

**Summary of the Testimony of  
Sean Dilweg, Wisconsin Commissioner of Insurance  
On Behalf of  
The National Association of Insurance Commissioners  
Before the House Energy and Commerce Committee  
Subcommittee on Oversight and Investigations  
July 24, 2008**

Since its entry into the marketplace in the 1980s, long-term care insurance has proved to be a challenging product to regulate. Because 15 to 20 years often elapse between the purchase of a policy and the onset of claims and the cost, nature, and delivery of long-term care services are constantly evolving, it has been a challenge for state regulators to ensure that policies are priced appropriately and that the benefits remain meaningful over the life of the policy.

Over the years, state regulators have been working hard to ensure that a viable long-term care insurance market exists in their respective states, with regulations for premium stability, benefits that are paid according to the insurance contract in a timely and accurate manner and sales that inform the consumer about the product and are suitable. As problems arise, we have taken steps to correct them and prevent them from occurring in the future. We are hopeful that recent changes to the NAIC models giving policyholders the opportunity to add coverage for new services and providers as they become available will result in the flexibility that will allow long-term care insurance to adapt to changes in long-term care services and the settings in which they are provided. Similarly, we believe that the changes made to the loss ratio, rate stability and disclosure standards have helped stabilize future premiums, though several years of experience under this structure will be required before we know whether further adjustments will be required. As additional challenges arise, we will continue to work to ensure that consumers are protected and that the market functions well.

One step that Congress could take would be to work with the NAIC to update the standards for tax qualified long-term policies and incorporate some of the latest consumer protections in the NAIC models, including contingent nonforfeiture benefits, policy disclosures, producer training requirements, and the mandatory offering of coverage of new services and providers. We would also encourage the Department of Health and Human Services to work with the NAIC in determining whether recent changes to the NAIC models are appropriate, under the DRA, to incorporate for qualified partnership policies. For example, the NAIC is working on independent external review standards for long-term care insurance and would encourage HHS, once they are adopted by the NAIC, to include this consumer protection for partnership policies.

Because the long-term care insurance market continues to change, state regulators, individually and through the NAIC, have made and will continue to make periodic adjustments to the model act and regulation, as we have done for many years. To ensure that future changes are incorporated in federal standards, Congress might consider allowing the relevant executive branch agency to update them in consultation with the NAIC, as it did for partnership plans in the DRA.

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**July 24, 2008**  
**10:00 AM**

Good morning Chairman Stupak, Ranking Member Shimkus, and members of the Committee. Thank you for the opportunity to testify this morning concerning the regulation of long-term care insurance. My name is Sean Dilweg, and I am the Insurance Commissioner for the State of Wisconsin and the Chair of the National Association of Insurance Commissioners' (NAIC) Senior Issues Task Force. I am testifying this morning on behalf of the NAIC, which represents the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories. The primary objective of insurance regulators is to protect consumers of all lines of insurance, including long-term care insurance, and to ensure that insurance markets function appropriately and efficiently.

I would like to begin by thanking you for holding this hearing on a very important topic. As our population ages, more and more Americans will be confronted by the need for long-term care services and the financial burden of paying for that care. Already, long-term care services account for over half of all Medicaid spending in the United States,

adding to the strain of health care costs on state budgets. Long-term care insurance is one way to finance these costs, providing individuals with protection against the financial burdens associated with the need for long-term care services.

However, it has proven to be a very challenging product to regulate. In this testimony, I will briefly discuss the long-term care marketplace, the types of policies available, as well as the difficulties that regulators have encountered and the steps that have been taken to overcome them. Finally, I will discuss current and future activities dealing with long-term care insurance at the NAIC, as well as federal involvement in the marketplace.

For those who have accumulated savings over their lifetime, long-term care insurance can be an important tool to protect their assets in the event that they enter a nursing home or assisted living facility, or receive long-term care services in another setting. This year, the average annual cost of nursing home care is nearly \$76,500, while assisted living facilities cost, on average, about \$36,100 per year<sup>1</sup>, amounts that could quickly deplete even a sizeable retirement nest-egg. People pay for this care in a variety of ways. Some choose to set aside a portion of their savings to finance long-term care, while others, who have fewer assets, will rely upon the Medicaid program for their long-term care needs. For others, long-term care insurance may be the best way to finance this care.

Those who elect to purchase long-term care insurance pay a premium to mitigate the risk of incurring long-term care expenses, which may not occur until well into the future.

Long-term care insurance policies provide protection, up to the limits of the policies, against the financial burdens of long-term care, thus protecting the assets that have been accumulated by consumers. With long-term care insurance, policyholders usually have

greater flexibility in choosing the source of their care than they would if they were relying upon the Medicaid program.

Long-term care insurance could also be an important product from the perspective of state and federal Medicaid budgets. Approximately 40 percent of all long-term care and 50 percent of all nursing home care is financed by state and federal governments through Medicaid.<sup>2</sup> Additionally, demographic trends are likely to increase the expenditures of long-term care services to governments, at the same time that the percentage of Americans who are of working age and paying taxes to support Medicare and Medicaid decreases. To the extent that long-term care insurance is able to help people avoid spending down their assets in order to receive care through Medicaid, long-term care insurance may be helpful to state and federal Medicaid budgets.

### **The Long-Term Care Insurance Market**

Though long-term care insurance, in its current form, has been available since the 1980s, it is still a relatively new product. The first long-term care policies, issued in 1965, were designed to supplement the limited benefits provided by the new Medicare program for skilled nursing facility care. These early long-term care policies functioned much like Medicare supplement policies, covering deductibles and coinsurance associated with care in a skilled nursing facility that was covered by Medicare. For this reason, they, like Medicare, required that the policyholder spend at least three days in the hospital prior to their admission to the skilled nursing facility and required that care in the facility be “medically necessary.”

By the 1980s, long-term care insurance had evolved into a product that stood on its own. It still generally covered only nursing home care, but it no longer was designed to wrap around Medicare's skilled nursing facility coverage. It covered nursing home admissions even if they were not immediately preceded by a hospital stay, as required under Medicare. The benefit triggers were redefined from a medical necessity trigger to the policyholder's inability to perform defined activities of daily living (ADLs) and cognitive impairment.

Since that time, the product has further evolved by adding more comprehensive coverage for additional types of long-term care services, such as home health care, respite care, hospice care, personal care in the home, and services provided in assisted living facilities, adult day care centers and other community facilities. Furthermore, in addition to individually purchased policies, group long-term care insurance policies began to make up a significant and growing portion of the market.

As the long-term care insurance product has developed, so have the states' long-term care insurance regulatory programs. States enacted additional consumer protections designed to keep up with changes in policy design and pricing and address the problems encountered in the market place by consumers.

Though long-term care insurance has not been a major player in funding today's long-term care expenditures, financing less than 10 percent of long-term care services in the United States, it has been growing steadily in recent years. In the past ten years, the market has grown from one that covered less than 3 million lives to one that now covers more than 7 million. In terms of premium volume, the market has grown from a \$16

billion marketplace to one in which consumers paid over \$110 billion in premiums in 2007.<sup>3</sup>

One factor in the growth of long-term care insurance has been the growth in sales of group long-term care policies offered as employment benefits. Group policies have grown from a small portion of the market to approximately 20 percent in 2006 and continue to grow faster than individual plans. One advantage of group coverage is that enrollees may not be required to meet medical underwriting requirements in order to purchase coverage, or the medical screening criteria may be more relaxed than in an individual long-term care insurance policy. Generally, group coverage may either be continued after an individual's employment ends, or the policy may be converted into an individual long-term care policy, though benefits and premiums may change.

In 2002, the federal government began offering long-term care insurance to its employees through the Federal Long-Term Care Insurance Program. As of September 2006, approximately 214,000 federal employees and their families had enrolled in the program, making the federal government the largest group sponsor of long-term care insurance in the country.

Another factor in the growth of long-term care insurance has been the deductibility of all or part of the premiums of tax-qualified long-term care policies. The Health Insurance Portability and Accountability Act (HIPAA) includes standards for qualified long-term care insurance policies, which must meet a number of consumer protection standards drawn from the NAIC's Long-Term Care Insurance Model Act and Regulation. The tax treatment that accompanies tax qualified long-term care insurance policies is that

premiums are considered a Schedule B itemized deduction, the same as medical expenses, after meeting the 7.5% of adjusted gross income limit. In addition, it is clear that benefits received from tax qualified long-term care insurance policies are not considered taxable income. In 2002, 90 percent of individual long-term care insurance policies were tax-qualified.<sup>4</sup>

Finally, the product itself has improved significantly in recent years by providing more comprehensive coverage, more stable premiums and consumer protections that make it more attractive in the market. These improvements to the product were, in part, the result of a collaborative effort between the long-term care insurance industry, state insurance regulators (NAIC) and consumer advocacy groups to improve the coverage and the market for long-term care insurance.

More recently, the Deficit Reduction Act of 2005 (DRA) included a provision authorizing long-term care partnerships. A LTC Partnership program allows an individual with a qualified long-term care insurance policy to retain a portion of the policyholder's assets for the purposes of Medicaid eligibility determination and protect those assets from estate recovery. The level of asset protection provided is equal to the amount of benefits paid by the policy. Partnership policies must be tax-qualified and contain all consumer protections required of a tax qualified plan and must provide inflation protection for all policies issued to those under 76 years of age.

### **The Regulation of Long-Term Care Insurance**

Long-term care insurance has, for several reasons, been a particularly challenging product to regulate. Besides being a relatively new product with claims experience just

beginning to accumulate, the product combines both life and health insurance features in a single product. The product is sold as a means to mitigate future long-term care expenses where those expenses may not occur until 15 to 30 years into the future, depending upon the age at which the policy was purchased, much like a life insurance policy. Once the policyholder develops a condition that makes them eligible to collect benefits, however, the policy acts more like a health insurance product. As in the health care industry, long-term care services are evolving and are subject to high levels of inflation in the cost of services and growing utilization of the services. Long-term care policies need to be able to provide meaningful coverage in this evolving environment. Long-term care insurance is also subject to the same rapid changes in delivery of care that affect health insurance. The combination of these factors results in a situation where insurers must price their insurance policies so that they will pay for services fifteen or thirty years from the date of purchase of the coverage, when the cost, utilization and nature of those services may have radically changed.

Coping with these and other regulatory challenges in this market requires a determined effort and constant attention from state regulators. Our three main priorities in regulating these products have been (1) ensuring the solvency of companies offering long-term care policies so that the companies can pay claims for the policies they have sold, (2) ensuring that all long-term care insurance sales are done in an appropriate manner and are suitable for those purchasing the policy, and (3) ensuring that sufficient consumer protections are in place so that premiums are relatively stable over the life of the policy and that consumers receive the benefits promised them in a timely and accurate manner.

One of the most important responsibilities of state insurance regulators is to ensure the solvency of the companies doing business in the market. This is accomplished through constant and careful monitoring of the financial condition of insurers doing business in the states.

The initial premiums developed for early long-term-care insurance policies were based on inaccurate assumptions, especially for lapse rates and future anticipated claims. Thus, the premiums charged for these policies were too low to cover their actual claims experience. The result was that premium increases needed to be made, some of which were multiple increases and significant. Without such increases, however, the insurance company's financial future would be in jeopardy, especially for those companies that wrote only long-term care insurance. Some states and the NAIC reacted to this situation very quickly and developed rate stabilization provisions that required companies to charge a more adequate initial premium so that future premium increases would be few and far between, if at all.

The long-term care insurance market has also experienced some marketing and sales challenges. In the 1980s and 1990s, the product was primarily sold to seniors. Some companies used deceptive and high-pressure sales tactics. Many sales were considered unsuitable because policies were sold to individuals who did not have the financial wherewithal to afford the premium for the long-term care insurance protection and were close to qualifying for Medicaid. There were also instances of improper long-term care insurance policy replacements, where one long-term care policy was replaced by another, to the benefit of the replacing insurance agent and company, but to the detriment of the

consumer. Additionally, some policies were priced using assumptions that were unrealistic, resulting in the need for large premium increases later in the life of those policies. It is from these early policies that we are seeing many of the premium increases today. These practices were primarily the result of a few bad actors and were addressed through successful regulatory protections initiated by the states and the NAIC. I will discuss these actions later in my testimony.

The question of suitability has always been an issue with these products. First, in the past, these products were sold on a standalone basis, outside of a consumer's financial plan. Now, because of all the options that consumers have to pay for long-term care services, buying a long-term care insurance policy without a financial plan would be unwise. In addition, these types of standalone sales often result in unsuitable purchases for the consumer. Consumers who have very little assets to protect and are relatively close to qualifying for Medicaid should think carefully about whether they will benefit from the purchase of a long-term care insurance policy. In response to the suitability concerns, many states and the NAIC developed suitability standards and processes to minimize unsuitable sales of long-term care insurance policies.

Older long-term care insurance policies do not have some of the consumer protections that are available in the current regulatory environment, especially in the area of rate stability, benefit adjustments, unintentional lapse protection, and inflation protection. I will discuss each of these items in more detail in a later section of my testimony.

Many of the problems we are seeing in today's market can be, in my opinion, attributed to policies that were issued prior to the implementation of the many of the consumer protections we have today.

### **The NAIC's Model Long-Term Care Insurance Act and Regulation**

The NAIC's earliest Long-Term Care Model Regulation was adopted in 1988. Since then, the NAIC, in collaboration with consumer advocates and the insurance industry, has amended its model act and regulation many times to address problems with products, such as the manner in which they were sold and stability of the premiums, to name a few. (I have attached a list of changes to the NAIC Long-Term Care Insurance Models since 1988 to this testimony.)

For example, the original model regulation contained a provision that required all individual long-term care insurance policies to meet a minimum 60 percent loss ratio. This meant that over the life of the policy, a minimum of 60 percent of the premium had to go towards the payment of claims. A maximum of 40 percent of the premium could be allocated to administrative costs and profit. This requirement, though an important consumer protection to ensure that a majority of the premium was being used for paying claims, did not address the potential underpricing of policies and the resultant premium increases. In response to this problem, the NAIC adopted amendments to the model regulation in 2000 designed to ensure greater premium stability. These amendments eliminated the 60 percent minimum initial loss ratio requirement, and substituted an actuarial certification that must be filed with the initial premium rate filings, attesting that premiums will not increase over the life of the policy under moderately adverse

conditions. However, in the event that future premium increases became necessary and were filed with the insurance department, the original premiums filed now needed to meet a 58 percent loss ratio, and the premium increases needed to meet an 85 percent loss ratio. Furthermore, following each rate increase, the insurer must file its subsequent experience with the Commissioner for three years. If the increase appears excessive, the Commissioner may require the company to reduce premiums or take other measures, such as reducing its administrative costs, to ensure that premium increases that turn out to be unnecessary are returned to policyholders.

The 2000 amendments to the model regulation also put in place two additional levels of protection against premium increases. If premiums rise above a given level, based upon the age of the policyholder, for a majority of policyholders, the company is required to file a plan for improved administration and claims processing or to demonstrate that appropriate claims processing is in effect. Furthermore, if the Commissioner believes that a rising rate spiral exists, he or she may require the company to offer policyholders affected by the premium increase to replace their existing policies with comparable ones currently being sold, without underwriting. This allows policyholders trapped in a rising rate spiral to switch to a more stable policy. Finally, as a last resort, if the Commissioner determines that a company has persistently filed inadequate initial premium rates, the Commissioner may ban the company from the long-term care insurance marketplace for up to five years, essentially putting the company out of business in the state.

These changes created a strong incentive for companies to price policies accurately upfront. in order to avoid future increases and to encourage suitable sales of the products.

In order to assist consumers in selecting a policy with premiums that do not drastically increase over time, insurers are required to disclose to prospective policyholders all prior rate increases for the past ten years. We believe that these provisions, plus the additional experience that companies have gained in pricing long-term care policies, will be effective in promoting long-term insurance suitability and premium stability.

Nevertheless, state regulators, on their own, and through the NAIC, will continue to watch the situation closely to see how these standards affect future premium increases.

A second focus of state regulators is to ensure that long-term care insurance policies are sold only to individuals for whom the policy is suitable. Whether to purchase a long-term care insurance policy is an individual decision and should take into account the potential purchaser's age, health status, overall retirement goals, income, and assets. For instance, if an individual relies solely upon Social Security, their income is not likely sufficient for them to afford long-term care insurance premiums. Senior citizens should not purchase long-term care insurance if paying premiums will prevent them from paying other important bills, such as shelter, food and clothing expenses, or if they are already enrolled in Medicaid.

For consumers with significant assets, a long-term care insurance policy may be a good way to protect their assets against large long-term care expenditures. For these people, long-term care insurance may be a viable option.

State regulators and the NAIC have taken a number of steps to ensure that long-term care insurance sales are suitable. The NAIC's Long-Term Care Insurance Model Regulation requires all long-term care insurers to develop suitability standards, based upon general

categories contained in the regulation outlined below, to determine whether the purchase of a long-term care insurance policy is appropriate for the applicant. These standards must take into account (1) the ability of the applicant to pay the premiums and other pertinent financial information related to the purchase, (2) the applicants' goals with respect to long-term care, and (3) the advantages and disadvantages of insurance to meet those goals and any insurance that the applicant may already have. The NAIC model also contains a worksheet for insurance agents to use to determine suitability prior to selling a policy. This worksheet collects relevant information about the prospective policyholder and helps to ensure that the applicant is aware of the various options available under the policy, and the consequences of decisions regarding those options with respect to both premiums and future benefits under the policy.

The insurer must review the worksheet prior to issuing the policy. If the insurer finds that the policy would not be suitable for the applicant, based upon its suitability standards, it must either reject the application or inform the applicant that the policy may not be suitable. Written confirmation must be obtained from an applicant that wishes to purchase the policy anyway.

The NAIC Model Regulation also requires agents to provide purchasers with copies of the NAIC's "Shopper's Guide to Long-Term Care Insurance" and a fact sheet entitled "Things You Should Know Before You Buy Long-Term Care Insurance." These publications outline some of the considerations that consumers should take into account when purchasing a policy so that all consumers have the opportunity to be informed prior

to committing to a purchase. All states have this requirement in their long-term care insurance regulations.

Finally, the Long-Term Care Insurance Model Act and all states' long-term care regulations provide consumers the right to return the policy within 30 days of receipt of the policy for a full refund if they are not satisfied for any reason. Notice of this right must be prominently included on the first page of the policy. This provides an opportunity for the applicant to reconsider the decision to purchase coverage and acts as a defense against high-pressure sales tactics and unsuitable sales.

State regulators' third priority in regulating long-term care insurance is ensuring that when consumers purchase long-term care insurance they are treated fairly and they receive the benefits that they are entitled to under their policies. Because most policyholders are elderly and living on fixed incomes when collecting benefits under a long-term care policy, and are likely suffering from a physical incapacity, cognitive impairment or both, consumer protections for access to benefits are of the utmost importance with long-term care insurance. States already have prompt claim payment laws that apply to long-term care insurance. As discussed later, the long-term care insurance market may need consumer protections for claim denials based upon the insurer's assessment of whether the policyholder has met the benefit trigger requirements under the policy. An independent external review for these types of situations would be a valuable consumer protection in challenging an insurer's claim denial.

Prior to being revised in 2000 and 2006, the NAIC Long-Term Care Model Act and Long-Term Care Insurance Model Regulations already contained many important

consumer protections. These protections were designed to help ensure that consumers understand what they are purchasing and that the purchase is suitable and affordable over the life of the policy. These protections include:

- **Guaranteed renewability:** All policies must either be guaranteed renewable or noncancellable. Guaranteed renewable policies may not be altered by the insurer, nor may they be cancelled except for the policyholder's failure to pay premium, but premiums may be increased. Noncancellable policies are similar to guaranteed renewable policies, except premiums may not be increased.
- **Mandatory offer of nonforfeiture benefits:** All applicants must be offered the opportunity to purchase nonforfeiture benefits, whereby if the policy were to lapse, the policyholder would be issued a paid-up policy with reduced benefits based upon the length of time the policy was held. Applicants who decline to purchase nonforfeiture benefits are still entitled to receive contingent nonforfeiture benefits, which are provided if premiums rise above a percentage of the initial premium. That percentage varies depending upon the policyholder's age at the time of purchase of the policy and ranges from 200 percent, for those purchasing prior to age 30, to 10 percent, for those purchasing after age 90.
- **Limitation on benefit triggers:** The conditions that must be satisfied before the policyholder becomes eligible to collect benefits are known as "benefit triggers." Benefits must be triggered when no more than three activities of daily living (bathing, dressing, eating, continence, toileting, and transfer) are impaired or the policyholder suffers from cognitive impairment. Additional benefit triggers may

be added, but the policy may be no more restrictive than the model's requirements.

- **Limitations on rescissions:** Policies may only be rescinded for fraud or misrepresentation during the first six months of the policy. After that time, and for the first two years of the policy, policies may be rescinded for material misrepresentations that pertain to the condition for which benefits are being sought. After two years, policies are incontestable, except for intentional and knowing misrepresentation of relevant facts about the insured's health. Once a policy is rescinded, previously paid benefits may not be recovered by the company.
- **Limitations on post-claims underwriting:** Health questions on an application must be clear and unambiguous. For applicants over the age of eighty, insurers must receive health information through a physical examination, an assessment of functional capacity, an attending physician's statement, or medical records.
- **Mandatory offer of inflation protection:** Applicants must be offered the opportunity to purchase inflation protection in the form of compound annual inflation protection of at least 5 percent or the opportunity to increase benefits by at least 5 percent every year without additional underwriting, as long as previous offers to increase benefits have not been declined. An applicant's rejection of inflation protection must be explicit and in writing.
- **Protection against unintentional policy lapse:** Each policyholder must be allowed to designate an individual who will be notified at least 30 days before the policy is cancelled for nonpayment of premium. If the policyholder suffers from

a cognitive impairment, the insurer must reinstate a lapsed policy if back premiums are paid within five months.

- **Prohibition on waiting periods on replacement policies:** If a policyholder who has begun collecting benefits replaces one contract with another, or the policyholder converts a group policy to an individual policy, the insurer may not require a new waiting period to be fulfilled. To qualify for this protection, the new policy must be from the same company, and the policyholder may not increase the benefits of the policy.
- **Standardized outline of coverage:** The insurer must provide a standardized outline of coverage to the applicant at the time of initial solicitation. The outline must describe the principal benefits and exclusions and limitations of the policy and must state the terms under which it may be continued or discontinued, as well as any right the company has to raise the premium. It must also inform the policyholder whether the policy is intended to be tax qualified.

More recently, regulators determined that additional changes to the models were necessary, and in December, 2006, adopted revisions to the model act and regulation. These revisions added several important new consumer protections, including a requirement that insurers offering new policies that cover new long-term care services or providers must make the new coverage available to existing policyholders. The intent of this change was to ensure that long-term care insurance coverage keeps pace with the changing nature of long-term care services.

Additionally, the model regulation was amended to require long-term care insurance policies to include a provision allowing policyholders to reduce their coverage and lower their premiums in order to avoid lapse due the policyholders' inability to pay the current premium. This provision will help ensure that if a policyholder's financial situation changes and they cannot afford their coverage at the current premium level, they can reduce their coverage to lower the premium.

Finally, new producer training requirements were put into place to ensure that agents selling long-term care insurance products, particularly Long-Term Care Insurance Partnership policies, are properly equipped to accurately explain coverage options to consumers. Long-term care insurance is a complex product to pay for care in a constantly changing long-term care service system. As a result, it is imperative that agents and brokers selling these products are adequately trained. Under the new producer training section of the model, agents and brokers must complete eight hours of initial training before they can sell long-term care insurance and then four hours of continuing education on long-term care every two years. The training must cover state and federal requirements pertaining to long-term care services, the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services.

These changes have been in effect for less than two years. However, more and more states have decided to implement the Long-Term Care Partnership and, as part of that process, have revised their laws to incorporate the most recent versions of the NAIC

model act and regulations. We believe that these changes will prove to be valuable consumer protections.

Moving forward, state regulators continue to carefully monitor the market and make adjustments as necessary. Recent articles in the *New York Times* outlined problems that some policyholders were having collecting benefits under their long-term care insurance policies.

As a result of these articles, interest shown by Congress in long-term care insurance issues and other state insurance regulators' concerns, the NAIC's Senior Issues Task Force and Market Analysis Working Group coordinated a data call by the domiciliary states of the 23 largest individual long-term care insurers in the United States. The call collected data from 2004 through 2006 including, premiums, claim payments, consumer complaints, and the promptness of claims payments, claims denials, and cost containment expenses.

The data showed that the individual long-term care insurance industry continues to grow, with the majority of the growth in the comprehensive policies. Complaints regarding claims have been increasing over time. In part, this is to be expected, as each year there are more policies in force with policyholders at an age where claims are likely to be filed. However, the data also showed an increase in the percentage of claims being denied, from 3.2 percent of claims submitted in 2004 to 3.9 percent in 2006. While this is not a statistically significant result, it may reveal a trend that we believe needs to be addressed. A separate survey conducted by the insurance industry found similar results.

In response to the results of the data call, the NAIC's Senior Issues Task Force is considering further revisions to its models. As I mentioned earlier, the Task Force is considering including independent external review of benefit trigger determinations in its models. This consumer protection will give a consumer an outside determination of whether a policyholder has met the conditions for benefit eligibility under the insurance policy. Currently, in most states, a policyholder's only avenue for appealing claims denials are through appeals or grievances filed with the insurance company that denied the claims, complaints to their insurance department and litigation. Independent external review will give consumers a new avenue for expeditiously resolving these disputes without resorting to litigation.

Regulators are also actively working on long-term care insurance standards, which once completed, will go to the Interstate Insurance Product Regulation Commission (IIPRC) for review and adoption. The Interstate Insurance Product Regulation Compact which, to date has been adopted by 33 Member States representing more than half of the premium volume nationwide, created the IIPRC, providing states with a vehicle to develop uniform national product standards that will afford a high level of protection to consumers of life insurance, annuities, disability income, and long-term care insurance products; establish a central point of filing for these insurance products; and thoroughly review product filings and make regulatory decisions according to the uniform product standards.

Finally, the NAIC's Shopper's Guide to Long-Term Care Insurance, which must be distributed to all prospective applicants prior to, or with, delivery of the application, is regularly revised to include changes to laws and regulations, as well as changes in the

marketplace, so that consumers are informed about their rights and options when it comes to purchasing long-term care insurance.

Over the past several years, several pieces of legislation have been introduced in Congress that would deal with long-term care insurance in various ways. Perhaps the most important policy lever that the federal government has at its disposal is the standards for tax-qualified long-term care policies. As I mentioned earlier, 90 percent of all policies sold in 2002 were tax qualified and contained a set of standards specified in HIPAA that were drawn from the NAIC models. These standards, however, have not been updated since the passage of HIPAA in 1996, while the NAIC models have been significantly improved since then.

The NAIC has a very open and collaborative process in developing and amending its long-term care insurance model act and regulation. Not only do state regulators participate in the process, but consumer advocacy groups, insurance industry representatives and other experts in the long-term care field are brought into the process, the result of which is a model regulation that addresses the issues in the marketplace by adopting best practices as minimum requirements for all to follow. While not all states have adopted the NAIC long-term care insurance models in their entirety, many have. Those who have their own laws have laws that are very similar to or build off of the NAIC models.

One step that Congress could take would be to update the standards for tax qualified long-term policies to incorporate some of the latest consumer protections in the NAIC models, including contingent nonforfeiture benefits, policy disclosures, producer training

requirements, and the mandatory offering of coverage of new services and providers. We would also encourage the Department of Health and Human Services, under the DRA, to incorporate the independent external review standards, once they are adopted by the NAIC, for partnership policies.

Because the long-term care insurance market continues to change, state regulators, individually and through the NAIC, are making periodic adjustments to the model act and regulation, as we have done for many years. To ensure that future changes are incorporated in federal standards, Congress might consider allowing the relevant executive branch agency to update them in consultation with the NAIC, as it did for partnership plans in the DRA.

I would offer a brief word of caution, on this subject, however. It is very likely that not all aspects of the NAIC models are as uniformly applicable to the entire country as others. While the consumer protections in the models can be applied around the country, I would caution that some states did not have many of the problems discussed in the *NY Times* articles. Overall, state regulation of long-term care insurance has worked very well and will continue to work well. For that reason, we would strongly encourage Congress to work with state regulators and the NAIC to ensure a strong, viable and healthy long-term care insurance market with good competition and consumers who have the knowledge and assistance to make good buying decisions.

State regulators have been working hard to ensure that a viable long-term care insurance market exists in their respective states, with regulations for premium stability, benefits that are paid according to the insurance contract in a timely and accurate manner and

sales that inform the consumer about the product and are suitable. As problems arise, we have taken steps to correct them and prevent them from occurring in the future. It is especially challenging to ensure the future value of a policy fifteen or thirty years from the date it was purchased when long-term care services continue to evolve. We are hopeful that recent changes to the NAIC models giving policyholders the opportunity to add coverage for new services and providers as they become available will result in the flexibility that will allow long-term care insurance to adapt to changes in long-term care services and the settings in which they are provided. Similarly, we believe that the changes made to the loss ratio, rate stability and disclosure standards in the 2000 models have helped stabilize future premiums, though several years of experience under this structure will be required before we know whether further adjustments will be required. As additional challenges arise, we will continue to work to ensure that consumers are protected and that the market functions well.

Again, thank you for the invitation to testify here today. I look forward to answering any questions that you might have.

## **Chronological Summary of Actions on NAIC Long-Term Care Insurance Model Act and Regulation**

### **Chronological Summary of Actions**

December 1986: Model Act adopted.

June 1987: Amendment adopted which provided that no long-term care insurance policy could cover skilled care only or provide higher benefits for skilled care than for lower levels of care. Waivers could not be used to reduce coverage for specifically named conditions beyond the waiting period for preexisting conditions. The preexisting condition definition was changed and the elimination period made a uniform six months.

December 1987: Technical amendment adopted regarding the exclusion of employer groups from preexisting condition requirements, and footnote was added on extraterritoriality.

December 1988: Prohibitions against a prior hospitalization requirement and conditioning receipt of institutional benefits on a prior institutionalization added. The requirements for the outline of coverage were changed, and a footnote added recognizing the viability of life insurance riders. Provision on continuation and conversion added.

June 1989: Model now provides that any policy marketed as long-term care must comply with the provisions of the Act. Authority for life insurance riders added. Free-look period made a uniform 30 days. One-year grace period for prior hospitalization prohibition removed.

December 1989: Eliminated language prohibiting prior hospital stays for home health care benefits.

December 1990: Changed definition to clarify distinction between regulation of long-term care insurance and accelerated benefits. Eliminated drafting note on prior hospitalization. Added sections providing statutory authority to promulgate regulations and impose penalties.

December 1992: Added Section 7 to provide for an incontestability period.

June 1993: Added new Section 8 to provide for nonforfeiture benefits.

June 1994: Added phrase to Section 9 to give authority to promulgate regulations on premium rate stabilization.

September 1996: Amended Section 6G to say that an outline of coverage is not required in group sales if similar information is contained in other enrollment materials.

September 1997: Adopted amendments to Section 6 and 7 relative to life insurance that accelerates benefits to cover long-term care expense.

June 1998: Changed requirement for mandated nonforfeiture to a mandated offer of a nonforfeiture benefit. Reference in Section 9 was changed from premium rate stabilization to regulations designed to protect the policyholder in the event of substantial rate increases.

March 2000: Model was amended to comply with the requirements of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

December 2006: Model amended to establish producer training requirements to comply with the Deficit Reduction Act of 2005 and to clarify what is meant by the term “field issued.”

## **Model Regulation: Chronological Summary of Actions**

December 1987: Model regulation adopted.

December 1988: Outline of coverage added, revision of continuation and conversion section. Addition to Section 8 requires disclosure of limitations of policy.

June 1989: Modifications of continuation and conversion section. Reserve requirements added.

December 1989: Adopted amendments to prevent post claims underwriting. Minimum standards for home health care benefits added to model. Inflation protection required.

June 1990: Added Section 30 to require delivery of shopper's guide.

December 1990: Added consumer protection amendments similar to those adopted for Medicare supplement coverage to help prevent abuses in marketplace.

December 1991: Amended model to prohibit attained age or duration rating and to add a rescission reporting form. Also modified sections on home health care and inflation protection.

September 1992: Amended Section 19 to remove reference to loss ratios of *individual* policies.

December 1992: Adopted amendments requiring third party notice and premium disclosure. Adopted new subsection on standards for marketing to association groups.

June 1993: Paragraph added to association responsibilities subsection to reference unfair trade practices act.

June 1994: Adopted amendments to Section 6F to restrict increases in premium rates.

March 1995: Adopted new Section 24 on suitability standards to replace provision on appropriateness and added Appendices B, C and D to implement the new requirements. Added Section 26 to implement the nonforfeiture benefit requirement in the model act.

September 1995: Adopted new Section 27 on standards for benefit triggers. Added new definition and made changes to outline of coverage.

September 1996: Added Section 6G to set standards for electronic enrollment of groups.

September 1997: Amended Sections 3, 6, 7, 14 and 19 relative to life insurance that accelerates benefits to cover long-term care expenses.

December 1997: Amended personal worksheet (Appendix B).

June 1998: Deleted Section 6F provisions adopted in 1994 to restrict increases in premium rates and replaced with clarification that more coverage or a reduction in benefits is not a premium rate change. Changed nonforfeiture benefits in Section 26 to mandated offer and added requirements for contingent nonforfeiture.

March 2000: Model amended to comply with the requirements of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), included adoption of a new Section 28.

August 2000: Model amended on issues of rating practices and consumer protection. Added Sections 9, 10 and 20, as well as Appendix F.

March 2002: Added Appendix G and references to it in Section 15.

December 2006: Model amended to recognize that states license long-term care facilities differently, to require explanation of additional contingent benefit upon lapse, to require availability of new services or products, to provide a right to reduce benefits and lower premiums, and to clarify contingent benefit upon lapse for policies with fixed or limited premium payment period.

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<sup>1</sup> Genworth 2008 Cost of Care Survey

<sup>2</sup> Kaiser Commission on Medicaid and the Uninsured, Medicaid's Long-Term Care Beneficiaries: An Analysis of Spending Patterns, November 2006, accessed July 8, 2008 at <http://www.kff.org/medicaid/upload/7576.pdf>.

<sup>3</sup> National Association of Insurance Commissioners, Long-Term Care Insurance Experience Reports for 2007, p.9

<sup>4</sup> America's Health Insurance Plans, Long-Term Care Insurance in 2002, June 2004, accessed July 15, 2008 at [http://www.ahipresearch.org/pdfs/18\\_LTC2002.pdf](http://www.ahipresearch.org/pdfs/18_LTC2002.pdf), p. 25.