SFA BILL ANALYSIS

Senate Fiscal Agency • Lansing, Michigan 48909 • (517) 373-5383

Senate Bill 310 (Substitute S-2 as reported)
Sponsor: Senator Doug Carl
Committee: Commerce and Technology

Date Completed: 8-30-89

RATIONALE

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, the responsibility to pay for the help many older people need with the activities of daily living falls increasingly on families and the government. According to a report by the Insurance Bureau and Office of Services to the Aging, Medicare pays for about 2% of all long-term care days in Michigan, while another 2% to 3% 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. Further, the report states that nursing home stays typically are in excess of a year in duration with costs in excess of $40 per patient day, and most individuals do not have the funds necessary to meet the charges, which will exceed $15,000 yearly. The report concludes that, as a result of not having adequate funds, patients must eventually be covered by the Medicaid program which pays for almost 70% of all long-term care patient days in Michigan. Researchers also report that seven out of 10 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. When people have dementing disorders, such as Alzheimer's Disease, the lack of available financing for 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 institutionalization in nursing homes. Slowly, the health insurance industry is beginning to move into the field of long-term care and some employers are beginning to offer or at least consider offering coverage for long-term care. Many who are concerned with the increasing need for, and cost of, long-term care reportedly are encouraged by the attention the issue is receiving from insurers, employers, and the public. They argue that if people buy such coverage when they are young or receive the benefit through large employer groups, the risks are spread more widely 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. The task force warned, however, that insurance products are valuable only if they are well designed, reasonably priced, understandable to the policyholders, and marketed in an honest and straightforward manner. It has been suggested that efforts be made to regulate this emerging area of insurance to encourage the marketing of new policies while at the same time protecting the interests of consumers.

CONTENT

The bill would amend the Insurance Code to provide for the regulation of long-term care coverage. The bill would define "long-term care insurance" 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 would not include coverage for rehabilitative and convalescent care that was not offered, advertised, or marketed as a long-term care policy, nor would it 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, limited benefit health coverage, basic hospital or medical-surgical expense coverage, catastrophic coverage, or comprehensive coverage. The bill would take effect January 1, 1990.

Rules

The Insurance Commissioner would be authorized to promulgate rules establishing specific standards for provisions contained in long-term care insurance policies and establishing loss ratio standards for such coverage. Rules could cover such matters as initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents if provided in the policy, 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.

Long-Term Care Policies

A long-term care policy would have to contain a guaranteed renewable provision, and insurers could not cancel or otherwise terminate a long-term care policy on the ground of the age or the deterioration of the mental or physical health of the member. If existing coverage were converted to or replaced by a long-term care policy with the same insurer, 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 provided coverage for care in an intermediate care facility or a skilled nursing facility also would have to provide coverage for home care services. An "intermediate care facility" would be a facility, or distinct part of a facility, certified by the Department of Public Health to provide intermediate care, custodial care, or basic care that was less than skilled nursing care but more than room and board. "Home care services" would mean medically prescribed services or assessment team recommended services for the long-term care and treatment of an insured that were provided by home health or care agencies in a noninstitutional setting according to a written diagnosis, or individual assessment and plan of care, and would include nursing services, nutritional services, personal care services, homemaker services, meal preparation, physical, speech, respiratory and occupational therapy, and similar medical and nonmedical services.

A long-term care policy could not contain a preexisting 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 groups, a policy could not use a definition of "preexisting condition" more restrictive than that found in the bill. Insurers would not, however, be prevented from eliciting complete health histories from applicants, and on the basis of their answers, underwriting in accordance with an insurer's 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 conditions beyond the waiting period.

A long-term care policy could not condition benefits on the prior institutionalization of the insured.

Group Coverage

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 also would provide 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 a 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 this State or another state with statutory or regulatory long-term care insurance requirements similar to those of Michigan determined that all requirements had been met.

Before advertising, marketing, or offering a group long-term care policy in the State to an association, a trust, or the trustees of a fund established for members of an association, the group or the 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.

Return of Policy

Long-term policyholders would have the right to return policies within 30 days and have the premium refunded if they were not satisfied for any reason and benefits had not been incurred under the policy, 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 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.

MCL 500.3405 et al.

FISCAL IMPACT

The bill would have no fiscal impact on State or local government.

ARGUMENTS

Supporting Argument

The bill is based on a model developed by the National Association of Insurance Commissioners and is designed to help protect the public while encouraging the marketing of long-term care coverage by commercial insurers. This is an emerging area of insurance and currently no standards exist. The bill 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 established to help ensure that long-term care policies available to Michigan residents provide meaningful coverage that meets the needs of customers. The bill would place restrictions on how insurers treat preexisting conditions, and would not allow insurers to require the prior institutionalization of the insured before long-term care benefits could begin. This is important because many people who need only home health care or go to nursing homes without first being hospitalized or institutionalized are not covered under some existing policies. The bill also would require that a long-term care policy provide coverage for at least some kind of home care, which is a low-cost alternative to nursing home care. Often it is the lack of available home care that forces people to enter nursing homes when they could otherwise live independently in their own home. Further, the bill would grant the Insurance Commissioner the power to permit the formation of new kinds of groups in order to increase the availability of group coverage.

Opposing Argument

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.

According to some industry representatives, few if any of the existing long-term care policies could meet the standards in the bill. If the standards were too stringent, the only coverage offered would be expensive and, therefore, unavailable to many consumers. For example, the bill would not allow an insurer to market a policy that required prior hospitalization before long-term care benefits could begin. Some companies now offer policies with and without prior hospitalization requirements and the policy with prior hospitalization requirements is far less expensive than the policy without the requirement. Why not let companies offer both and allow consumers to choose? This package would go beyond the NAIC model by prohibiting prior "institutionalization" rather than prior hospitalization. Industry officials say there must be some standard for determining when benefits are to begin (a "gatekeeper", such as prior hospitalization) and insurers are uncomfortable allowing the Insurance Commissioner to decide that standard. The industry has other specific complaints as well, including the requirement that long-term care policies cover home health care. Industry representatives claim that mandating coverage always increases the costs to the insurers and their customers and decreases the number of people who can obtain coverage. Mandating that insurers offer to provide home health care coverage, if customers requested it, would keep policies affordable while protecting the interests of the customer. Under the NAIC model act, they say, home health care is optional, not mandatory, coverage.

Response: Coverage for home care should reduce costs to insurers by reducing the need for payments to nursing homes and to customers by enabling them to remain in their home, rather than having to spend time unnecessarily in a hospital or other institution. Besides, the bill would require that only one of a list of home care services be provided. For example, a policy could provide only housekeeping coverage. (In fact, what many people need is not medical care but help with so-called activities of daily living.) Finally, mandating home health care coverage would help eliminate the possibility that a person will buy long-term care coverage expecting to have home care services covered only to find out later that they were not.

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