SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: Banking and Insurance Committee

BILL: SB 2290

INTRODUCER: Senator Fasano

SUBJECT: Long-Term Care Insurance

DATE: March 15, 2006 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Deffenbaugh	BI	**Favorable**
2.			HE	
3.			GA	
4.				
5.				
6.				

I. Summary:

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 two 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.

This bill substantially amends the following sections of the Florida Statutes: 627.9403, 627.9404, 627.9407, 627.9408, and 641.9408 and creates the following section of the Florida Statutes: 627.94075.

II. Present Situation:

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. This may be caused by 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 long-term care disabilities are due to cognitive impairment from stroke, depression, dementia, Alzheimer's disease, Parkinson's disease and other medical conditions that affect the brain.

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 study by the U.S. Department of Health and Human Services noted 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 five years or more.[1]

Long-Term Care Financing

The costs associated with long-term care services are substantial. The average cost of a nursing home stay is more than $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.[2]

[1] United States Department of Health and Human Services, Centers for Medicare and Medicaid Services. March 2005. Found at http://www.medicare.gov/LongTermCare/Static/Home.asp.

[2] *Overview of the Long-Term Care Partnership Program* (GAO-05-1021R), U.S. Government Accountability Office, September 2005. Found at: http://www.gao.gov/new.items/d051021r.pdf.

Florida is particularly affected by Medicaid long-term care costs as it has the highest proportion of persons aged 65 to 84 of any state in the nation, and this population is expected to grow 130 percent by 2025. In fiscal year 2002-03, Florida Medicaid spent $3.2 billion (or 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.[3] Florida Medicaid currently pays for 66 percent of all nursing home days for the elderly in Florida.

Elderly individuals often believe, mistakenly, that Medicare pays for long-term costs. As a result, many individuals often find out too late that they must spend down the majority 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 persons 65 years of age and older has incomes below $21,570 (250 percent of the Federal Poverty Limit in 2002). As a result, most of these individuals would have to pay at least 10 percent of their annual income for such coverage.[4]

As a result of the federal Heath Insurance Portability and Accountability Act of 1996, many insurance companies offer tax qualified policies that provide a federal income tax benefit.[5] This act allows the premiums charged for a long-term care policy to be deducted as itemized medical expenses on federal tax returns, if certain conditions are met. Generally, the qualified policies offer many of the same benefits; however, the eligibility requirements may differ. Some of these eligibility requirements include: the insured must be chronically ill or unable to perform at least two activities of daily living without substantial assistance in order to receive benefits and require that a person be expected to need care for at least 90 days.

Regulation of Long-Term-Care Insurance in Florida

The Office of Insurance Regulation is responsible for the regulation of long-term care insurance under part I of chapter 627 and Part XVIII of ch. 627, F.S., known as the "Long-Term Care Act." This 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 for receiving benefits under the policy.

Section 627.410, F.S., prohibits an insurer from issuing or renewing in this state any 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 any change in applicable premium rates. This provision does not apply to group health insurance policies, issued and delivered in this state, 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

[3] Agency for Health Care Administration. *Medicaid Long Term Care: Overview and Update*. Presentation to the Senate Health and Human Services Appropriations Committee. December 15, 2004.
[4] Kassner, Enid. *Private Long-Term Care Insurance: The Medicaid Interaction*. May 2004 (AARP Issue Brief).
[5] Section 7702(B) of the Internal Revenue Code of 1986, as amended.

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 insured 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 age 65 or over. In addition, the experience of all policy forms providing similar benefits must be combined for all rating purposes.

Each insurer is required to make an annual filing with the OIR demonstrating the reasonableness of benefits in relation to the premium rates. The OIR may exempt an insurer by line of coverage from filing rates or rate certifications under section 627.410, F.S., if the OIR determines the insurer has 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 also prohibits a long-term care insurance policy from containing a provision creating a new waiting period in the event 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.

In 2002, legislation was enacted to authorize the OIR to implement the provisions of the National Association of Insurance Commissioners' (NAIC) Long-Term Care Insurance Model Regulation 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's 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, described above and 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

[6] Ch. 2002-282, L.O.F.
[7] Rule 69O-157, F.A.C.

payment of benefits. For example, most policies require that a person is unable to perform a given number of activities of daily living. Many policies have a benefit trigger for cognitive impairment. Policyholders can only qualify for these benefits if they are unable to pass tests assessing their mental functioning. Policies contain an elimination period, which is 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 that offers 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 the 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 provisions:

> "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."

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."

The 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, 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 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 do rate comparisons between carriers. Any additional options offered by the carrier above the standard policy would 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. This is similar to what is required in the small group market to prevent carriers from closing forms in one company and continuing to do business through another.
6. Create an ombudsman position.
7. Consider corporate tax incentives.
8. Implement an organized public awareness campaign.

III. Effect of Proposed Changes:

Section 1 creates s. 627.94075, F.S., to revise the current contestability provisions relating to a long-term care insurance policy. This section provides that, notwithstanding s. 627.607, F.S., each long-term care insurance policy is incontestable after the policy has been in force for 2 years from the date of issuance, except for nonpayment of premiums. This would revise and lower the current incontestability standard to comport with the requirement for life insurance and annuity policies under s. 627.455, F.S., which are incontestable after being in force for a period of 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.

Sections 2 and 3 amend ss. 627.9403 and 627.9404, F.S., to clarify that any limited benefit policy that limits certain coverage in a nursing home is a type of long-term care insurance policy that must meet the requirements of this part that apply 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 referenced as cancer, dread disease policies. In 1997, the revised 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 “limited benefit policy” but were included under the long-term care insurance laws. These two terms have caused misunderstanding and this change is to clarify which policies are long-term care insurance and which are excluded.

Section 4 amends s. 627.9407, F.S., to revise certain requirements for long-term care insurance policies. The section would generally prohibit an insurer from imposing a new waiting period for existing coverage converted to or replaced by a new or other form with any affiliated insurer.

However, the term, "affiliated," is not defined. Currently, the waiting period provisions only apply to the insurer not to an affiliate of the insurer.

The section 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 would allow insurers flexibility in providing less coverage to address the financial needs of consumers. 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 benefit that would allow the policyholder the following options, if there was a significant rate increase: pay the rate increase, apply an amount equal to the sum of premiums paid to date towards a paid-up policy with fewer benefits, or reduce coverage to avoid loss of all coverage. This provision would apply 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.

This section also revises laws governing rate regulation. This section prohibits rates for existing policyholders to exceed rates for new policyholders. If an insurer is not currently issuing new coverage, the new business rate would be published by the OIR at the rate representing 80 percent of the insurers currently issuing policies with similar coverage as determined by the prior calendar year earned premium. This section requires that compliance with the pooling provisions of s. 627.410, F.S., would be determined by pooling the experience of all affiliated insurers. The section would require insurers 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 5 amends s. 627.9408, F.S., to require the Financial Services Commission to adopt by rule a standardized benefit plan that all insurers offering long-term care insurance coverage would be required to offer to prospective insureds. Any marketing materials for long-term care products would be required to include a reference to the availability of the standardized benefit plan. Insurers would still be able to offer other benefit plans.

Section 6 amends s. 641.2018, F.S., to provide a technical, conforming cross-reference.
Section 7 appropriates the sum of $72,500 from the Insurance Regulatory Trust Fund to the Office of Insurance Regulation for the purpose of funding a full-time position to implement the provisions of this act for fiscal year 2006-2007.

Section 8 provides that this act would 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 would apply to such policy only upon renewal on or after July 1, 2008, and would provide so by endorsement to the policy.

Section 9 provides that this act would take effect on July 1, 2006.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

Section 4 of the bill mandates that an insurer offer a policyholder a contingent benefit upon lapse, effective July 1, 2006, regardless of the date the policy was issued or renewed. It may be an unconstitutional impairment of contract to apply the bill's requirements to policies in effect on July 1, 2006. On March 1, 2003, this same provision was applied to policies issued on or after March 1, 2003, pursuant to a rule adopted on that date.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill would provide 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 options 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 making premiums payments 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. The intent of this provision is to ensure that

insurers will not be able to avoid the intent of Florida's requirement to pool all claims experience in the calculation of premiums by closing a block of forms with one of their affiliated companies and open 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 two 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. A minimum benefit plan would ensure that applicants for new policies receive a minimal amount of coverage in their policy.

The elimination of the mandatory 24 months of coverage for nursing home care is designed to allow insurers flexibility in offering products in the market and address affordability concerns.

C. Government Sector Impact:

The bill appropriates $72,500 from the Regulatory Trust Fund to fund a full-time employee, (a senior actuarial analyst position) who is intended to monitor rates, 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.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Summary of Amendments:

None.