House Legislative Analysis Section

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REGULATE LONG-TERM CARE COVERAGE

House Bill 5235 (Substitute H-2)
Sponsor: Rep. Mary C. Brown

House Bill 5313 (Substitute H-2)
Sponsor: Rep. Walter J. DeLange

House Bills 4566-4568 (Substitutes H-5)
Sponsor: Rep. Donald Van Singel
Committee: Insurance

House Bills 5315 (Substitute H-3)
Sponsor: Rep. Lloyd F. Weeks
Committee: Public Health

First Analysis (3-8-88)

THE APPARENT PROBLEM:

Increasingly, public attention is focusing on the need to find ways to finance so-called long-term health care, particularly basic nursing home care. As the population ages — more people are living longer — the burden on families and government programs to pay for the help many older people need with the activities of daily living grows. According to a report by the Insurance Bureau and Office of Services to the Aging: "In Michigan, Medicare pays for about 2 percent of all long term care days. Another 2 to 3 percent of long term care patient days are paid by private insurance. About a quarter of the patients must pay for their own care out of their family funds. Nursing home stays are typically in excess of a year in duration with costs in excess of $40 per patient day. Most individuals do not have the funds necessary to meet the charges which will exceed $15,000 yearly. As a result of not having adequate funds, patients must eventually be covered by the Medicaid program which pays for almost 70 percent of all long term care patient days in Michigan." Researchers also report that seven of ten older persons living alone spend their income down to poverty levels after 13 weeks in a nursing home and that more than half of married couples are impoverished after one of the partners has spent six months in a nursing home. In the case of people with dementing disorders, such as Alzheimer's Disease, the lack of available financing of appropriate care, including help for families looking after an afflicted person, drains the economic and emotional resources of families and results in unnecessarily early and expensive institutionalizion in nursing homes. Slowly, the health insurance industry is beginning to move into this field and some employers are beginning to offer or at least consider offering coverage for long-term care. This is considered a hopeful sign because if people buy such coverage when they are young or receive the benefit through large employer groups, the risks are better spread and the cost of coverage is reduced. A recent state task force on Alzheimer's Disease and related conditions pointed out that it is in the interest of the state to encourage the insurance industry to develop and market long-term care policies in Michigan. But they warned: "The insurance products which are marketed are valuable only if they are well designed, reasonably priced, are understandable to the policyholders, and are marketed in an honest and straightforward manner." A package of bills regulating this emerging area of insurance has been developed that is intended to encourage the marking of new policies while at the same time protecting the interests of consumers.

THE CONTENT OF THE BILLS:

The bills would all regulate long-term care coverage. House Bill 5235 would amend the Insurance Code (MCL 500.2280) to apply to commercial health insurers. House Bill 5313 would amend the Nonprofit Health Care Corporation Reform Act (MCL 550.1420) to apply to Blue Cross and Blue Shield of Michigan. House Bill 5315 would amend the Public Health Code (MCL 333.21053a) to apply to health maintenance organizations (HMOs). House Bills 4566-4568 would amend each of those acts to require long-term care policies to cover basic and intermediate care and to prevent them from excluding certain conditions from coverage, including Alzheimer's Disease and related disorders. The three main regulatory bills, generally speaking, contain many similar provisions, although the HMO-related bill contains some significantly different provisions. Among the main features of the long-term regulations are the following.

- The insurance commissioner would be authorized to promulgate rules establishing specific standards for provisions contained in long-term care coverage and, for commercial insurers and HMOs, establishing loss ratio standards for such coverage. Rules would cover such matters as initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, definition of terms, terms of renewability, and standards setting forth the manner, content, and required disclosures for the sale of long-term care coverage. In the case of HMOs, the insurance commissioner and the director of the Department of Public Health would jointly promulgate rules (since HMOs are regulated by both). Those rules could not be more restrictive than the rules for insurance companies.
- A long term care policy (or certificate) would have to contain a guaranteed renewable provision, and companies would not be allowed to cancel or otherwise terminate a long-term care policy on the grounds of the age or the deterioration of the mental or physical health of the insured. If existing coverage was converted to or replaced by a long-term care policy, the new policy could not contain a new waiting period except for voluntarily selected benefit increases. (The waiting period provision for HMOs is found in House Bill 5314, which otherwise is not dealt with in this analysis.)

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- A long-term care policy that provides coverage for care in an intermediate care facility or a skilled nursing facility would also have to provide coverage for home care services.
- Group coverage could be provided to employer and labor organizations, to professional, trade, and occupational associations, and to other kinds of associations and trusts if they met certain standards. The bill would also allow for the establishment of "discretionary groups" (those not specifically allowed to act as conduits for insurance) if the insurance commissioner determined that the issuance of the group policy was not contrary to the best interests of the public and would result in economies of acquisition or administration and that the benefits were reasonable in relation to the premiums charged. (House Bill 5315, dealing with HMOs, does not contain this language, but simply allows HMOs to offer long-term care contracts to "groups or individuals.")
- Group long-term care coverage could not be offered to a Michigan resident under a policy issued in another state to a discretionary group unless Michigan regulators or those of another state with similar requirements determined that all requirements had been met. (This is not in the HMO bill.)
- Before advertising, marketing, or offering a group long-term care policy in the state to an association or combination of associations (other than employer, labor, professional or trade associations), an insurer would have to file evidence with the insurance commissioner that the group consisted of at least 100 members, had been in active existence for at least one year, held regular meetings at least annually, collected dues or solicited contributions from members, afforded members voting privileges and representation on the governing board and committees, and had been organized in good faith for purposes other than obtaining insurance, unless the commissioner waived the last requirement. (This is not in the HMO bill.)
- A long-term care policy could not contain a pre-existing condition limitation period extending more than six months beyond the effective date of coverage. A different period of time could be set by the insurance commissioner if he or she determined it to be in the best interest of the public and if he or she considered it justified because the group in question was specially limited by age, group categories, or other specific policy provisions. (For HMOs, the financial viability of the long-term products could also be a factor.) Except for those issued to labor or employer groups, a policy could not use a definition of "preexisting condition" more restrictive than that found in the bills. (This would not appear to apply to HMOs.) Companies would not, however, be prevented from eliciting complete health histories from applicants. Commercial insurers and HMOs could underwrite on the basis of those histories using their established underwriting standards. Unless the policy said otherwise, a preexisting condition would not have to be covered until after the waiting period. A policy could not exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period (although in the case of HMOs this would not apply if a waiver or rider doing so had been approved by the Insurance Bureau and the Department of Public Health).
- A long-term care policy could not condition benefits on the prior institutionalization of the policyholder. (This provision is not in the HMO-related bill.)
- Policyholders or subscribers would have the right to return policies within 30 days and have the premium refunded if they were not satisfied for any reason and would have up to 45 days to return a policy obtained as a result of a direct response solicitation (i.e., direct mail, magazine or television advertisements). In each case, the policy or certificate and the accompanying outline of coverage would have to notify the customer of the right to return in a prominently printed notice on the first page. In the case of HMOs, the right to return and notice provisions would apply to nongroup subscribers, and subscribers would be responsible for payment of reasonable fees for any services received prior to cancellation.
- House Bills 5235 and 5313 would define "long-term care insurance" or "long-term care coverage" as individual or group coverage promising or designed to cover at least 12 consecutive months of necessary services of a wide variety provided in other than an acute care unit of a hospital. The term does not include basic Medicare supplemental coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident-only coverage, specific disease or specific accident coverage, or limited benefit health coverage. House Bill 5315 contains similar language, although it allows hospice care coverage to be limited to six months.
- House Bill 5325 would amend a section of the no-fault auto insurance act to stipulate that auto insurers could not offer and a personal protection insurance policy could not provide deductibles or exclusions related to long-term care coverage of an insured. Generally speaking, this means that long-term care coverage would be secondary to auto insurance coverage. House Bill 5315, applying only to HMOs, would stipulate that coverage under any nongroup long-term care contract would have to be coordinated with and be secondary to any benefits to which the enrollee was entitled under any other policy or coverage, including auto insurance and including employee benefits as part of an employee health benefits plan, workers' compensation plan, disability benefit plan, or retirement benefit plan.
- House Bill 5315 contains some provisions specific to HMOs. The bill specifically allows benefits under a long-term care contract to be limited to a specified dollar per day amount, a maximum total dollar amount, or a specified length of time. (This is not typical of HMO coverage generally, although it is common in other forms of insurance.) An HMO could only issue long-term care contracts if it was in full compliance with requirements for adequate working capital, statutory deposits and reserves, and was not operating under any limitation to its license. Further the bill requires HMOs to provide applicants for nongroup coverage a summary of benefits in the form specified in the bill (as other insuring entities must) and a list of affiliated providers and facilities. HMOs that issue a long-term care contract in conjunction with other HMO coverage would have to assure that the benefits under the long-term contract do not duplicate benefits under the basic health services contract of the HMO.
- House Bills 4566-4568 would each require that long-term care coverage issued or renewed after the effective date of the bills (1) include coverage for intermediate/basic care, and (2) not limit or exclude coverage by type of illness, treatment, medical condition, or accident, except for: preexisting conditions; mental or nervous disorders, but not Alzheimer's disease or related disorders; alcoholism and drug addiction; and conditions arising out of wars, riots and insurrections, service in the armed forces, suicide or intentionally inflicted injury, and aviation. The bills specify that they do not intend to prohibit exclusions and limitations by type of provider or

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territorial limitations. House Bill 4566 would apply to Blue Cross and Blue Shield and is tie-barred to House Bill 5313. House Bill 4567 would apply to commercial insurance companies and is tie-barred to House Bill 5235. House Bill 4568 would apply to HMOs and is tie-barred to House Bill 5315.

FISCAL IMPLICATIONS:

The Department of Licensing and Regulation says in its draft analyses that the bills have no revenue or budgetary implications to the state. (3-1- 88)

ARGUMENTS:

For:

The bills regulating long-term care insurance are based on a model developed by the National Association of Insurance Commissioners and have as their aim protecting the public while encouraging the marketing of long-term care coverage by commercial insurers, Blue Cross and Blue Shield, and HMOs. This is an emerging area of insurance and currently no standards exist. The package of bills would establish long-term care as a separate sphere of insurance with its own standards. Considering the problems that have existed (and, to some extent, still exist) with the design and marketing of Medicare supplemental policies, it is considered essential that standards be in place that ensure that long-term care policies available to Michigan residents provide meaningful coverage that meets the need of the customers. The bills would, for example, not allow companies to exclude coverage or benefits to people suffering from Alzheimer's Disease or other dementing disorders, as many existing types of coverage do. The bills would place restrictions on how companies treat pre-existing conditions, and would not allow companies to require the prior institutionalization of the insured before long-term care benefits can begin. This is important because many people need home health care or go to nursing homes without the need for hospitalization and are then not covered under some existing policies. The package also makes long-term care coverage secondary to auto no-fault coverages (meaning auto insurance pays first when applicable), which will keep costs down. Further, the bills allow the insurance commissioner the power to permit the formation of new kinds of groups in order to make group coverage more available.

Against:

Generally speaking, the problem with regulatory legislation of this kind is that it discourages insurance companies from entering the market and, thus, reduces the availability of coverage. Few if any of the existing long-term care policies could meet the standards in the bill, say some industry representatives. By setting standards too high, the legislature could make available only expensive coverages and take away from consumers the right to buy cheaper, albeit less comprehensive, long-term care coverage. For example, the bills would not allow a company to market a policy that requires prior hospitalization before long-term care benefits could begin. Some companies now offer both a policy with and one without prior hospitalization requirements and the former is far less expensive than the latter. Why not let companies offer both and allow consumers to choose? Further, there needs to be some standard for when benefits are to begin and companies are uncomfortable allowing the insurance commissioner to decide that standard. The industry has other specific complaints, including the length of time for the right to return policies.

Against:

There is opposition to including in the bills a provision making long-term care benefits secondary to auto no-fault coverage. The Insurance Bureau says this is contrary to current practices as determined by state supreme court decisions and should best be dealt with as a separate issue. Auto insurers say that it establishes a precedent for making auto coverage primary and erodes their ability to offer discounts to customers for the coordination of benefits.

Response: Making auto primary to long-term care (as a special, separate kind of insurance) will allow companies to keep the cost of this coverage down. It will also prevent people from using up their benefits as a result of an auto accident and then being left without the coverage they had anticipated (and had paid premiums for) later. At this point, it is important to hold down the costs of long-term care coverage, and make sure that the policies are used for the circumstances anticipated. It is also important to encourage people under 65 to purchase long-term care coverage, and the coordination of benefits provision advances that effort. This does not affect the larger issue of how to coordinate health insurance and auto no-fault insurance.

POSITIONS:

The Department of Licensing and Regulation, which houses the Insurance Bureau, said in draft analyses that it supports the bills (although it has proposed an amendment to remove the coordination of benefits provision). (3-1-88)

The Office of Services to the Aging strongly supports the package but would prefer strengthening of consumer protections. (3-7-88)

Blue Cross and Blue Shield supports House Bill 5313. (3-1-88)

A representative of the Association of HMOs testified before the House Insurance Committee that it supported the HMO regulation bill. (3-1-88)

The Health Insurance Association of America supports the package with amendments (although it takes no position on the bills dealing with HMOs and Blue Cross and Blue Shield). (3-7-88)

The Michigan Insurance Federation testified before the House Insurance Committee it would oppose House Bill 5235 if the coordination of benefits provision was not removed. (3-1-88)