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Testimony

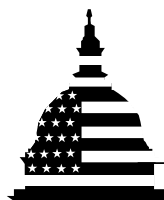
Before the Special Committee on Aging, U.S. Senate

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**LONG-TERM CARE
INSURANCE**

**Better Information Critical
to Prospective Purchasers**

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Health Financing and Public Health Issues
Health, Education, and Human Services Division



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Accountability * Integrity * Reliability

Long-Term Care Insurance: Better Information Critical to Prospective Purchasers

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss the challenges the baby boom generation and society face in planning for and financing its future long-term care needs, and the role that private long-term care insurance may play in meeting those challenges. Long-term care includes an array of health, personal care, and social and supportive services provided in a range of settings including nursing homes, assisted living facilities, and people's own homes. While much care is provided by family members, paying for purchased services presents a significant financial burden for many individuals and for public health care programs. Of the nation's approximately 35 million elderly people aged 65 and older, an estimated 5.2 million—or over one-seventh—have some form of long-term physical or mental disability for which they require assistance, such as help with bathing, dressing, eating, preparing meals, or taking medicines. For those needing nursing home or other extensive continuous care, the costs can be substantial. On average, nursing home care currently costs \$55,000 annually, with many nursing home residents paying much of that out of their own pockets.

Long-term care financing will be an increasing concern as the 76 million baby boomers age and begin, in just over a decade, to turn 65 and become Medicare eligible. Over the next 30 years, the number of elderly individuals is expected to double as the baby boom generation enters its senior years. Similar growth is expected for the number of individuals needing long-term care. With baby boomers living longer and greater numbers reaching age 85 and older, this generation is expected to have a dramatic effect on the number of people needing long-term care services and will challenge these individuals, their families, and public programs to finance and furnish that care.

My remarks today focus on (1) the increased demand the baby boom generation will likely create for long-term care, (2) an overview of current spending for long-term care of the elderly, including recent changes in Medicaid and Medicare financing of long-term care, and (3) the potential role of private long-term care insurance in helping finance this care, including who buys this insurance, its affordability, and the critical need for consumer information and protections. My comments are based on our previous work and other published and ongoing research. A list of related GAO products follows my statement.

In summary, estimates of the magnitude of the baby boomers' future long-term care needs vary, with estimates of the number of disabled elderly when the baby boom generation becomes elderly ranging from 2 to 4 times

the current number. Estimates of cost are even more imprecise due to the uncertain effect of several important factors, including how many will be needing care, the types of care they will need, and the availability of public and private sources to pay for that care. Nonetheless, the confluence of the aging baby boom generation, longer life expectancies, and evolving options for providing and financing long-term care services will require substantial public and private investment in long-term care and the development of sufficient capacity to serve the growing number of disabled elderly.

Spending for long-term care for the elderly, including post-acute and chronic care in nursing homes and home care, is an estimated \$123 billion this year. Medicaid and Medicare will pay for nearly 60 percent of these services, contributing \$43 billion and \$29 billion respectively. Medicaid funds go primarily to nursing homes and other institutional settings of long-term care, but home and community-based services represent a growing share of Medicaid spending and recipients. Medicare primarily covers acute care services, and thus plays a lesser role in financing nursing home care—by paying only for short-term stays following a hospitalization—but has grown to play a significant role in covering long-term care through its home health benefit. Recent federal legislative changes in response to rapid and inexplicable growth in spending for long-term care services in Medicare have already resulted in a reduction in home health spending, but it remains uncertain how much Medicare will be spending for long-term care services in the future. In part, this is because the new Medicare prospective payment system provides incentives to control home health services, but it also is based on an increased number of visits per user than currently provided, thereby making funding available for a large expansion of home health services. Public programs pay for the majority of long-term care expenditures, but out-of-pocket costs paid by individuals and their families are substantial, representing 30 percent of total long-term care expenditures (\$43 billion in 2000). These amounts, however, do not include many hidden costs of long-term care because nearly 60 percent of the disabled elderly living in the community rely exclusively on their families as caregivers and other unpaid sources for their care.

Private long-term care insurance has been viewed as a possible means of reducing catastrophic financial risk for the elderly needing long-term care and of relieving some of the financing burden currently falling on public long-term care programs. Given concerns about the long-term financial solvency of the Medicare program, the additional financial stress created by the forthcoming eligibility of the baby boom generation, and the potential costs of proposed new benefits for prescription drugs,

congressional interest in stimulating long-term care financing through private means has grown. Several recent congressional initiatives, including establishing a program to make group long-term care insurance available to federal employees and proposals to provide tax subsidies to individuals purchasing long-term care insurance, aim to expand the role of private long-term care insurance. Yet private long-term care insurance represents a small fraction of long-term spending—about \$5 billion. Less than 10 percent of the elderly and an even lower percentage of near-elderly individuals have purchased long-term care insurance, although these numbers are increasing. Questions remain about the affordability of policies and the value of the coverage relative to the premiums charged. If long-term care insurance is to have a more significant role in addressing the baby boom generation's upcoming chronic health care needs, the policies offered must be viewed by consumers as good, affordable products that are easily understandable. To that end, the National Association of Insurance Commissioners has recently strengthened its model regulation for long-term care insurance, including recommending that states enact laws requiring additional disclosure to consumers about the potential for future policy rate increases and better ensuring that long-term care insurers accurately price their policy premiums.

Background

Long-term care includes many types of chronic care services needed because of physical or mental disability. Individuals needing long-term care have difficulty performing some functions involved in normal daily living, such as bathing, dressing, toileting, eating, and moving from one location to another without assistance. They may also have mental impairments, such as Alzheimer's disease, which may require supervision and assistance with tasks such as taking medications. Although a chronic physical or mental disability may occur at any age, the older an individual becomes, the more likely a disabling condition will develop or worsen. Nearly one-seventh of the nation's current elderly population—an estimated 5.2 million—have a limitation in either activities of daily living (ADL), instrumental activities of daily living (IADL), or both. More than one-third of these have limitations in 2 or more ADLs.

Long-term care for the elderly has often been misunderstood to mean only institutional care provided by nursing homes for individuals with chronic care needs, but it is more than that. Nearly 80 percent of the elderly requiring assistance with ADLs or IADLs live at home or in community-based settings, while more than 20 percent live in nursing homes or other institutions. The majority of long-term care is provided by unpaid family caregivers to elderly individuals living either in their own homes or with their families. However, a growing minority receives paid assistance from

various sources. For example, Medicare pays for home care for a small percentage of beneficiaries who received home health services for longer-term care. In addition alternatives to nursing home care, such as assisted living arrangements, are developing. An estimated 1 million individuals live in residential settings, such as assisted living facilities, that have long-term care services available. As the baby boom demand for long-term care grows, so must the capacity for providing long-term care in individuals' homes and other appropriate settings.

The Baby Boom Generation Will Greatly Expand Demand For Long- Term Care

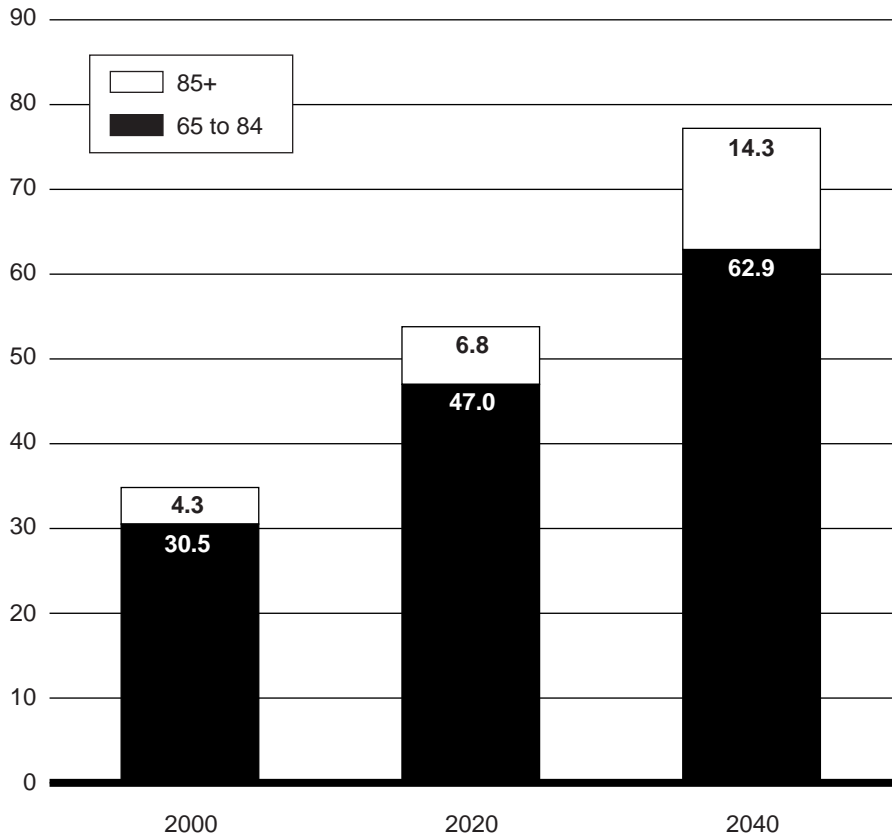
The baby boom generation, about 76 million people born between 1946 and 1964, will contribute significantly to the growth in the number of elderly individuals who need long-term care and the increased amount of resources required to pay for it. The oldest baby boomers are currently in their fifties. In 2011, the first of the baby boomers born in 1946 will turn 65 years old and become eligible for Medicare. The Medicaid program, which pays for many health care services for low-income elderly, including nursing home care, will also begin to feel their impact. The effect on long-term care demand is expected to grow even more after 2030 when the first baby boomers reach 85 years of age, the age at which the need for long-term care services is greatest.

Today's elderly comprise 12.7 percent of our nation's total population. That percentage will increase by nearly one-third to 16.5 percent in 2020. At that time, one in six Americans will be 65 years old or older and will represent nearly 20 million more seniors than today. By 2040, the number of seniors aged 85 years and older, the age group most likely to require long-term care, will more than triple to 14 million (see fig. 1).

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Figure 1: Estimated Number of Elderly Individuals in 2000, 2020, and 2040

In Millions



Source: U.S. Census Bureau, "Projections of the Total Resident Population by 5-Year Age Groups and Sex With Special Age Categories: Middle Series," selected years 2000 to 2040, January 2000.

Besides their numbers, the extended life spans of the baby boom generation will have an impact on long-term care. Life expectancy has grown over the last decades, increasing more than 6 years since 1965 when life expectancy at birth was 70.2 years to 76.5 years in 1997. With aging individuals who reach 65 today expected, on average, to live to 80.9 years for males and 84.2 years for females, many baby boomers can expect to survive well into their eighties. The increasing proportion of baby boomers who will live to 85 and beyond will be most likely to need long-term care services.

Estimating the exact number of baby boomers who will need long-term care services is complicated by several factors. While experts agree that

population aging will increase the number of disabled elderly needing long-term care over the next several decades, no consensus exists on the size of that increase. Long-range estimates of the magnitude of the baby boomers' long-term care needs vary with estimates of the number of disabled elderly ranging from 2 to 4 times the current number. Conclusions differ concerning the effects of better health care and healthier lifestyles on the baby boomers' need for long-term care. Some researchers contend that medical advances have increased life expectancy but have not changed the age at onset of illness and therefore the need for long-term care may have increased. Others contend that better treatment and prevention could decrease the number of years long-term care is needed. How these factors will translate into the need for long-term care services and actual spending also will depend on the types of care used and the public and private resources devoted to purchasing long-term care.

Baby boomers in general are expected to be wealthier in retirement than their parents. Those who are single, have less education, or do not own homes, however, may not do as well. While many baby boomers will have greater financial resources, they will have fewer social resources because a smaller proportion of this generation will have a spouse or adult children to provide unpaid caregiving. The geographic dispersion of families and the large percentage of women who work outside the home also may reduce the number of unpaid caregivers available to elderly baby boomers, thus creating greater need for purchased long-term care services.

For women of the baby boom generation, long-term care needs are an especially significant concern. More than 7 out of 10 unpaid caregivers are currently women, three-quarters of nursing home residents 65 years and older are female, and two-thirds of home health care users are female. Given their longer life expectancies and the fact that married women usually outlive their spouses, many women face a higher risk of needing long-term care and not having a spouse to serve as a caregiver.

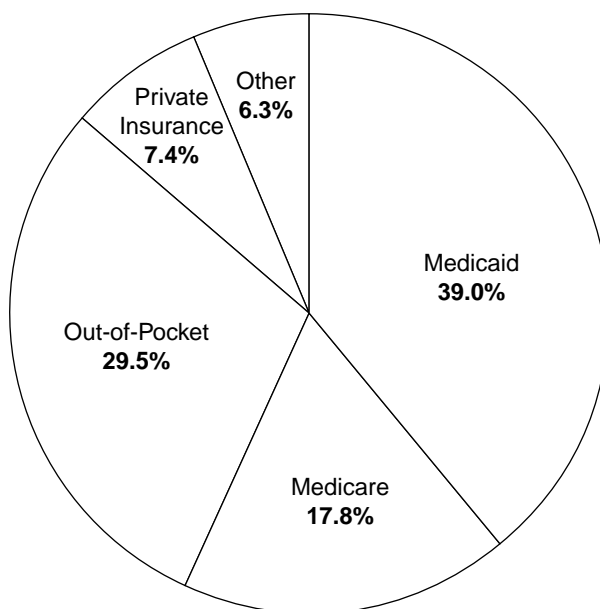
Long-Term Care Expenditures Estimated to Double in 25 Years

Over the next 40 years, between 2000 and 2040, the Congressional Budget Office estimates that long-term care expenditures for the elderly, adjusted for inflation, will grow annually by 2.6 percent. In 1998, long-term care spending for nursing home and home health care was estimated at more than \$117 billion. Individuals needing care and their families paid for almost 30 percent of these total expenditures out-of-pocket, Medicaid and Medicare funded 57 percent, private health insurance accounted for about 7 percent, and other sources paid the remaining 6 percent (see figure 2). These amounts, however, do not include the many hidden costs of long-

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term care, because an estimated 60 percent of the disabled elderly living in their community rely exclusively on their families as caregivers and other unpaid sources for their care. CBO estimates \$123 billion in total long-term care spending for the elderly in calendar year 2000, projecting that these expenditures will reach \$207 billion in 2020 and \$346 billion in 2040. Based on these projections, long-term care expenditures would roughly double in 25 years.

Figure 2: Elderly Long-Term Care Expenditures, by Source of Payment, 1998



Source: Office of the Actuary, National Health Statistics Group, Personal Health Care Expenditures, HCFA, Department of Health and Human Services, 2000.

Medicaid

Medicaid, a joint federal-state health financing program for low-income individuals, continues to be the largest public funding source for long-term care. Within broad federal guidelines, states design and administer Medicaid programs that include coverage for certain mandatory services, such as skilled nursing facility care, and other optional coverages, such as home and community-based services. Although most Medicaid long-term care expenditures are for nursing home care, in the last two decades there has been a shift to more home and community-based care. The result is a significant change in the proportion of people with the need for long-term care that are receiving Medicaid-financed services and in the average costs

of those services. By fiscal year 1998, the number of Medicaid recipients receiving home health or home and community-based services was similar to the number of Medicaid recipients receiving nursing facility services.

State Medicaid programs have, by default, become the major form of insurance for long-term care, but only after individuals have become nearly impoverished by “spending down” their assets. Medicaid eligibility for many elderly results from having become poor as the result of depleting assets to pay for nursing home care, the average price of which is \$55,000 per year. In most states, nursing home residents without a spouse must have less than \$2,000 in countable assets to become eligible for Medicaid coverage. About two-thirds of nursing home residents in 1998 relied on Medicaid to help pay for their care, and just over half (58 percent) of Medicaid expenditures for long-term care were for institutional care in nursing homes.²

States historically limited coverage of in-home services under Medicaid due to concern about the potential cost of covering services for the large number of disabled who were being cared for by their families. However, as part of the Omnibus Budget Reconciliation Act of 1981, the Congress established the home and community-based service waiver program. The waiver program gave states the option of applying for Medicaid waivers to fund home and community-based services for people who met Medicaid eligibility requirements for nursing home care. These waivers also gave states the ability to restrict the number and costs of eligible individuals to be served under Medicaid in home and community-based settings. All states now have home and community-based waivers, and more than 200 waiver programs served more than 450,000 individuals nationwide in fiscal year 1998. Medicaid expenditures for home and community-based waivers have increased an average of 25 percent per year from 1993 to 1999, reaching a level of \$10.5 billion in 1999.

Medicare

During the 1990s, costs for both skilled nursing facility services and home health care became the fastest growing components of Medicare spending,

¹The MetLife Mature Market Institute survey also found that nursing home costs vary widely by region of the country, from nearly \$33,000 per year in Hibbing, Minnesota to more than \$100,000 per year in Manhattan.

²An additional 17 percent of Medicaid long-term care expenditures were for intermediate care facilities for people with mental retardation, with the remaining quarter of Medicaid long-term care expenditures for noninstitutional care provided through home health, personal care services, and home and community-based service waivers.

although changes introduced by the Balanced Budget Act of 1997 (BBA) have significantly altered this situation. In contrast to Medicaid, which is estimated to pay about 46 percent of total nursing home and other institutional care expenditures in 2000, Medicare plays a relatively small role, paying only about 12 percent of total nursing home and other institutional care expenditures. Medicare primarily covers acute health care costs, and therefore limits its nursing home coverage to short-term, post-acute stays of up to 100 days per spell of illness following hospitalization. Medicare nursing home spending increased from \$1.7 billion in 1990 to \$10.4 billion in 1998.

Since 1989, Medicare became a significant funding source of home care, financing \$10.4 billion in care—or more than one-third of the home care purchased for the elderly—in 1998. Court decisions and legislative changes in coverage guidelines essentially transformed the Medicare home health benefit from one focused on patients needing acute, short-term care after hospitalization to one that also served chronic, long-term care patients. By 1994, only about one-fourth of home health visits covered by Medicare occurred within 60 days following a hospitalization. As a result, Medicare, on a de facto basis, has financed an increasing amount of long-term care through its home health care benefit. Both the number of beneficiaries receiving home health care and the number of visits per user more than doubled from 1989 to 1996. From 1990 to 1997, the average annual growth rate for Medicare home health care spending was 25.2 percent—more than 3 times the growth rate for Medicare spending as a whole. The increase in the use of these services cannot be explained by any increase in the incidence of illness among Medicare beneficiaries.

In response to concerns about the growth in spending for Medicare services, including skilled nursing facility and home health services, Congress enacted the BBA which included provisions to slow growth. The Act required prospective payment systems to be implemented for Medicare services provided through home health care agencies and skilled nursing facilities, replacing the retrospective, cost-based reimbursement that did not provide adequate incentives to control costs. The skilled nursing facility prospective payment system began to be implemented in July 1998 and will be completely phased in by 2001. Even though nursing home use has continued to increase during the phase-in of the new payment system, a temporary increase in Medicare payments to nursing homes caring for certain high-cost patients, pending the inclusion of a refined case-mix adjustment for payments to nursing homes, was enacted in response to complaints from the industry that payments were inadequate.

For home health, rather than immediately introducing a prospective payment system, an interim home health care payment system was implemented in October 1997, pending development of a case-mix adjusted prospective payment system. Between 1997 and 1998, Medicare home health spending fell by nearly 15 percent, while home health visits dropped sharply by 40 percent, and this decline continued in 1999.³ The home health prospective payment system (PPS), scheduled to be in place by October 1 of this year, is expected to be a more appropriate payment tool than the interim payment system because it is designed to more closely align payments with patient needs.⁴ The PPS rates are based on a higher number of home health visits per user than those currently being provided. As a result, the new payment system can support a large expansion of services. However, PPS incentives are intended to reward efficiency and control use of services. Because criteria for what constitutes appropriate home health care do not exist, it may be difficult for Medicare to ensure that patients receive all necessary services. How home health agencies respond to the PPS and its incentives could have major implications for the amount of future Medicare funding for home health care and the services provided.

Private Long-Term Care Insurance Represents A Very Small But Growing Share of Long-Term Care Expenditures

While many baby boomers will have more financial resources in retirement than their parents and may be better able to absorb some long-term care costs, long-term care will represent a catastrophic cost for a relatively small portion of families. This type of situation can be ideal for a private insurance program because it spreads risk among many individuals. Private long-term care insurance has been viewed as a means of both reducing potential catastrophic financial risk for the elderly needing long-term care and relieving some of the financing burden currently falling on public long-term care programs. Some observers also believe private long-term care insurance could provide individuals greater choice in selecting services to satisfy their long-term needs. However, less than 10 percent of elderly individuals and even fewer near-elderly individuals have purchased long-term care insurance to protect against the financial risks of the potential high costs of future care. The National Association of Insurance Commissioners reported that in 1998 approximately 4.1 million persons were insured through long-term care

³See *Medicare Home Health Care: Prospective Payment System Could Reverse Recent Declines in Spending* (GAO/HEHS-00-176, Sept. 8, 2000).

⁴See *Medicare: Refinements Should Continue to Improve Appropriateness of Provider Payments* (GAO/T-HEHS-00-160, July 19, 2000).

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insurance policies, compared with 1.7 million persons in 1992.⁵ In contrast, about two-thirds of the elderly—about 23 million individuals—have private Medicare supplemental insurance policies to cover other non-Medicare covered expenses such as copayments, deductibles, and prescription drug costs.

Private long-term care insurance is still a little known product with insurance providers seeking to build a larger market. Barriers to purchasing long-term care policies still exist. Many baby boomers continue to believe they will never need such coverage. A recent survey of the elderly and near elderly found that only about 40 percent believe that they or their family will be responsible for paying for their long-term care. Some mistakenly believe that public programs, including Medicaid and Medicare, or their own health care insurance will provide comprehensive coverage for the services they need. This lack of awareness decreases people's perceived need for protection, thus decreasing demand for long-term care insurance. Others may be concerned about whether they can afford such insurance now or in the future when their premiums may increase and their retirement incomes may have decreased.

Some employers offer their employees a voluntary group policy option for long-term care insurance, but this market remains small and is offered predominantly by large employers. Usually employers do not pay for any of the costs of these policies, but group policies have lower administrative costs than individually-purchased policies which can result in lower premiums for those employees choosing to purchase a policy. The American Council of Life Insurance reported in 1998 that only 29 percent of long-term care insurance policies in force were group policies. Studies estimate that 6 to 9 percent of eligible active employees took advantage of employer-provided group long-term care insurance where it was available. The House and Senate have recently passed legislation that would offer group long-term care insurance to federal employees and retirees beginning by fiscal year 2003, an initiative that, if enacted, would likely establish the largest group offering of long-term care insurance and could significantly expand this market.⁶

⁵The accuracy of these policy numbers is dependent upon the accuracy of the information filed by the insurers themselves with the National Association of Insurance Commissioners.

⁶The House and Senate passed the Long-Term Care Security Act, H.R. 4040 and S. 2420, on July 27, 2000. The legislation awaits further action.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) extended tax deductibility of some premiums and tax exemptions for certain benefits to qualified long-term care insurance policies. Qualified policies have to satisfy certain requirements including consumer protection standards.⁷ The consumer protection standards are deemed satisfied if a policy complies with the National Association of Insurance Commissioners' (NAIC) Long-Term Care Model Act. As of July 1998, the Health Insurance Association of America reported that all 50 states (which have primary responsibility for regulating insurance policies) required policies adhere to at least 3 NAIC long-term care insurance standards. These three standards require policies to not require prior institutionalization as a condition for coverage, to have an outline of coverage provided by the policy, and to be guaranteed to be renewable and non-cancelable. In addition, all but one state adheres to the NAIC definition of long-term care insurance (policies providing coverage for at least 12 months for necessary services provided in settings other than acute care hospital units), and all but two states adhere to the pre-existing conditions standard. Overall, 14 of the 19 HIPAA long-term care insurance standards had been adopted by at least 35 states as of July 1998.

Long-Term Care Insurance Affordability of Concern to Many Elderly Individuals

Questions exist about the affordability of policies for many elderly and near-elderly, and the value of the coverage relative to the premiums charged. The affordability of long-term care insurance has a large effect on its marketability, and is a key factor in individuals' decisions to purchase and retain a long-term care insurance policy. Although assessing whether individuals can afford a policy is a subjective judgement, some studies estimate that long-term care insurance is affordable for only 10 to 20 percent of elderly individuals. Affordability is even more difficult for married couples who must each purchase coverage. While some insurers offer discounts to married couples when both purchase long-term care coverage, elderly couples are likely to pay at least several thousand dollars annually for long-term care coverage. Individuals who consider and then

⁷A qualified long-term care insurance plan is defined as a contract that covers only long-term care services; does not pay for services covered under Medicare; is guaranteed to be renewable; does not provide for a cash surrender value or other money that can be paid, assigned, or pledged as collateral for a loan, or borrowed; applies all refunds of premiums and all policy holder dividends or similar amounts as a reduction in future premiums or to increase future benefits; and meets certain consumer protection standards. Also, payments received from a qualified plan are considered medical expenses and are excluded from gross income for determining income taxes. Per diem policies that pay on the basis of disability rather than reimbursing for services used are subject to a cap of \$180 per day per person in 1998. Out-of-pocket expenses for long-term care are allowed as itemized deductions along with other medical expenses, if they exceed 7.5 percent of adjusted gross income.

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decide against purchasing long-term care insurance cite skepticism about whether private policies will provide adequate coverage. Those who do find long-term care insurance affordable may later decide it is not affordable because their financial circumstances have changed or the premiums have increased. An industry group estimates that only 55 to 65 percent of all long-term care insurance policies sold as of June 1998 remain in force.

Insurers try to convince individuals that it is prudent to decide to buy long-term care insurance early in life rather than later because policy premiums are based largely on an individual's age when the policy is purchased. A policy purchased when a person is in his or her 40s or 50s has much lower premiums than a policy purchased later in one's life; however, those premiums will be paid over a longer period. A person purchasing a long-term care policy with inflation protection at age 65 may pay premiums as high as \$2,000 annually for the policy. If an individual waits until age 79 to purchase a policy, the premiums are typically about 2.5 times higher than if the same policy had been purchased when the individual was 65 years, and about six to ten times higher than if the policy was purchased at age 50.

The unfamiliarity and uncertain value of long-term care insurance may deter some individuals from purchasing a policy. A low premium at age 45 may seem high for a risk that may not be realized for 40 years. Individuals need to determine if they can afford the long-term care policy premium both now and in the future when their retirement income may be lower and their policy premiums may have increased. Concerns about premiums relative to the value of policies may be a factor, especially when premiums for a similar policy for the same individual can vary widely. For example, a 65-year-old in Wisconsin could pay \$857 to \$2061 per year for a long-term care insurance policy from different carriers with similar terms.⁸

⁸Annual premiums for individual basic long-term care insurance policies marketed in Wisconsin with \$100 per day nursing home benefit, \$50 per day home health benefit, lifetime benefits, a 90 or 100-day elimination period, and no optional benefits as of October 1999.

**Consumer Information and
Protection Is Necessary,
Especially If Private
Insurance Is to Assume a
Larger Role in Financing
Long-Term Care**

While consumers deserve complete and accurate information about any insurance product they purchase, sales of long-term care policies are not likely to increase significantly unless consumers have adequate and understandable information to assess them. If long-term care insurance is to have a role in addressing the baby boom generation's upcoming long-term care needs, individuals need to be able to understand clearly what they are buying at the time of purchase and what changes, if any, they may face in their policy's coverage or premiums in the future. We have previously reported on a number of problems in the long-term care insurance market, including those related to disclosure standards, inflation protection options, clear and uniform definitions of services, eligibility criteria, grievance procedures, nonforfeiture of benefits, options for upgrading coverage, and sales commission structures that potentially create incentives for marketing abuses.⁹

Long-term care insurance policies are not standardized by law as are Medicare supplemental (Medigap) policies, making comparisons among different policies difficult. Although long-term care policies provide many options for individuals to choose among to create a policy to meet their perceived needs and financial situation, these choices can complicate the purchasing decision. If people do not fully understand their options, they may not make the best choices. Further, for some prospective purchasers, the cost of some options, such as inflation protection, can compromise the affordability of the policy.

Several checklists exist to help individuals considering a policy purchase determine the options they should buy to create a policy that best fits their needs. However, the specific policy information required to make these reasoned decisions may not be readily available, and the decisions themselves may be too daunting. Among the questions an individual should try to answer when purchasing a long-term care insurance policy are:

- What is the probability that long-term care services will be needed in the future and for how long will they be needed?
- How much coverage can the individual afford, will the premium remain affordable over time, and will the coverage provide sufficient services?

⁹*Health Care Reform: Supplemental and Long-Term Care Insurance* (GAO/T-HRD-94-58, Nov. 9, 1993).

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- Should the policy cover only nursing home care, or also home care, or other alternatives such as assisted living?
- Should the individual purchase a less expensive policy that has a waiting period before the policy begins paying for services received?
- What level of coverage for specific services should be purchased? For example, what per day amount (such as \$100 or \$130 per nursing home day) should be stipulated for nursing home care? For home health, what per month or per visit amount is adequate? Should total coverage be provided for 3 years, 5 years or for lifetime coverage?
- Should inflation protection be purchased (for an additional 25 to 40 percent of the premium) to preserve more of the policy's future value?
- Should optional nonforfeiture protection be purchased (for an additional 10 to 100 percent of the premium) to allow the purchaser to retain some coverage if he or she stops making premium payments?

Particularly important for many consumers is a clear understanding of the current price of the policy and whether that price is subject to future increases. This concern was highlighted by a recent class action lawsuit involving long-term care policyholders in North Dakota, which was brought against two insurers who sold individual, guaranteed renewable, level premium policies. To the policyholders, level premium policies meant that the amount of their premiums at the time of purchase would remain at the same level. They believed that the premiums would not increase as long as they held their policies, which they were guaranteed could be annually renewed. To the insurers, level premiums meant an individual's policy premiums would not be increased unless the entire class holding the same type of policy had a premium increase. After the insurers stopped selling these policies to new purchasers in 1990, premiums for existing policyholders began increasing—for some by more than 700 percent. For example, one female policyholder's annual policy premium at purchase was \$829.86 and increased to \$6,638.42. As a result, some policyholders were unable to afford the increases and were forced to drop their policies at a time when their age made buying another policy very expensive. Others at high risk of needing coverage had to continue paying very high premiums to maintain their policies. The class action suit contended that the insurers did not explain to purchasers that a level premium policy could result in premium increases for an entire class of policyholders and did not appropriately determine the initial premium rate for the policy. In 1999, the class action in North Dakota was settled along with class actions in several other states for monetary payments to former

policyholders, premium rate reductions for those still holding policies, and agreement by two insurers to have no future rate increases for these policies.

In August, the National Association of Insurance Commissioners amended its Long-Term Care Insurance Model regulation to strengthen consumer disclosure to address problems such as those highlighted by the class action suit. In states that adopt the Model regulation amendments as part of their insurance regulations, insurers will have to provide written information to prospective purchasers explaining

- that a policy's premium may increase in the future,
- why premium increases may occur,
- what options a policyholder has in the event of an increase, and
- what the 10-year rate history for their policies has been.

Consumers will also have to specifically acknowledge that they understand their policy's premiums may increase, and insurers must explain any contingent benefit available to policyholders who let the policy lapse due to a substantial rate increase. Additionally, the NAIC adopted amendments to better ensure that long-term care insurers accurately price their policy premiums to be sufficient over the lifetime of the policy, so as to minimize the need for future premium increases. As a further consumer protection, these amendments require insurers to reimburse policyholders when any rate increase is found to be unnecessary and allow state insurance commissioners to ban insurers from the long-term care market if they have a pattern of offering initial policy purchasers inadequate premium rates.

Concluding Observations

In conclusion, the aging of the baby boomers will lead to a very large increase in this nation's elderly population in the next 3 decades, and an even greater increase in the number of individuals aged 85 and over who are likely to need long-term care services. Recent Congressional proposals, including the passage of legislation that would authorize a new federal employees' long-term care insurance offering and proposed tax subsidies for the purchase of private long-term care insurance, aim to increase the role private insurance plays in financing long-term care. Increased consumer information about and confidence in long-term care insurance and the availability of affordable, reliable products are also

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crucial components of private insurance if it is expected to play a larger role in financing future generations' long-term care needs.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you or Members of the Committee might have at this time.

**GAO Contacts and
Acknowledgments**

For more information regarding this testimony, please contact William J. Scanlon or Kathryn G. Allen at (202) 512-7114. John Dicken and Opal Winebrenner also made key contributions to this statement.

Related GAO Products

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Medicare: Refinements Should Continue to Improve Appropriateness of Provider Payments (GAO/T-HEHS-00-160, July 19, 2000).

Low-Income Medicare Beneficiaries: Further Outreach and Administration Could Increase Enrollment (GAO/HEHS-99-61, April 9, 1999).

Long-Term Care: Baby Boom Generation Presents Financing Challenges (GAO/T-HEHS-98-107, March 9, 1998).

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