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: General Government Appropriations Committee

BILL:	CS/SB 2290
INTRODUCER:	General Government Appropriations Committee, Senator Fasano, and others
SUBJECT:	Long-term Care Insurance
DATE:	April 25, 2006 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Deffenbaugh	BI	**Favorable**
2.	Garner	Wilson	HE	**Fav/1 amendment**
3.	Kynoch	Hayes	GA	**Fav/CS**
4.				
5.				
6.				

I. Summary:

The bill amends laws governing long-term care insurance to:

- Provide 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 two years, unless there is a fraudulent misrepresentation in the application.
- Prohibit an insurer from imposing a new waiting period when a policy is replaced through an affiliated insurer.
- Eliminate the current minimum nursing home benefit of 24 months of coverage.
- Require all existing policyholders to 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.
- Prohibit existing policyholders from being charged premiums that exceed the premiums the insurer is charging to new policyholders.
- Require 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.
- Provide an appropriation to the Office of Insurance Regulation (OIR) for a full-time position.
- Require the Agency for Health Care Administration (AHCA) to establish a qualified state Long-term Care Partnership Program in Florida, in compliance with the requirements of the Social Security Act as amended by the federal Deficit Reduction Act of 2005, and in consultation with the OIR and the Department of Children and Family Services (DCF).

- Provide certain regulatory and administrative requirements for AHCA and OIR.
- Require that, for purposes of determining Medicaid eligibility, assets in an amount equal to the insurance benefit payments made to, or on behalf of, an individual who is a beneficiary under an approved qualified state Long-term Care Partnership Program policy shall be disregarded.

The bill also repeals two provisions of chapter law that specify the design and function of the Florida Long-term Care Partnership Program, so that the language in this bill will regulate the partnership's activities.

The bill directs the Office of Program Policy Analysis and Government Accountability to prepare a report on the implementation of a qualified state Long-Term Care Insurance Partnership Program in Florida.

This bill reenacts and amends section 409.9102, Florida Statutes.

The bill amends the following sections of the Florida Statutes: 27.9403, 627.9404, 627.9407, 627.9408, and 641.2018.

The bill creates section 627.94075, Florida Statutes, and two undesignated sections of law.

The bill repeals chapter 2005-252(1) and (2), Laws of Florida

The bill amends chapter 2005-252(4), Laws of Florida.

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 ten percent of the people who enter a nursing home will stay there five years or more.[1]

[1] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. March 2005. Found at http://www.medicare.gov/LongTermCare/Static/Home.asp. (last visited March 30, 2006)

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; 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 nine percent in 2003.[2]

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 2002-2003, 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 mistakenly believe 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 ten 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.

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[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. (last visited March 30, 2006)
[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.

Long-term Care Partnership Programs

States have adopted three strategies to encourage younger persons to purchase private long-term care insurance. First, states offer tax incentives to individuals or employers to purchase private long-term care insurance. Tax deductions tend to be small and most likely will not constitute a significant savings for individuals or to the system. Second, many states offer, or are in the process of offering, long-term care insurance to their employees and retirees and, on occasion, to parents and parents-in-law of employees. In these cases, employees pay all of the cost but states may offer fringe benefits. Finally, states are developing public/private partnerships to encourage people to purchase long-term care insurance. Under these partnerships, people who purchase long-term care insurance can keep more assets and still become eligible for Medicaid.

The interests of the states in exploring ways to make private long-term care insurance more appealing and affordable to the public encouraged the Robert Wood Johnson Foundation (RWJF) to launch an initiative that provided planning grants to selected states that demonstrated an interest in this issue.[6] California, Connecticut, Indiana, Massachusetts, New Jersey, New York, Oregon, and Wisconsin received support to define and develop a public-private insurance partnership to pay for long-term care, although only four states ultimately implemented their public-private partnerships (California-1994, Connecticut-1992, Indiana-1993, and New York-1993).

With the help of the National Program Office, based at the University of Maryland Center on Aging, the states participating in the planning phase developed strategies to encourage the purchase of private insurance. The states recognized that to broaden the market for long-term care insurance it was important both to decrease the cost of the policies and to increase their quality. This is a special challenge, since increasing the quality of insurance policies generally increases the premium, which cuts down on the market. In the end, the key incentive to making the system work was a unique approach that allows people who purchase a state-certified long-term care insurance "partnership" policy to get help from Medicaid without having to exhaust their assets.

Normally, when a long-term care insurance policy runs out, policyholders risk having to spend virtually all their savings before qualifying for Medicaid. In contrast, when a partnership policy is exhausted, the policyholder is eligible for coverage under Medicaid without having to deplete previous savings. The details of the models differed from state to state. The most significant difference was between New York and the three other states.

In New York, partnership policies are required to pay three years of nursing home care, six years of home care, or some combination, after which all remaining assets are protected, known as the "total assets" model. A high priority of the New York approach is to offer middle- and upper-income seniors a viable alternative to giving away their assets and impoverishing themselves in order to qualify for Medicaid.

[6] Meiners, Mark, Hunter McKay, and Kevin Mahoney (2002). "Partnership Insurance: An Innovation to Meet Long-term Care Financing Needs in an Era of Federal Minimalism." *Journal of Aging & Social Policy*. Vol. 14, No. 3/4, pp. 75-93.

The underlying logic of this total-assets model is that the period of insurance is equal to or exceeds the time during which a person would be penalized by having to pay for long-term care if he or she had transferred assets in order to become eligible for Medicaid. When the program in New York began, this period was 30 months. Securing a three-year commitment to pay nursing home costs with private insurance would save the state money as compared to when someone is divested of his or her assets to receive Medicaid's assistance.

California, Connecticut, and Indiana adopted a "dollar-for-dollar" model. In addition to serving as an alternative to transferring assets, it allows people to buy a policy that protects a specified amount of their assets. An individual with $50,000 in assets might buy $50,000 in insurance protection while another individual with $150,000 in assets might buy $150,000 in insurance protection. Payments for long-term care by the insurance company are considered the equivalent of spending assets for the purpose of establishing Medicaid eligibility. Thus, a person who purchased a $75,000 policy would be able to keep $75,000 when he or she became eligible for Medicaid.

In later years, Indiana revised its program to include a hybrid approach intended to get the best of both asset-protection strategies. Up to a set amount of coverage (the dollar equivalent of four years in the average Indiana nursing home), the purchaser is eligible for dollar-for-dollar asset protection while getting Medicaid benefits. But those who buy a policy covering more than this amount will receive total-asset protection along with help from Medicaid once they use up their insurance.

In 2004, the number of partnership policies purchased ranged from about 4,000 in Indiana to nearly 10,000 in California. The number of partnership policies purchased each year has increased significantly since the programs began in the early 1990s, though there has been a decline or leveling off in the number of policies purchased in recent years. Based on the most recently available data, there are 172,477 active partnership policies insured by a total of 17 participating insurance companies throughout the states of California, Connecticut, Indiana, and New York. The percentage of partnership policyholders who were first-time policyholders of long-term care coverage was 94 percent in California, 92 percent in Connecticut, 94 percent in Indiana and 95 percent in New York.[7]

Less than one percent of active partnership policyholders are currently accessing their long-term care insurance benefits. Since the programs began, 251 policyholders in all four states have exhausted their long-term care insurance benefits. Of those 251 policyholders, 119 (47 percent) have accessed Medicaid. The remaining 53 percent have not accessed Medicaid. According to interviews with state officials, this may be because they are spending down income or unprotected assets, their health has improved, or their families provide informal care. More policyholders have died while receiving long-term care insurance benefits (899 policyholders) than have exhausted their long-term care insurance benefits (251 policyholders), which could suggest that the Long-term Care Partnership Program may be succeeding in eliminating some participants' need to access Medicaid. However, it is difficult to determine whether and to what extent the Long-Term Care Partnership Program has resulted in cost savings to the Medicaid

[7] *Overview of the Long-Term Care Partnership Program* (GAO-05-1021R), U.S. Government Accountability Office, September 2005.

program, because there are insufficient data to determine if those individuals who have purchased partnership policies would have accessed Medicaid had they not purchased long-term care insurance benefits.

Barriers to Implementing Long-Term Care Partnership Programs

While every RWJF Partnership was enacted as a result of unanimous votes in the state legislatures, the opposition at the federal level resulted in legislation that grandfathered the four RWJF State Partnerships but put restrictions on further replication. The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) required that any states implementing Partnership Programs after May 14, 1993, must recover assets from the estates of all persons receiving services under Medicaid. The result of this language is that, for replication states, the asset-protection component of the partnership is still in effect but only while the insured is alive. After the policyholder dies, those states must recover what Medicaid spent from the estate, including protected assets.

This provision in OBRA '93 has had the effect of stifling interest in replicating the long-term care partnership programs. Prior to passage of this legislation, interest in the partnership program had grown well beyond the four states funded by RJWF. At least seventeen states (including Florida) passed legislation over the years to implement a partnership if the OBRA '93 restrictions were withdrawn or waived.

Florida's Long-term Care Partnership Program

In the 2005 Regular Session, the Florida Legislature passed CS/SB 1208, signed into law in June 2005 (ch. 2005-252, L.O.F.). The law amends s. 409.905, F.S., by providing that, for purposes of eligibility determinations for nursing facility services funded by Medicaid, individuals who are beneficiaries of approved long-term care partnership program insurance policies with exhausted policy benefits shall have their total countable assets reduced by $1 for each $1 of benefits paid out under such policy.

The legislation further created s. 409.9102, F.S., directing AHCA to establish the Florida Long-term Care Partnership Program, which shall:

- Provide incentives for an individual to obtain insurance to cover the costs of long-term care.
- Establish standards for long-term care insurance policies for designation as approved long-term care partnership program policies in consultation with OIR.
- Provide a mechanism to qualify for coverage of the costs of long-term care needs under Medicaid without first being required to substantially exhaust his or her resources, including a reduction of the individual's asset valuation by $1 for each $1 of benefits paid out under the individual's approved long-term care partnership program policy as a determination of Medicaid eligibility.
- Provide and approve long-term care partnership plan information distributed to individuals through insurance companies offering approved partnership policies.
- Alleviate the financial burden on the state's medical assistance program by encouraging the pursuit of private initiatives.

Additionally, AHCA was directed to develop a plan for the program's implementation, and to present the plan in the form of recommended legislation to the President of the Senate and the Speaker of the House of Representatives prior to the commencement of the 2006 Legislative Session.

The amendments to s. 409.905, F.S., and the creation of s. 409.9102, F.S., in the bill were to take effect contingent upon amendment of s. 1917(b)(1)(c) of the Social Security Act by the U.S. Congress to delete the "May 14, 1993" deadline for approval by states of long-term care partnership plans.

The Federal Deficit Reduction Act of 2005

In 2005, the idea of expanding the long-term care Partnership Program re-emerged at the national level. President Bush's proposed 2006 Budget included a proposal to eliminate the disincentive on new programs.[8] In addition, partnership and non-partnership states began working to design a national partnership program, with reciprocity agreements among all participating states. This was intended to increase the portability of the partnership program in the future. The National Governors Association made expanding the partnership program a priority.

As a result of these activities, the changes necessary to expand partnership programs were included in the federal Deficit Reduction Act of 2005, signed into law on February 8, 2006. Specifically, the Deficit Reduction Act (among other changes to the Medicare and Medicaid programs) amends s. 1917(b)(1)(c)(ii) of the Social Security Act, to allow groups of individuals in states with plan amendments approved after May 14, 1993 to be exempt from estate recovery requirements if the amendment provides for a qualified state long-term care insurance partnership program.

For purposes of the Social Security Act, the term "qualified state long-term care insurance partnership" means a Medicaid state plan amendment providing for the disregard of any assets or resources in the amount equal to the amount of insurance benefit made to or on behalf of an individual who is a beneficiary under an approved long-term care policy (including a certificate issued under a group insurance contract), if the following requirements are met:

- The policy covers an insured who was a resident of such state when coverage first became effective under the policy. In the case of a long-term care insurance policy exchanged for another such policy, this requirement would apply based on the coverage of the first such policy that was exchanged.
- The policy is a qualified long-term care insurance policy (as defined in s. 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the state plan amendment.

[8] *Major Savings and Reforms in the President's 2006 Budget*, February 11, 2005, pg. 191; available at http://www.whitehouse.gov/omb/budget/fy2006/pdf/savings.pdf (last visited on March 10, 2006)

- The policy meets the requirements of the long-term care insurance model regulation and the long-term care insurance model act, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000).
- If the policy is sold to an individual who:
  - has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection.
  - has attained age 61 but has not attained age 76 as of the date of purchase, the policy provides some level of inflation protection.
  - has attained age 76 as of the date of purchase, the policy may (but is not required to) provide some level of inflation protection.
- The state Medicaid agency, under s. 1902(a)(5) of the Social Security Act, provides information and technical assistance to the state insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.
- The issuer of the policy provides regular reports, including notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information appropriate to the administration of such partnerships.
- The state does not impose any requirement affecting the terms or benefits of such a policy, unless the state imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

The Deficit Reduction Act also requires the Secretary of Health and Human Services to develop, no later than January 1, 2007, standards for the uniform reciprocal recognition of long-term care insurance policies among states with qualified state long-term care insurance partnerships, so that benefits paid under such policies will be treated the same by all such states.

The Deficit Reduction Act also establishes a National Clearinghouse for Long-term Care Information. The clearinghouse is responsible for:

- Educating consumers with respect to the availability and limitations of coverage for long-term care under the Medicaid program, and providing contact information for obtaining state-specific information on long-term care coverage, including eligibility and estate recovery requirements under State Medicaid programs.
- Providing objective information to assist consumers with the decision-making process for determining whether to purchase long-term care insurance or to pursue other private market alternatives for purchasing long-term care, and providing contact information for additional objective resources on planning for long-term care needs.
- Maintaining a list of states with state long-term care insurance partnerships under the Medicaid program that provide reciprocal recognition of long-term care insurance policies issued under such partnerships.

Regulation of Long-Term Care Insurance in Florida

The Office of Insurance Regulation (OIR) is responsible for the regulation of long-term care insurance under Part I, ch. 627, F.S., and Part XVIII, ch. 627, F.S., known as the "Long-Term Care Insurance 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 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 duration is pre-funded in the premium. An insurer is prohibited from applying the following rating practices: select and ultimate premium schedules, premium class definitions which classify insureds 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 s. 627.410, F.S., if the OIR determines the insurer has an insignificant number of policies in force or an insignificant premium.

Section 627.9407, F.S., prohibits a long-term care insurance 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.[9] 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.[10] 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 increases; 2) reducing coverage to maintain the same or close to the same rate; or 3) terminating

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

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 five 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 March 1, 2003 effective date, 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 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 non-forfeiture 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 that 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 Public 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:

- Extend the current regulatory requirements and consumer protections to long-term care insurance policies purchased prior to March 1, 2003.
- 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.
- Require all policies to be incontestable after they have been in force for two years, to prevent the rescission of a policy due to allegations of fraud in the application.
- 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.
- Create an ombudsman position.
- Consider corporate tax incentives.
- 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 two 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 two 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 two 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 Part XVIII, ch. 627, F.S., Long-Term Care Insurance Policies. The definition of the term, "long-term care insurance policy," 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 a "limited benefit policy," but were still 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 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 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 of the bill also revises laws governing rate regulation. This section prohibits rates for existing policyholders to exceed rates for new policyholders, except to reflect benefit differences. 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. 641.2018, F.S., to provide a technical, conforming cross-reference correction.

Section 6 reenacts and amends s. 409.9102, F.S., to direct AHCA to establish a qualified state Long-term Care Partnership Program in Florida, in compliance with the requirements of the Social Security Act as amended by the federal Deficit Reduction Act of 2005, and in consultation with OIR and DCF. The bill specifies that the program shall:

- Provide incentives for an individual to obtain or maintain long-term care insurance.
- Provide a mechanism for an individual to qualify for coverage of the costs of long-term care needs under Medicaid without being required to substantially exhaust his or her assets, and that Medicaid eligibility will disregard any assets equal to the insurance benefit paid to or on behalf of an individual with a partnership plan.
- Encourage the pursuit of private initiatives to provide financing for long-term care needs.

The bill requires AHCA, in consultation with OIR and DCF, to create standards for qualified state long-term care partnership plan information distributed to individuals through insurance companies and requires AHCA to amend the Medicaid state plan and adopt rules pursuant to ss. 120.536(1) and 120.54, F.S., to implement this section.

The bill requires DCF, when determining eligibility for Medicaid long-term care services for an individual who is the beneficiary of an approved long-term care partnership policy, to reduce the total countable assets of the individual by an amount equal to the insurance benefit payments that are made to or on behalf of the individual. The department is authorized to adopt rules to implement this subsection.

Section 7 creates s. 627.94076, F.S., to require the Financial Services Commission, in consultation with AHCA and DCF, to develop standards for the designation of eligible long-term care policies to be issued in accordance with the partnership program requirements in s. 409.9102, F.S., and to develop forms to be used by insurers and the program to determine policy eligibility. The bill requires insurers, upon request by OIR, to provide information necessary to determine the number of eligible policies, the amount of benefits paid, and the types of products offered, in order to monitor the implementation of the program. The bill authorizes the Financial Services Commission to adopt rules to implement applicable provisions of the long-term care partnership program.

Section 8 repeals ss. 1 and 2 of ch. 2005-252, L.O.F. Section 1 specified that, when determining eligibility for nursing and rehabilitative services under the Medicaid program, if an individual is a beneficiary of a long-term care partnership policy and has exhausted the benefits of the policy, the total countable assets of an individual shall be reduced by $1 for each $1 of benefits paid out

under the policy. Section 2 created s. 409.9102, F.S., to establish the Long-term Care Partnership Program.

Section 9 amends s. 4 of ch. 2005-252, L.O.F., to remove the language making implementation of the program contingent on an amendment to federal law, thus providing that the act is effective upon becoming a law.

Section 10 directs the Office of Program Policy Analysis and Government Accountability to prepare a report on the implementation of a qualified state Long-Term Care Insurance Partnership Program in Florida.

Section 11 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 12 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 13 provides that the bill takes effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of s. 18, Art. VII of the State Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of s. 24(a) and (b), Art. I of the State Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of s. 19(f), Art. III of the State Constitution.

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 insurance policy, both in terms of premium rate increases and in terms of the availability and affordability of the policy. 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 premium 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, except to reflect benefit differences. 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 opening 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.

The bill may have the effect of stimulating the private long-term care insurance market, although the amount of economic growth cannot be determined at this time.

C. Government Sector Impact:

The bill appropriates $72,500 from the Insurance Regulatory Trust Fund to fund a full-time employee (a senior actuarial analyst position), who is intended to monitor rates, to 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 no longer being actively marketed.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Summary of Amendments:

None.