House Legislative Analysis Section

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REGULATE LONG-TERM CARE COVERAGE

House Bills 4391-4396

Committee: Insurance
Sponsors:
Rep. Walter J. DeLange (HB 4391)
Rep. William J. Runco (HB 4392)
Rep. Donald Van Singel (HBs 4393-4394)
Rep. Bart Stupak (HB 4395)
Rep. Mary C. Brown (HB 4396)
Complete to 3-14-89

A SUMMARY OF HOUSE BILLS 4391-4396 AS INTRODUCED 3-7-89

The bills would regulate long-term care coverage, whether provided by a commercial insurance company or Blue Cross and Blue Shield of Michigan (BCBSM). House Bills 4391 (applying to BCBSM) and House Bill 4396 (applying to commercial insurers) are the two main regulatory bills. House Bills 4392 and 4395 each would require that applicants for long-term care policies and renewing customers be provided with a summary of benefits as outlined in the bills and would prohibit anyone in the insurance business from inducing a person to terminate one long-term policy and replace it with another unless there was a substantial cost advantage to the customer or the customer had previously demonstrated dissatisfaction with the service being provided. If fewer benefits would be provided under a new policy, a company would have to obtained a signed acknowledgement from the customer. House Bills 4391 and 4392 would both amend the Nonprofit Health Care Corporation Act, which regulates Blue Cross and Blue Shield of Michigan and are tie-barred to one another; and House Bills 4395 and 4396 would amend the Insurance Code and are tie-barred to one another. House Bills 4393 and 4394 would require long-term care policies to cover basic and intermediate care and would prevent them from excluding certain conditions from coverage, including Alzheimer's Disease and related disorders. House Bill 4393 would apply to Blue Cross and Blue Shield and House Bill 4394 would apply to commercial insurers.

The two main regulatory bills contain basically the same provisions. Among their major features 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, 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 nature of required disclosures involved in the sale of long-term care coverage.
- 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.
- Each long-term care policy would have to contain a conversion provision permitting an individual entitled to benefits under a group policy to convert to an individual policy with the option of receiving substantially similar benefits.
- 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.
- 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.
- 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.
- 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. Except for those issued to labor or employer

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groups, a policy could not use a definition of "preexisting condition" more restrictive than that found in the bills. Companies would not, however, be prevented from eliciting complete health histories from applicants. Commercial insurers 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.

- A long-term care policy could not condition benefits on the prior institutionalization of the policyholder.
- 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 30 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.
- The bills 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 Bills 4393 and 4394 would require that long-term care coverages 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 including Alzheimer's Disease or related disorders; alcoholism and drug addiction; and conditions arising out of wars, riots, and insurrections, service in the armed forces, suicides, or intentionally inflicted injury, and aviation.

House Bills 4392 and 4395 would, as mentioned earlier, require that prospective applicants for long-term care policies and customers renewing policies be provided with a summary of benefits and would prohibit the substitution of one policy for another unless there were cost benefits to the customer or the customer was dissatisfied with the service being received under the first policy. A company could replace one policy with another with fewer aggregate benefits only if the customer signed an acknowledgment that fewer benefits would be received under the new policy. Also, companies would have to obtain the signatures of the customer and of their own agent or representative acknowledging receipt of the summary of benefits.

MCL 550.1101 et al. (House Bills 4391-4393) and

MCL 500.100 et al. (House Bills 4394-4396)