HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1349 Long-Term Care Insurance
SPONSOR(S): Farkas and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 2290

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Insurance Committee		Tinney	Cooper
2) Elder & Long-Term Care Committee			
3) State Administration Appropriations Committee			
4) Commerce Council			
5)			

SUMMARY ANALYSIS

Long-term care refers to a broad range of supportive medical, personal and social services needed by people who are unable to meet their basic living needs for an extended period of time. Insurance companies offer individual or group long-term care insurance policies that provide benefits for a range of these services.

On October 10, 2005, the Office of Insurance Regulation held a public hearing on long-term care insurance in Tampa, Florida. The OIR assembled a panel comprised of consumers, representatives of the insurance industry, and legislators to discuss ways to enhance the long-term care insurance market in Florida and to provide greater consumer protections. The bill amends laws governing long-term care insurance to incorporate the following options discussed by the panel:

- Provides that a long-term care policy is incontestable after being in force for 2 years, except in instances of non-payment of premium. Currently, the insurer may not contest claims based on the application for coverage for a period of 2 years, unless there is a fraudulent misrepresentation in the application.
- Prohibits an insurer from imposing a new waiting period when a policy is replaced through an affiliated insurer.
- Eliminates the current minimum nursing home benefit of 24 months of coverage.
- Requires all existing policyholders be given an option to receive contingent benefit options upon lapse in the event of a significant rate increase. These options include a reduced benefit plan for the existing premium amount, a paid up policy equal to the sum of premiums paid to date, or continuation of current policy if the increased premiums are paid.
- Prohibits existing policyholders from being charged premiums that exceed the premiums the insurer is charging to new policyholders.
- Requires insurers to pool the claims experience of all affiliated carriers when calculating rates rather than only the policy forms providing similar benefits of the insured.
- Authorizes the Financial Services Commission (FSC) to adopt by rule a standard, minimum benefit package for long-term care insurance policies that must be offered by all long-term care insurers.
- Provides an appropriation to the Office of Insurance Regulation for a full-time position.

The bill provides an appropriation of $72,500 from the Insurance Regulatory Trust Fund; the money will be used to hire one FTE to implement the provisions of the bill.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government and **Promote Personal Responsibility**—The bill regulates long-term care insurance policies by imposing new restrictions and changing existing ones. Some provisions of the bill will protect elderly policyholders and those on limited or fixed incomes.

B. EFFECT OF PROPOSED CHANGES:

Background

Long-term care refers to a broad range of supportive medical, personal and social services needed by people who are unable to meet their basic living needs for an extended period of time. For example, nursing home services, home health and personal care services, assisted living, and noninstitutional group homes all offer long-term care.

A person may be unable to meet his or her living needs due to an accident, illness or frailty. Such conditions include the inability to move about, dress, bathe, eat, use a toilet, medicate and avoid incontinence. Also, care may be needed to help the disabled with household cleaning, preparing meals, shopping, paying bills, visiting the doctor, answering the phone and taking medications. Additional disabilities requiring long-term care due to cognitive impairment include stroke, depression, dementia, Alzheimer's disease, Parkinson's disease, and other medical conditions that affect the brain.[1]

By 2020, it is estimated that 12 million older Americans will need long-term care. Most will be cared for at home (family and friends are the sole caregivers for 70 percent of the elderly). A recent federal study reported that people who reach age 65 will likely have a 40 percent chance of entering a nursing home. About 10 percent of the people who enter a nursing home will stay there 5 years or more.[2]

Long-Term Care Financing

The costs associated with long-term care services are substantial. The average cost of a nursing home exceeds $55,000 per year, and as much as $100,000 in some urban areas. In 2003, the most recent year for which national data are available, national spending on long-term care totaled $183 billion, and nearly half of that was paid for by the Medicaid program, the joint federal-state health care financing program that covers basic health and long-term care services for certain low-income individuals. Private insurance paid a small portion of long-term care expenditures—about $16 billion—or 9 percent in 2003.[3]

Florida is particularly affected by long-term care costs paid by Medicaid as the state has the highest proportion of persons aged 65-84 of any state in the nation; this population is expected to grow 130 percent by 2025. In FY 2002-03, Florida's Medicaid program spent $3.2 billion (28 percent of the Medicaid budget) on four core long-term care services: nursing homes; Intermediate Care Facilities for Persons with Development Disabilities; Home and Community Based Services waivers; and assistive care services. Florida Medicaid currently pays for 66 percent of all nursing home days for the elderly in Florida.[4]

---

[1] Information from the American Association for Long-Term Care Insurance; available at http://www.aaltci.org/consumer/know.html; viewed March 29, 2006.
[2] U.S. Department of Health and Human Services; Centers for Medicare and Medicaid Services; available at http://www.medicare.gov/LongTermCare/Static/Home.asp; viewed March 29, 2006.
[3] *Overview of the Long-Term Care Partnership Program*; U.S. Government Accountability Office; GAO-05-1021R; September 2005; available at http://www.gao.gov/new.items/d051021r.pdf; viewed March 28, 2006.
[4] Personal Communication with staff of the Medicaid Office; Agency for Health Care Administration; dated March 29, 2006; on file with the House Insurance Committee.

Unfortunately, many older Americans often believe, mistakenly, that Medicare pays the costs for long-term care. As a result, many individuals are surprised to discover they must spend or dispose of most of their assets before gaining eligibility for Medicaid services.

The long-term care insurance market has grown rapidly over the past decade, yet long-term care insurance pays for a very small share of nursing home care. The main reason for the low number of purchasers is the cost of long-term insurance policies. The average annual premium for a policy for a 65-year old was $2,273 in 2001. Almost half of the U.S. population of individuals aged 65 or older has an income below $21,570 (250 percent of the federal poverty limit in 2002). This means the cost for long-term care insurance for many of these citizens would be at least 10 percent of their annual income.[5]

As a result of the federal Heath Insurance Portability and Accountability Act of 1996 (HIPAA), many insurance companies offer tax qualified policies that provide a federal income tax benefit. The federal law allows the premiums charged for a long-term care policy to be deducted as itemized medical expenses on federal tax returns, under specified conditions. Generally, the qualified policies offer many of the same benefits, however, eligibility requirements may differ. For example, some of the eligibility criteria require the insured to be chronically ill, or unable to perform at least two activities of daily living without substantial assistance in order to receive benefits.

Regulation of Long-Term-Care Insurance in Florida

The Office of Insurance Regulation (OIR) is responsible for the regulation of long-term care insurance under parts XVIII of chapter 627, F.S., known as the "Long-Term Care Insurance Act." The act specifies filing requirements, disclosure, advertising, and performance standards for such policies, minimum standards for home health care benefits, mandatory offers, cancellation requirements, and standards for benefit triggers to receive benefits under the policy.

Section 627.410, F.S., prohibits an insurer in Florida from issuing or renewing a health insurance policy form until it has filed with the OIR a copy of every applicable rating manual, rating schedule, change in rating manual, change in rating schedule; or applicable premium rates and changes to the rates. This provision does not apply to group health insurance policies insuring groups of 51 or more persons, except for Medicare supplement insurance, long-term care insurance, and any coverage under which the increase in claim costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.

An insurer is prohibited from applying the following rating practices: select and ultimate premium schedules, premium class definitions which classify insureds based on year of issue or duration since issue, and attained age premium structures on policy forms under which more than 50 percent of the policies are issued to persons 65 or older. In addition, the experience of all policy forms providing similar benefits must be combined for all rating purposes.

Each insurer is required to file annually with OIR to demonstrate the reasonableness of benefits in relation to premium rates. OIR may exempt an insurer by line of coverage from filing rates or rate certifications under section 627.410, F.S., if OIR determines the insurer has an insignificant number of policies in force or an insignificant premium.

Section 627.9407, F.S., prohibits a long-term care policy from canceling or nonrenewing on the basis of the age of the insured individual. The policy must also provide coverage for nursing home care for a minimum of 24 months. The law prohibits a long-term care insurance policy from requiring a new waiting period if existing coverage is converted to or replaced by a new or other form within the same insurer, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder.

[5] Kassner, Enid; Private Long-Term Care Insurance: The Medicaid Interaction; AARP Issue Brief; May, 2004.

In 2002, legislation was enacted authorizing OIR to implement the provisions of the Long-Term Care Insurance Model of the National Association of Insurance Commissioners (NAIC) through the rulemaking process.[6] On March 1, 2003, pursuant to its authority under s. 627.4098, F.S., the Financial Services Commission adopted by rule the NAIC model. These provisions are applicable to long-term care insurance policies issued on or after March 1, 2003.[7]

The policies must offer a contingent benefit policy upon lapse in the event of a significant rate increase. Insurers are required to offer policyholders the following options: 1) paying the rate increase; 2) reducing coverage to maintain the same or close to the same rate; or 3) terminating the coverage and taking a paid up policy. This paid-up policy would provide future benefits limited to the sum of the premiums previously paid on the policy. Loss ratios are established by rule and are determined for the original premium revenue and the rate increase component. Policies issued on or after March 1, 2003 that are part of a closed book of business are also subject to additional regulations. The premiums for existing policyholders cannot exceed premiums for new policyholders. The OIR may also prohibit an insurer from marketing for 5 years, if the insurer has exhibited a persistent practice of filing inadequate rates for long-term care insurance.

For policies issued or renewed prior to the rule's effective date, March 1, 2003, the benefits are deemed reasonable in relation to premiums charged, provided the expected loss ratio is at least 60 percent for individual policies and group policies. Provisions relating to the offer of the contingent benefit upon lapse and caps on renewal rates, required for policies issued on or after March 1, 2003, do not apply to policies issued before March 1, 2003.

Long-term care insurance policies vary in the types of care they cover, the daily benefit, and the length of time the coverage lasts. Certain requirements must be met to activate or trigger the payment of benefits. For example, most policies require that a person be unable to perform a specified number of activities related to daily living. Many policies have a benefit trigger for cognitive impairment. A policyholder qualifies for these benefits if he or she is unable to pass tests assessing mental functioning. Policies contain an elimination period, i.e., the number of days an insured must be in a nursing home or receive a lower level of care before receiving benefits from the policy.

Section 627.94072, F.S., requires an insurer offering long-term care insurance to offer inflation protection, including the option to purchase a policy that provides benefit level increases with benefit maximums or durations to account for anticipated increases in the costs of services. The insurer must also offer a nonforfeiture protection (contingent benefit upon lapse) providing paid-up insurance, extended term, shortened benefit period, or any other benefits approved by OIR if all or part of a premium is not paid.

According to the NAIC Long-Term Care Insurance Model Regulation, the contingent benefit on lapse must be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium, as prescribed in the model, based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased.

Section 627.607, F.S., requires an insurance contract to include the following information:

"Time Limit on Certain Defenses: After 2 years from the issue date, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability starting after the 2-year period."

[6] Chapter 2002-282, Laws of Florida.
[7] *See* Rule 69O-157, Florida Administrative Code.

As an alternative, a policy may include the following provision:

"Incontestable:
(a) Misstatements in the Application: After this policy has been in force for 2 years during the insured's lifetime (excluding any period during which the insured is disabled), the insurer cannot contest the statements in the application.
(b) Preexisting Conditions: No claim for loss incurred or disability starting after 2 years from the issue date will be reduced or denied because a sickness or physical condition, not excluded by name or specific description before the date of loss, had existed before the effective date of coverage."

OIR Long-Term Care Insurance Hearing

On October 10, 2005, the Office of Insurance Regulation held a public hearing on long-term care insurance in Tampa. For the hearing, OIR assembled a panel comprised of consumers, representatives of the insurance industry, and legislators to discuss ways to enhance the long-term care insurance market in Florida and to provide greater consumer protections. The panel discussed the following options:

1. Extend the current regulatory requirements and consumer protections to long-term care insurance policies purchased prior to March 1, 2003.
2. Require all insurers to offer a basic, standardized plan in order to give consumers a baseline understanding of long-term care insurance benefits and to have a comparative base for the consumer to compare rates among carriers. Any additional options offered by the carrier above the standard policy should be separately priced.
3. Require all policies to be incontestable after they have been in force for 2 years to prevent the rescission of a policy due to allegations of fraud in the application.
4. Require all policies to be incontestable after they have been in force for 2 years to prevent the rescission of a policy due to allegations of fraud in the application.
5. Require that current Florida pooling laws, which require all experience of forms with similar benefits, be expanded to include forms between company affiliates. This will broaden the insurance pool for rating purposes providing greater protection against closed blocks. Similar provisions in the small group market prevent carriers from closing forms in one company and continuing to issue policies through another.
6. Create an ombudsman position.
7. Consider corporate tax incentives.
8. Implement an organized public awareness campaign.

Changes Proposed by the Bill

Section 627.94075, F.S., is created by the bill to revise the current contestability provisions relating to a long-term care insurance policy, notwithstanding the provisions of s. 627.607, F.S. As proposed by the bill, a long-term care insurance policy becomes incontestable after the policy has been in force for 2 years, unless the policyholder fails to pay premiums as agreed. This lowers the current incontestability standard to comport with the requirement for life insurance and annuity policies under s. 627.455, F.S., which also are incontestable after being in force for 2 years from the date of issue, except for nonpayment of premium. Section 627.607, F.S., the current contestability law applicable to long-term care insurance, provides that fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability starting 2 years after the issue date.

The bill amends ss. 627.9403 and 627.9404, F.S., to clarify that a limited benefit policy that limits certain coverage in a nursing home is a type of long-term care insurance policy and thus, must meet the statutory requirements applying to long-term care insurance policies. The definition of the term, "long-term care insurance," is amended to exclude limited health insurance coverage not otherwise defined as long-term care insurance.

Prior to 1997, the definition of long-term care insurance and the applicability of the statutes that govern long-term care insurance excluded certain health insurance policies referred to as limited benefit health coverage. These policies are often referred to as “cancer policies” or “dread disease policies”. In 1997, the definition of the term, “long term care insurance policy,” did not include coverage for nursing home or home health care only. The statute required that these long-term care insurance policies be disclosed as a “limited benefit policy” but were included under the long-term care insurance laws. OIR reports that these two terms have caused misunderstanding; this change is intended to clarify which policies are considered to be long-term care insurance and which ones are excluded.

Section 627.9407, F.S., is amended to revise certain requirements for long-term care insurance policies. The bill prohibits an insurer from imposing a new waiting period for existing coverage converted to or replaced by a new or other form with an affiliated insurer. The bill does not define the word “affiliated,” however. Currently, provisions governing the waiting period only apply to the insurer, but not to an affiliate of the insurer.

The bill eliminates the current minimum 24 months of consecutive nursing home care for each covered person. The elimination of the minimum 24 consecutive months of coverage for nursing home coverage will provide insurers with flexibility to offer fewer benefits, or less coverage in order to attract consumers of various income levels. The NAIC model defines long-term care insurance to mean coverage that provides at least 12 months of long-term care services.

Upon issuance or renewal of a policy, an insurer is required to offer a policyholder a contingent benefit upon lapse. This benefit is intended to offer a policyholder a range of options if the insurer increases a premium significantly. In the NAIC model act, the options available to a policyholder include paying the higher premium; applying an amount equal to the sum of premiums paid to date towards a paid-up policy with fewer benefits; or reducing coverage to avoid loss of all coverage.

This provision regarding the contingent benefit upon lapse applies to policies issued prior to March 1, 2003. Policies issued after that date are already subject to this provision, pursuant to Rule 69O-157, F.A.C. The amount of rate increase that will trigger the contingent benefit upon lapse options varies depending on the age at which a policyholder purchases their policy.

As an example, an individual who purchased a policy at age 65 must be provided options if the cumulative rate increases on the policy exceed 50 percent. For a 55 year old, it would require a 90 percent increase. For a 75 year old, it would require a 35 percent increase.

The bill also revises laws governing rate regulation. As proposed, rates for existing policyholders may not exceed rates for new policyholders. If an insurer is not currently issuing new coverage, the new business rate would be determined by OIR as the rate representing 80 percent of the insurers currently issuing policies with similar coverage as determined by the earned premium for the prior calendar year.

The bill further requires that compliance with the pooling provisions of s. 627.410, F.S., would be determined by pooling the experience of all affiliated insurers. This means insurers are required to pool the experience not only of the issuing insurer’s long-term care policy experience (as currently required pursuant to s. 627.410(6)(e), F.S.), but also the experience of affiliated insurers issuing long-term care coverage. This requirement assures a broader spread of risk for long-term care insurance and prevents an insurer from using an affiliated company to issue coverage, thus leaving current policyholders in a group whose experience worsens over the life of the policy, resulting in an increase in premiums.

Section. 627.9408, F.S., is amended to require the Financial Services Commission to adopt by rule a standardized benefit plan that all insurers offering long-term care insurance coverage are required to offer to prospective insureds. Any marketing materials for long-term care products are required to include a reference to the availability of the standardized benefit plan. Insurers still are authorized to offer other benefit plans, however.

Section 641.2018, F.S., is amended to correct a technical, conforming cross-reference.

The sum of $72,500 is appropriated from the Insurance Regulatory Trust Fund to the Office of Insurance Regulation for the purpose of funding a full-time position to implement the bill for FY 2006-2007.

Provisions in the bill apply to long-term care insurance policies issued or renewed on or after July 1, 2006. For any long-term care policy issued prior to July 1, 2006, the incontestability provisions of section 1 of this act will apply to the policy if it is renewed after July 1, 2008, and is required to so state by endorsement to the policy.

C. SECTION DIRECTORY:

Section 1 Creates new s. 627.94075 which revises the current contestability provisions relating to a long-term care insurance policy.

Section 2 Amends s. 627.9403 to clarify limited benefit insurance policies.

Section 3 Amends s. 627.9404 clarifying the definition of long-term care insurance policy and limited benefit policy.

Section 4 Amends s. 627.9407 revises certain requirements for long-term care insurance policies.

Section 5 Creates new subsection in s. 627.9408 to require by rule adoption of standardized benefit plans for all insurers offering long-term care insurance coverage.

Section 6 Corrects a cross-reference.

Section 7 Provides an appropriation.

Section 8 Provides applicability.

Section 9 Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill appropriates $72,500 to OIR from the Insurance Regulatory Trust Fund. The appropriation is to be used to hire 1 FTE, a senior actuarial analyst, to monitor rates compliance, conduct the periodic survey of market rates for policies currently being sold in the market, and to perform analyses of rate components that are used to establish specific rates applicable to different policy forms in force, but are no longer being actively marketed (to implement the allowable premium increase pursuant to subsection (7)(d)).

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill provides significant consumer protections for individuals with a long term care policy, both in terms of premium rate increases and in terms of the availability and affordability. By requiring an insurer to provide the policyholder a contingent benefit upon lapse option in the event of a substantial rate increase, a consumer could retain a level of long-term coverage. Without such protections, policyholders, who cannot afford a rate increase, could be forced to drop their policy entirely, thus receiving no benefit after paying premiums, in some cases, for years.

The bill also ensures that existing policyholders' premiums will not be increased to an amount higher than the premiums for new policies issued by the insurer. If the insurer no longer writes new policies, the rate would be limited to the rate representing the new business rate of insurers representing 80 percent of the insurers currently issuing similar policies. In addition, the bill requires that carriers pool the claims experience of all affiliated carriers when calculating rates. According to OIR, this provision is intended to curtail the ability of an insurer to avoid pooling its claims experience in the calculation of premiums by closing a block of forms with one of their affiliated companies and opening a new one with another affiliated company.

Consumers will also be protected from an insurer alleging fraud and rescinding a policy if the policy has been in force for at least 2 years. This provision is intended to ensure that a person who is unable to adequately defend against a fraud allegation, as a result of cognitive or other impairments, will not lose benefits.

Since insurers offer many different features and policy structures for long-term care coverage, it is difficult for applicants to compare prices. The creation of a minimum benefit plan would assist consumers in comparing products and prices. Additionally, a minimum benefit plan ensures that applicants for new policies receive a standard level of benefits in their policies.

The elimination of the mandatory 24 months of coverage for nursing home care is designed to provide flexibility to insurers so they may offer policies with different levels of benefits. This should afford consumers with different levels of income the opportunity to purchase a policy compatible with both their needs and income.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

None.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill directs the Financial Services Commission to adopt a standardized core benefit plan by administrative rule. Once the core benefit plan is adopted, all insurers offering long-term care insurance

will be required to offer a policy with the core benefits. This will provide a baseline for consumers to use in comparing benefits offered by different insurers.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

None.