House Legislative Analysis Section

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LONG-TERM CARE: DISCLOSURE OF COVERAGE

House Bills 5246-5249 as passed by the House
Sponsor: Rep. Agnes Dobronski

House Bills 5257, 5259-5260 as passed by the House
Sponsor: Rep. Sharon Gire

House Bills 5272-5275 as passed by the House
Sponsor: Rep. Kay M. Hart

House Bills 5289-5294 as passed by the House
Sponsor: Rep. Roland Niederstadt

House Bills 5306-5307 as passed by the House
Sponsor: Rep. Thomas Mathieu

Committee: Insurance

House Bill 5314 as passed by the House
Sponsor: Rep. Lloyd F. Weeks

Committee: Public Health

Second Analysis (4-6-88)

THE APPARENT PROBLEM:

It is a commonplace that many senior citizens are confused or misinformed about the nature of their health insurance coverages. Shopping for insurance is confusing for all consumers because analyzing and comparing policies are technical and complicated tasks. These tasks are all the more difficult when the marketing of insurance products is both aggressive and less than straightforward. Older people face additional problems, in part because they have some underlying coverage from the federal Medicare program that need not be bought in the private market but should be supplemented carefully. Researchers say many older citizens buy duplicate or overlapping insurance policies while at the same time believing they are covered for certain kinds of care when they are not. Many people on Medicare are not fully informed about what that program does and does not cover and, thus, do not fully appreciate the need for supplements to the coverage provided by the federal program and the need to evaluate carefully the nature of the coverages provided by a policy that claims to fill in the gaps left by Medicare. A recent survey by the American Association of Retired Persons (AARP) revealed that four out of five of its members believed — falsely — that they had coverage for long-term care (i.e., basic nursing home care). As public attention increasingly focuses on the need for protection against the high costs of long-term care, and as more companies begin to market long-term care products, the kinds of consumer problems traditionally associated with the marketing of Medicare supplemental policies will multiply. Education in this area is essential. There are a number of ways of accomplishing it. One way of helping senior citizens who are shopping for insurance is to require that policies carry a descriptive label (e.g., "this is a long-term care policy"), or a protective warning (e.g., "this policy does not cover custodial care in a nursing home"), or be accompanied by useful summaries of what they do and do not cover. It would also be useful if consumers could get help from knowledgeable yet neutral sources in evaluating the policies they were considering buying. Further, the onus should be on companies and their agents to make sure that they are not selling duplicative or unnecessary coverages.

THE CONTENT OF THE BILLS:

House Bills 5246-5249 would require that applicants for long-term care coverage be provided with a summary of coverage similar to that required for Medicare supplemental coverage. House Bill 5257 and House Bills 5259-5260 would prohibit companies or agents from inducing a person to replace long-term care or Medicare supplemental coverages with new coverages that provided fewer benefits for the same price or the same benefits at a higher price. House Bills 5272-5275 would require applications for long-term care and Medicare supplemental coverages to carry a notice that additional information was available from the insurance bureau and the local area agency on aging. House Bills 5289-5294 would require that applications for certain kinds of coverage carry prominent notices about the nature of the coverage. House Bills 5306 and 5307 would (1) prohibit the issuing of a Medicare supplemental policy to a person not eligible for Medicare, and (2) require insurers to determine, before offering an applicant an individual policy, if the applicant was already covered under a group policy providing substantially the same benefits and then notify the applicant how the individual policy would duplicate or coordinate with the existing group policy. House Bill 5314 would apply the regulations that now apply to Medicare supplemental insurance policies of insurance companies and Blue Cross-Blue Shield to supplemental coverage offered by health maintenance organizations (HMOs), and would apply to HMOs provisions similar to those found in House Bills 5306 and 5307.

Summary of Coverage

House Bills 5246 and 5247 would require that a prospective

applicant for a long-term care insurance policy be provided a summary of coverage before application and at any other time before renewal upon request. The insurer would have to obtain an acknowledgement of receipt of the summary by collecting the signatures of the prospective applicant and the agent or representative. The bills would require that the coverage summary be substantially in the form detailed in the bill. House Bill 5246 would amend the Insurance Code (MCL 500.8302) and apply to commercial insurance companies. House Bill 5247 would amend the Nonprofit Health Care Corporation Reform Act (MCL 550.1430) and apply to Blue Cross and Blue Shield of Michigan.

House Bills 5248 and 5249 would apply the same requirements to Medicare supplemental policies. Currently, applicants for these policies must be provided an outline of coverage at the time of application, not before application. The bills would also make some changes in the nature of the outline that must be provided. House Bill 5248 would apply to commercial insurance companies (MCL 500.2267). House Bill 5249 would apply to Blue Cross and Blue Shield (MCL 550.1413).

Policy Replacement

House Bills 5257, 5259 and 5260 would prohibit an insurance company or Blue Cross and Blue Shield, or their representatives, from inducing a person to cancel or otherwise terminate either a long-term care policy or a Medicare supplemental policy and replace it with a policy that had fewer benefits and the same or greater premium or that had equal benefits and a greater premium than the canceled policy.

House Bill 5257 and 5259 would amend the Insurance Code (MCL. 500.2005) to apply to, respectively, Medicare supplemental and long-term care policies of commercial insurance companies. House Bill 5260 would amend the Nonprofit Health Care Corporation Reform Act (MCL 500.1402) to apply to the long-term care and Medicare supplemental certificates of Blue Cross and Blue Shield.

Advice About Policies

House Bills 5272-5275 would require applications for certain kinds of coverage to carry on the first page in capital letters the statement: "For additional information about (this kind of) coverage call the Michigan Insurance Bureau (phone number) or the area agency on aging in your community." House Bill 5272 would amend the Insurance Code (MCL 500.2292) to apply to the long-term care policies of commercial health insurers. House Bill 5273 would amend the Nonprofit Health Care Corporation Reform Act (MCL 550.1432) to apply to the long-term care certificates of Blue Cross-Blue Shield. House Bill 5274 would amend the Insurance Code (MCL 500.2267c) to apply to Medicare supplemental policies issued by commercial health insurers. House Bill 5275 would apply to Medicare supplemental certificates of Blue Cross-Blue Shield (MCL 550.1413c).

Disclosure

House Bills 5289 and 5294 would require applications for both disability insurance policies of commercial insurers and certificates of Blue Cross-Blue Shield that do not provide coverage for basic custodial nursing care to each contain a statement at the top of the first page in capital letters of not less than 14-point boldface type that the policy or certificate "does not cover custodial care in a nursing care facility." The requirement would apply to both Medicare supplemental policies and to other disability policies that provide hospital, medical, surgical, or sick-care benefits. House Bill 5289 would amend the Insurance Code (MCL 5100.2267b) to apply to commercial insurers. House Bill 5294 would amend the Nonprofit Health Care Corporation Reform Act (MCL 5510.1413b) to apply to Blue Cross and Blue Shield of Michigan.

House Bills 5290 and 5291 would require the application for a long-term care insurance policy or certificate to carry an equally prominent statement to the effect that "This is an application for a long-term care policy/certificate." House Bill 5290 would apply to Blue Cross-Blue Shield (MCL 550.1431). House Bill 5291 would apply to commercial insurers (MCL 500.2291).

House Bills 5292 and 5293 would require the application for a Medicare supplemental policy or Medicare supplemental certificate to carry the statement, "This is an application for a Medicare supplemental insurance policy/ certificate." House Bill 5292 would apply to commercial insurers (MCL 500.2267a). House Bill 5293 would apply to Blue Cross-Blue Shield (MCL 550.1413a).

Irrelevant and Duplicate Coverage

House Bills 5306 and 5307, in general, would prohibit the issuance of a Medicare supplemental policy to a person who is not eligible for Medicare. Insurers would be required to verify that a person was eligible for Medicare before issuing the supplemental policy. An application for a policy, however, could be taken prior to determining the applicant's eligibility. All premiums paid by a non-eligible person for a supplemental policy would have to be refunded.

The bills would also require companies to determine, before offering an applicant an individual policy, if the applicant was already covered under a group policy providing substantially the same benefits and then notify the applicant how the individual policy being offered would duplicate or coordinate with the existing group policy.

House Bill 5306 would amend the Nonprofit Health Care Reform Act (MCL 550.1413d) to apply to Blue Cross and Blue Shield. House Bill 5307 would amend the Insurance Code (MCL 500.2267d) to apply to commercial insurance companies.

Health Maintenance Organizations

House Bill 5314 would amend the Public Health Code (MCL 333.21054a) to apply Medicare supplemental regulations that apply currently to commercial insurance companies and Blue Cross and Blue Shield to health maintenance organizations (HMOs). These include: contracts labeled as Medicare supplemental contracts must at a minimum contain coverage equal to those found in either a "type 1" or (less expensive) "type 2" supplemental package prescribed by statute; an HMO must allow an enrollee the right to convert to a guaranteed renewable or noncancelable supplemental contract if the enrollee would lose coverage due to his or her becoming eligible for Medicare; a coverage outline prescribed in the bill must be provided to applicants; and a prescribed buyer's guide must also be provided. The bill would also impose Medicare supplemental requirements similar, but not identical, to those found in bills described earlier. A supplemental contract could not be offered to a person not enrolled in Parts A and B of Medicare. An HMO would have to verify that a customer for nongroup supplemental coverage was enrolled in Medicare. A person provided supplemental coverage but not eligible for Medicare would get the premiums refunded (but would have to pay for services rendered). Before offering nongroup coverage, an HMO would have to inquire if the person was a group subscriber with substantially the same benefits available and notify the person how the nongroup coverage would duplicate

or coordinate with the existing group coverage. Further, the bill would allow an HMO contract to require that, with some exceptions, benefits would be available only when services were provided or authorized by HMO providers in accordance with HMO procedures.

FISCAL IMPLICATIONS:

According to the Department of Licensing and Regulation, only House Bills 5272-5275 have revenue or budgetary implications to the state. The Insurance Bureau points out that its consumer assistance workload would be increased with the dissemination of its phone number to all customers for Medicare supplemental and long-term care policies. Staffing levels are already insufficient, the bureau says, and an additional staff positions will be necessary to provide additional assistance. (3-1-88)

ARGUMENTS:

For:

The aim of the bills is to help people buy the long-term health care coverages and Medicare supplemental coverages they need and only the coverages they need. To do that successfully, senior citizens (and others) need to know what coverage they already have and how to evaluate policies they are contemplating purchasing. And they need protection from marketing techniques that benefit agents and insurance companies at the expense of the customer. Consumers need clear explanations of what is covered by the policies they are evaluating and, just as important, what is not covered. None of this is as simple as it sounds, as anyone who has shopped for insurance knows. But it is essential if people are to be protected against possibly enormous future health care and nursing home expenses and if they are to avoid wasting money on insurance policies that they do not need or on policies that will not offer them meaningful protection. Some of the bills in the package require that applications for certain policies commonly marketed to senior citizens state clearly the nature of their contents, with particular attention given to clearing up common misconceptions (e.g., that a Medicare supplemental policy covers basic nursing home care). Others require that clear but comprehensive summaries of coverage be provided. Others demand that applications for policies carry the phone numbers of the insurance bureau and the local aging agency so that customers can get additional information. House Bill 5314 makes sure that health maintenance organizations follow the same regulations as other kinds of insurance entities if they market Medicare supplemental coverage.

For:

Several of the bills in the package protect insurance consumers by preventing companies and their agents or representatives from engaging in harmful marketing practices. They would be prohibited from inducing a customer to cancel one policy in favor of another if the new policy offered fewer benefits at the same or at a higher price or if the new policy offered the same benefits at a higher price. Researchers charge that agents engage in this practice in great part because of the higher sales commissions paid in the early years of a policy. Further, companies could not sell a Medicare supplemental policy to someone who is not eligible for Medicare. Reportedly, one woman in Western Michigan paid premiums for 15 years before discovering that her supplemental policy was of no use! Should it happen again, the policyholder would be entitled to a return of all premiums (which did not occur in the case cited). Companies selling non-group policies would have to inquire as to the existence of any group coverage and explain how the non-group policy would fit. This would help to avoid unnecessary and duplicative coverages, a common problem with Medicare supplemental policies and an anticipated problem with long-term care coverage as that product becomes more common.

Against:

While these bills have laudable goals, they have raised a number of concerns.

- Some people argue that the bills, while addressing the need to educate consumers, do not sufficiently deal with abuses in the sale of policies to the elderly. Senior advocates have made several proposals, including that a special category of agent's license be created restricting who can sell insurance to older people; that a separate bureau be created for the investigation of senior complaints against insurance agents and companies; and that a program be established to allow trained volunteers to assist senior citizens in making their insurance plans.
- Industry representatives say that the bills would create unnecessary burdens on them without addressing real problems. Requiring companies to verify the Medicare eligibility of applicants for supplemental policies is an example. Other than one extraordinary case (which did not involve a commercial health insurer), there is no evidence that this is a problem, and it is not clear how this verification is to be accomplished. The prohibition against inducing a person to replace one policy with another of "less value" is unworkable for several reasons; for example, there may be reasons other than benefits and price for switching from one insurance company to another. Also, it is not clear what kind of behavior would be considered "inducing."
- The Insurance Bureau has objected to House Bills 5289 and 5294, which require applications for some policies to say that the policies do not cover custodial care in a nursing home, on the grounds that such a warning might lead people to believe other kinds of nursing home care are covered when they are not.

POSITIONS:

The Department of Licensing and Regulation, which houses the Insurance Bureau, says in its draft analyses that it supports House Bills 5246-5249, House Bills 5272-5275, and House Bill 5314, does not oppose House Bills 5290-5293 or House Bills 5257-5260, but does not support House Bills 5289 and 5294. (3-1-88)

The Office of Services to the Aging strongly supports the long-term care package. (3-7-88)

The Health Insurance Association of America is opposed to the bills. (3-7-88)

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MEDICARE SUPPLEMENTAL POLICY OUTLINE

House Bills 5248-5249 as enrolled
Third Analysis (1-9-89)

Sponsor: Rep. Agnes Dobronski
House Committee: Public Health
Senate Committee: Commerce and Technology

THE APPARENT PROBLEM:

Insurance companies that offer Medicare supplemental policies are required by Michigan law to provide applicants for the policies with an outline of coverage. The form of the outline, which includes what the federal program does and does not cover, is prescribed both in the Insurance Code, which regulates commercial insurance companies, and the Nonprofit Health Care Corporation Reform Act, which regulates Blue Cross and Blue Shield of Michigan. Changes at the federal level providing so-called catastrophic coverage require a change in the prescribed outline.

THE CONTENT OF THE BILL:

House Bill 5248 and House Bill 5249 would amend separate acts to update the outline of coverage required of companies offering Medicare supplemental policies to take into account changes in the federal program. House Bill 5248 would amend the Insurance Code (MCL 500.2267). House Bill 5249 would amend the Nonprofit Health Care Corporation Reform Act (MCL 550.1413).

FISCAL IMPLICATIONS:

The bills contain no fiscal implications for the state, according to the Department of Licensing and Regulation. (3-1-88)

ARGUMENTS:

For:

The policy outlines that companies offering Medicare supplemental policies are required to provide to applicants need updating to take into account recent changes made in the federal Medicare program.

H.B. 5248 & 5249 (1-9-89)

H.B. 5248 & 5249 (1-9-89)