standards.) However, a recent survey found that 88 percent of premiums for new policies sold during 2000 were for tax-qualified plans (Glickman). The relatively few non-qualified policies still being marketed tend to include the medical necessity trigger or provide coverage when the policyholder needs help with just one, rather than two, ADLs. When the insurer offers both qualified and non-qualified plans, premiums are generally higher for the non-qualified plan, because of the more generous benefit trigger.

---

<sup>5</sup> Note, however, that this deduction is available only to itemizers and only to the extent that medical expenses (including LTCI premiums) exceed 7.5 percent of adjusted gross income (AGI). In 2002, the House passed legislation (H.R. 4946) that would have provided a separate itemized deduction for LTCI. (The deduction would therefore have been available without the 7.5 percent of income threshold.) The President's budget proposal for FY2003 would have made the deduction "above the line" — available to non-itemizers. The self-employed may deduct LTCI premiums whether or not they itemize deductions. As with health insurance, this deduction is limited to 70 percent of the cost in 2002; 100 percent of the cost will be deductible in 2003 and later years, subject to dollar limits that rise with the age of the taxpayer.

<sup>6</sup> In addition, some insurers offer non-qualified (and hence nondeductible) riders to tax-qualified plans; these may include the "medical necessity" trigger or other benefits not allowed by HIPAA.

## Consumer Protection in Practice

This section reviews in more detail how states have responded to each of the key consumer protection areas described earlier: suitability and other issues in choosing a policy, policy replacement, benefit triggers and other coverage issues, and post-claims underwriting. (The problem of premium rate regulation is considered in the next section.)

### Methodology

To learn more about enforcement of these long-term care insurance consumer protections, we conducted interviews in 2001 with state insurance department officials in four states, California, Colorado, Florida, and Illinois. The four study states were selected from among states that had adopted most or all of the key consumer protections explored in this study and had some years of experience in enforcing them. We also looked for states with a large elderly population and those with a reputation among regulators for being especially active in LTCI oversight. The selection was necessarily somewhat arbitrary, and the chosen states should not be thought of as representative; on the contrary, the aim was to gather insights from states that are leaders in LTCI regulation.<sup>7</sup>

**Table 3. Year of Adoption of Key Consumer Protections, Study States**

	Benefit triggers	Post-claims underwriting	Replacement	Suitability
California	1993	1993	1989	1997
Colorado	1997	1997	1992	1997
Florida	1997	1996	1989	2002
Illinois	1998	1994	1998	1998

Source: NAIC.

After identifying the four study states, we contacted a senior member of the state insurance departments' staff to describe the purpose of the study,

---

<sup>7</sup> Our choices have since been validated to some extent by a study of LTCI premium rate regulation that ranks states in order of "regulatory capacity". Three of the study states were in the top ten; the fourth, California did not participate in the study. (Lutzky, Alexih, and Foreman 2002.)

request their participation, and schedule an interview with the appropriate staff member. In each of the states we were referred to someone knowledgeable about long-term care insurance. In one state, the insurance department staff member who we interviewed was the head of the senior counseling program who also dealt with long-term care insurance policy issues. In another case, the individuals we interviewed dealt largely with contracts, rates and forms, and actuarial issues. In two of the states, we interviewed staff responsible for policy related to long-term care insurance and other health insurance products. In most states we were referred to other staff members as well to obtain more specific information on enforcement actions or complaints.

To broaden our understanding, we also interviewed individuals who worked closely with consumers and were familiar with the states' long-term care insurance laws, as well as agents who sell or have recently sold LTCI. We identified the consumer representatives and agents through either state insurance department staff or the state health insurance assistance programs. Overall, we spoke with eight regulators, three consumer advocates, and four agents. Interview guides were used during our telephone interviews with state insurance regulators, consumer representatives and agents. Interviews were conducted on a "background" basis. Consequently, interviewee remarks are not attributed to a specific individual.

## **Suitability**

LTCI can be costly, especially for purchasers who wait until late in life to buy coverage or who buy very comprehensive policies. Purchasers who are very worried about their future needs may buy more coverage than they can really afford. Over time, they may find that they cannot continue premium payments. This may be especially true if the price of the coverage rises over time because of class-wide premium increases, or if the buyer has fixed retirement income and general inflation means that the buyer must gradually devote more of that income to other needs. Unless the buyer has paid extra for a nonforfeiture benefit, a buyer who cannot afford to continue paying premiums loses everything he or she has invested.<sup>8</sup>

In 1990, the NAIC developed model suitability rules, under which each insurer must have procedures for determining whether the purchase of LTCI is "appropriate" for a given applicant, taking into account the applicant's ability to

---

<sup>8</sup> Obviously, the policyholder has had the benefit of protection against the need for LTC services. However, the amount invested in the product can be considered to be the excess of past premium payments over the value of past insurance protection. This amount can be considerable because premiums for LTCI are designed to provide for a significant amount of advanced funding.

pay and goals or needs. The insurer or agent must obtain financial and other information, using a personal information worksheet to be completed by the applicant, and must then assess suitability using standards developed by the insurer itself. For example, an insurer might specify a minimum annual income threshold, or a maximum ratio of the premium to income. If an applicant is found not to meet the insurer's suitability standards, the insurer *may* reject the application. Alternatively, it may notify the applicant that the purchase of LTCI appears to be inappropriate, and complete the sale only after obtaining documentation that the applicant still wishes to proceed. The model rules require that agents be trained in the use of the standards.

Of the 30 states that had adopted any form of suitability standard as of January 2001, 15 have followed the NAIC model. Most of the rest simply require that agents determine whether the purchase of LTCI is appropriate for a particular applicant. All four of our study states have largely adopted NAIC's standards. (However, Florida adopted its suitability standards in late 2002, after our interviews were completed.)

One of our interviewees identified suitability as a particularly difficult protection to monitor and enforce. Because the rules do not actually specify financial thresholds, regulators do not have a straightforward standard against which to measure insurer compliance. Instead, they can only evaluate whether insurers are following their own standards, training agents to use those standards, and presenting applicants with the required information. To some extent, the suitability rules might seem to present a conflict of interest for insurers: why would they set standards that would discourage interested purchasers? On the other hand, it may not be beneficial for an insurer to enroll applicants who drop coverage so quickly that the insurer cannot even recover the initial costs of marketing and writing the policy. Nor is it good public relations for an insurer to have many marginal buyers who did not understand what they were getting into. So there may be some incentive for insurers to develop reasonable standards—although there is little agreement on what a reasonable standard might consist of.<sup>9</sup>

There is little direct information on whether the suitability requirements are achieving their purpose. Under the NAIC model, insurers are required to report annually on the number of applications they receive, the number that fail to meet suitability standards, and the number of these who buy the coverage anyway. However, while these data may be collected and noted by state insurance regulators, they are maintained in individual insurer files, instead of in a database that might be used to search for trends in market conduct. Several

---

<sup>9</sup> For a fuller discussion of the problem of assessing affordability, see Merlis (2002).

states noted that limited staff resources make it difficult to convert this information into an electronic format, although Florida and Illinois have begun to do so.

Still, all of our interviewees agreed that there are fewer very low-income purchasers of long-term care insurance than there were in the early 1990s. Surveys of LTCI purchasers sponsored by the Health Insurance Association of America support this conclusion. In 2000, only 9 percent of purchasers had annual incomes under \$20,000, compared to 29 percent in 1990 and 21 percent in 1995. The proportion of purchasers spending 8 percent or more of their income on premiums went from 25 percent in 1995 to 16 percent in 2000. (NAIC has suggested, as a rule of thumb, that purchasers should not spend more than 7 percent of income on LTCI premiums. HIAA, on the other hand, suggests a limit of 10 percent.) In addition, there has been a steady decline in lapse rates—the proportion of policyholders who voluntarily terminate coverage; the trends are discussed in the section on rate setting, below. This suggests that fewer purchasers are having trouble paying renewal premiums.

While these trends are encouraging, there may still be some purchasers who are overextending themselves to buy LTCI. The percent of purchasers who liquidated assets in order to pay part or all of their LTCI premiums rose from 45 percent in 1995 to 52 percent in 2000. Lower-income purchasers are especially likely to draw on savings; 67 percent of buyers with incomes below \$25,000 used liquid assets to pay premiums in 2000. Use of savings is not necessarily inappropriate, particularly as growing numbers of retirees plan to live on accumulated assets rather than defined pension benefits. Nevertheless, there is reason for concern that some buyers still may not understand that they will need to go on paying premiums for many years in order to maintain their benefits.

## **Choosing a policy**

LTCI is available from many different companies, and any one company may offer many different coverage levels or options. For example, an insurer might offer four different benefit periods (2-year, 3-year, 4-year, and lifetime); four elimination periods (0, 30, 60, and 90 days), and four daily benefit levels (\$50, \$75, \$100, and \$150 per day of nursing home care). If the insurer also offers coverage with or without inflation protection, with or without a nonforfeiture benefit, and a choice of home care benefits at 50 percent or 100 percent of the daily nursing home benefit, then the consumer must choose from among 512 possible policies, each with a different price, from just this one insurer. Consumers may not be able to assess what policy is most appropriate for them.

The NAIC model rules require that an insurer's suitability assessment process consider the applicant's long-term care goals or needs and the appropriateness of the insurance to meet them. This requirement is vague, however, and the standard personal information worksheet completed by applicants does not include questions that would elicit information about goals or needs. In practice, it is left to individual agents to craft policies that meet each consumer's needs.

Interviewees from consumer assistance organizations expressed concerns that agents focus on providing as much in benefits as buyers can afford without helping them assess the trade-offs involved. For example, an agent might start out with a very comprehensive plan and then begin dropping features until an acceptable price is reached. The result might be that the buyer will get lifetime coverage with a low daily benefit and no inflation protection, when it might have made more sense to buy a policy with a shorter coverage period but better benefits.

Consumers' choices may also be affected by the different incentives placed on "career" agents (who sell policies for only one company) and "independent" agents (who sell policies from several companies). Independent agents can try to find the policy most suitable to a particular consumer's goals from among different companies' offerings; a career agent can offer only a limited number of products, and the company may even encourage or require the agent to push one or two policy designs. In addition, several interviewees pointed out that career agents often have quotas to meet. On the other hand, career agents may be interested in establishing a long-term relationship with their clients to sell a whole line of insurance products, thus creating an incentive to avoid inappropriate sales. In addition, independent agents may use their ability to compare the products of many companies to find the policy that best suits their own needs (e.g., a low premium and a high commission) rather than the policy that best suits their clients' needs.

## **Education Initiatives**

Most of the regulatory attention in this area involves the development of information materials and resources to help consumers understand their choices, the key questions they should consider, and the implications of their decision. Regulators' educational activities largely consist of disseminating various publications and presenting to community groups.

The most ambitious information initiative has been undertaken in California. In April 2001, California's Department of Insurance published its first

rate guide for consumers. Updated in December 2001, the *Long-Term Care Insurance Company Rate and History Guide*, provides a comparison of policies and premium history for all insurers operating in California. It includes an extensive overview to help consumers understand what they need to consider when choosing a long-term care insurance policy, along with comprehensive information on each insurer's rate increase history (not only in California but also in other states in which they operate).

California, Colorado and Illinois require insurers to provide enrollees with a publication such as a *Shopper's Guide to Long-Term Care Insurance* developed by the NAIC that provides information explaining the basic components of an LTCI policy. Colorado has additional publications providing an overview of LTCI, information on standardized plans, and comparisons of financial standing of insurers offering those plans. Florida has published an extensive consumer guide on LTCI that explains the various features of long-term care insurance, along with factors to consider before deciding to buy LTCI, when choosing a policy, and when selecting a company. It also contains a comparison-shopping checklist and examples to illustrate, as well as a listing of companies that offer LTCI in the state. Further, the consumer guide discusses the consumer's rights and responsibilities. Illinois also has a publication highlighting some of the basic features of the policies sold in the state, as well as a document that outlines the key features of policies offered by each LTCI insurer.

All states have State Health Insurance Assistance Programs (SHIPs), funded by the Centers for Medicare and Medicaid Services and sponsored by state aging units or insurance departments. Staffed mainly by volunteers, SHIPs provide counseling on Medicare, Medicaid, Medigap, and other insurance issues. These and similar beneficiary assistance programs are a critical information resource for consumers. The Illinois SHIP, for example, provided face-to-face or telephone counseling in 57,000 individual contacts in 2000 and gave educational presentations reaching an estimated 660,000 people.<sup>10</sup> However, volunteer counselors must deal with a wide range of issues, including Medicare billing problems, Medicare+Choice concerns, and so on. While they receive some training on LTCI issues, their ability to provide expert advice is necessarily limited.

## **Standardization of Policies**

In an effort to minimize consumer confusion and provide benchmarks for comparison, Colorado requires each LTCI insurer to offer two standardized LTCI

---

<sup>10</sup> <http://www.state.il.us/ins/ship/shipfacts.htm>, accessed Mar. 14, 2002.

policies: a “basic” plan, designed to be suitable for people with moderate incomes, and a “standard” plan meant for higher-income buyers. Insurers or agents remain free to offer other policies and may also sell riders that expand the coverage in the basic and standard plans. The specifications for the plans were revised in August 2001. They are relatively comprehensive, providing coverage at a daily rate of \$110 for both nursing home and home care, with a lifetime maximum of \$115,000 (about three years) for the basic plan and \$192,000 (about five years) for the standard plan.

It is unknown how many of the standardized policies have actually been sold, although there is a strong consensus that agents are not encouraging consumers to purchase them. Industry representatives argued against their development, in part, on the grounds that they would increase costs and reduce the ability to meet individual needs. Several interviewees, including some consumer advocates, questioned whether standardized policies are particularly helpful at this point, given the still evolving nature of the marketplace. One suggested that standardization of terms, definitions and conditions might be more helpful to the consumer instead.

One possible effect of standardized plans is to promote price competition, because consumers can readily compare different insurers’ premiums for identical packages. While this seems beneficial, there is an important drawback: the insurers offering the lowest prices may be using optimistic assumptions in setting their rates and may be the most likely to raise their rates later on.

## **Replacement**

A key problem that emerged as the LTCI industry grew was a high degree of replacement of existing policies with new policies. Not all replacements are inappropriate. For example, someone who bought one of the early policies that covered only nursing home care might reasonably shift to a newer policy that included home care. But there were reports that many people were buying new policies that were not markedly different from the coverage they replaced. Agents had strong incentives to encourage inappropriate replacement, because the commission paid to an agent during the first year of a policy is often much higher than the commission for renewal years. A review of 16 policies by the General Accounting Office in 1991 found that the average initial commission was 60 percent of the first year premium (GAO 1991).

Inappropriate replacement has several disadvantages for consumers. First, because premiums are based on the buyer’s age at the time a policy is first issued, a buyer who replaces an older policy with a similar new policy will pay

more for the same benefits. Second, many policies have pre-existing condition exclusions that limit coverage for some period after a policy is purchased; an enrollee who was no longer subject to the restriction under the older policy might start a new exclusion period under the replacement policy.<sup>11</sup> Third, because HIPAA treats all policies bought before 1997 as tax-qualified, a buyer who trades an older policy for a new non-qualified policy may lose the tax benefits available through this grandfather provision.

The NAIC adopted standards on replacement policies in 1990. The current model regulation includes several notice and reporting requirements to discourage unjustified replacement of existing policies. It requires insurers to include questions in their application forms that will identify applicants who are replacing an existing policy. The insurer or agent must notify the applicant of the implications of buying replacement coverage; in addition, if the applicant chooses to proceed, the existing insurer must be notified. Finally, insurers are required to collect and report to the insurance agency data on replacement sales and to identify the 10 percent of agents with the highest replacement volume.

The vast majority of states have adopted the NAIC rules or comparable requirements. Of the four study states explored, California goes a step farther than the other states by requiring that replacement be contingent on the insurer's declaration that the replacement policy materially improves the position of the insured as determined by this more detailed process. (This provision does not apply to policies replaced by group coverage).<sup>12</sup>

A few states have also addressed one of the underlying causes of replacement by regulating agent commission structures. The NAIC model includes an optional provision that would prohibit agents from receiving substantially more compensation for a replacement policy than he or she would for a renewal policy. The NAIC recommends that the first-year commission be no more than 200 percent of the renewal commission in the second year, and that renewal commissions remain the same for a reasonable number of years. Only five states limit commissions for replacement policies, and only eleven have any form of commission regulation.

During the debate on this issue, agents and insurers objected to limits on how insurers pay agents (Stone 1992). Comments from interviewees indicate that agents' actions are influenced by an array of factors, not only the amount of their commissions. One agent with whom we spoke noted that agents are less

---

<sup>11</sup> Some states require the replacement carrier to waive the exclusion when it was satisfied under the previous policy.

<sup>12</sup> The NAIC standards also include requirements related to the replacement of a group policy with another group policy. About 30 states have adopted standards in this area.

likely to be driven by commissions than by the ability to place a high volume of policyholders with insurers who have lower underwriting standards for applicants to meet. Other factors that influence an agent's actions are the requirements, such as quotas, imposed on company agents by the insurers for which they may work.

As in the case of suitability, although insurers are reporting data on replacement sales to insurance regulators, the agencies are not compiling the data in such a way as to allow tracking of trends in these sales. Most of the regulators interviewed believe that the incidence of inappropriate replacement has been reduced, although some regulators noted that replacements still occur too frequently. The Illinois Department of Insurance reported only one complaint in this area. Florida, however, reported that it fined an insurer who, among other things, failed to follow the law's procedural requirement to notify an existing insurer about a replacement policy. HIAA survey data indicate that 11 percent of policies sold in 2000 replaced an existing policy; it is not known how many of these replacements represented significant improvements in coverage.

## **Benefit triggers and other coverage issues**

Benefit triggers govern when the policyholder becomes eligible to receive benefits. Early LTCI policies often left unclear exactly what circumstances would make a policyholder eligible. Policy language was often vague or used undefined terms. If the policy relied on an individual's functional abilities, it might not have indicated precisely which functional abilities would matter. Criteria often excluded eligibility for individuals who had cognitive impairments or who needed custodial rather than medical services. Depending on how the trigger was structured, those who really needed long-term care services could continue to be ineligible for coverage because the standard was very strict. Further, there was no process in place for policyholders to seek an independent review of the insurer's eligibility decision (GAO 1991).

In 1995, the NAIC adopted minimum benefit triggers to help standardize the approach used by insurers. The HIPAA requirements for tax-qualified policies, enacted in 1996, include slightly different standards, as shown in table 4. The NAIC model rule has been amended to clarify that HIPAA tax-qualified policies may be treated as meeting NAIC model requirements.

**Table 4. Benefit Triggers under NAIC Model Regulation and HIPAA**

	NAIC model rule	HIPAA tax-qualified
Policy must pay benefits for:		
Functional disability	Policyholder needs “hands-on” assistance with any 3 of a list of 6 ADLs (bathing, continence, dressing, eating, toileting, transferring).	Policyholder needs “substantial” assistance with any 2 of a list of any 5 ADLs to be specified by the insurer.
Cognitive disability	Policyholder needs supervision or verbal cueing to protect self or others.	Policyholder needs “substantial” supervision to protect self.
Duration of disability	No requirement.	Functional disability must be expected to last at least 90 days; no requirement for cognitive disability.
Less restrictive trigger permitted	Yes. Insurer could add to list of ADLs or allow benefits when assistance is needed with only 1 or 2 ADLs.	Yes. Insurer could use all 6 ADLs, but could not allow benefits when assistance is needed with fewer than 2 ADLs.
Patient assessment	Must be performed by licensed or certified professional.	Must be performed by licensed health care practitioner.
Appeal of benefit determination	Policy must describe process for appealing and resolving benefit determinations.	Insurer must provide written explanation of claim denial but need not have appeal process.

About twenty states have adopted standards for benefit triggers, and not all of these states have adopted the NAIC’s model language. That fewer states have passed their own benefit trigger standards may reflect the fact that the vast majority of policies now sold are designed to meet the HIPAA standards. According to one study, 90 percent of recently sold policies were tax-qualified (LifePlans 1999). Although the NAIC standards do not interfere with the implementation of the HIPAA standards, insurers are concerned that a state standard that differs from HIPAA's may result in conflicting interpretations that could cause confusion for policyholders and insurers.

There are insurers who continue to offer non-tax-qualified policies. In a state that has adopted NAIC or similar trigger standards, these would not be very different from tax-qualified plans. In other states, however, non-tax-

qualified plans may use entirely different benefit triggers, such as the “medical necessity” trigger that was once common, or they may add this trigger to an ADL-based trigger as an alternative path to benefits.<sup>13</sup> Older policies may also use this standard. Common wisdom is that the medical necessity standard is more generous than the ADL approach but is more confusing for everyone involved. In addition, while premiums for pre-HIPAA policies that use this trigger are deductible under HIPAA’s grandfather rule, it is not clear that benefits paid out under these policies will be tax-exempt.

Each of the study states requires health plans to file their contracts and policies before they are used. It is in the review of these filings that regulators look at such elements as the insurer’s benefit trigger standards. They also, at that time, can make sure the insurer has noted the availability of a process for policyholders to appeal benefit eligibility decisions.<sup>14</sup> None of the regulators have the authority to impose any particular requirements for this process or assess the effectiveness of its implementation. Illinois regulators, however, became concerned when they realized that insurers’ contracts were also requiring that policyholders submit to binding arbitration. Under such a system, policyholders would be unable to seek further review of an insurer’s decision to deny eligibility for benefits. Regulators in that state informed insurers that they cannot require binding arbitration or limit a policyholder’s ability to seek an attorney to challenge the insurer’s decision. Florida also forbids binding arbitration requirements.

Interviewees did not perceive a high level of conflict between insurers and policyholders about eligibility for benefits. In both Florida and Illinois, about 11 percent of the complaints in 2000 involved claims denials. The agents with whom we spoke also noted that their clients were not experiencing problems and that insurers were responsive. Of course, there are a great many policies that were sold only in the last few years to relatively young buyers; very few claims have been filed under these policies. As claim volume rises, some insurers may move more aggressively to control spending, and the possibility of disputes may increase.

Despite improvement in this area, consumer advocates and other interviewees continue to raise several key concerns.

---

<sup>13</sup> Some insurers offer a non-tax-qualified rider to a tax-qualified plan. The tax-qualified plan conforms to HIPAA, and the premiums are deductible; the rider adds a medical necessity trigger, and the premiums are not deductible.

<sup>14</sup> California is an example of a state that requires long-term care insurers to have a system for appeals that extend beyond benefit determinations to other issues such as eligibility, care plans, services and payment, but that requirement has only recently been imposed.

## **Eligibility determination**

Under NAIC and HIPAA standards and state law, licensed or certified health care professionals must assess a claimant's functional or cognitive status to determine eligibility for benefits. It is not always clear that the policyholder has the right to an assessment performed by a clinician who is independent of the insurer. There has been some concern that insurers have a conflict of interest and will have an incentive to encourage strict findings by their clinicians, particularly as the number of claims rise. As a result, some states require that independent providers make assessments of a policyholder's functional or cognitive status. As a result of its review of contract filings, Florida regulators learned that a Florida insurer required assessments to be performed by the insurer's care coordinator. Insurance regulators clarified that, in that state, policyholders could not be limited to assessments conducted by the insurer's provider. California regulators also note that the policyholder has the right to an independent assessment. Colorado and Illinois, on the other hand, do not prohibit the insurer from relying exclusively on its own clinical staff to make the assessments.

## **Care management plans**

One area about which consumer assistance organizations would like further exploration is how insurers use care management coordinators. Care management coordinators have become a common tool used by insurers to conduct assessments, assist policyholders in locating care settings or home care providers, and develop plans for care management. The agents whom we interviewed spoke very highly of care coordinators and considered them an effective way for policyholders to navigate the long-term care system. A regulator did acknowledge that assessments conducted by care coordinators who work for the insurer could be to the policyholder's disadvantage but is not aware of any problems in this area.

According to a recent industry survey, insurers use care management in different ways but largely do not limit benefits in the policy based on the policyholder's compliance with a care management plan (Glickman 2001). Of the 48 companies surveyed, 26 companies offer care management but do not obligate the policyholder to conform to a plan. Another 14 companies actually augment the benefits provided to the policyholder if he follows the care management plan. Examples of additional benefits given include a waiver of the elimination period or payment to a relative or spouse to serve as the caregiver. Only four insurers actually require the policyholder to conform to the recommendations of the care management coordinator in order to receive all of the benefits under the policy.

The survey indicates that these four companies do not represent a sizable portion of the long-term care insurance policies issued.

Colorado's rules for basic and standard long-term care insurance policies required that individuals be offered a choice between case management agencies affiliated and not affiliated with the insurer; the rules also require that the care plans developed by the case management agency be advisory. Consumer assistance representatives want to understand this process better and expressed concern that the use of care management coordinators may become more restrictive as more policies are purchased and claims are filed. At this time, however, there were no concrete complaints about this process from regulators, agents or consumer assistance representatives.

### **Benefit trigger definitions**

While consumer assistance representatives believe that benefit trigger standards have greatly clarified when an insured is eligible for benefits, they cite some specific issues arising from the remaining leeway given to insurers in deciding how restrictive to make their triggers. Generally, the more restrictive the trigger, the lower the premium. But policyholders may not fully understand the trade-offs at the time of purchase, and may be confused if they later learn that they cannot access benefits despite a disability.

- **HIPAA five-ADL rule.** Under HIPAA, an insurer may choose five ADLs from a list of six as the basis for eligibility assessment. Some insurers are choosing to use a list of five ADLs by excluding bathing. This means that someone who would meet a 2-out-of-6 trigger (by needing assistance with bathing and one other ADL) would not qualify for benefits under the 2-out-of-5 trigger. This is of concern because, in the course of functional decline, bathing is often the first ADL with which an individual needs help. The effect of omitting it from the list is to delay eligibility for some disabled people.
- **HIPAA 90-day rule.** Under HIPAA, tax-qualified policies can only pay benefits if it is determined that the policyholder will meet the two-ADL eligibility threshold continuously for at least 90 days. This does not necessarily mean that the policyholder must wait 90 days for benefits. The determination that a disability will be of long duration could be made at the time the disability begins, in which case the wait for benefits will depend on the elimination period provided for in the policy. While a growing number of purchasers are reportedly buying policies with 90-day elimination periods, the average elimination period for comprehensive

policies bought in 2000 was 47 days, and there are still many people buying policies with zero-day elimination periods. If these people experience an episode of disability that can be expected to be of short duration—for example, recovery after a hospital stay—coverage will be precluded by the 90-day rule even though they have paid for a first-dollar policy.<sup>15</sup> The rule may also present problems for people with conditions, such as Parkinson’s disease, that get better and worse; this may mean that, while they experience periods of severe disability, they may not meet the requirement that the disability continue for the full 90 days.

- **Need for assistance.** While some people need hands-on assistance to perform an ADL, others need only “standby assistance”: the individual can perform the ADL on her own but needs someone close by, for example to catch her if she slips while leaving a bathtub or shower. As noted in table 4, the NAIC model and many existing policies specify that a person meets an ADL trigger only if he or she needs hands-on assistance.<sup>16</sup> There have also been reports that some insurers will not count a policyholder as requiring assistance with an ADL if a home modification would make it possible to perform the ADL without assistance.

## Post-Claims Underwriting

Long-term care insurers assess an applicant’s physical and mental health to learn if the applicant has a pre-existing condition that would affect its decision to issue coverage or to adjust the standard premium. This process is called underwriting. It is done through a variety of strategies including specific questions on the application, a review of an applicant’s medical records, a face-to-face functional assessment, or a telephone interview. It may be performed by the agent and/or the insurer and is usually completed within 30 days after receipt of an application.<sup>17</sup> Regulators became aware that, in some cases, insurers were failing to conduct underwriting before issuing coverage but were denying claims or rescinding the policy once claims were filed, on the ground that the applicants had withheld information about their condition.

---

<sup>15</sup> Medicare will pay for post-hospital care in a skilled nursing facility or for home care, but only if the beneficiary requires skilled services. A beneficiary requiring only assistance with ADLs might not qualify.

<sup>16</sup> The HIPAA requirement for “substantial assistance” has been interpreted by the IRS as including both hands-on and standby assistance. However, an insurer that used a hands-on standard before 1997 may continue to use this standard in tax-qualified policies (IRS 1997).

<sup>17</sup> For a more detailed discussion on the frequency with which long-term care insurers use these methods see, Glickman 2001.

In 1989, the NAIC's model regulation incorporated requirements in this area. The model requires insurers to inquire about the health condition of the applicant before issuing the policy. Insurers also must keep data on involuntary policy rescissions – that is, instances in which the insurer cancels the policy. The insurer must give these data to the insurance commissioner every year. These standards help regulators keep tabs on the extent to which insurers are canceling policies because of pre-existing conditions that could have been discovered before the policy was issued.

There has been a marked increase in the number of states that enacted this requirement. While in 1991 only 11 states had these standards, by 2000 over 40 states – including the four study states – prohibited insurers from post-claims underwriting. That is, in those states, insurers must assess the physical and mental health condition of an applicant before issuing a policy. An insurer cannot issue a policy to an applicant and then deny a claim or rescind a policy for a condition they could have discovered during underwriting just because the enrollee begins to make claims (unless the enrollee provided false information at the time of application).

In general, interviewees indicated that insurers were not rescinding policies based on pre-existing conditions that could have been discovered during underwriting. Illinois data indicate that there was one complaint to the insurance department last year in this area. But most of the interviewees reported no knowledge of violations of the states' prohibitions against post-claims underwriting.

## Premium Rates

Most people buy long-term care insurance many years before they are likely to require services. Because prices are much lower for younger purchasers, buying coverage earlier in life and paying premiums for a longer period can be a sensible investment – *if* the premiums stay at the same level over time. As was noted earlier, LTCI insurers cannot increase the premium for an individual because he or she grows older or develops health problems after buying the coverage. However, the insurer may impose a general rate increase applicable to an entire class of purchasers if it can show regulators that more revenue is needed to cover current or future costs.

If increases are large enough, many policyholders--especially those living on fixed retirement incomes – may find it difficult to continue their coverage. Some may allow their policies to terminate, losing everything their insurer has accumulated with their premiums over the years. Those who go on paying premiums may be those at the greatest risk of needing services. As a result, a further rate increase may be needed. If this cycle continues, the insurer may enter a “rate spiral,” covering a dwindling number of high risks at very high prices.

While insurers are supposed to set their initial premium rates at levels sufficient to cover their ultimate projected costs, this is difficult because LTCI is a fairly new product. Policies were not widely sold until the 1980s, and most of the earliest purchasers did not begin to use services until even more recently. As a result, even well-intentioned insurers did not always have sufficient experience to accurately estimate revenue requirements and have had to seek rate increases. Some less scrupulous insurers have deliberately “low-balled” – offered unrealistically low initial premiums to gain market share, with the expectation (or at least the knowledge of a high probability) that they would raise rates later on. In a class action suit settled in North Dakota in 2000, policyholders claimed that their LTCI insurer had raised their premiums by an average of 700 percent between 1989 and 1996. Some saw their annual premium go from \$700 to \$10,000.<sup>18</sup>

Other insurers have made a business of acquiring underpriced policies from other companies and then raising the rates. Some policyholders whose

---

<sup>18</sup> *Hanson v. Acceleration Life Insurance Company*, Civ. No. A3:97-152 (D.N.D.), described in U.S. Senate, Special Committee on Aging (2000).

policies were acquired by such companies as Pioneer Life Insurance or Conseco Senior Health have seen their rates more than double since the acquisition.<sup>19</sup> Still other insurers have set initial prices that were apparently more reasonable but have failed to screen out high-risk applicants. Industry observers suggest that loose underwriting was a factor in the recent financial difficulties experienced by one major LTCI carrier, Penn Treaty.

There are other insurers who have never sought a rate increase. And it may be that people who buy LTCI today will be less likely than earlier buyers to face huge rate increases, partly because insurers have better data to work with, and partly because stronger regulation and the threat of policyholder suits may have discouraged some abusive practices.<sup>20</sup> Still, pricing of LTCI policies remains subject to considerable uncertainty. This is especially true for newer kinds of coverage, for which adequate experience data are not yet available. Moreover, as insurers sell coverage to younger and younger purchasers, they must project expenses many decades into the future. Even insurers who use conservative assumptions in setting their initial premium rates cannot promise that these rates will be adequate to meet future costs.

In August 2000, the NAIC adopted new model regulations intended to improve the accuracy of initial rate proposals and to set standards for approval of requests for rate increases. These standards, even if fully implemented by states, do not guarantee that policyholders will never see substantial rate increases. Instead, they seek to discourage deliberate underpricing and assure that any rate increases are justified. In addition, the rules include requirements for information to be supplied to purchasers, intended to help them better evaluate the possibility of future rate increases.

The following discussion begins with an explanation of how LTCI policies are priced and why pricing remains more uncertain than for other kinds of insurance. It then describes the new NAIC model requirements and offers some thoughts about how well the rules balance insurer and consumer interests.

---

<sup>19</sup> Based on increases reported in California Department of Insurance (2001).

<sup>20</sup>In lawsuits that have already occurred, a key to success has been that companies plan future rate increases without notifying policyholders of their plans. This can occur in two situations. The first is when a company plans several future modest increases as opposed to one large needed increase. This leaves policyholders with a choice to lapse or continue paying premiums at each increase without the knowledge of future planned increases. Thus, the policyholders may believe that each increase will be the last. The second situation occurs when there is a plan to increase premiums after acquiring a block of business from another company. This essentially lets the selling company avoid or mitigate losses. The seller will look for the buyer who gives it the best price for the block, and the best price will usually come from the buyer most willing to increase premiums after purchase.

## How premiums are developed

Before an insurer can determine a premium for long-term care insurance, it must first make assumptions in five major categories:

- **Persistency.** The percentage of policies sold that will remain in force each future year.
- **Utilization.** The use of long-term care services in each future year.
- **Expenses.** The expenses incurred in selling and maintaining policies in force and in processing claims.
- **Interest.** The interest earned on policy reserves.
- **Risk.** The risk/profit margin necessary to maintain solvency under adverse experience and to generate a profit.

Estimates in the first two areas have proved especially problematic, because of the short history and rapid evolution of LTCI.

### Persistency

The pricing of long-term care insurance entails the projection of future benefit payments, expenses, and premium payments. Key to the projection of these amounts is an estimate of how long policyholders will hold on to their policies. The need for long-term care is modest among persons in their sixties, but increases significantly for those in their late seventies and eighties. If a company sells coverage to a group of 65 year-olds, it can anticipate that some of these purchasers will die before using LTC services, while others will voluntarily “lapse” – stop paying premiums at some point and allow their policies to terminate. The premiums paid by these purchasers before their death or lapse remain in the pool available to fund future services for purchasers whose policies remain in force. In effect, those who drop out subsidize those who stay. Thus a low persistency rate – that is, a high rate of mortality and lapse – reduces premiums, while high persistency increases premiums.

One of the reasons that some early LTCI policies were underpriced is that insurers used mortality tables with high death rates and assumed unrealistically high lapse rates. This was due in part to inappropriate reliance on experience with other types of insurance.

Some insurance companies used a mortality table for pricing LTCI that was designed for pricing life insurance, the 1958 Commissioners’ Standard Ordinary mortality table (1958 CSO). This table was based on the experience of

individuals who purchased life insurance; these mortality rates were then increased in order to produce “conservative” reserves—that is, the higher reserves needed to pay claims if life insurance policyholders died sooner than expected. In LTCI, however, the “conservative” assumption is that *fewer* policyholders will die and more will live to use long-term care services. A more appropriate mortality table would be one used in pricing annuities, for which the conservative assumption is that purchasers will live longer and thus receive larger payouts. A paper published by the Society of Actuaries recommended the use of the 1983 Group Annuity Mortality table (1983 GAM) for the calculation of reserves, and regulators have switched to this more appropriate table (Society of Actuaries 1995). Many insurers now use this table or similar tables for pricing.

Even this table may not be conservative enough. The Long-Term Care Experience Committee of the Society of Actuaries has made an intercompany study of the LTC experience between 1984 and 1993 of several insurance companies combined (Society of Actuaries 2000). This study shows that mortality rates for LTC policyholders dropped significantly during the period of the study and that the rates were actually lower than the rates in the 1983 GAM. A more recent annuitant mortality table has been published by the Society of Actuaries, the 1994 GAM table. This table shows lower mortality rates than the 1983 GAM table, but it has not yet been adopted by regulators for calculating LTCI reserves.

There have been similar problems in estimating lapse rates. Many insurance companies initially relied on their experience with other forms of health insurance for the aged, particularly that of Medicare Supplement (Medigap) insurance. Lapse rates for these products were often very high, especially in the first few years after purchase; it was not uncommon for 20 percent of buyers to lapse in a given year. Early experience in LTCI showed a similar pattern, for several reasons. First, many policyholders did not understand that their premiums were building a large reserve for future costs that would be forfeited if they dropped their policies. Second, as was discussed earlier, there was a high degree of replacement of policies, both appropriate—to obtain improved benefits—and agent-induced.

The 1984-1993 intercompany study shows that lapse rates experienced by insurance companies during the period of study actually were quite high. Lapse rates averaged 15 percent during the first policy year, nearly 11 percent in the second year, and 9 percent in each of the third and fourth years. This meant that, within four years after purchase, nearly 40 percent of purchasers had let their policies lapse. Even within the study period, however, there was evidence of increasing stability. First-year lapse rates fell from 17 percent for policies purchased in 1984-1987 to below 12 percent for policies purchased in 1991-1992.

Today a reasonably conservative insurer would assume a lapse rate of 10 percent in the first year, 7 percent in the second policy year, and 3 percent thereafter. Many companies now assume that ultimate lapse rates will be only 2 percent. As companies lower the lapse rates that they assume in pricing, initial premiums will be higher, but the likelihood that premiums will need to be further increased will be reduced significantly.

## Utilization

When LTCI was first introduced, there was little relevant experience on which to base premium calculations. Insurance companies that offered Medigap policies had some data on Medicare nursing home utilization. However, Medicare covers only short post-hospital stays, not long-term care needed as a result of frailty or cognitive impairment. Companies that relied on Medicare data significantly underpriced their policies. Better estimates could be developed using population-wide surveys on the prevalence of frailty and the use of long-term care services. The Society of Actuaries has published analyses of several of these surveys.<sup>21</sup> In general, the utilization rates derived from these studies are actually higher than the experience of insurance companies. This is likely to be due to the differences in the health status and socioeconomic status between insured lives and the general population, as well as the effects of underwriting.

Now that LTCI has been available for some time, there is a growing body of data on actual utilization by policyholders. But the data are still not sufficient to predict the ultimate utilization levels that will be experienced under policies being sold today, for several reasons. Most of the data are from older policies that covered only nursing home care. Little is known about the likely use of the home care benefits that are now included in most policies or of the disability-based cash payments now available from some insurers. Benefit triggers have also been evolving, from the “medical necessary” model to a myriad of different ADL-based standards to the current standardized triggers that conform to HIPAA requirements. Finally, underwriting standards have changed over time.

---

<sup>21</sup>See Society of Actuaries (1992), estimating nursing home utilization on the basis of the 1985 National Nursing Home Survey conducted by the National Center for Health Statistics (NCHS). An analysis of frailty among noninstitutionalized individuals was conducted in conjunction with Society of Actuaries (1995). Finally, Society of Actuaries (1999) studied use of home and community-based services by elderly people without LTCI, using the 1982, 1984, and 1989 National Long Term Care Surveys conducted on a sample of Medicare beneficiaries age 65 and over by the Health Care Financing Administration.

Until companies obtain data on experience over a long period of time on the actual policies being underwritten and sold currently, they will not be certain of the utilization to be expected under LTC policies. Particularly uncertain at this point is the “ultimate” level of care needed. This is because before an applicant is issued a long-term care policy, he is “underwritten” or determined by the company to be in good health. Thus, an insured individual is a much better risk than the average person in the general population. As time passes after the underwriting event, a person’s health will tend to become more like the average. The time between the underwriting event and the return to average health is called the “select” period, which may last for many years. Because long-term care insurance is so new, most of the experience that insurance companies have currently is in the select period. There is little experience on which to base projections of ultimate utilization.

### **Potential variation in premiums**

Insurers selling the same benefit package to comparable individuals may offer very different premium rates. Weiss Ratings, which surveyed 25 insurers, found that price quotations for nearly identical coverage could vary by as much as four to one.<sup>22</sup> As noted earlier, some insurers may deliberately underprice to gain a market advantage, assuming that they can raise prices later on. However, given the very limited experience to date, even insurers that seek to price their products accurately can use very different assumptions about lapse, utilization, and other key factors.

Table 5 illustrates the degree of potential variation, using a range of assumptions that could be justified by an actuary as reasonable and that could be accepted by an insurance regulator.<sup>23</sup> The “optimistic” and “conservative” carrier are each pricing a policy to be sold to 65 year-olds, providing \$100 per day for nursing home or \$50 per day for home care for up to four years, with a 30-day elimination period and a benefit trigger based on any two of a list of six ADLs.

---

<sup>22</sup> <http://www.insure.com/health/ltc/policycosts.html>, accessed Feb. 20, 2002.

<sup>23</sup> Actuaries have to justify their assumptions as being reasonable both individually and in aggregate. It is conceivable that an actuary could use a set of assumptions wherein each individual assumption is judged to be within a range of reasonableness, but the set of assumptions taken in aggregate are unreasonable. This could occur if each individual assumption was on the optimistic (or conservative) side of the range of reasonableness.

**Table 5. Illustration of Premium Variation Using Optimistic and Conservative Pricing Assumptions**

Assumption	Optimistic	Conservative	Increase in premium using conservative assumption
Effect of underwriting	Assume strong effect	Assume weak effect	6%
Ultimate lapse rate	5%	2%	26%
Change in risk profile of policyholders remaining after lapses	No change	Remaining policyholders are higher risk	8%
Utilization by policyholders relative to general population	30% lower	Same as general population	42%
Interest on reserves	7%	5%	11%
Loss ratio	66%	58%	7%
Final premium	\$840	\$2,088	149%

The optimistic insurer assumes that its underwriting process has screened more of the highest-risk applicants. It assumes a higher annual lapse rate and also assumes that the policyholders who continue their coverage will have the same risk profile as those who lapse. The conservative insurer, on the other hand, assumes that people who continue their policies are those who anticipate a greater need for services. The optimistic insurer assumes that policyholders will use fewer services than the general population, and it anticipates a higher return on its reserves than the conservative insurer does. Finally it projects a higher loss ratio; that is, it expects to need only 34 percent of premiums for administration and profit, while the conservative insurer allows 42 percent. When all of these assumptions are put together, the conservative insurer could set a premium nearly two and one-half times as high as the premium offered by the optimistic insurer.

If the optimistic insurer's assumptions on any of these factors prove wrong, it may need to seek rate increases in the future. Moreover, the size of the needed rate increase will be greater the longer the insurer takes to discover its mistake. In the early years of a policy, premiums go to build up reserves that will ultimately be used to pay claims. If the insurer finds, years after selling the coverage, that it has underestimated the needed reserves, it will need to charge

higher rates at that point than it would have charged if it had correctly estimated its future needs at the time of sale. For example, suppose an insurer that sold coverage to 65 year-olds determined, ten years after the initial sale, that its actual claims would be 10 percent higher than assumed in the initial pricing. If this insurer chose to maintain its original loss ratio—as was permitted under the NAIC model in effect before 2000—it would need to raise its premiums, not by 10 percent, but by 37 percent.

## **The New NAIC Model Rules**

When LTCI was first introduced, state insurance departments had no principles for regulating it and tended to treat it as analogous to health insurance. They accepted the likelihood that rates could increase over time, just as they do under health insurance, and rate review focused on assuring that benefits were reasonable in relation to premiums.

Until 2000, NAIC model rules for LTCI pricing specified minimum loss ratios. State regulators have typically required that expected benefit payments under LTCI policies be at least 60 percent of expected premiums. (Similar rules often apply to nongroup health insurance and, under federal law, to Medigap policies.) Under a loss ratio requirement, premiums are examined by regulators only to assure that the premiums are not too high. There is no examination to assure that premiums are not too low; on the contrary, insurers are discouraged from including any margin for error. Moreover, use of a fixed 60 percent loss ratio can create a perverse incentive to allow claim expenses to rise, because the insurer can retain 40 percent of any resulting rate increase for administrative expenses and/or profit (NAIC 2000).

The NAIC Model Law and Regulations drastically changed its approach to the regulation of LTCI in August 2000. Under the new regulations, projected loss ratios are no longer required for approval of initial premiums. The new regulations place a strong responsibility on insurance companies to make initial premiums adequate, rather than relying on experience after policies are sold to make corrections in the premiums. A qualified actuary must now certify that proposed premiums are sufficient to cover anticipated costs under “moderately adverse” experience and are reasonably expected to be sustained over the life of the product with no future premium increases anticipated. The aim is to assure that actuaries will use somewhat conservative assumptions in pricing. Under

prior regulation it was possible to use liberal assumptions that could be changed (through a premium increase) if they did not come true.<sup>24</sup>

The actuary must also certify that he or she has taken into account certain specific factors, including the policy design and coverage provided, the insurance company's current or planned underwriting and claims adjudication process, and the adequacy of reserves. These additional certifications focus on areas that have raised problems in the past, such as failing to adjust experience data from existing policies to account for new benefit offerings; assuming "typical" utilization levels that might not be achieved because of lax underwriting or liberal claims payment policies; or failing to allow a sufficient margin to cover future expense and profit requirements. Finally, the premiums may not be less than the premiums for existing similar policies available from the insurer.

Insurers will still be able to ask for rate increases later on if they can show that their premiums are inadequate. Projected loss ratios, which under the new model are no longer considered in approving the initial rates, will be considered at this point. The insurer will have to show that projected ultimate claims cost will equal the sum of 58 percent of the original premium amount and 85 percent of the increased amount. For example, if an insurer raised an annual premium from \$1,000 to \$1,100, it would have to project claims costs of at least \$665 (0.58 times \$1,000 plus 0.85 times \$100). Less stringent requirements apply for "exceptional" increases, those that are due to a change in laws or regulations or to increased and unexpected utilization that affects the majority of LTC insurers – not just a single insurer requesting a rate change. These rules assure that most of any rate increase will be returned to policyholders in the form of claims payments, rather than retained for expenses or profit.

In addition to requiring that rate increases be justified, the rules spell out actions that will be taken by regulators in response to large or repeated increases:

- If policyholders have experienced cumulative increases beyond a specified threshold, they must be offered three options: (a) to pay the higher premium and continue their current coverage; (b) to continue their current premium rate and accept reduced benefits; or (c) to stop paying premiums and receive a "contingent nonforfeiture benefit," under which they will

---

<sup>24</sup> Some actuaries are concerned that the term "moderately adverse" is hardly self-explanatory and that they will face competing pressures to use conservative assumptions on the one hand and to keep their employers' rates competitive on the other (Munson 2002). The American Academy of Actuaries has provided some guidance on compliance with the new standards through a draft Health Practice Note 2002-1, *Long-Term Care Insurance Compliance with the NAIC LTCI Model Regulation Relating to Rate Stability* (June 2002).

remain covered for the same per diem amount but with a reduced maximum benefit period.<sup>25</sup> Policyholders who drop their policies when the increases first exceed the threshold must be provided this nonforfeiture benefit even if their original policy did not include a nonforfeiture feature. The threshold varies with the age at which the policyholder initially bought the coverage. Someone who bought the policy at age 65 must receive the contingent benefit when cumulative rate increases total 50 percent. Someone who bought the policy at age 40 receives the benefit only if cumulative increases total 150 percent.

- Regulators may determine that a particular block of business has gone into a rate spiral – the situation, described earlier, in which repeated rate increases have led many purchasers to let their policies lapse, leaving a steadily diminishing pool of high-risk policyholders. If this occurs, the company may be required to offer at least one other comparable, currently marketed product without underwriting, and based on the issue age of the insured (not the attained age). In effect, the remaining members of the deteriorating pool are allowed to shift to a broader, more stable pool with better rates.<sup>26</sup>
- If an insurer consistently “low-balls” – repeatedly files inadequate initial rates – it may be prohibited from selling LTCI in the state for 5 years. Or it may be allowed to sell only the existing products that have had recent rate increases and no new products. This prevents the insurer from segregating past purchasers into high-cost pools, while continuing to offer unreasonably low prices to new buyers.

Finally, the rules call for new disclosures to be made to potential purchasers, including a notice that future rate increases are possible, an explanation of the options the policyholder will have in the event of an increase, and information on any rate increases for the same or similar policies during the last ten years. However, if the insurer acquired the business from another company, it need not disclose increases prior to or for 24 months after the acquisition.<sup>27</sup>

From the new regulation, it is clear that the NAIC has taken a proactive approach to preventing rate increases. Again, this should result in higher initial

---

<sup>25</sup> The length of this period depends on how much the policyholder had paid in premiums before letting coverage lapse.

<sup>26</sup> The rule includes provisions that limit the extent to which shifting the poorer risks to a different pool affects rates for the original purchasers in that pool.

<sup>27</sup> The selling company must disclose pre-sale increases to buyers of other similar policies, and the buyer must disclose the whole history of rate increases if it increases rates after 24 months.

premiums, but premiums that are much less likely to increase in the future. As was noted earlier, however, there is still enough uncertainty about rating assumptions that some policies could be seriously underpriced and still pass regulatory review. There are some additional concerns about the new rules.

First, the regulation leaves significant leeway to companies that acquire a block of business from another company. Often, the blocks of business that are the most seriously underpriced are then sold to other carriers. The new NAIC regulations appear to allow an acquiring company to increase premiums for two years after purchase without the normal regulatory scrutiny or consequences. This can lead to a situation where a block of business that is seriously underpriced can have its premiums increased more easily by being sold to another company. Further, in the negotiations for the price of the sale, rate increases can be taken into account. This, of course, leaves the policyholders with the responsibility for covering the mistakes of the original company, not the company itself.

Second, if a company must raise its rates because of underestimates of utilization or other factors, it is allowed to devote part of the increase to administration and profit. Table 6 gives an example in which a company's original premium for a given policy was \$1,000, of which the company initially projected that 60 percent would go for benefits and 40 percent for administration and profit. Under the NAIC formula, the loss ratio on the policy must rise if the insurer requests subsequent increases. Note, however, that if the insurer must double its rates – from \$1,000 to \$2,000 – it is allowed to increase the administrative component from \$400 to \$570, or 43 percent. Higher utilization doubtless entails some higher administrative cost, for eligibility determination, claims processing, or care management. Still, given that the largest element of administrative cost is related to initial promotion and sales, it seems unlikely that an increase of this size is justifiable. An insurer might, then, actually profit from the increase instead of just meeting unexpected costs. It can at least be argued that insurers should be required to justify any part of a rate increase that will not be devoted to additional benefit payments, so that no part of the increase will go to raise the absolute value of the insurer's profit.

**Table 6. Distribution of Benefits and Administrative Load, Original Premium of \$1,000 and Later Increases**

Premium	Benefits	Administration and profit
\$ 1,000	\$ 600	\$ 400
\$ 1,250	\$ 793	\$ 458
\$ 1,500	\$ 1,005	\$ 495
\$ 1,750	\$ 1,218	\$ 533
\$ 2,000	\$ 1,430	\$ 570

Third, the new rules afford no protection to current policyholders. Even in the 14 states that have adopted the revised model so far, the requirements will apply only to policies sold 6 months or more after the rules are adopted in a particular state. This is the usual practice when a state changes its insurance law: the state doesn't interfere with existing contracts. This means that, for millions of holders of existing policies, any rate increases for those policies will be subject to the older NAIC rules, under which an insurer's administrative and profit allowance was allowed to rise in direct proportion to the amount of any rate increase.

Finally, the new rules require much more extensive scrutiny by regulators of initial premium filings and requests for premium increases. A recent study for AARP (Lutzky, Alecxih, and Foreman 2002) has found that many states are not vigorously enforcing even the weaker existing rules. Many states collect insufficient information or use staff who lack sufficient training to evaluate rate filings.

## Conclusions

There has been real progress in addressing some of the most troublesome practices that emerged in the early years of the long-term care insurance market. The NAIC's model language for law and regulations has been highly influential in encouraging states to adopt stronger rules, although there are still states that have not adopted key components of the models. It should also be emphasized that the four study states are ones with reputations for active regulation of LTCI. Other states, even those that have adopted all the components of the NAIC models or have similar rules, may not be vigorously enforcing them.

In the four study states, regulators and advocates concur that some problems, such as post-claims underwriting, have largely disappeared. In other areas, such as inappropriate purchase of coverage by lower-income people or

inappropriate sales of replacement coverage, some problems may persist, but interviewees believed there had been improvement. The percent of complaints involving claims denials may be an indication of some continuing confusion about benefit eligibility standards (see appendix B for complaint data from Florida and Illinois). Regulators note that most of the complaints they receive involve (a) older policies with limited coverage, (b) slow payment, and (c) premium and rate increase issues.

Even in the study states, it may be too early to assess the real strength of consumer protections. Most purchasers of long-term care insurance have not begun to file claims on their policies. Consequently, we do not know the extent to which policyholders or their insurers may face problems when a larger number of claims are filed. And there is reason for concern that states may not be in a position to document patterns of complaints and identify new challenges as they emerge. Not all states even compile complaints in a way that identifies whether a complaint involves long-term care insurance. The study states generally maintain the data submitted by insurers in company-specific files instead of a searchable electronic database. While Florida and Illinois are beginning to compile the information in a usable format, regulators elsewhere noted that a lack of resources diminishes their ability to develop such systems.

Lack of resources may affect the overall effectiveness of LTCI regulation. LTCI is still a tiny part of the total insurance industry, accounting for just 6 billion dollars of over a trillion dollars in premium revenues.<sup>28</sup> It is understandable that it may not be the highest priority for many state insurance departments.

Even if every state adopted and vigorously enforced every part of the NAIC model, there remain some issues that are not fully addressed in the model and that may require renewed attention as the market develops further.

- Consumers still need more assistance in determining whether LTCI is right for them and in choosing from among available plans. Despite state educational efforts, this problem may grow: as LTCI increases in popularity, there has been a corresponding increase in sales by agents and other financial advisors whose knowledge of the product is limited.
- While state laws now require insurers to have a process for policyholders to seek review of an insurer's eligibility decision, they do not give regulators the ability to ensure that those procedures are effective or set out minimum standards for those procedures. Further, some state laws

---

<sup>28</sup> Based on Glickman (2001) and U.S. Census Bureau (2000).

do not ensure that independent providers conduct benefit eligibility assessments.

- State laws do not address whether the policyholder must comply with the insurer's care management plan in order to receive benefits. If insurers begin to use care management as a way of controlling costs, it is possible that regulators may find themselves facing the kinds of disputes that have arisen under managed health insurance plans. While insurers are required to have some internal process for resolving such disputes, there is no requirement for external review or appeal.
- Finally, even under the new NAIC rate-setting rules, purchasers of LTCI still face a real possibility that their premiums may rise substantially in the future. To some extent this is unavoidable. Given the limited experience insurers have to work from, future costs remain unpredictable. Someone – either the insurer or the policyholder – must assume the risk that the insurer's guesses are wrong. As a practical matter, the insurers cannot be expected to shoulder all of the risk themselves; it is unlikely that many would continue to sell LTCI if they could not pass unexpected losses on to the purchasers. Still, there is at least some room for debate over whether the NAIC rules have fairly apportioned the risk among insurers and consumers.

## References

- American Council of Life Insurers (ACLI). 1999. *Long-Term Care Insurance: An Undiscovered Necessity*.
- California Department of Insurance. 2001. *Long-Term Care Insurance Company Rate and History Guide*.
- Glickman, James. 2001. "Special Focus: Third Annual Long Term Care Survey," *Broker World* (July).
- Health Insurance Association of America (HIAA). 2000. *Long-Term Care Insurance in 1997-1998*.
- , 2002. *Long-Term Care Insurance in 1998-1999*.
- LifePlans, Inc. 1999. *A Descriptive Analysis of Patterns of Informal and Formal Caregiving among Privately Insured and Non-Privately Insured Disabled Elders Living in the Community*. Report to the Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy.
- Lutzky, Steven, Lisa Maria B. Alecxih and Ryan Foreman. 2002. *Assessing States' Long-Term Care Insurance Regulatory Capacity*. Washington, AARP.
- Merlis, Mark. 2002. *Private Long-Term Care Insurance: Who Should Buy It and What Should They Buy?* (forthcoming)
- Munson, Bartley L. "Actuarial Certification: A Reason for Pondering," *Long-Term Care* (Newsletter of the Society of Actuaries Long-Term Care Insurance Section), n. 4 (Apr. 2001).
- Society of Actuaries, Long-Term Care Experience Committee. 1992. "1985 National Nursing Home Survey Utilization Data," *Transactions of the Society of Actuaries, 1988-90 Reports*.
- , Long-Term Care Insurance Valuation Methods Task Force. 1995. "Long-Term Care Insurance Valuation Methods." *Transactions of the Society of Actuaries*, v. XLVII.
- , Long-Term Care Experience Committee, Non-Insured Home and Community Experience Subcommittee. 1999. *Non-Insured Home and*

- Community-Based Long-Term Care Incidence and Continuance Tables*, available at [http://www.soa.org/sections/ltc\\_home&community.html](http://www.soa.org/sections/ltc_home&community.html)
- , Long-Term Care Experience Committee. 2000. *Intercompany Study: 1984-1993*, available at [http://www.soa.org/sections/ltc\\_experience.html](http://www.soa.org/sections/ltc_experience.html).
- Spillman, B. and J. Lubitz, "New Estimates of Lifetime Nursing Home Use: Have Patterns of Use Changed?" *Medical care*, v. 40, n. 10 (Oct. 2002).
- Stone, Robyn, et al. 1992. *State Variation in the Regulation of Long-Term Care Insurance Products*. American Association of Retired Persons.
- U.S. Census Bureau. 2000. *Economic Census 1997: Finance and Insurance*.
- U.S. General Accounting Office (GAO). 1991. *Long-Term Care Insurance: Risks to Consumer Should be Reduced*.
- U.S. Internal Revenue Service (IRS). 1997. "Notice 97-31: Long-Term Care Services and Insurance," *IRS Bulletin* (1997-21, May 27).
- U.S. Senate, Special Committee on Aging. 2000. *Long-Term Care Insurance: Protecting Consumers from Hidden Rate Hikes*, testimony by Allen Kanner (Hearing, 106<sup>th</sup> Cong., Sep. 13).



## Appendix A. State Reporting Requirements

**Table 7. Selected State Filing and Reporting Requirements**

	NAIC (2001)	California	Colorado	Florida	Illinois
Claims Denials	Every insurer shall report annually for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied.	Every insurer shall report annually the total number of claims denied for each class of business and the number of these claims denied for failure to meet the waiting period or because of a preexisting condition as of the end of the preceding calendar year. The insurer shall annually report to the department the number of denied claims.	No provision	No provision	NAIC model.
Suitability	A copy of the insurer's suitability standards shall be made available for inspection on request of the commissioner. Insurer shall report annually the total number of applications, those who declined to	NAIC model	NAIC model except the insurer's personal worksheet shall be maintained on file by the insurer for three	NAIC model	NAIC model

	NAIC (2001)	California	Colorado	Florida	Illinois
	provide information on the personal worksheet, who did not meet the suitability standards, who chose to confirm after receiving a suitability letter. A copy of the insurer's personal worksheet shall be filed with the commissioner.		years and made available for inspection on the request of the commissioner.		
Replacement	Every insurer shall maintain records on the amount of each agent's replacement sales. Insurers shall report annually the ten percent of its agents with the greatest percentage of replacements, the total number of replacement policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.	NAIC model	NAIC model	Insurer must maintain in its offices a copy of the notice regarding replacement of long-term care insurance signed by the applicant for at least 3 years or until the end of the next insurance department examination, whichever is later.	NAIC model
Lapses	Every insurer shall maintain records on the amount of lapses of ltc policies sold by each agent as a percent of the agent's total sales. Insurers shall report annually the ten percent of its agents with the greatest percentage of lapses, the total number of lapsed policies as a percent of its total annual sales and as a percent of its total annual number of policies in force as of the end of the preceding calendar year.	NAIC model	NAIC model	No provision, but reviewed during market conduct examinations.	NAIC model except only insurance producers with at least 10 total renewing sales or five new sales in the report period shall be included.

	NAIC (2001)	California	Colorado	Florida	Illinois
Rescissions	Insurers must maintain a record of all rescissions, both state and countywide, and annually furnish this information to the commissioner using the NAIC rescission reporting form.	NAIC model	NAIC model	No provision, but reviewed during market conduct examinations.	NAIC model

Source: Telephone interviews and review of state laws and regulations.

## Appendix B. Complaint Data, Florida and Illinois

**Table 8. Complaints on Long-Term Care/Home Health Care Coverage, Florida  
Department of Insurance, January 1, 2000-December 31, 2000**

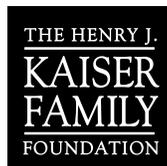
Complaint	Number of Complaints
Premium refund	83
Premium issue	72
Claim denial	53
Claim handling delay	52
Agent handling	37
Misrepresentation	26
Coverage question	25
Information requested	19
CO delays/no response	13
Cancel/nonrenewal other	12
Other unfair trade practices	10
Claim problem not listed	8
Cancel/nonrenewal nonpayment	7
Refusal to insure - other	7
Underwriting issue	7
Advertising/marketing	6
Other	5
Company information	3
Agent information	1
Premium misquote	1
<b>Total complaints</b>	<b>447</b>

Source: Florida Department of Insurance, Consumer Assistance Master File Service Request Summary Report, July 2001.

**Table 9. Long-Term Care Complaints, Illinois Department of Insurance,  
January 1, 2000-December 31, 2000**

<b>Complaints</b>	<b>Number of Complaints</b>
Service	27
Claims	23
Underwriting	20
Marketing/Sales	6
<b>Total Complaints</b>	<b>76</b>

Source: Illinois Department of Insurance, 2000.



**The Henry J. Kaiser Family Foundation**

2400 Sand Hill Road  
Menlo Park, CA 94025  
(650) 854-9400 Fax: (650) 854-4800

**Washington Office:**

1330 G Street NW  
Washington, DC 20005  
(202) 347-5270 Fax: (202) 347-5274

[www.kff.org](http://www.kff.org)

This publication (#6073) is available on the  
Kaiser Family Foundation's website at [www.kff.org](http://www.kff.org)