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Consumer protection and long-term care insurance: Predictability of premiums

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In any insurance market, regulation may be necessary to assure that consumers are informed about the scope and limits of the protection they are buying, and that they are receiving value in the products they purchase. The long-term care insurance market is no exception, posing many of the same consumer protection issues as other markets and some that arise from this product's specific characteristics.

This policy brief highlights one specific consumer protection issue in long-term care insurance—consumers' expectations regarding the premiums they will pay over the life of their insurance policies.[1] After a brief discussion of the issue, a review of regulatory actions that may be taken to protect consumers is provided. The focus is on actions recommended by the National Association of Insurance Commissioners (NAIC), the organization representing the states' insurance regulators, whose "model" laws and regulations aim to promote consumer protection around the nation.

Background

What happens to insurance premiums over time is a particular (though not a unique) concern in the long-term care insurance market because of the way policies are usually designed and priced. In contrast to health insurance policies, which are products designed and priced on a year-to-year basis, long-term care insurance policies are typically designed as products that people will hold over a long period of time and priced so that the premium will be constant over this time. The period over which purchasers may hold a policy is substantial. One in three purchasers of long-term care insurance is under the age of 65.[2]

Consumers are encouraged to buy policies when they are young and the risk of needing long-term care is relatively low, so that they can "prepay" some of their insurance costs and pay a premium that is low, relative to risk, when they are older. With "level premium policies," consumers are assured that premiums will not increase with their age or de-

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teriorating health status. According to the Health Insurance Association of America, "premiums generally don't increase with age but remain the same each year (unless they are increased for an entire class of policyholders at once)."[3]

But the use of level premiums does not mean that premiums will never increase. Although increases cannot occur due to characteristics of the particular policyholder, they can occur for other reasons. Long-term care insurance policies are difficult to accurately price.[4] Even if insurers intend to do their best to sustain level premiums, experiences that change expectations for future claims (or for future investment income) could necessitate a premium increase in order to sustain promised benefits. For example, in recent years the lapse rate—that is, the proportion of policyholders who drop their policy—has declined.[5] A larger than expected share of policyholders keeping coverage will mean an increase in claims liabilities relative to the cumulative premiums collected. If an insurer did not anticipate the decline in the lapse rate, it may need to increase premiums to assure financial soundness.[6]

Premiums can also change for less acceptable reasons. Every market has "bad actors"—in this case, insurers who set premiums for short-term gain rather than long-term price stability. One such practice is the use of "loose" underwriting rules—selling to less-healthy people along with others—and then setting rates that are too low to cover the long-term risk level of the purchasers. Another is setting inappropriately low rates (that is, "low-balling") in order to sell a particular policy and then closing enrollment in that policy (or "block of business")—enrolling new applicants in a new and separate policy and raising the premiums for holders of the closed policy. The result is a "death spiral" for the initial policy—individuals who can pass medical underwriting drop such policies because they are able to purchase less expensive ones, and individuals who cannot are forced to pay significantly higher rates or lose their insurance.

Although the prevalence of such practices is unknown, news reports and legal actions demonstrate that they do indeed occur. For example, the press reported that two leading nationwide companies attracted less healthy elderly persons for enrollment and "offered very low premiums for the amount of risk they took."[7] According to the *Wall Street Journal*, the two companies then increased premiums in their largest markets (California, Florida, and Pennsylvania)—one by 8 percent to 20 percent and the other by 10 percent to 40 percent.[8]

The practice of setting rates too low and closing blocks of business to cover risks was the subject of a class action lawsuit, *Hanson v. Acceleration Life Insurance Company et al.* According to testimony before the

U.S. Senate Special Committee on Aging by the lead counsel for plaintiffs in the lawsuit, the insurer increased premiums by as much as 700 percent, affecting over 13,000 policyholders.[9] The case was settled and policyholders received cash payments totaling $12.6 million and an immediate reduction of premiums for all current policyholders valued at $2.1 million in the next year.[10] The company also agreed not to increase premiums in the future for these policies.

Finally, some companies may market their products without disclosing to potential buyers that premiums can in fact increase. In July of 2001, the Attorney General of Texas filed a lawsuit against American Travellers Life Insurance Company and Conseco Senior Health Insurance Company. The lawsuit involved more than 10,000 Texans who had bought policies between 1992 and 1999 and, according to court papers, were later subjected to double-digit rate increases after being led to believe their premiums would remain stable.[11] In a nationwide lawsuit against the same insurers, *Milkman v. American Travellers Life Insurance Company et al.,* the plaintiff alleged that Conseco (which acquired American Travellers in December of 1996) fraudulently concealed from 750,000 long-term care insurance policyholders nationwide that the insurer was likely to raise its premiums.[12]

Regulatory Responses

States have been the primary regulators of private long-term care insurance. Although in 1996 the Internal Revenue Service acquired authority over tax-qualified long-term care policies, their authority is limited to enforcement of the specific standards in the federal law. Consumers must therefore look to the states for protections related to rates. According to one study that examined rate increases, among the thirty states in the study with complete data, about half had disapproved or modified premium increases; only seven states had objected to 10 percent or more of all rate increase filings.[13] None of the remaining twenty-one states (including the District of Columbia) with incomplete data reported disapproving or modifying a rate increase, according to the study. This study does not examine the reasons for the lack of regulatory intervention. As noted previously, rate increases may become necessary due to changing circumstances or information. However, experiences like those described above have generated concern that limited statutory authority and limited enforcement activity may be putting consumers at risk.

In August of 2000 the NAIC adopted a new regulatory approach intended to encourage stronger state legal protections, expand the authority of regulators, and guide state regulators in overseeing rates. The NAIC worked with various stakeholders, including consumer groups and

the insurance industry,[14] to develop a new regulation that would serve as a "model" for state consumer protection.

The NAIC *Long-Term Care Insurance Model Act and Regulation* seek to better protect consumers from rate instability in several ways. As amended in August of 2000, the model act and regulation financially penalize companies that intentionally underprice policies and, furthermore, allow state regulators to prohibit insurers that repeatedly engage in such behavior from selling policies in their state. In addition, the new model requires greater disclosure of premium increases and provides policyholders more options when their premiums are increased. The following discusses some of the key 2000 amendments to the model act and regulation.

Financial requirements for rate increases

The NAIC model's primary innovation is the introduction of financial disincentives to underprice policies.[15] The disincentives apply through rules regarding the "loss ratio"—that is, the share of premium the insurer is expected to pay in claims (based on estimates of future revenues and future claims) over the life of the policy for all its policyholders. Under the new model, projected claims must account for at least the sum of: (a) 58 percent of the revenues that will be generated by the existing premium and (b) 85 percent of the revenue generated by the premium increase. Setting a higher loss ratio requirement for the premium increase than applies to the initial premium creates what is essentially a penalty for increasing rates, and should discourage underpricing in the first place.[16]

Rate certification from an insurer's actuary that initial rates are reasonable

The new model requires that insurers obtain certification from an actuary that initial premiums are reasonable.[17] Reliance on actuarial certification assumes that, in general, the actuary will use acceptable actuarial practices while evaluating available data. It is also assumed that a company seeking to "low-ball" rates would have difficulty finding an actuary who would make a certification that such rates are adequate.

Enforcement and new consumer rights

The new model requires more regulatory attention to filings of premium increases and stricter enforcement of rate stability. First, the new model authorizes insurance commissioners to review the impact of premium increases on policyholders. If commissioners find that a significant number of policyholders have dropped their policy they can require the insurer to offer policyholders the option to buy a different

policy from the insurer. In pricing the new policy, the insurer cannot use underwriting and must base the premium rate on the policyholder's age at the time of the original issue of the policy for which the price has increased, and not the person's attained age.[18] Second, under the new model state regulators are authorized to prohibit insurers that persistently sell coverage at inadequate rates from selling policies in their state.[19]

Additionally, policyholders have new rights under the new model.[20] In the case of substantial cumulative premium increases since the policy was first issued, the policyholder has two options.[21] The policyholder may continue to pay the same rate, but receive a decreased level of benefits. Or, the policyholder may choose to convert the coverage to a "paid-up" status, which means an individual no longer pays the premium, but the period that benefits are paid is shortened. Although consumers are better protected because they will not completely lose their coverage, they receive less than what was originally expected—fewer benefits or a shorter benefit period.

Consumer disclosure

The NAIC model requires insurers to disclose rate increase histories for the past ten years for policies similar to the one being offered to the consumer.[22] Such disclosure allows consumers to make more informed decisions about the company from which they may purchase a policy. Regulators believe that disclosure of rate increases will encourage consumers to buy long-term care insurance from companies whose rates have been stable. Additionally, regulators believe this enhanced disclosure will discourage companies from inappropriately pricing their products. The new model also requires the purchaser to sign a form stating that he or she understands that premiums may increase in the future.[23]

Implications

Pricing long-term care insurance will always involve uncertainty—about lapse rates, utilization of services, future costs, and investment performance. However, stronger standards and more active oversight can help policymakers and regulators better protect consumers.

Development of the model regulation is an important step, reflecting the shared concern of the NAIC, the industry, and consumers about problematic rate practices. It is important to note, however, that the 2000 model regulation is not without limitations.[24] Key limitations include:

- *Limited state adoption.* States are not required to adopt the new model. As of July 2003 (three years after the NAIC adopted the

model), only twenty-one states had adopted the new rating requirements and enhanced consumer disclosure amendments in the new model.[25]

- *Focus on new purchasers.* If adopted, the new model only protects consumers buying new policies in states that have adopted the new consumer protections. Consumers with existing policies lack the newly established protections.

- *Limited capacity for enforcement.* Alongside concern about standards for insurance, the effort and capacity of states to enforce those standards has been a concern for over a decade. In 1989, the U.S. House of Representatives, Select Committee on Aging, Subcommittee on Health and Long-Term Care examined states' shortcomings as regulators. Subsequent investigations have shown that persistent staff and resource shortages in state insurance departments limit states' capacity to regulate premium rates. The amount of effort and resources available to ensure suitable training for individuals reviewing rates is also a concern.[26] To ensure that rates are appropriately reviewed, California, for example, established standards for actuaries, requiring the Insurance Department only to use actuaries who are members of the American Academy of Actuaries with at least five years relevant experience in long-term care insurance industry pricing.[27] The NAIC model, however, does not have similar standards for insurance department staff reviewing rate filings.

- *Limited data.* The NAIC model does not require insurers to report the number of policyholders affected by a premium increase. The fact that national data on the number of policyholders affected by rate increases do not exist makes it difficult to assess the extent of the problem.

Regulatory response to rate instability, primarily by the states and the NAIC, is certainly a step toward stabilizing premiums. Given the limitations of current regulation and the difficulty of pricing private long-term care insurance, the courts will likely continue to be an avenue for recourse for consumers who have been affected by substantial rate increases. Additional regulation and enforcement are needed to educate consumers about the coverage they are buying (and its limitations) and to assure that they are receiving value in the insurance they purchase.

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Notes

1. For a discussion of a broad range of consumer protection issues and the regulatory mechanisms used to address them see Stephanie Lewis, John Wilkin, and Mark Merlis, *Regulation of Private Long-Term Care Insurance: Implementation Experience and Key Issues* (Washington, DC: The Kaiser Family Foundation, 2003).

2. American Council of Life Insurers (ACLI), *Making the Retirement Connection: The Importance of Long-Term Care Insurance in Retirement Planning* (Washington, DC: ACLI, 2001), p. 16.

3. Health Insurance Association of America (HIAA), *A Guide to Long-Term Care Insurance* (Washington, DC: HIAA, 2002), p. 8.

4. For additional information on the difficulties in pricing private long-term care insurance see Lewis, Wilkin, and Merlis, *Regulation of Private Long-Term Care Insurance*, p. 28.

5. Julia Philips (Life Actuary Fellow with the Minnesota Commerce Department and the Chair of the Working Group of the National Association of Insurance Commissioners that developed rate standards for the Long-Term Care Insurance Model and Rate Manual), e-mail message to the authors, August 19, 2003.

6. Ibid.

7. Ann Davis, "Shaky Policy: Unexpected Rate Rises Jolt Elders Insured for Long-Term Care," *Wall Street Journal*, June 22, 2000.

8. Ibid.

9. Senate Special Committee on Aging, *Long-Term Care Insurance: Protecting Consumers from Hidden Rate Hikes,* testimony by Allan Kanner, 106th Cong., 2nd Sess., September 13, 2000, p. 2.

10. Memorandum and Final Order on Approval of Settlement, Hanson v. Acceleration Life Insurance Company et al., Civ. No. A3:97-152 (D.N.D. Dec. 11, 1999).

11. Plaintiff's Original Petition and Application for Injunctive Relief, at 5-6, Texas v. Conseco Senior Health Insurance Company, No. GV102103 (Tx. D. Travis County July 2001). At the time, the Texas Department of Insurance did not have the authority to approve long-term care rate increases. In 2001, Texas adopted the new rating practices and consumer disclosure amendments. National Association of Insurance Commissioners (NAIC), *NAIC State Survey on LTCI Rating Practices and Consumer Disclosure Amendments: September 2002* (Kansas City, MO: NAIC, 2002).

12. See Amicus Curiae Brief of the Attorney General, Milkman v. American Travellers Life Insurance Company et al., Case No. 03775 (Phila. C. of Common Pleas Jan. 2001); and Vicki Lankarg, "Pennsylvania Acts to Prevent Long-Term Care Insurance Rate Spirals," *The Insurance Guide*, http://info.insure.com/states/pa/health/ltcprotection302.html (accessed March 20, 2002).

13. Larson Long-Term Care Group, *Rate Increases by Long-Term Care Insurance Companies* (Bothell, WA: Larson Long-Term Care Group, 1999), cited in Steven Lutzky, Lisa Alecxih, and Ryan Foreman, *Long-Term Care Insurance: An Assessment of States' Capacity to Review and Regulate Rates* (Washington, DC: AARP Public Policy Institute, 2002.)

14. Senate Special Committee on Aging, *Long-Term Care Insurance: Protecting Consumers from Hidden Rate Hikes,* statement by Charles N. Kahn III (President of HIAA), 106th Cong., 2nd Sess., September 13, 2000.

15. NAIC, *Guidance Manual for Rating Aspects of the Long-Term Care Insurance Model Regulation* (draft, Kansas City, MO: NAIC, May 15, 2002), p. 3.

16. NAIC, *Long-Term Care Insurance Model Regulation* (Kansas City, MO: NAIC, 2000), Section 20, C(2).

17. When a company requests a premium increase the model also requires the actuary to certify that "no further premium rate schedule increases are anticipated." NAIC, *Long-Term Care Insurance Model Regulation*, Section 20, (B)(2)(a), p. 34.

18. NAIC, *Long-Term Care Insurance Model Regulation*, Section 20, H(2).

19. NAIC, *Long-Term Care Insurance Model Regulation*, Section 20, I.

20. See NAIC, *Long-Term Care Insurance Model Regulation*, Section 26, D(4). These protections are called contingent non-forfeiture. Different from non-forfeiture protection, which is triggered for any lapse or non-payment even if premiums remain stable, contingent non-forfeiture protection is only applicable when an insurer raises premiums substantially.

21. See NAIC, *Long-Term Care Insurance Model Regulation*, Section 26, D(3). The cumulative percentage increase that triggers these options varies by the age of the policyholder at the initial purchase. For example, the contingent non-forfeiture protection is triggered if premiums increase by 150 percent (cumulative) of the initial rate for a consumer who purchased the policy at age 40. For purchases made at age 60, the corresponding cumulative percentage increase before contingent non-forfeiture protection is triggered is 70 percent.

22. NAIC, *Long-Term Care Insurance Model Regulation*, Section 9, B(5). In some circumstances, such as a merger with another company, the model does not require a company to disclose rate increases. Ibid at Section 9, (B)(5)(c) to (5)(e).

23. NAIC, *Long-Term Care Insurance Model Regulation*, Section 8; Section 9; Appendix B; Appendix F.

24. For additional information and a discussion of other limitations of the NAIC Model Act and Regulation, see Lewis, Wilkin, and Merlis, *Regulation of Private Long-Term Care Insurance*.

25. Lynn Boyd (ACLI), telephone interview by Lee Thompson, July 31, 2003. The following states adopted the model provisions: Arizona, California, Illinois, Iowa, Idaho, Kentucky, Maryland, Michigan, Minnesota, Missouri, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma, Pennsylvania, South Dakota, Texas, Utah, Virginia, and Wisconsin. Massachusetts and the District of Columbia are looking into adopting the amendments. States' decisions on adopting the amendments, however, may become part of a broader decision to join an Interstate Compact (a model the NAIC developed in 2003). Under the compact, companies selling certain types of insurance, including long-term care insurance, in states that are part of the compact will have to meet all the standards in the NAIC model or other standards adopted by the Interstate Insurance Compact Commission. Some states that would not otherwise have adopted these amendments may do so within this broader context. Interstate Compact National Standards Working Group, *Interstate Compact National Standards & Filing Procedures* (draft, Kansas City, MO: NAIC, December 19, 2003), http://www.naic.org/compact/index.htm.

26. House Select Committee on Aging, Subcommittee on Health and Long-Term Care, *Long-Term Care Insurance: State Regulatory Practices Provide Inconsistent Consumer Protection* (Washington, DC: General Accounting Office, 1989); and Lutzky, Alecxih, and Foreman, *Long-Term Care Insurance.*

27. Cal. Ins. Code § 10236.12.

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