1988

Session Law 88-057

Florida Senate & House of Representatives

Follow this and additional works at: https://ir.law.fsu.edu/staff-analysis

Part of the Legislation Commons

Recommended Citation


This Article is brought to you for free and open access by the Florida Legislative Documents at Scholarship Repository. It has been accepted for inclusion in Staff Analysis by an authorized administrator of Scholarship Repository. For more information, please contact efarrell@law.fsu.edu.
A bill to be entitled
An act relating to long-term care insurance;
creating a new part XIX of chapter 627, F.S.;
creating s. 627.9401, F.S.; creating the "Long-
Term Care Insurance Act"; creating s. 627.9402,
F.S.; providing purpose; creating s. 627.9403,
F.S.; providing for the scope of the act;
creating s. 627.9404, F.S.; providing
definitions; creating s. 627.9405, F.S.;
providing filing requirements for authorized
groups; creating s. 627.9406, F.S.; providing
for the use of out-of-state group long-term
care insurance under certain circumstances;
creating s. 627.9407, F.S.; providing for
disclosure and performance standards for long-
term care insurance; creating s. 627.9408,
F.S.; providing for rules; providing for review
and repeal; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Part XIX of chapter 627, Florida Statutes,
is renumbered as part XX of said chapter, and a new part XIX
of chapter 627, Florida Statutes, consisting of sections
627.9401, 627.9402, 627.9403, 627.9404, 627.9405, 627.9406,
627.9407, and 627.9408, is created to read:

PART XIX
LONG-TERM CARE INSURANCE
POLICIES
627.9401 Short title.--This part may be cited as the
"Long-Term Care Insurance Act."

CODING: Words stricken are deletions; words underlined are additions.
627.9402 Purpose.--The purpose of this part is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

627.9403 Scope.--The provisions of this part shall apply to long-term care insurance policies delivered or issued for delivery in this state, and to policies delivered or issued for delivery outside this state to the extent provided in s. 627.9406, by an insurer, a fraternal benefit society as defined in s. 632.601, a health care services plan as defined in s. 641.01, a health maintenance organization as defined in s. 641.19, a prepaid health clinic as defined in s. 641.402, or a multiple-employer welfare arrangement as defined in s. 624.437. A policy which is advertised, marketed, or offered as a long-term care policy and as a Medicare supplement policy shall meet the requirements of this part and the requirements of ss. 627.671-627.675 and, to the extent of a conflict, be subject to the requirement that is more favorable to the policyholder or certificateholder.

627.9404 Definitions.--For the purposes of this part:

(1) "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for not less than 24 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative,
maintenance, or personal care services provided in a setting other than an acute care unit of a hospital. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

(2) "Applicant" means:
(a) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits.
(b) In the case of a group long-term care insurance policy, the proposed certificateholder.

(3) "Certificate" means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

(4) "Policy" means any policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in this state by any of the entities specified in s. 627.9403.

627.9405 Authorized groups; filing requirements.--
(1) No group long-term care insurance policy shall be delivered or issued for delivery in this state insuring more than one individual unless issued to one of the following groups:
(a) One or more employers or labor organizations, or a trust or the trustees of a fund established by one or more employers or labor organizations, or a combination thereof.

CODING: Words stricken are deletions; words underlined are additions.
for employees or former employees or a combination thereof; or
for members or former members or a combination thereof, of
such employers or labor organizations.

(b) Any professional, trade, or occupational
association for its members or former or retired members, or a
combination thereof, if such association:

1. Is composed of individuals all of whom are or were
actively engaged in the same profession, trade, or occupation;
and

2. Has been maintained in good faith for purposes
other than obtaining insurance.

(c) An association or a trust or the trustees of a
fund established, created, or maintained for the benefit of
members of one or more associations, which association or
associations:

1. Have at the outset a minimum of 100 persons;
2. Have been organized and maintained in good faith
for purposes other than that of obtaining insurance;
3. Have been in active existence for at least 1 year;
and
4. Have a constitution and bylaws which provide that:
   a. The association or associations hold regular
      meetings not less than annually to further purposes of the
      members;
   b. Except for credit unions, the association or
      associations collect dues or solicit contributions from
      members; and
   c. The members have voting privileges and
      representation on the governing board and committees.

CODING: Words stricken are deletions; words underlined are additions.
(d) A group other than as described in paragraph (a), paragraph (b), or paragraph (c), subject to a determination by the department that:

1. The issuance of the group policy is not contrary to the best interest of the public;

2. The issuance of the group policy would result in economies of acquisition or administration; and

3. The benefits are reasonable in relation to the premiums charged.

(2) No group long-term care policy may be issued or issued for delivery in this state to any of the groups specified in subsection (1) unless all members of the group, or all of any class or classes thereof, are declared eligible and acceptable to the insurer at the time of issuance of the policy.

(3) Prior to advertising, marketing, or soliciting a group long-term care insurance policy in this state, the insurer shall demonstrate to the department that the requirements of this section have been met pursuant to the filing procedures specified in s. 627.410.

627.9406 Out-of-state group long-term care insurance.—No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in s. 627.9405(1)(c) or (d), unless this state or such other state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met. Evidence to this effect shall be filed by the insurer with the department pursuant to the procedures specified in s. 627.410.
Disclosure and performance standards for long-term care insurance.--

(1) STANDARDS.--The department may adopt rules that include standards for full and fair disclosure setting forth the manner, content, and required disclosures of the sale of long-term care insurance policies, terms of renewability, 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, and definitions of terms.

(2) RESTRICTIONS.--No long-term care insurance policy may:

(a) Be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificateholder; provided, however, that the department may authorize nonrenewal for an insurer on a statewide basis on terms and conditions determined to be necessary by the department to protect the interests of the insureds, if the insurer demonstrates that renewal will jeopardize the insurer's solvency or that substantial and unexpected loss experience cannot reasonably be mitigated or remedied;

(b) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

CODING: Words stricken are deletions; words underlined are additions.
(c) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

(3) PREEXISTING CONDITION.--

(a) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in s. 627.9405(1)(a) shall use a definition of "preexisting condition" which is more restrictive than the following: "Preexisting condition" means a condition for which medical advice or treatment was recommended by or received from a provider of health care services within 6 months preceding the effective date of coverage of an insured person.

(b) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in s. 627.9405(1)(a) may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within 6 months following the effective date of coverage of an insured person.

(c) The department may extend the limitation periods set forth in paragraphs (a) and (b) as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(d) The definition of "preexisting condition" pursuant to paragraph (a) does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting

CODING: Words struck are deletions; words underlined are additions.
condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in paragraph (b) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in paragraph (b).

(4) PRIOR INSTITUTIONALIZATION.—
(a) No long-term care insurance policy which provides benefits only following institutionalization shall condition such benefits upon a length of stay in a facility for a period of time longer than 3 days.
(b) No long-term care insurance policy which provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related conditions within a period of less than 30 days after discharge from the institution.
(c) An entity that advertises, markets, or solicits a long-term care insurance policy in this state which provides benefits only following institutionalization shall also offer to each policyholder, as part of the application, a policy which does not condition benefits upon following institutionalization, subject to an appropriate additional premium, if any.

(5) LOSS-RATIO STANDARDS.—The department may adopt rules establishing loss-ratio standards for long-term care insurance policies, provided that a specific reference to long-term care insurance policies is contained in the rule. Such loss-ratio standards shall be established at levels at which benefits are reasonable in relation to premiums and

CODING: Words stricken are deletions; words underlined are additions.
calculated in a manner which provides for adequate reserving
of the long-term care insurance risk.

(6) RIGHT TO RETURN; FREE LOOK.--Individual long-term
care insurance policyholders shall have the right to return
the policy within 30 days of its delivery and to have the
premium refunded if, after examination of the policy, the
policyholder is not satisfied for any reason. Individual
long-term care insurance policies shall have a notice
prominently printed on the first page of the policy or
attached thereto stating in substance that the policyholder
shall have the right to return the policy within 30 days of
its delivery and to have the premium refunded if, after
examination of the policy, the policyholder is not satisfied
for any reason.

(7) STAMPED AS "LONG-TERM CARE INSURANCE POLICY".--All
long-term care insurance policies shall contain a stamp
prominently displayed on the first page of the policy that the
policy has been approved as a "Long-Term Care Insurance
Policy" meeting the requirements of Florida law.

(8) OUTLINE OF COVERAGE.--An outline of coverage shall
be delivered to an applicant for an individual long-term care
insurance policy at the time of application for an individual
policy. In the case of direct response solicitations, the
insurer shall deliver the outline of coverage upon the
applicant's request, but regardless of request shall make such
delivery no later than at the time of policy delivery. Such
outline of coverage shall include:

(a) A description of the principal benefits and
coverage provided in the policy;
(b) A statement of the principal exclusions,
reductions, and limitations contained in the policy.
(c) A statement of the renewal provisions, including any reservation in the policy of a right to change premiums;

(d) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions; and

(e) A statement that the policy has been approved as a long-term care insurance policy meeting the requirements of Florida law.

(9) CERTIFICATE.—A certificate issued pursuant to a group long-term care insurance policy which policy is delivered or issued for delivery in this state shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy; and

(c) A statement that the description of principal benefits is a summary of the policy and that the group master policy should be consulted to determine governing contractual provisions.

627.9408 Rules.—The department may adopt such rules as are necessary and proper in furtherance of the provisions of this part.

Section 2. Part XIX of chapter 627, Florida Statutes, as created by this act, is repealed on October 1, 1992, and shall be reviewed by the Legislature pursuant to s. 11.61, Florida Statutes.

Section 3. This act shall take effect October 1, 1988, and shall apply to policies issued on or after such date.

CODING: Words stricken are deletions; words underlined are additions.
Creates the Long-Term Care Insurance Act to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for such insurance from unfair or deceptive sales or enrollment practices, to establish standards, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

Defines long-term care insurance as any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for not less than 24 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

See bill for details.
A bill to be entitled
An act relating to long-term care insurance;
creating a new part XIX of chapter 627, F.S.;
creating the "Long-Term Care Insurance Act";
providing purpose; providing for the scope of
the act; providing definitions; providing
filing requirements for authorized groups;
providing for the use of out-of-state group
long-term care insurance under certain
circumstances; providing for disclosure,
advertising, and performance standards for
long-term care insurance; providing for rules;
providing for review and repeal; providing an
effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Part XIX of chapter 627, Florida Statutes,
is renumbered as part XX of said chapter, and a new part XIX
of chapter 627, Florida Statutes, consisting of sections
627.9401, 627.9402, 627.9403, 627.9404, 627.9405, 627.9406,
627.9407, and 627.9408, is created to read:

PART XIX
LONG-TERM CARE INSURANCE
POLICIES

627.9401 Short title.--This part may be cited as the
"Long-Term Care Insurance Act."

627.9402 Purpose.--The purpose of this part is to
promote the public interest, to promote the availability of
long-term care insurance policies, to protect applicants for
long-term care insurance from unfair or deceptive sales or

CODING: Words stricken are deletions; words underlined are additions.
enrollment practices, to establish standards for long-term
care insurance, to facilitate public understanding and
comparison of long-term care insurance policies, and to
facilitate flexibility and innovation in the development of
long-term care insurance coverage.

627.9403 Scope.—The provisions of this part shall
apply to long-term care insurance policies delivered or issued
for delivery in this state, and to policies delivered or
issued for delivery outside this state to the extent provided
in s. 627.9406, by an insurer, a fraternal benefit society as
defined in s. 632.601, a health care services plan as defined
in s. 641.01, a health maintenance organization as defined in
s. 641.12, a prepaid health clinic as defined in s. 641.402,
or a multiple-employer welfare arrangement as defined in s.
624.637, A policy which is advertised, marketed, or offered
as a long-term care policy and as a Medicare supplement policy
shall meet the requirements of this part and the requirements
of ss. 627.671-627.675 and, to the extent of a conflict, be
subject to the requirement that is more favorable to the
policyholder or certificateholder. The provisions of this
part shall not apply to a continuing care contract issued
pursuant to chapter 651.

627.9404 Definitions.—For the purposes of this part:
111. "Long-term care insurance" means any insurance
policy or rider advertised, marketed, offered, or designed to
provide coverage on an expense-incurred, indemnity, prepaid,
or other basis for one or more necessary or medically
necessary diagnostic, preventive, therapeutic, rehabilitative,
maintenance, or personal care services provided in a setting
other than an acute care unit of a hospital. Long-term care
insurance shall not include any insurance policy which is

CODING: Words struck are deletions; words underlined are additions.
offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

(2) "Applicant" means:

(a) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits.

(b) In the case of a group long-term care insurance policy, the proposed certificateholder.

(3) "Certificate" means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

(4) "Policy" means any policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in this state by any of the entities specified in either 627.9403, 627.9405 Authorized groups; filing requirements;—

(1) No group long-term care insurance policy shall be delivered or issued for delivery in this state insuring more than one individual unless issued to one of the following groups:

(a) One or more employers or labor organizations, or a trust or the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof, or for members or former members or a combination thereof, of such employers or labor organizations.

CODING: Words stricken are deletions; words underlined are additions.
(b) Any professional, trade, or occupational association for its members or former or retired members, or a combination thereof, if such association:

1. Is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation, and

2. Has been maintained in good faith for purposes other than obtaining insurance.

(c) An association or a trust or the trustees of a fund established, created, or maintained for the benefit of members of one or more associations, which association or associations:

1. Have at the outset a minimum of 100 persons; and

2. Have been organized and maintained in good faith for purposes other than that of obtaining insurance; and

3. Have been in active existence for at least 1 year; and

4. Have a constitution and bylaws which provide that:

a. The association or associations hold regular meetings not less than annually to further purposes of the members;

b. Except for credit unions, the association or associations collect dues or solicit contributions from members; and

c. The members have voting privileges and representation on the governing board and committees.

(d) A group other than as described in paragraph (a), paragraph (b), or paragraph (c), subject to a determination by the department that:

1. The issuance of the group policy is not contrary to the best interest of the public;
2. The issuance of the group policy would result in economies of acquisition or administration, and
3. The benefits are reasonable in relation to the premiums charged.

(2) No group long-term care policy may be issued or issued for delivery in this state to any of the groups specified in subsection (1) unless all members of the group, or all of any class or classes thereof, are declared eligible and acceptable to the insurer at the time of issuance of the policy.

(3) Prior to advertising, marketing, or soliciting a group long-term care insurance policy in this state, the insurer shall demonstrate to the department that the requirements of this section have been met pursuant to the filing procedures specified in s. 627.410.

627.9406 Out-of-state group long-term care insurance.—No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in s. 627.9405(1)(c) or (d), unless this state or such other state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met. Evidence to this effect shall be filed by the insurer with the department pursuant to the procedures specified in s. 627.410.

627.9407 Disclosure, advertising, and performance standards for long-term care insurance.—

(1) STANDARDS.—The department shall adopt rules that include standards for full and fair disclosure setting forth the manner, content, and required disclosures of the sale of

CODING: Words struck through are deletions; words underlined are additions.
long-term care insurance policies, terms of renewability,
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, and definitions of terms.

(2) ADVERTISING.—The department shall adopt rules
setting forth standards for advertising, marketing, and sale
of long-term care policies in order to protect applicants from
unfair or deceptive sales or enrollment practices. An insurer
shall file with the department any long-term care insurance
advertising material intended for use in this state at least
30 days before the date of use of the advertisement in this
state. Within 30 days after the date of receipt of the
advertising material, the department shall review the material
and shall disapprove any advertisement if, in the opinion of
the department, such advertisement violates any of the
provisions of this part or of part X of chapter 626 or any
rule of the department. The department may disapprove an
advertisement at any time and enter an immediate order
requiring that the use of the advertisement be discontinued if
it determines that the advertisement violates any of the
provisions of this part or of part X of chapter 626 or any
rule of the department.

(3) RESTRICTIONS.—No long-term care insurance policy
may:

(a) Be canceled, nonrenewed, or otherwise terminated
on the grounds of the age or the deterioration of the mental
or physical health of the insured individual or

certificateholder; provided, however, that the department may

CODING: Words stricken are deletions; words underlined are additions.
authorize nonrenewal for an insurer on a statewide basis on terms and conditions determined to be necessary by the department to protect the interests of the insureds, if the insurer demonstrates that renewal will jeopardize the insurer's solvency or that substantial and unexpected loss experience cannot reasonably be mitigated or remedied.

(b) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder.

(c) Restrict its coverage to care only in a nursing home licensed pursuant to part I of chapter 400 or provide significantly more coverage for such care than coverage for lower levels of care. The department shall adopt rules defining what constitutes significantly more coverage in nursing homes licensed pursuant to part I of chapter 400 than for lower levels of care.

(d) Provide coverage for less than 24 consecutive months for each covered person.

(e) Contain an elimination period in excess of 120 days. As used in this paragraph, "elimination period" means the number of days at the beginning of a period of confinement for which no benefits are payable.

(f) PREEXISTING CONDITION.--

(g) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in s. 627.9405(1)(a) shall use a definition of "preexisting condition" which is more restrictive than the following: "Preexisting condition" means the existence of symptoms which would cause an ordinarily prudent person to
seek diagnosis, care, or treatment, or a condition for which medical advice or treatment was recommended by or received from a provider of health care services within 6 months preceding the effective date of coverage of an insured person.

(b) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in s. 627.6405(1)(a) may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within 6 months following the effective date of coverage of an insured person.

(c) The department may extend the limitation periods set forth in paragraphs (a) and (b) as to specific age groups or categories in specific policy forms upon findings that the extension is in the best interest of the public.

(d) The definition of "preexisting condition" pursuant to paragraph (a) does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in paragraph (b) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in paragraph (b).

(5) PRIOR INSTITUTIONALIZATION.--

CODING: Words stricken are deletions; words underlined are additions.
(a) No long-term care insurance policy which provides benefits only following institutionalization shall condition such benefits upon a length of stay in a facility for a period of time longer than 3 days.

(b) No long-term care insurance policy which provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related conditions within a period of less than 30 days after discharge from the institution.

(c) An entity that advertises, markets, or solicits a long-term care insurance policy in this state which provides benefits only following institutionalization shall also offer to each policyholder, as part of the application, a policy which does not condition benefits upon following institutionalization, subject to an appropriate additional premium, if any.

(6) LOSS-RATIO STANDARDS.--The department shall adopt rules establishing loss-ratio standards for long-term care insurance policies, provided that a specific reference to long-term care insurance policies is contained in the rule. Such loss-ratio standards shall be established at levels at which benefits are reasonable in relation to premiums and calculated in a manner which provides for adequate reserving of the long-term care insurance risk.

(7) RIGHT TO RETURN; FREE LOOK.--Individual long-term care insurance policyholders shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. Individual long-term care insurance policies shall have a notice prominently printed on the first page of the policy or

CODING: Words stricken are deletions; words underlined are additions.
attached thereto stating in substance that the policyholder
shall have the right to return the policy within 30 days of
its delivery and to have the premium refunded directly to the
policyholder if, after examination of the policy, the
policyholder is not satisfied for any reason.

(8) STAMPED AS "LONG-TERM CARE INSURANCE POLICY": All
long-term care insurance policies shall contain a stamp
prominently displayed on the first page of the policy that the
policy has been approved as a "Long-Term Care Insurance
Policy" meeting the requirements of Florida law. In addition,
the following statement shall be prominently displayed on the
first page of the policy: "Notice to Buyer: This policy may
not cover all of the costs associated with long-term care
which may be incurred by the buyer during the period of
coverage. The buyer is advised to periodically review this
policy in relation to the changes in the cost of long-term
care."

(9) OUTLINE OF COVERAGE: An outline of coverage shall
be delivered to an applicant for an individual long-term care
insurance policy at the time of application for an individual
policy. In the case of direct response solicitations, the
insurer shall deliver the outline of coverage upon the
applicant's request, but regardless of request shall make such
delivery no later than at the time of policy delivery. Such
outline of coverage shall include:

(a) A description of the principal benefits and
coverage provided in the policy;

(b) A statement of the principal exclusions,
reductions, and limitations contained in the policy;

CODING: Words stricken are deletions; words underlined are additions.
(c) If the policy is not expected to cover 100 percent of the cost of services for which coverage is provided, a statement clearly describing any such limitation.

(d) A statement of the renewal provisions, including any reservation in the policy of a right to change premiums;

(e) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions; and

(f) A statement that the policy has been approved as a long-term care insurance policy meeting the requirements of Florida law.

(10) CERTIFICATE.—A certificate issued pursuant to a group long-term care insurance policy, which policy is delivered or issued for delivery in this state, shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy; and

(c) A statement that the description of principal benefits is a summary of the policy and that the group master policy should be consulted to determine governing contractual provisions.

§27.9408 Rules.—The department may adopt such rules as are necessary and proper in furtherance of the provisions of this part.

Section 2. Part XIX of chapter 627, Florida Statutes, as created by this act, is repealed on October 1, 1992, and shall be reviewed by the legislature pursuant to §11.61, Florida Statutes.

CODING: Words stricken are deletions; words underlined are additions.
Section 3. This act shall take effect October 1, 1968, and shall apply to policies issued or renewed on or after such date.

This publication was produced at an average cost of 1.12 cents per single page in compliance with the Rules and for the information of members of the Legislature and the public.

CODING: Words stricken are deletions; words underlined are additions.
A bill to be entitled
An act relating to long-term care insurance;
creating a new part XIX of chapter 627, F.S.;
creating s. 627.9401, F.S.; creating the "Long-
Term Care Insurance Act"; creating s. 627.9402,
F.S.; providing purpose; creating s. 627.9403,
F.S.; providing for the scope of the act;
creating s. 627.9404, F.S.; providing
definitions; creating s. 627.9405, F.S.;
providing filing requirements for authorized
groups; creating s. 627.9406, F.S.; providing
for the use of out-of-state group long-term
care insurance under certain circumstances;
creating s. 627.9407, F.S.; providing for
disclosure, advertising, and performance
requirements for long-term care insurance;
creating s. 627.9408, F.S.; providing for
rules; providing for review and repeal;
providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Part XIX of chapter 627, Florida Statutes,
is renumbered as part XX of said chapter, and a new part XIX
of chapter 627, Florida Statutes, consisting of sections
627.9401, 627.9402, 627.9403, 627.9404, 627.9405, 627.9406,
627.9407, and 627.9408, is created to read:

PART XIX
LONG-TERM CARE INSURANCE
POLICIES

CODING: Words stricken are deletions; words underlined are additions.
627.9401 Short title.--This part may be cited as the "Long-Term Care Insurance Act."

627.9402 Purpose.--The purpose of this part is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

627.9403 Scope.--The provisions of this part shall apply to long-term care insurance policies delivered or issued for delivery in this state, and to policies delivered or issued for delivery outside this state to the extent provided in s. 627.9406, by an insurer, a fraternal benefit society as defined in s. 632.601, a health care services plan as defined in s. 641.01, a health maintenance organization as defined in s. 641.19, a prepaid health clinic as defined in s. 641.402, or a multiple-employer welfare arrangement as defined in s. 624.437. A policy which is advertised, marketed, or offered as a long-term care policy and as a Medicare supplement policy shall meet the requirements of this part and the requirements of ss. 627.671-627.675 and, to the extent of a conflict, be subject to the requirement that is more favorable to the policyholder or certificateholder. The provisions of this part do not apply to a continuing care contract issued pursuant to chapter 651.

627.9404 Definitions.--For the purposes of this part:

(1) "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered, or designed to...
provide coverage on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

(2) "Applicant" means:

(a) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits.
(b) In the case of a group long-term care insurance policy, the proposed certificateholder.

(3) "Certificate" means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

(4) "Policy" means any policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in this state by any of the entities specified in s. 627.9403.

627.9405 Authorized groups; filing requirements.--

(1) No group long-term care insurance policy shall be delivered or issued for delivery in this state insuring more than one individual unless issued to one of the following groups:

CODING: Words strucken are deletions; words underlined are additions.
(a) One or more employers or labor organizations, or a
trust or the trustees of a fund established by one or more
employers or labor organizations, or a combination thereof,
for employees or former employees or a combination thereof, or
for members or former members or a combination thereof, of
such employers or labor organizations.

(b) Any professional, trade, or occupational
association for its members or former or retired members, or a
combination thereof, if such association:
1. Is composed of individuals all of whom are or were
actively engaged in the same profession, trade, or occupation;
and
2. Has been maintained in good faith for purposes
other than obtaining insurance.

(c) An association or a trust or the trustees of a
fund established, created, or maintained for the benefit of
members of one or more associations, which association or
associations:
1. Have at the outset a minimum of 100 persons;
2. Have been organized and maintained in good faith
for purposes other than that of obtaining insurance;
3. Have been in active existence for at least 1 year;
and
4. Have a constitution and bylaws which provide that:
a. The association or associations hold regular
meetings not less than annually to further purposes of the
members;
b. Except for credit unions, the association or
associations collect dues or solicit contributions from
members; and

CODING: Words strike-through are deletions; words underline are additions.
c. The members have voting privileges and
representation on the governing board and committees.

(d) A group other than as described in paragraph (a),
paragraph (b), or paragraph (c), subject to a determination by
the department that:

1. The issuance of the group policy is not contrary to
the best interest of the public;

2. The issuance of the group policy would result in
economies of acquisition or administration; and

3. The benefits are reasonable in relation to the
premiums charged.

(2) No group long-term care policy may be issued or
issued for delivery in this state to any of the groups
specified in subsection (1) unless all members of the group,
or all of any class or classes thereof, are declared eligible
and acceptable to the insurer at the time of issuance of the
policy.

(3) Prior to advertising, marketing, or soliciting a
group long-term care insurance policy in this state, the
insurer shall demonstrate to the department that the
requirements of this section have been met pursuant to the
filing procedures specified in s. 627.410.

627.9406 Out-of-state group long-term care
insurance.--No group long-term care insurance coverage may be
offered to a resident of this state under a group policy
issued in another state to a group described in s.
627.9405(1)(c) or (d), unless this state or such other state
having statutory and regulatory long-term care insurance
requirements substantially similar to those adopted in this
state has made a determination that such requirements have
been met. Evidence to this effect shall be filed by the

CODING: Words struck are deletions; words underlined are additions.
27-813C-88

insurer with the department pursuant to the procedures
specified in s. 627.410.

627.9407 Disclosure, advertising, and performance
requirements for long-term care insurance.—

(1) STANDARDS.—The department shall adopt rules that
include standards for full and fair disclosure setting forth
the manner, content, and required disclosures of the sale of
long-term care insurance policies, terms of renewability,
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, and definitions of terms.

(2) ADVERTISING.—The department shall adopt rules
setting forth standards for advertising, marketing, and sale
of long-term care policies in order to protect applicants from
unfair or deceptive sales or enrollment practices. An insurer
shall file with the department any long-term care insurance
advertising material intended for use in this state at least
30 days before the date of use of the advertisement in this
state. Within 30 days after the date of receipt of the
advertising material, the department shall approve or
disapprove the material, unless the insurer consents to a
further delay. The department shall disapprove any
advertisement if, in the opinion of the department, such
advertisement violates any of the provisions of this part or
of part X of chapter 626 or any rule of the department. The
department may, for cause, withdraw a previous approval and
enter an immediate order requiring that the use of the
advertisement be discontinued. If requested by the insurer,
the department shall conduct a hearing within 10 days after
the entry of such order. If, after the hearing or by
agreement with the insurer, a final determination is made that
the advertising violated a provision of this part or part X of
chapter 626 or of any rule of the department, the department
may, in lieu of revoking the insurer's certificate of
authority, require the insurer to publish a corrective
advertisement; impose an administrative penalty of not more
than $10,000 on the insurer; and, in the case of an initial
solicitation, require that the insurer, before accepting any
application received in response to the advertisement, provide
an acceptable clarification of the advertisement to each
individual applicant.

(3) RESTRICTIONS.--No long-term care insurance policy
may:

(a) Be canceled, nonrenewed, or otherwise terminated
on the grounds of the age or the deterioration of the mental
or physical health of the insured individual or
certificateholder; provided, however, that the department may
authorize nonrenewal for an insurer on a statewide basis on
terms and conditions determined to be necessary by the
department to protect the interests of the insureds, if the
insurer demonstrates that renewal will jeopardize the
insurer's solvency or that substantial and unexpected loss
experience cannot reasonably be mitigated or remedied;

(b) Contain a provision establishing a new waiting
period in the event existing coverage is converted to or
replaced by a new or other form within the same company,
except with respect to an increase in benefits voluntarily
selected by the insured individual or group policyholder; or

CODING: Words struck are deletions; words underlined are additions.
(c) Restrict its coverage to care only in nursing homes licensed pursuant to part I of chapter 400 or provide significantly more coverage for such care than coverage for lower levels of care.

(d) Provide coverage for less than 24 consecutive months for each covered person.

(4) PREEXISTING CONDITION.--

(a) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in s. 627.9405(1)(a) shall use a definition of "preexisting condition" which is more restrictive than the following: "Preexisting condition" means a condition for which medical advice or treatment was recommended by or received from a provider of health care services within 6 months preceding the effective date of coverage of an insured person.

(b) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in s. 627.9405(1)(a) may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within 6 months following the effective date of coverage of an insured person.

(c) The department may extend the limitation periods set forth in paragraphs (a) and (b) as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(d) The definition of "preexisting condition" pursuant to paragraph (a) does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on
that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in paragraph (b) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in paragraph (b).

(5) PRIOR INSTITUTIONALIZATION.--

(a) No long-term care insurance policy which provides benefits only following institutionalization shall condition such benefits upon a length of stay in a facility for a period of time longer than 3 days.

(b) No long-term care insurance policy which provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related conditions within a period of less than 30 days after discharge from the institution.

(c) An entity that advertises, markets, or solicits a long-term care insurance policy in this state which provides benefits only following institutionalization shall also offer to each policyholder, as part of the application, a policy which does not condition benefits upon following institutionalization, subject to an appropriate additional premium, if any.

(6) LOSS-RATIO STANDARDS.--The department shall adopt rules establishing loss-ratio standards for long-term care insurance policies, provided that a specific reference to

CODING: Words strucken are deletions; words underlined are additions.
Such loss-ratio standards shall be established at levels at which benefits are reasonable in relation to premiums and calculated in a manner which provides for adequate reserving of the long-term care insurance risk.

(7) RIGHT TO RETURN; FREE LOOK.—Individual long-term care insurance policyholders shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. Individual long-term care insurance policies shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

(8) STAMPED AS "LONG-TERM CARE INSURANCE POLICY".—All long-term care insurance policies shall contain a stamp prominently displayed on the first page of the policy that the policy has been approved as a "Long-Term Care Insurance Policy" meeting the requirements of Florida law.

(9) STAMPED AS "NOT A LONG-TERM CARE INSURANCE POLICY".—A policy that provides coverage for care in a nursing home only or that provides significantly more coverage for such care than for lower levels of care, as prohibited for long-term care policies pursuant to subsection (3), must contain a stamp prominently displayed on the first page of the policy stating: "This is not a long-term care insurance policy and does not meet the requirements of Florida law for such policies."
(10) OUTLINE OF COVERAGE.--An outline of coverage shall be delivered to an applicant for an individual long-term care insurance policy at the time of application for an individual policy. In the case of direct response solicitations, the insurer shall deliver the outline of coverage upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. Such outline of coverage shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy;

(c) A statement of the renewal provisions, including any reservation in the policy of a right to change premiums;

(d) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions; and

(e) A statement that the policy has been approved as a long-term care insurance policy meeting the requirements of Florida law.

(11) CERTIFICATE.--A certificate issued pursuant to a group long-term care insurance policy which policy is delivered or issued for delivery in this state shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy; and

(c) A statement that the description of principal benefits is a summary of the policy and that the group master

CODING: Words strucken are deletions; words underlined are additions.
policy should be consulted to determine governing contractual provisions.

627.9408 Rules.--The department may adopt such rules as are necessary and proper in furtherance of the provisions of this part.

Section 2. Part XIX of chapter 627, Florida Statutes, as created by this act, is repealed on October 1, 1992, and shall be reviewed by the Legislature pursuant to s. 11.61, Florida Statutes.

Section 3. This act shall take effect October 1, 1988, and shall apply to policies issued or renewed on or after such date.

LEGISLATIVE SUMMARY

Creates the Long-Term Care Insurance Act to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for such insurance from unfair or deceptive advertising, sales, or enrollment practices, to establish standards, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage. Defines long-term care insurance as any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for each covered person on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

See bill for details.

CODING: Words stricken are deletions; words underlined are additions.
A bill to be entitled
An act relating to long-term care insurance;
creating a new part XIX of chapter 627, F.S.;
creating the "Long-Term Care Insurance Act";
providing purpose; providing for the scope of
the act; providing definitions; providing
filing requirements for authorized groups;
providing for the use of out-of-state group
long-term care insurance under certain
circumstances; providing for disclosure,
advertising, and performance standards for
long-term care insurance; providing for rules;
providing for review and repeal; providing an
effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Part XIX of chapter 627, Florida Statutes,
is renumbered as part XX of said chapter, and a new part XIX
of chapter 627, Florida Statutes, consisting of sections
627.9401, 627.9402, 627.9403, 627.9404, 627.9405, 627.9406,
627.9407, and 627.9408, is created to read:

PART XIX
LONG-TERM CARE INSURANCE
POLICIES

627.9401 Short title.--This part may be cited as the
"Long-Term Care Insurance Act."

627.9402 Purpose.--The purpose of this part is to
promote the public interest, to promote the availability of
long-term care insurance policies, to protect applicants for
long-term care insurance from unfair or deceptive sales or
enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

627.9403 Scope.—The provisions of this part shall apply to long-term care insurance policies delivered or issued for delivery in this state, and to policies delivered or issued for delivery outside this state to the extent provided in s. 627.9406, by an insurer, a fraternal benefit society as defined in s. 632.601, a health care services plan as defined in s. 641.01, a health maintenance organization as defined in s. 641.19, a prepaid health clinic as defined in s. 641.402, or a multiple-employer welfare arrangement as defined in s. 624.437. A policy which is advertised, marketed, or offered as a long-term care policy and as a Medicare supplement policy shall meet the requirements of this part and the requirements of ss. 627.671-627.675 and, to the extent of a conflict, be subject to the requirement that is more favorable to the policyholder or certificateholder. The provisions of this part shall not apply to a continuing care contract issued pursuant to chapter 651.

627.9404 Definitions.—For the purposes of this part:

(1) "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital. Long-term care insurance shall not include any insurance policy which is

CODING: Words struck are deletions; words underlined are additions.
offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-
surgical expense coverage, hospital confinement indemnity
coverage, major medical expense coverage, disability income
protection coverage, accident only coverage, specified disease
or specified accident coverage, or limited benefit health
coverage.

(2) "Applicant" means:
(a) In the case of an individual long-term care
insurance policy, the person who seeks to contract for
benefits.
(b) In the case of a group long-term care insurance
policy, the proposed certificateholder.
(c) "Certificate" means any certificate issued under a
group long-term care insurance policy, which policy has been
delivered or issued for delivery in this state.

(4) "Policy" means any policy, contract, subscriber
agreement, rider, or endorsement delivered or issued for
delivery in this state by any of the entities specified in s.

627.9403.

627.9405 Authorized groups; filing requirements.--
(1) No group long-term care insurance policy shall be
delivered or issued for delivery in this state insuring more
than one individual unless issued to one of the following
groups:
(a) One or more employers or labor organizations, or a
trust or the trustees of a fund established by one or more
employers or labor organizations, or a combination thereof,
for employees or former employees or a combination thereof, or
for members or former members or a combination thereof, of
such employers or labor organizations.

CODING: Words strucken are deletions; words underlined are additions.
(b) Any professional, trade, or occupational association for its members or former or retired members, or a combination thereof, if such association:

1. Is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation; and

2. Has been maintained in good faith for purposes other than obtaining insurance.

(c) An association or a trust or the trustees of a fund established, created, or maintained for the benefit of members of one or more associations, which association or associations:

1. Have at the outset a minimum of 100 persons;

2. Have been organized and maintained in good faith for purposes other than that of obtaining insurance;

3. Have been in active existence for at least 1 year; and

4. Have a constitution and bylaws which provide that:

a. The association or associations hold regular meetings not less than annually to further purposes of the members;

b. Except for credit unions, the association or associations collect dues or solicit contributions from members; and

c. The members have voting privileges and representation on the governing board and committees.

(d) A group other than as described in paragraph (a), paragraph (b), or paragraph (c), subject to a determination by the department that:

1. The issuance of the group policy is not contrary to the best interest of the public;
2. The issuance of the group policy would result in economies of acquisition or administration; and

3. The benefits are reasonable in relation to the premiums charged.

(2) No group long-term care policy may be issued or issued for delivery in this state to any of the groups specified in subsection (1) unless all members of the group, or all of any class or classes thereof, are declared eligible and acceptable to the insurer at the time of issuance of the policy.

(3) Prior to advertising, marketing, or soliciting a group long-term care insurance policy in this state, the insurer shall demonstrate to the department that the requirements of this section have been met pursuant to the filing procedures specified in s. 627.410.

627.9406 Out-of-state group long-term care insurance.--No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in s. 627.9405(1)(c) or (d), unless this state or such other state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met. Evidence to this effect shall be filed by the insurer with the department pursuant to the procedures specified in s. 627.410.

627.9407 Disclosure, advertising, and performance standards for long-term care insurance.--

(1) STANDARDS.--The department shall adopt rules that include standards for full and fair disclosure setting forth the manner, content, and required disclosures of the sale of

CODING: Words stricken are deletions; words underlined are additions.
long-term care insurance policies, terms of renewability,
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, and definitions of terms.

(2) ADVERTISING.—The department shall adopt rules
setting forth standards for advertising, marketing, and sale
of long-term care policies in order to protect applicants from
unfair or deceptive sales or enrollment practices. An insurer
shall file with the department any long-term care insurance
advertising material intended for use in this state at least
30 days before the date of use of the advertisement in this
state. Within 30 days after the date of receipt of the
advertising material, the department shall review the material
and shall disapprove any advertisement if, in the opinion of
the department, such advertisement violates any of the
provisions of this part or of part X of chapter 626 or any
rule of the department. The department may disapprove an
advertisement at any time and enter an immediate order
requiring that the use of the advertisement be discontinued if
it determines that the advertisement violates any of the
provisions of this part or of part X of chapter 626 or any
rule of the department.

(3) RESTRICTIONS.—No long-term care insurance policy
may:

(a) Be canceled, nonrenewed, or otherwise terminated
on the grounds of the age or the deterioration of the mental
or physical health of the insured individual or
certificateholder; provided, however, that the department may
authorize nonrenewal for an insurer on a statewide basis on
terms and conditions determined to be necessary by the
department to protect the interests of the insureds, if the
insurer demonstrates that renewal will jeopardize the
insurer's solvency or that substantial and unexpected loss
experience cannot reasonably be mitigated or remedied.

(b) Contain a provision establishing a new waiting
period in the event existing coverage is converted to or
replaced by a new or other form within the same company,
except with respect to an increase in benefits voluntarily
selected by the insured individual or group policyholder.

(c) Restrict its coverage to care only in a nursing
home licensed pursuant to part I of chapter 400 or provide
significantly more coverage for such care than coverage for
lower levels of care. The department shall adopt rules
defining what constitutes significantly more coverage in
nursing homes licensed pursuant to part I of chapter 400 than
for lower levels of care.

(d) Provide coverage for less than 24 consecutive
months for each covered person.

(e) Contain an elimination period in excess of 120
days. As used in the paragraph, the term "elimination period"
means the number of days at the beginning of a period of
confinement for which no benefits are payable.

(4) PREEXISTING CONDITION.--

(a) No long-term care insurance policy or certificate
other than a policy or certificate thereunder issued to a
group as defined in s. 627.9405(1)(a) shall use a definition
of "preexisting condition" which is more restrictive than the
following: "Preexisting condition" means the existence of
symptoms which would cause an ordinarily prudent person to
seek diagnosis, care, or treatment, or a condition for which medical advice or treatment was recommended by or received from a provider of health care services within 6 months preceding the effective date of coverage of an insured person.

(b) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in s. 627.9405(1)(a) may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within 6 months following the effective date of coverage of an insured person.

(c) The department may extend the limitation periods set forth in paragraphs (a) and (b) as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(d) The definition of "preexisting condition" pursuant to paragraph (a) does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in paragraph (b) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in paragraph (b).

(5) PRIOR INSTITUTIONALIZATION.—
(a) No long-term care insurance policy which provides benefits only following institutionalization shall condition such benefits upon a length of stay in a facility for a period of time longer than 3 days.

(b) No long-term care insurance policy which provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related conditions within a period of less than 30 days after discharge from the institution.

(c) An entity that advertises, markets, or solicits a long-term care insurance policy in this state which provides benefits only following institutionalization shall also offer to each policyholder, as part of the application, a policy which does not condition benefits upon following institutionalization, subject to an appropriate additional premium, if any.

(6) LOSS-RATIO STANDARDS.--The department shall adopt rules establishing loss-ratio standards for long-term care insurance policies, provided that a specific reference to long-term care insurance policies is contained in the rule. Such loss-ratio standards shall be established at levels at which benefits are reasonable in relation to premiums and calculated in a manner which provides for adequate reserving of the long-term care insurance risk.

(7) RIGHT TO RETURN; FREE LOOK.--Individual long-term care insurance policyholders shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. Individual long-term care insurance policies shall have a notice prominently printed on the first page of the policy or...
attached thereto stating in substance that the policyholder shall have the right to return the policy within 30 days of its delivery and to have the premium refunded directly to the policyholder if, after examination of the policy, the policyholder is not satisfied for any reason.

(8) STAMPED AS "LONG-TERM CARE INSURANCE POLICY".--All long-term care insurance policies shall contain a stamp prominently displayed on the first page of the policy that the policy has been approved as a "Long-Term Care Insurance Policy" meeting the requirements of Florida law. In addition, the following statement shall be prominently displayed on the first page of the policy: "Notice to Buyer: This policy may not cover all of the costs associated with long-term care which may be incurred by the buyer during the period of coverage. The buyer is advised to periodically review this policy in relation to the changes in the cost of long-term care."

(9) OUTLINE OF COVERAGE.--An outline of coverage shall be delivered to an applicant for an individual long-term care insurance policy at the time of application for an individual policy. In the case of direct response solicitations, the insurer shall deliver the outline of coverage upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. Such outline of coverage shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy;
(c) If the policy is not expected to cover 100 percent of the cost of services for which coverage is provided, a statement clearly describing any such limitation;

(d) A statement of the renewal provisions, including any reservation in the policy of a right to change premiums;

(e) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions; and

(f) A statement that the policy has been approved as a long-term care insurance policy meeting the requirements of Florida law.

(10) CERTIFICATE.--A certificate issued pursuant to a group long-term care insurance policy, which policy is delivered or issued for delivery in this state, shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy; and

(c) A statement that the description of principal benefits is a summary of the policy and that the group master policy should be consulted to determine governing contractual provisions.

627.9408 Rules.--The department may adopt such rules as are necessary and proper in furtherance of the provisions of this part.

Section 2. Part XIX of chapter 627, Florida Statutes, as created by this act, is repealed on October 1, 1992, and shall be reviewed by the Legislature pursuant to s. 11.61, Florida Statutes.
Section 3. This act shall take effect October 1, 1988, and shall apply to policies issued or renewed on or after such date.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN COMMITTEE SUBSTITUTE FOR Senate Bill 606

The committee substitute:

(a) modifies the requirements for advertising of long-term care insurance policies;

(b) requires the Department of Insurance to adopt rules defining what constitutes significantly more coverage in nursing homes than for lower levels of care;

(c) provides that a long-term care policy may not contain an elimination period in excess of 120 days;

(d) modifies the definition of "preexisting condition;"

(e) requires a "Notice to Buyer" statement on the first page of the policy; and

(f) deletes the stamp on certain policies "This is not a long-term care policy."

CODING: Words struck are deletions; words underlined are additions.
FLORIDA LEGISLATURE

FINAL
LEGISLATIVE BILL
INFORMATION

1987 Special Sessions B, C, D
1988 Regular Session
1988 Special Sessions E, F

RE: 88-57

prepared by:

Joint Legislative Management Committee
Legislative Information Division
Capitol Building, Room 826 — 488-4371
S 606 GENERAL BILL/CS by Commerce, Myers (Identical CS/H 478)

Long-Term Care Insurance Act: creates said act; provides purpose, scope, & definitions; provides filing requirements for authorized groups; provides for use of out-of-state group long-term care insurance under certain circumstances; provides for disclosure, advertising, & performance standards for such insurance; provides for rules; provides for review & repeal; provides applicability. Creates 627.9401-9408 Effective Date 10/01/88

(CONTINUED ON NEXT PAGE)

S 606 (CONTINUED)

03/30/88 SENATE Prefiled
04/12/88 SENATE Introduced, referred to Commerce; Health and Rehabilitative Services; Appropriations—SJ 74
04/15/88 SENATE Extension of time granted Committee Commerce
04/18/88 SENATE On Committee agenda—Commerce, 04/20/88, 2:00 pm, Room-A
04/20/88 SENATE Comm. Report: CS by Commerce—SJ 142
04/21/88 SENATE CS read first time—SJ 162, Now in Health and Rehabilitative Services—SJ 142
04/25/88 SENATE Withdrawn from Health and Rehabilitative Services—SJ 179, Now in Appropriations
05/04/88 SENATE Extension of time granted Committee Appropriations
05/05/88 SENATE Withdrawn from Appropriations—SJ 233; Placed on Calendar
05/11/88 SENATE Placed on Special Order Calendar—SJ 267
05/12/88 SENATE Placed on Special Order Calendar—SJ 267; CS passed; YEAS 35 NAYS 0—SJ 288; Immediately certified—SJ 289
05/12/88 HOUSE In Messages
05/15/88 HOUSE Received, placed on Calendar—HJ 474; Substituted for CS/HB 478; Read second time—HJ 477
05/17/88 HOUSE Read third time, CS passed; YEAS 113 NAYS 0—HJ 502
05/18/88 HOUSE Ordered enrolled—SJ 319
05/19/88 HOUSE Signed by Officers and presented to Governor—SJ 357
05/26/88 HOUSE Approved by Governor; Chapter No 88-57—SJ 468

H 478 GENERAL BILL/CS by Insurance; Press; Abrams (Identical CS/S 606)

Long-Term Care Insurance Act: creates said act; provides purpose, scope, & definitions; provides filing requirements for authorized groups; provides for use of out-of-state group long-term care insurance under certain circumstances; provides for disclosure, advertising, & performance standards for such insurance; provides for rules; provides for review & repeal; provides applicability. Creates 627.9401-9408. Effective Date 10/01/88

03/03/88 HOUSE Prefiled
03/17/88 HOUSE Referred to Insurance; Appropriations
04/05/88 HOUSE Introduced, referred to Insurance; Appropriations—HJ 48

(CONTINUED ON NEXT PAGE)

H 478 (CONTINUED)

04/07/88 HOUSE Subreferred to Subcommittee on Health and Life Insurance and General Insurance Regulation. On subcommittee agenda—Insurance, 04/11/88, 3:30 pm—24-HOB
04/11/88 HOUSE Subcommittee Recommendation pending ratification by full Committee: Favorable as a proposed Committee Substitute
04/12/88 HOUSE On Committee agenda—Insurance, 04/14/88, 8:00 am, 317C—For ratification of subreferral. On Committee agenda—Insurance, 04/14/88, 8:00 am, 317C
04/14/88 HOUSE Preliminary Committee Action by Insurance: Favorable as a Committee Substitute
04/20/88 HOUSE Comm. Report: CS by Insurance—HJ 229, CS read first time—Hj 229; Now in Appropriations—HJ 229
04/29/88 HOUSE On Committee agenda—Appropriations, 05/03/88, 1:15 pm, Morris Hall
05/04/88 HOUSE Comm. Report: Favorable by Appropriations, placed on Calendar—HJ 339
05/10/88 HOUSE Idem./Sim. Senate Bill substituted; Laid on Table under Rule, Idem./Sim./Compare Bill passed, refer to CS/SB 606 (Ch. 88-57) —HJ 477
05/16/88 HOUSE Placed on Special Order Calendar
I. SUMMARY:

This bill sets forth minimum standards for long-term care insurance policies including provisions relating to advertising, renewability, waiting periods, required coverage, preexisting conditions, prior institutionalization, loss ratios, and consumer protection.

A. PRESENT SITUATION:

Long-term care is prolonged assistance with daily living activities required by individuals who are dependent upon others as a result of some physical or mental disability. Long-term care ranges from non-medical support in the home to intense, continuous monitoring and services in skilled nursing facilities.

Four levels of long-term care services are:

1. Skilled nursing home care - nursing and rehabilitative services given by skilled medical personnel on a daily basis under the orders of a physician;

2. Intermediate nursing home care - skilled nursing care provided on an occasional basis;

3. Custodial nursing home care - assistance in requirements of daily living such as eating and bathing, which can be provided by persons without medical skills (also referred to as personal care); and
4. Home care - a variety of services provided in the home, including skilled nursing care, speech, physical and occupational therapy, social work, personal care, and homemaker services.

Eighty to 90 percent of all long-term care needs are in the form of non-institutional personal care. The need for long-term care is of particular significance to Florida, since 23 percent of the population is over 60 years of age. The Health Insurance Association of America estimates that by 1990, 7.7 million elderly people will need long-term care and one out of every four will enter a nursing home.

Long-term care costs range between $20,000-36,000 per year for nursing home care and $1,000-16,000 per year for home health care, depending on the severity of the disability.

Medicare, the federal health insurance program for the elderly and disabled, provides only short term physician, hospital, and rehabilitative care for acute disorders. Medicare will only cover a maximum of 100 days in a skilled nursing home, under special circumstances and subject to co-payments by the individual. A survey by the American Association of Retired Persons indicated that 80 percent of the elderly people believed medicare covered long-term care. Medicare Supplement Insurance, which is health insurance offered by insurers to individuals entitled to medicare, provides reimbursement for medical expenses which are not covered by medicare due to deductibles, co-payments, and other limitations imposed by medicare. Seldom do these policies cover long-term care to any extent.

Medicaid is the federal and state health insurance for the poor. To qualify for Medicaid an individual must have no more than $1,800 in assets, and must have income of no more than $918 monthly. Medicaid will cover extended nursing home stays, but only after the individual has qualified by exhausting his assets. The United States General Accounting Office reported that seven out of 10 elderly individuals exhaust their life savings after 13 weeks in a nursing home. Only one percent of the total nursing home costs in 1987 were paid by private long-term care insurance.

Currently, 59 companies are marketing some form of long-term care insurance in Florida, offering 112 policies. These policies vary widely in terms of indemnity payments per day, maximum benefits offered, age limitations, deductibles, waiting periods, level of care covered, pre-existing conditions, illnesses excluded, prior hospitalization requirements, and renewability. There are currently no laws specifically regulating the form, content and manner of sale of these policies. State regulations addressing health insurance and medicare supplement insurance were not designed to regulate long-term care insurance, which differs in scope from other types of insurance, and are therefore inappropriate and ineffective for this purpose.
In June of 1987, the National Association of Insurance Commissioners (NAIC) adopted model legislation setting forth a definition of long-term care insurance, its scope and purpose, minimum benefit standards and specific consumer protections. Of the 112 policies offered in Florida, only 45 percent qualify as long-term care policies under the NAIC definition. Ten states have adopted legislation based on this model.

B. EFFECT OF PROPOSED CHANGES:

This bill creates the Long-Term Care Insurance Act, as a new part of chapter 627, Florida Statutes. This act is based on the NAIC Model Act of 1987. The purpose of the Long-Term Care Insurance Act, as set forth in s. 627.9402, F.S., is to establish standards for long-term care insurance, promote its availability, protect consumers from unfair trade practices, and facilitate flexibility and innovation in the development of coverage.

In a report to the U.S. House of Representatives Select Committee on Aging, the General Accounting Office (GAO) concluded that the lack of uniform standards and marketing requirements result in consumers having little protection against substandard policies and sales abuses. They also reported that the same abusive marketing practices prevalent in the marketing of medicare supplement insurance also exist in the long-term care market. GAO also reported that many companies have not been in the market long enough to experience sufficient claims to build actuarially sound data for determining long-term care risks. In order to assure the availability of this type of insurance, minimum standards must balance the needs of the insurer with the needs of the consumer. The NAIC model attempts to strike this balance.

Application of the act (Page 2, line 6) The provisions of this act will apply to all long-term care policies issued for delivery in this state and to policies issued for delivery outside this state as provided for in s. 627.906, F.S., by an insurer, fraternal benefit society, health care services plan, health maintenance organization, prepaid health clinic, and multiple-employer welfare arrangement. Policies marketed as both long-term care and medicare supplement policies must meet the requirements of this act and the Florida Medicare Supplement Reform Act. To the extent the requirements of these acts are inconsistent, the policy is subject to the requirement which is more favorable to the policyholder.

Definitions (Page 2, line 23) Long-term care insurance is defined as insurance marketed or offered to provide coverage for necessary diagnostic, preventative, therapeutic, rehabilitative or personal care services provided in a setting other than in an acute care unit of a hospital. A policy which is not
advertised, marketed or offered as long-term care insurance is not required to comply with this act.

For the purposes of this act, "applicant" is defined as the person who contracts for coverage, or in the case of a group policy, the certificate holder.

Authorized Groups (Page 3, line 21) This section allows group insurance to be delivered or issued for delivery in this state only to the following groups: employer, labor organization, professional or trade association composed of individuals who are or were engaged in the same occupation and have been maintained for purposes other than obtaining insurance, an association which in addition to other requirements has at the outset 100 members, has been in existence for one year for purposes other than obtaining insurance, other groups if the department determines the issuance of the group policy is in the best interests of the public, would result in economics of administration, and has reasonable benefits in relation to premiums.

Prior to marketing a group policy in this state, the insurer must demonstrate that the policy will be issued to one of the groups authorized by this section. If the department does not disapprove the issuance of the policy within 30 days, the issuance to the group will be deemed approved. The department may extend the period within which it may disapprove issuance of the policy an additional 15 days.

Additionally, an insurer may not issue a policy to one of these groups unless all members are declared eligible and acceptable to the insurer at the time the policy is issued. This prevents the practice of individual underwriting in the group market, which is also prohibited with respect to employer and labor organization group health insurance under ss. 627.653 and 627.654, F.S. There is no similar requirement in the NAIC model, because not all states prohibit individual underwriting with respect to group policies.

Out-of-State Groups (Page 5, line 16) This section prohibits a group long-term care insurance policy from being offered to a resident in this state under a group policy issued in another state, unless it meets the requirements of this act, or meets the requirements of a state having long-term care insurance requirements substantially similar to those adopted in this state.

An insurer issuing a policy in a state without minimum standards for long-term care insurance may not offer a long-term care policy to a resident of this state under a group policy unless the policy meets the requirements of this act.

This section applies to association and discretionary groups only. Out-of-state group policies offered to residents of this state under a group policy issued in another state to an
employee or labor organization are not required to comply with this act.

**Standards** (Page 5, line 29) Requires the department to adopt regulations including: standards for full and fair disclosures of policy terms and conditions, terms of renewability, initial and subsequent conditions of eligibility, non-duplication, preexisting conditions, and coverage limitations.

**Advertising** (Page 6, line 8) The department is also required to adopt rules setting forth standards for the advertising and sale of long-term care policies, in order to protect consumers from deceptive practices. The insurer is required to file advertising material with the department at least 30 days before use in this state. The department may disapprove an advertisement at any time and enter orders requiring advertisements to be discontinued, if it determines there has been a violation of the Unfair Insurance Trade Practices Act of chapter 626, F.S., the provisions of this act, or any rule of the department.

Currently, the department has the authority under the Unfair Insurance Trade Practices Act to order a violator to cease engaging in an unlawful practice, which includes misrepresentations and false advertising of insurance policies. This section departs from existing law in that it requires all advertising materials to be pre-filed before use.

**Renewability** (Page 6, line 28) This section prohibits the insurer from cancelling or refusing to renew a policy based on the age or deterioration of the health of the insured. The department may, however, authorize non-renewal for an insurer on a statewide basis if the insurer demonstrates that renewal will jeopardize solvency or that substantial and unexpected loss cannot be mitigated or remedied. Many of the insurers offering coverage today offer optionally renewable policies, either because they feel guaranteeing renewability is too risky, or because they regard their policies as experimental. Others oppose offering coverage in this market that is not guaranteed renewable, arguing that it is against public policy to cancel coverage for elderly people who have faithfully paid their premiums and therefore have a right to expect continued coverage as risk increases with age.

**Waiting Periods** (Page 7, line 7) Long-term care insurance policies vary in terms of the number of days insured must wait before they are eligible to collect benefits. Waiting periods prohibit an insured from collecting any benefits before a specified period of time has passed. This section prohibits insurers from establishing a new waiting period when existing coverage is replaced by new coverage within the same company, except with respect to an increase in benefits selected by the
insured. This requirement reduces the incentive for an insurer to "twist" a policyholder out of an existing policy, thereby subjecting him to a new waiting period.

Coverage (Page 7, line 12) This section also prohibits an insurer from limiting coverage to nursing home care only, or from providing significantly more coverage for nursing home care than for lower levels of care. Dr. Sutton's survey indicated that of the policies offered in Florida, 94 percent offered skilled nursing care as its principle component, which creates a bias toward more expensive care. Only 58 percent of the policies offered coverage for home health care. Many elderly individuals in need of long-term care do not require skilled nursing care.

Additionally, this section requires policies to provide coverage for at least 24 consecutive months. The NAIC model act only requires policies marketed as long-term care insurance to provide coverage for one year. The bill departs from the model in this respect. According to a study by Dr. Nancy Sutton of Florida State University, only 37 percent of the insurers who covered skilled nursing care offered protection for more than one year. Only 18 percent of the insurers offering home health care provided coverage for over one year. Many of the products covered services for periods of less than one year and, therefore, do not meet even the NAIC definition of long-term care. Additionally, the GAO reported that 91 percent of all nursing home residents spend an average of 2.5 years in the nursing home. The two year coverage requirement of this bill aligns the length of coverage with the average length of stay for most nursing home residents.

The bill prohibits an elimination period of longer than 120 days. Elimination periods are the equivalent of a deductible, requiring the insured to incur a specified number of days of expenses before coverage will begin. The May 1988 edition of Consumer Reports found elimination periods ranging from 20-100 days in the 55 long-term care policies it reviewed. This provision was not recommended by the NAIC.

Preexisting Conditions (Page 7, line 25) Regarding preexisting conditions, this section prohibits an insurer from defining "preexisting condition" more restrictively than a condition for which medical advice was received from a health care provider or the existence of symptoms which would cause an ordinarily prudent person to seek treatment, within 6 months preceding the effective date of coverage. Additionally, coverage for care required as a result of a preexisting condition may not be excluded unless the care begins within 6 months after the effective date of coverage. This definition of preexisting condition provides uniformity among policies, and prohibits an insurer from excluding an insured from benefits due to an overly broad definition of "preexisting condition." The "ordinary
The department is given the authority to extend the restrictions on preexisting condition limitations as to specific age categories in specific policy forms. An insurer may still use application forms to elicit the complete health history of the applicant, and may underwrite in accordance with the insurer's established standards. The preexisting condition limitations do not apply to employee or labor organization groups.

Prior Institutionalization (Page 9, line 1) Many policies contain restrictive clauses that attempt to establish medical necessity in order for the services to be covered. These clauses tend to reduce the likelihood that policies will pay benefits, especially for custodial care, which is often based more on the need for assistance in performing activities of daily living, than on the need for medical care. This section prohibits policies which provide benefits only following institutionalization from conditioning the benefits upon admission to a facility within a period of less than 30 days after discharge from the previous institutionalization. This prevents an insured from being subject to an inadequate period of time within which to locate and enter an institution in order to be compensated under his policy. A time period of fewer than 30 days may also result in the insured being placed in an institution at an inappropriate level of care.

Two additional provisions in this section which are not included in the NAIC model prohibit a policy from conditioning benefits upon a length of stay in a facility for more than three days, and require an insurer to offer to each applicant, a policy which does not condition benefits upon prior institutionalization. While 73 percent of the products in Florida required prior hospitalization for benefits, 85 percent of these products required hospitalization for three or fewer days. Therefore, the three day prior institutionalization limitation would not affect the majority of the policies offered in Florida today. Optional coverage without a prior institutionalization requirement will be subject to an appropriate additional premium. The May 1988 edition of Consumer Reports indicated that 61 percent of nursing home patients are admitted without being hospitalized beforehand. Presumably, almost 40 percent of these patients have the need for nursing home services but have not had prior hospitalization. Since prior hospitalization is a method used by insurers to control insurance-induced demand for services, it will be difficult for insurers to adequately assess the utilization of this benefit, therefore, the premium for this type of coverage may be prohibitive.

Loss Ratios (Page 9, line 17) Loss ratios are the proportion of gross premiums that must be returned to the policyholder as benefits. Minimum loss ratios are currently used in the
regulation of medicare supplement policies. Since long-term care insurance is a relatively new product, the availability of actuarially sound data for evaluating the risk is not yet available. Additionally, in this market there is the potential for adverse selection and insurance induced demand. Insurers are concerned that regulation limiting the premium to a specified percent of the losses would not provide a fair profit margin and adequate reserves for future loss. Realizing the difficulty of setting an appropriate loss ratio, the NAIC recommended that the department adopt a loss ratio at a level where benefits are reasonable in relation to premiums and calculated to provide adequate reserves. This section requires the department to set an appropriate loss ratio, and allows the department flexibility to adjust the loss ratio by rule as more actuarial data becomes available with respect to the long-term care risk.

Consumer Protection (Page 9, line 25) Finally, this section sets forth specific consumer protections including the right to return the policy within 30 days, requiring long-term care insurance policies to carry a stamp stating that the policy meets the requirements of Florida law, and requiring insurers to provide applicants with an outline of the benefits, limitation, exclusions, and renewal provisions contained in the policy. The "stamp of approval" was not recommended by the NAIC. Additionally, the NAIC recommended a 10-day free look period for individual policies, and a 30-day free look period for policies issued pursuant to a direct response solicitation. Certificates issued for group long-term care policies shall include a statement similar to the outline required for individual policies.

Section 627.9408, F.S., gives the department rulemaking authority with respect to the provisions of this act.

The act takes effect on October 1, 1998, and will apply to policies issued or renewed on or after that date. The act is scheduled to sunset on October 1, 1992.

C. SECTION-BY-SECTION ANALYSIS:

See B. above

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring or First Year Start-Up Effects:

   None

2. Recurring or Annualized Continuation Effects:

   None
3. **Long Run Effects Other Than Normal Growth:**

   None

4. ** Appropriations Consequences:**

   None

B. **FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:**

1. **Non-recurring or First Year Start-Up Effects:**

   None

2. **Recurring or Annualized Continuation Effects:**

   None

3. **Long Run Effects Other Than Normal Growth:**

   None

C. **DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:**

1. **Direct Private Sector Costs:**

   It is estimated that the average cost of a long-term care policy meeting the minimum standards ranges from $600 to $1,700 annually, depending upon the age of the policyholder and the benefit provided. Policies that provide lower benefits covered by a long-term care policy but which fall short of the minimum standards are obviously cheaper, and can be as low as $85 to $200 annually.

   Insurance products are targeted to individuals for whom the cost of the premium represents less than 5 to 7 percent of total income. Persons with $12,000 in income may be able to afford minimum standard policies at younger ages ($600 or less in premiums), and persons with at least $34,000 in income may be able to afford the more costly policies at older age groups ($1,700 or less in premiums). Today an estimated 21 percent of elderly fall into the latter category. Forty-five to 50 percent of the elderly should be able to afford coverage in the future. In Florida, this represents about 460,000 persons over 65 years of age, which may be understated since Florida elderly tend to have higher incomes than the national average.

2. **Direct Private Sector Benefits:**

   Persons buying insurance marketed as a long-term care policy to meet their long-term health care needs will receive the benefit of the minimum standards provided under this bill.
3. **Effects on Competition, Private Enterprise, and Employment Markets:**

Currently most policies do not meet the minimum standards of this bill, however, such policies would not be prohibited. Policies not meeting the minimum standards could not be marketed as "long-term care policies" and would be expected to be at a competitive disadvantage to long-term care policies meeting the minimum standards.

D. **FISCAL COMMENTS:**

The department advises that the workload impact of this bill can be absorbed by existing resources.

III. **LONG RANGE CONSEQUENCES:**

The effect of this bill is to regulate an area of insurance previously without minimum standards and guidelines. Policies offered after the effective date of this act will be more uniform as a result. A larger proportion of the elderly will purchase long-term care policies as the population of elderly individuals increases in Florida.

IV. **COMMENTS:**

None

V. **LEGISLATIVE HISTORY:**

A. **Enacted Bill:**

SB 606 was taken up by the Senate Commerce Committee and was amended to modify the requirements for advertising long-term care policies and delete the required stamp on long-term care policies not meeting minimum standards. Additionally, amendments added by the Commerce Committee allow policies to contain an elimination period of no longer than 120 days, and modify the definition of pre-existing condition.

A committee substitute was adopted by the Commerce Committee. The bill was withdrawn from the Health & Rehabilitative Services and Appropriations Committees. On 5/12/88, the bill passed the Senate by a vote of 35-0. CS/SB 606 passed the House by a vote of 113-0 on 5/17/88 and was approved by the Governor on 5/26/88.

B. **Disposition of Companion:**

HB 478 was amended by the Subcommittee on Health & Life Insurance & General Insurance Regulation to provide for the regulation of long-term care insurance advertising, require refunds to be made directly to policyholders, provide for notice to the buyer explaining that the policy may not cover all of the costs of long-term care, require insurers to provide consumers
with outlines of coverages which describe limitations, and to extend the application of this act to policies "renewed" after October 1, 1988. The subcommittee also amended the bill to provide a more expansive definition of "pre-existing condition."

HB 478 was submitted to the Insurance Committee on 4/14/88 as a proposed committee substitute.

The Insurance Committee took up the proposed committee substitute and adopted an additional amendment which permits policies to contain elimination periods of up to 120 days. The proposed committee substitute was adopted as amended. CS/HB 478 was reported favorably by the Appropriations Committee on 5/4/88 and CS/SB 606 was substituted for the House bill on 5/16/88.

VI. SIGNATURES:

INSURANCE COMMITTEE:
Prepared by: Debbi Zappi
Staff Director: William Leary

FINANCE & TAXATION:
Prepared by:
Staff Director:

APPROPRIATIONS:
Prepared by:
Staff Director:
I. SUMMARY:

This bill sets forth minimum standards for long-term care insurance policies including provisions relating to advertising, renewability, waiting periods, required coverage, preexisting conditions, prior institutionalization, loss ratios, and consumer protection.

A. PRESENT SITUATION:

Long-term care is prolonged assistance with daily living activities required by individuals who are dependent upon others as a result of some physical or mental disability. Long-term care ranges from non-medical support in the home to intense, continuous monitoring and services in skilled nursing facilities.

Four levels of long-term care services are:

1. Skilled nursing home care - nursing and rehabilitative services given by skilled medical personnel on a daily basis under the orders of a physician;

2. Intermediate nursing home care - skilled nursing care provided on an occasional basis;

3. Custodial nursing home care - assistance in requirements of daily living such as eating and bathing, which can be provided by persons without medical skills (also referred to as personal care); and

4. Home care - a variety of services provided in the home, including skilled nursing care, speech, physical and occupational therapy, social work, personal care, and homemaker services.

Eighty to 90 percent of all long-term care needs are in the form of non-institutional personal care. The need for long-term care is of particular significance to Florida, since 23 percent of the population is over 60 years of age. The Health Insurance Association of America estimates that by 1990, 7.7
million elderly people will need long-term care and one out of every four will enter a nursing home.

Long-term care costs range between $20,000-36,000 per year for nursing home care and $1,000-16,000 per year for home health care, depending on the severity of the disability.

Medicare, the federal health insurance program for the elderly and disabled, provides only short term physician, hospital, and rehabilitative care for acute disorders. Medicare will only cover a maximum of 100 days in a skilled nursing home, under special circumstances and subject to co-payments by the individual. A survey by the American Association of Retired Persons indicated that 80 percent of the elderly people believed medicare covered long-term care. Medicare Supplement Insurance, which is health insurance offered by insurers to individuals entitled to medicare, provides reimbursement for medical expenses which are not covered by medicare due to deductibles, co-payments, and other limitations imposed by medicare. Seldom do these policies cover long-term care to any extent.

Medicaid is the federal and state health insurance for the poor. To qualify for Medicaid an individual must have no more than $1,800 in assets, and must have income of no more than $918 monthly. Medicaid will cover extended nursing home stays, but only after the individual has qualified by exhausting his assets. The United States General Accounting Office reported that seven out of 10 elderly individuals exhaust their life savings after 13 weeks in a nursing home. Only one percent of the total nursing home costs in 1987 were paid by private long-term care insurance.

Currently, 59 companies are marketing some form of long-term care insurance in Florida, offering 112 policies. These policies vary widely in terms of indemnity payments per day, maximum benefits offered, age limitations, deductibles, waiting periods, level of care covered, pre-existing conditions, illnesses excluded, prior hospitalization requirements, and renewability. There are currently no laws specifically regulating the form, content and manner of sale of these policies. State regulations addressing health insurance and medicare supplement insurance were not designed to regulate long-term care insurance, which differs in scope from other types of insurance, and are therefore inappropriate and ineffective for this purpose.

In June of 1987, the National Association of Insurance Commissioners (NAIC) adopted model legislation setting forth a definition of long-term care insurance, its scope and purpose, minimum benefit standards and specific consumer protections. Of the 112 policies offered in Florida, only 45 percent qualify as long-term care policies under the NAIC definition. Ten states have adopted legislation based on this model.

B. EFFECT OF PROPOSED CHANGES:

This bill creates the Long-Term Care Insurance Act, as a new part of chapter 627, Florida Statutes. This act is based on the NAIC Model Act of 1987. The purpose of the Long-Term Care Insurance Act, as set forth in s. 627.9402, F.S., is to establish standards for long-term care insurance, promote its availability, protect consumers from unfair trade practices, and facilitate flexibility and innovation in the development of coverage.
In a report to the U.S. House of Representatives Select Committee on Aging, the General Accounting Office (GAO) concluded that the lack of uniform standards and marketing requirements result in consumers having little protection against substandard policies and sales abuses. They also reported that the same abusive marketing practices prevalent in the marketing of medicare supplement insurance also exist in the long-term care market. GAO also reported that many companies have not been in the market long enough to experience sufficient claims to build actuarially sound data for determining long-term care risks. In order to assure the availability of this type of insurance, minimum standards must balance the needs of the insurer with the needs of the consumer. The NAIC model attempts to strike this balance.

Application of the act (Page 2, line 6) The provisions of this act will apply to all long-term care policies issued for delivery in this state and to policies issued for delivery outside this state as provided for in s. 627.906, F.S., by an insurer, fraternal benefit society, health care services plan, health maintenance organization, prepaid health clinic, and multiple-employer welfare arrangement. Policies marketed as both long-term care and medicare supplement policies must meet the requirements of this act and the Florida Medicare Supplement Reform Act. To the extent the requirements of these acts are inconsistent, the policy is subject to the requirement which is more favorable to the policyholder.

Definitions (Page 2, line 23) Long-term care insurance is defined as insurance marketed or offered to provide coverage for necessary diagnostic, preventative, therapeutic, rehabilitative or personal care services provided in a setting other than in an acute care unit of a hospital. A policy which is not advertised, marketed or offered as long-term care insurance is not required to comply with this act.

For the purposes of this act, "applicant" is defined as the person who contracts for coverage, or in the case of a group policy, the certificate holder.

Authorized Groups (Page 3, line 21) This section allows group insurance to be delivered or issued for delivery in this state only to the following groups: employer, labor organization, professional or trade association composed of individuals who are or were engaged in the same occupation and have been maintained for purposes other than obtaining insurance, an association which in addition to other requirements has at the outset 100 members, has been in existence for one year for purposes other than obtaining insurance, other groups if the department determines the issuance of the group policy is in the best interests of the public, would result in economics of administration, and has reasonable benefits in relation to premiums.

Prior to marketing a group policy in this state, the insurer must demonstrate that the policy will be issued to one of the groups authorized by this section. If the department does not disapprove the issuance of the policy within 30 days, the issuance to the group will be deemed approved. The department may extend the period within which it may disapprove issuance of the policy an additional 15 days.

Additionally, an insurer may not issue a policy to one of these groups unless all members are declared eligible and acceptable to the insurer at the time the policy is issued. This prevents the practice of individual underwriting in the
group market, which is also prohibited with respect to employer and labor organization group health insurance under ss. 627.653 and 627.654, F.S. There is no similar requirement in the NAIC model, because not all states prohibit individual underwriting with respect to group policies.

Out-of-State Groups (Page 5, line 16) This section prohibits a group long-term care insurance policy from being offered to a resident in this state under a group policy issued in another state, unless it meets the requirements of this act, or meets the requirements of a state having long-term care insurance requirements substantially similar to those adopted in this state.

An insurer issuing a policy in a state without minimum standards for long-term care insurance may not offer a long-term care policy to a resident of this state under a group policy unless the policy meets the requirements of this act.

This section applies to association and discretionary groups only. Out-of-state group policies offered to residents of this state under a group policy issued in another state to an employee or labor organization are not required to comply with this act.

Advertising (Page 6, line 8) The department is also required to adopt rules setting forth standards for the advertising and sale of long-term care policies, in order to protect consumers from deceptive practices. The insurer is required to file advertising material with the department at least 30 days before use in this state. The department may disapprove an advertisement at any time and enter orders requiring advertisements to be discontinued, if it determines there has been a violation of the Unfair Insurance Trade Practices Act of chapter 626, F.S., the provisions of this act, or any rule of the department.

Currently, the department has the authority under the Unfair Insurance Trade Practices Act to order a violator to cease engaging in an unlawful practice, which includes misrepresentations and false advertising of insurance policies. This section departs from existing law in that it requires all advertising materials to be pre-filed before use.

Restrictions (Page 6, line 26) Requires the department to adopt regulations including: standards for full and fair disclosures of policy terms and conditions, terms of renewability, initial and subsequent conditions of eligibility, non-duplication, preexisting conditions, and coverage limitations.

Renewability (Page 6, line 28) This section prohibits the insurer from cancelling or refusing to renew a policy based on the age or deterioration of the health of the insured. The department may, however, authorize non-renewal for an insurer on a statewide basis if the insurer demonstrates that renewal will jeopardize solvency or that substantial and unexpected loss cannot be mitigated or remedied. Many of the insurers offering coverage today offer optionally renewable policies, either because they feel guaranteeing renewability is too risky, or because they regard their policies as experimental. Others oppose offering coverage in this market that is not guaranteed renewable, arguing that it is against public policy to cancel coverage for elderly people who have faithfully paid their premiums and therefore have a right to expect continued coverage as risk increases with age.
Waiting Periods (Page 7, line 7) Long-term care insurance policies vary in terms of the number of days insured must wait before they are eligible to collect benefits. Waiting periods prohibit an insured from collecting any benefits before a specified period of time has passed. This section prohibits insurers from establishing a new waiting period when existing coverage is replaced by new coverage within the same company, except with respect to an increase in benefits selected by the insured. This requirement reduces the incentive for an insurer to "twist" a policyholder out of an existing policy, thereby subjecting him to a new waiting period.

Coverage (Page 7, line 12) This section also prohibits an insurer from limiting coverage to nursing home care only, or from providing significantly more coverage for nursing home care than for lower levels of care. Dr. Sutton's survey indicated that of the policies offered in Florida, 94 percent offered skilled nursing care as its principle component, which creates a bias toward more expensive care. Only 58 percent of the policies offered coverage for home health care. Many elderly individuals in need of long-term care do not require skilled nursing care.

Additionally, this section requires policies to provide coverage for at least 24 consecutive months. The NAIC model act only requires policies marketed as long-term care insurance to provide coverage for one year. The bill departs from the model in this respect. According to a study by Dr. Nancy Sutton of Florida State University, only 37 percent of the insurers who covered skilled nursing care offered protection for more than one year. Only 18 percent of the insurers offering home health care provided coverage for over one year. Many of the products covered services for periods of less than one year and, therefore, do not meet even the NAIC definition of long-term care. Additionally, the GAO reported that 91 percent of all nursing home residents spend an average of 2.5 years in the nursing home. The two year coverage requirement of this bill aligns the length of coverage with the average length of stay for most nursing home residents.

The bill prohibits an elimination period of longer than 120 days. Elimination periods are the equivalent of a deductible, requiring the insured to incur a specified number of days of expenses before coverage will begin. The May 1988 edition of Consumer Reports found elimination periods ranging from 20-100 days in the 55 long-term care policies it reviewed. This provision was not recommended by the NAIC.

Preexisting Conditions (Page 7, line 25) Regarding preexisting conditions, this section prohibits an insurer from defining "preexisting condition" more restrictively than a condition for which medical advice was received from a health care provider or the existence of symptoms which would cause an ordinarily prudent person to seek treatment, within 6 months preceding the effective date of coverage. Additionally, coverage for care required as a result of a preexisting condition may not be excluded unless the care begins within 6 months after the effective date of coverage. This definition of preexisting condition provides uniformity among policies, and prohibits an insurer from excluding an insured from benefits due to an overly broad definition of "preexisting condition." The department is given the authority to extend the restrictions on preexisting condition limitations as to specific age categories in specific policy forms. An insurer may still use application forms to elicit the complete health history of the applicant, and may underwrite in
accordance with the insurer's established standards. The preexisting condition limitations do not apply to employee or labor organization groups.

Prior Institutionalization (Page 9, line 1) Many policies contain restrictive clauses that attempt to establish medical necessity in order for the services to be covered. These clauses tend to reduce the likelihood that policies will pay benefits, especially for custodial care, which is often based more on the need for assistance in performing activities of daily living, than on the need for medical care. This section prohibits policies which provide benefits only following institutionalization from conditioning the benefits upon admission to a facility within a period of less than 30 days after discharge from the previous institutionalization. This prevents an insured from being subject to an inadequate period of time within which to locate and enter an institution in order to be compensated under his policy. A time period of fewer than 30 days may also result in the insured being placed in an institution at an inappropriate level of care.

Two additional provisions in this section which are not included in the NAIC model prohibit a policy from conditioning benefits upon a length of stay in a facility for more than three days, and require an insurer to offer to each applicant, a policy which does not condition benefits upon prior institutionalization. While 73 percent of the products in Florida required prior hospitalization for benefits, 85 percent of these products required hospitalization for three or fewer days. Therefore, the three day prior institutionalization limitation would not affect the majority of the policies offered in Florida today. Optional coverage without a prior institutionalization requirement will be subject to an appropriate additional premium. The May 1988 edition of Consumer Reports indicated that 61 percent of nursing home patients are admitted without being hospitalized beforehand. Presumably, almost 40 percent of these patients have the need for nursing home services but have not had prior hospitalization. Since prior hospitalization is a method used by insurers to control insurance-induced demand for services, it will be difficult for insurers to adequately assess the utilization of this benefit, therefore, the premium for this type of coverage may be prohibitive.

Loss Ratios (Page 9, line 17) Loss ratios are the proportion of gross premiums that must be returned to the policyholder as benefits. Minimum loss ratios are currently used in the regulation of medicare supplement policies. Since long-term care insurance is a relatively new product, the availability of actuarially sound data for evaluating the risk is not yet available. Additionally, in this market there is the potential for adverse selection and insurance induced demand. Insurers are concerned that regulation limiting the premium to a specified percent of the losses would not provide a fair profit margin and adequate reserves for future loss. Realizing the difficulty of setting an appropriate loss ratio, the NAIC recommended that the department adopt a loss ratio at a level where benefits are reasonable in relation to premiums and calculated to provide adequate reserves. This section requires the department to set an appropriate loss ratio, and allows the department flexibility to adjust the loss ratio by rule as more actuarial data becomes available with respect to the long-term care risk.

Consumer Protection (Page 9, line 25) Finally, this section sets forth specific consumer protections including the right to return the policy within 30 days,
requiring long-term care insurance policies to carry a stamp stating that the policy meets the requirements of Florida law, and requiring insurers to provide applicants with an outline of the benefits, limitation, exclusions, and renewal provisions contained in the policy. The "stamp of approval" was not recommended by the NAIC. Additionally, the NAIC recommended a 10-day free look period for individual policies, and a 30-day free look period for policies issued pursuant to a direct response solicitation. Certificates issued for group long-term care policies shall include a statement similar to the outline required for individual policies.

Section 627.9408, F.S., gives the department rulemaking authority with respect to the provisions of this act.

The act takes effect on October 1, 1998, and will apply to policies issued or renewed on or after that date. The act is scheduled to sunset on October 1, 1992.

C. SECTION-BY-SECTION ANALYSIS:

See B. above

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT: FY 88-89 FY 89-90 FY 90-91

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring or First Year Start-Up Effects:
   None

2. Recurring or Annualized Continuation Effects:
   None

3. Long Run Effects Other Than Normal Growth:
   None

4. Appropriations Consequences:
   None

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring or First Year Start-Up Effects:
   None

2. Recurring or Annualized Continuation Effects:
   None

3. Long Run Effects Other Than Normal Growth:
   None
C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:
   Indeterminate (See Comments)

2. Direct Private Sector Benefits:
   Indeterminate (See Comments)

3. Effects on Competition, Private Enterprise, and Employment Markets:
   Indeterminate (See Comments)

D. FISCAL COMMENTS:

The department predicts the workload impact for this bill can be absorbed with existing resources.

Private sector costs vary, depending on the age of the policyholder and the benefit provided. It is estimated that the average cost of a long-term care policy meeting the minimum standards ranges from $600 to $1,700 annually. Policies that provide lower benefits covered by a long-term care policy but which fall short of the minimum standards are obviously cheaper, and can be as low as $85 to $200 annually.

Insurance products are targeted to individuals for whom the cost of the premium represents less than 5 to 7 percent of total income. Persons with $12,000 in income may be able to afford minimum standard policies at younger ages ($600 or less in premiums), and persons with at least $34,000 in income may be able to afford the more costly policies at older age groups ($1,700 or less in premiums). Today, an estimated 21 percent of elderly fall into the latter category. Forty-five to 50 percent of the elderly should be able to afford coverage in the future. In Florida, this represents about 460,000 persons over 65 years of age, which may be understated since Florida elderly tend to have higher incomes than the national average.

The private sector will benefit from the minimum standards provided under this bill when they purchase long-term health care.

Most "long-term care" policies do not meet the minimum standards of this bill, however, such policies would not be prohibited. These policies could not be marketed as long-term care policies and would be expected to be at a competitive disadvantage to long-term policies which do meet the minimum standards.

III. LONG RANGE CONSEQUENCES:

The effect of this bill is to regulate an area of insurance previously without minimum standards and guidelines. Policies offered after the effective date of this act will be more uniform as a result. A larger proportion of the elderly will purchase long-term care policies as the population of elderly individuals increases in Florida.
IV. COMMENTS:

A similar bill has been filed in the Senate (SB 606).

V. AMENDMENTS:

VI. SIGNATURES:

SUBSTANTIVE COMMITTEE:
Prepared by: Debbi Zappi

FINANCE & TAXATION:
Prepared by:

APPROPRIATIONS:
Prepared by: Lori Kilpatrick

Staff Director:
William Leary
Staff Director:
Staff Director:
Dr. James A. Zingale
SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Wilkes	Fort	1. COM	Fav/CS
2. 		2. HRS	-
3. 		3. AP	-
4. 		4. 	-

SUBJECT: BILL NO. AND SPONSOR:
Long-Term Care Insurance	CS/SB 606 by Commerce and Senator Myers

I. SUMMARY:
A. Present Situation:

Long-term care is prolonged assistance with daily living activities required by individuals who are dependent upon others as a result of some physical or mental disability. Long-term care ranges from non-medical support in the home to intense, continuous monitoring and services in skilled nursing facilities.

Four levels of long-term care services are:
1. Skilled nursing home care - nursing and rehabilitative services given by skilled medical personnel on a daily basis under the orders of a physician;
2. Intermediate nursing home care - skilled nursing care provided on an occasional basis;
3. Custodial nursing home care - assistance in requirements of daily living such as eating and bathing, which can be provided by persons without medical skills (also referred to as personal care); and
4. Home care - a variety of services provided in the home, including skilled nursing care, speech, physical and occupational therapy, social work, personal care, and homemaker services.

Eighty to 90 percent of all long-term care needs are in the form of non-institutional personal care. The need for long-term care is of particular significance to Florida, since 23 percent of the population is over 60 years of age. The Health Insurance Association of America estimates that by 1990, 7.7 million elderly people will need long-term care and one out of every four will enter a nursing home.

Long-term care costs range between $20,000 - $36,000 per year for nursing home care and $1,000 - $16,000 per year for home health care, depending on the severity of the disability.

Medicare, the federal health insurance program for the elderly and disabled, provides only short term physician, hospital, and rehabilitative care for acute disorders. Medicare will only cover a maximum of 100 days in a skilled nursing home, under special circumstances and subject to co-payments by the individual. A survey by the American Association of Retired Persons indicated that 80 percent of the elderly people believed Medicare covered long-term care. Medicare Supplement Insurance, which is health insurance offered by insurers to individuals entitled to Medicare, provides reimbursement for medical expenses which are not covered by Medicare due to deductibles, co-payments, and other limitations imposed by
Medicare. Seldom do these policies cover long-term care to any extent.

Medicaid is the federal and state health insurance for the poor. To qualify for Medicaid an individual must have no more than $1,800 in assets, and must have income of no more than $918 monthly. Medicaid will cover extended nursing home stays, but only after the individual has qualified by exhausting his assets. The United States General Accounting Office reported that seven out of ten elderly individuals exhaust their life savings after 13 weeks in a nursing home. Only one percent of the total nursing home costs in 1987 were paid by private long-term care insurance.

Currently, 59 companies are marketing some form of long-term care insurance in Florida, offering 112 policies. These policies vary widely in terms of indemnity payments per day, maximum benefits offered, age limitations, deductibles, waiting periods, level of care covered, preexisting conditions, illnesses excluded, prior hospitalization requirements, and renewability. There are currently no laws specifically regulating the form, content and manner of sale of these policies. State regulations addressing health insurance and Medicare supplement insurance were not designed to regulate long-term care insurance, which differs in scope from other types of insurance, and are therefore inappropriate and ineffective for this purpose.

In June of 1987, the National Association of Insurance Commissioners (NAIC) adopted model legislation setting forth a definition of long-term care insurance, its scope and purpose, minimum benefit standards and specific consumer protections. Of the 112 policies offered in Florida, only 45 percent qualify as long-term care policies under the NAIC definition. Ten states have adopted legislation based on this model.

B. Effect of Proposed Changes:

This bill creates the Long-Term Care Insurance Act, as a new part of ch. 627, F.S. This act is based on the NAIC Model Act of 1987. The purpose of the Long-Term Care Insurance Act, as set forth in s. 627.9402, F.S., is to establish standards for long-term care insurance, promote its availability, protect consumers from unfair trade practices, and facilitate flexibility and innovation in the development of coverage.

In a report to the U.S. House of Representatives Select Committee on Aging, the General Accounting Office (GAO) concluded that the lack of uniform standards and marketing requirements result in consumers having little protection against substandard policies and sales abuses. They also reported that the same abusive marketing practices prevalent in the marketing of Medicare supplement insurance also exist in the long-term care market. GAO also reported that many companies have not been in the market long enough to experience sufficient claims to build actuarily sound data for determining long-term care risks. In order to assure the availability of this type of insurance, minimum standards must balance the needs of the insurer with the needs of the consumer. The NAIC model attempts to strike this balance.

Application of the act (s. 627.9403, F.S.) The provisions of this act will apply to all long-term care policies issued for delivery in this state and to policies issued for delivery outside this state as provided for in s. 627.9406, F.S., by an insurer, fraternal benefit society, health care services plan, health maintenance organization, prepaid health clinic, and multiple-employer welfare arrangement. Policies marketed as both long-term care and Medicare supplement policies must meet the requirements of this act and the Florida Medicare Supplement Reform Act. To the extent the requirements of these
acts are inconsistent, the policy is subject to the requirement which is more favorable to the policyholder. The act does not apply to a continuing care contract issued pursuant to ch. 651, F.S.

Definitions (s. 627.9404, F.S.) Long-term care insurance is defined as insurance marketed or offered to provide coverage for necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services provided in a setting other than in an acute care unit of a hospital.

For the purposes of this act, "applicant" is defined as the person who contracts for coverage, or in the case of a group policy, the certificateholder.

Authorized Groups (s. 627.9405, F.S.) This section allows group insurance to be delivered or issued for delivery in this state only to the following groups: employer, labor organization, professional or trade association composed of individuals who are or were engaged in the same occupation and have been maintained for purposes other than obtaining insurance, association which in addition to other requirements has at the outset 100 members, has been in existence for 1 year for purposes other than obtaining insurance, other groups if the department determines the issuance of the group policy is in the best interests of the public, would result in economies of administration, and has reasonable benefits in relation to premiums.

Prior to marketing a group policy in this state, the insurer must demonstrate that the policy will be issued to one of the groups authorized by this section. If the department does not disapprove the issuance of the policy within 30 days, the issuance to the group will be deemed approved. The department may extend the period within which it may disapprove issuance of the policy an additional 15 days.

Additionally, an insurer may not issue a policy to one of these groups unless all members are declared eligible and acceptable to the insurer at the time the policy is issued. This prevents the practice of individual underwriting in the group market, which is also prohibited with respect to employer and labor organization group health insurance under ss. 627.653 and 627.654, F.S. There is no similar requirement in the NAIC model, because not all states prohibit individual underwriting with respect to group policies.

Out-of-State Groups (s. 627.9406, F.S.) This section prohibits a group long-term care insurance policy from being offered to a resident in this state under a group policy issued in another state, unless it meets the requirements of this act, or meets the requirements of a state having long-term care insurance requirements substantially similar to those adopted in this state.

An insurer issuing a policy in a state without minimum standards for long-term care insurance may not offer a long-term care policy to a resident of this state under a group policy unless the policy meets the requirements of this act.

This section applies to association and discretionary groups only. Out-of-state group policies offered to residents of this state under a group policy issued in another state to an employee or labor organization are not required to comply with this act.

Restrictions (s. 627.9407, F.S.) Requires the department to adopt regulations including: standards for full and fair disclosures of policy terms and conditions, terms of renewability, initial and subsequent conditions of eligibility,
non-duplication, preexisting conditions, and coverage limitations.

The department is also required to adopt rules setting forth standards for the advertising and sale of long-term care policies, in order to protect consumers from deceptive practices. The insurer is required to file advertising material with the department at least 30 days before use in this state. The department may disapprove an advertisement at any time and enter orders requiring advertisements to be discontinued, it it determines there has been a violation of the Unfair Insurance Trade Practices Act or ch. 626, F.S., the provisions of this act, or any rule of the department.

Currently, the department has the authority under the Unfair Insurance Trade Practices Act to order a violator to cease engaging in an unlawful practice, which includes misrepresentations and false advertising of insurance policies. This section departs from existing law in that it requires all advertising materials to be pre-filed before use.

This section prohibits the insurer from cancelling or refusing to renew a policy based on the age or deterioration of the health of the insured. The department may, however, authorize non-renewal for an insurer on a statewide basis if the insurer demonstrates that renewal will jeopardize solvency or that substantial and unexpected loss cannot be mitigated or remedied. Many of the insurers offering coverage today offer optionally renewable policies, either because they feel guaranteeing renewability is too risky, or because they regard their policies as experimental. Others oppose offering coverage in this market that is not guaranteed renewable, arguing that it is against public policy to cancel coverage for elderly people who have faithfully paid their premiums and therefore have a right to expect continued coverage as risk increases with age.

Long-term care insurance policies vary in terms of the number of days insured must wait before they are eligible to collect benefits. Waiting periods are the equivalent of a deductible, requiring the insured to incur a specified number of days of expenses before coverage will begin. This section prohibits insurers from establishing a new waiting period when existing coverage is replaced by new coverage within the same company, except with respect to an increase in benefits selected by the insured. This requirement reduces the incentive for an insurer to "twist" a policyholder out of an existing policy, thereby subjecting him to a new deductible.

This section also prohibits an insurer from limiting coverage to care only in nursing homes, or from providing significantly more coverage for such care than for lower levels of care. Dr. Sutton's survey indicated that of the policies offered in Florida, 94 percent offered skilled nursing care as its principle component, which creates a bias toward more expensive care. Only 58 percent of the policies offered coverage for home health care. Many elderly individuals in need of long-term care do not require skilled nursing care.

Additionally, this section requires policies to provide coverage for at least 24 consecutive months. The NAIC model act only requires policies marketed as long-term care insurance to provide coverage for one year. The bill departs from the model in this respect. According to a study by Dr. Nancy Sutton of Florida State University, only 37 percent of the insurers who covered skilled nursing care offered protection for more than one year. Only 18 percent of the insurers offering home health care provided coverage for over 1 year. Many of the products covered services for periods of less than 1 year and, therefore, do not meet the NAIC definition of long-term care. Additionally, the GAO reported that 91 percent of
all nursing home residents spend an average of 2.5 years in the nursing home. The 2-year coverage requirement of this bill aligns the length of coverage with the average length of stay for most nursing home residents.

Regarding preexisting conditions, this section prohibits an insurer from defining "preexisting condition" more restrictively than a condition for which medical advice was received from a health care provider or the existence of symptoms which would cause an ordinarily prudent person to seek treatment within 6 months preceding the effective date of coverage. Additionally, coverage for care required as a result of a preexisting condition may not be excluded unless the care begins within 6 months after the effective date of coverage. This definition of preexisting condition provides uniformity among policies, and prohibits an insurer from excluding an insured from benefits due to an overly broad definition of "preexisting condition." The department is given the authority to extend the restrictions on preexisting condition limitations as to specific age categories in specific policy forms. An insurer may still issue application forms to elicit the complete health history of the applicant, and may underwrite in accordance with the insurer's established standards. The preexisting condition limitations do not apply to employee or labor organization groups.

Many policies contain restrictive clauses that attempt to establish medical necessity in order for the services to be covered. These clauses tend to reduce the likelihood that policies will pay benefits, especially for custodial care, which is often based more on the need for assistance in performing activities of daily living, than on the need for medical care. This section prohibits policies which provide benefits only following institutionalization from conditioning the benefits upon admission to a facility within a period of less than 30 days after discharge from the previous institutionalization. This prevents an insured from being subject to an inadequate period of time within which to locate and enter an institution in order to be compensated under his policy. A time period of fewer than 30 days may also result in the insured being placed in an institution at an inappropriate level of care.

Two additional provisions in this section which are not included in the NAIC model prohibit a policy from conditioning benefits upon a length of stay in a facility for more than 3 days, and require an insurer to offer to each applicant, a policy which does not condition benefits upon prior institutionalization. While 73 percent of the products in Florida required prior hospitalization for benefits, 85 percent of these products required hospitalization for 3 fewer days. Therefore, the 3 day prior institutionalization limitation would not affect the majority of the policies offered in Florida today. Optional coverage without a prior institutionalization requirement would subject the insured to an appropriate additional premium. Since prior hospitalization is a method used by insurers to control insurance-induced demand for services, it will be difficult for insurers to adequately assess the utilization of this benefit; therefore, the premium for this type of coverage may be prohibitive.

Loss ratios are the proportion of gross premiums that must be returned to the policyholder as benefits. Minimum loss ratios are currently used in the regulation of Medicare supplement policies. Since long-term care insurance is a relatively new product, the availability of actuarially sound data for evaluating the risk is not yet available. Additionally, in this market there is the potential for adverse selection and insurance-induced demand. Insurers are concerned that regulation limiting the premium to a specified percent of the losses would not provide a fair profit margin and adequate
reserves for future loss. Realizing the difficulty of setting an appropriate loss ratio, the NAIC recommended that the department adopt a loss ratio at a level where benefits are reasonable in relation to premiums and calculated to provide adequate reserves. This section requires the department to set an appropriate loss ratio, and allows the department flexibility to adjust the loss ratio by rule as more actuarial data becomes available with respect to the long-term care risk.

Finally, this section sets forth specific consumer protections including the right to return the policy within 30 days, requiring long-term care insurance policies to carry a stamp stating that the policy meets the requirements of Florida law, and requiring insurers to provide applicants with an outline of the benefits, limitation, exclusions, and renewal provisions contained in the policy. The "stamp of approval" was not recommended by the NAIC. Certificates issued for group long-term care policies shall include a statement similar to the outline required for individual policies.

Section 627.9408, F.S., gives the department rulemaking authority with respect to the provisions of this act.

The act takes effect on October 1, 1988, and will apply only to policies issued on or after that date. The act is scheduled for Sunset review and repeal on October 1, 1992.

II. ECONOMIC IMPACT AND FISCAL NOTE:

A. Public:

It is estimated that the average cost of a long-term care policy meeting the minimum standards ranges from $600 to $1,700 annually, depending upon the age of the policyholder and the benefits provided. Policies that provide lower benefits covered by a long-term care policy but which fall short of the minimum standards are obviously cheaper, and can be as low as $85 to $200 annually.

Insurance products are targeted to individuals for whom the cost of the premium represents less than 5 to 7 percent of total income. Persons with $12,000 in income may be able to afford minimum standard policies at younger ages ($600 or less in premiums), and persons with at least $34,000 in income may be able to afford the more costly policies at older age groups ($1,700 or less in premiums). Today an estimated 21 percent of elderly fall into the latter category. Forty-five to 50 percent of the elderly should be able to afford coverage in the future. In Florida, this represents about 460,000 persons over 65 years of age, which may be understated since Florida elderly tend to have higher incomes than the national average.

Persons buying insurance marketed as a long-term care policy to meet their long-term health care needs will receive the benefit of the minimum standards provided under this bill.

B. Government:

The department advises that the workload impact of this bill can be absorbed by existing resources.
III. COMMENTS:

None.

IV. AMENDMENTS:

None.
SENATE BILL 606 (CHAPTER 88— ) creates the Long-Term Care Insurance Act, as a new part of ch. 627, F.S. The act is based upon the National Association of Insurance Commissioners Model Act of 1987. Long-term care insurance is defined as insurance marketed or offered to provide coverage for necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services provided in a setting other than in an acute care unit of a hospital. The bill requires the Department of Insurance to establish standards for long-term care insurance by adopting regulations including: standards for full and fair disclosures of policy terms and conditions, terms of renewability, initial and subsequent conditions of eligibility, non-duplication, preexisting conditions, and coverage limitations. The department is also required to adopt rules setting forth standards for the advertising and sale of long-term care policies, in order to protect consumers from deceptive practices. All advertising materials must be pre-filed with the Department of Insurance before use.

The bill also prohibits an insurer from limiting coverage to care only in nursing homes, or from providing significantly more coverage for at least 24 consecutive months.

Specific consumer protections are set forth, including the right to return the policy within 30 days, requiring long-term care insurance policies to carry a stamp stating that the policy meets the requirements of Florida law, and requiring insurers to provide applicants with an outline of the benefits, limitation, exclusions, and renewal provisions contained in the policy.
I. SUMMARY:

A. Present Situation:

Long-term care is prolonged assistance with daily living activities required by individuals who are dependent upon others as a result of some physical or mental disability. Long-term care ranges from non-medical support in the home to intense, continuous monitoring and services in skilled nursing facilities.

Four levels of long-term care services are:

1. Skilled nursing home care - nursing and rehabilitative services given by skilled medical personnel on a daily basis under the orders of a physician;

2. Intermediate nursing home care - skilled nursing care provided on an occasional basis;

3. Custodial nursing home care - assistance in requirements of daily living such as eating and bathing, which can be provided by persons without medical skills (also referred to as personal care); and

4. Home care - a variety of services provided in the home, including skilled nursing care, speech, physical and occupational therapy, social work, personal care, and homemaker services.

Eighty to 90 percent of all long-term care needs are in the form of non-institutional personal care. The need for long-term care is of particular significance to Florida, since 23 percent of the population is over 60 years of age. The Health Insurance Association of America estimates that by 1990, 7.7 million elderly people will need long-term care and one out of every four will enter a nursing home.

Long-term care costs range between $20,000 - $36,000 per year for nursing home care and $1,000 - $16,000 per year for home health care, depending on the severity of the disability.

Medicare, the federal health insurance program for the elderly and disabled, provides only short term physician, hospital, and rehabilitative care for acute disorders. Medicare will only cover a maximum of 100 days in a skilled nursing home, under special circumstances and subject to co-payments by the individual. A survey by the American Association of Retired Persons indicated that 80 percent of the elderly people believed Medicare covered long-term care. Medicare Supplement Insurance, which is health insurance offered by insurers to individuals entitled to Medicare, provides reimbursement for medical expenses which are not covered by Medicare due to deductibles, co-payments, and other limitations imposed by
Medicare. Seldom do these policies cover long-term care to any extent.

Medicaid is the federal and state health insurance for the poor. To qualify for Medicaid an individual must have no more than $1,800 in assets, and must have income of no more than $918 monthly. Medicaid will cover extended nursing home stays, but only after the individual has qualified by exhausting his assets. The United States General Accounting Office reported that seven out of ten elderly individuals exhaust their life savings after 13 weeks in a nursing home. Only one percent of the total nursing home costs in 1987 were paid by private long-term care insurance.

Currently, 59 companies are marketing some form of long-term care insurance in Florida, offering 112 policies. These policies vary widely in terms of indemnity payments per day, maximum benefits offered, age limitations, deductibles, waiting periods, level of care covered, preexisting conditions, illnesses excluded, prior hospitalization requirements, and renewability. There are currently no laws specifically regulating the form, content and manner of sale of these policies. State regulations addressing health insurance and Medicare supplement insurance were not designed to regulate long-term care insurance, which differs in scope from other types of insurance, and are therefore inappropriate and ineffective for this purpose.

In June of 1987, the National Association of Insurance Commissioners (NAIC) adopted model legislation setting forth a definition of long-term care insurance, its scope and purpose, minimum benefit standards and specific consumer protections. Of the 112 policies offered in Florida, only 45 percent qualify as long-term care policies under the NAIC definition. Ten states have adopted legislation based on this model.

B. Effect of Proposed Changes:

This bill creates the Long-Term Care Insurance Act, as a new part of ch. 627, F.S. This act is based on the NAIC Model Act of 1987. The purpose of the Long-Term Care Insurance Act, as set forth in s. 627.9402, F.S., is to establish standards for long-term care insurance, promote its availability, protect consumers from unfair trade practices, and facilitate flexibility and innovation in the development of coverage.

In a report to the U.S. House of Representatives Select Committee on Aging, the General Accounting Office (GAO) concluded that the lack of uniform standards and marketing requirements result in consumers having little protection against substandard policies and sales abuses. They also reported that the same abusive marketing practices prevalent in the marketing of Medicare supplement insurance also exist in the long-term care market. GAO also reported that many companies have not been in the market long enough to experience sufficient claims to build actuarially sound data for determining long-term care risks. In order to assure the availability of this type of insurance, minimum standards must balance the needs of the insurer with the needs of the consumer. The NAIC model attempts to strike this balance.

Application of the act (s. 627.9403, F.S.) The provisions of this act will apply to all long-term care policies issued for delivery in this state and to policies issued for delivery outside this state as provided for in s. 627.9406, F.S., by an insurer, fraternal benefit society, health care services plan, health maintenance organization, prepaid health clinic, and multiple-employer welfare arrangement. Policies marketed as both long-term care and Medicare supplement policies must meet the requirements of this act and the Florida Medicare Supplement Reform Act. To the extent the requirements of these
acts are inconsistent, the policy is subject to the requirement which is more favorable to the policyholder. The act does not apply to a continuing care contract issued pursuant to ch. 651, F.S.

Definitions (s. 627.9404, F.S.) Long-term care insurance is defined as insurance marketed or offered to provide coverage for necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services provided in a setting other than in an acute care unit of a hospital.

For the purposes of this act, "applicant" is defined as the person who contracts for coverage, or in the case of a group policy, the certificateholder.

Authorized Groups (s. 627.9405, F.S.) This section allows group insurance to be delivered or issued for delivery in this state only to the following groups: employer, labor organization, professional or trade association composed of individuals who are or were engaged in the same occupation and have been maintained for purposes other than obtaining insurance, association which in addition to other requirements has at the outset 100 members, has been in existence for 1 year for purposes other than obtaining insurance, other groups if the department determines the issuance of the group policy is in the best interests of the public, would result in economies of administration, and has reasonable benefits in relation to premiums.

Prior to marketing a group policy in this state, the insurer must demonstrate that the policy will be issued to one of the groups authorized by this section. If the department does not disapprove the issuance of the policy within 30 days, the issuance to the group will be deemed approved. The department may extend the period within which it may disapprove issuance of the policy an additional 15 days.

Additionally, an insurer may not issue a policy to one of these groups unless all members are declared eligible and acceptable to the insurer at the time the policy is issued. This prevents the practice of individual underwriting in the group market, which is also prohibited with respect to employer and labor organization group health insurance under ss. 627.653 and 627.654, F.S. There is no similar requirement in the NAIC model, because not all states prohibit individual underwriting with respect to group policies.

Out-of-State Groups (s. 627.9406, F.S.) This section prohibits a group long-term care insurance policy from being offered to a resident in this state under a group policy issued in another state, unless it meets the requirements of this act, or meets the requirements of a state having long-term care insurance requirements substantially similar to those adopted in this state.

An insurer issuing a policy in a state without minimum standards for long-term care insurance may not offer a long-term care policy to a resident of this state under a group policy unless the policy meets the requirements of this act.

This section applies to association and discretionary groups only. Out-of-state group policies offered to residents of this state under a group policy issued in another state to an employee or labor organization are not required to comply with this act.

Restrictions (s. 627.9407, F.S.) Requires the department to adopt regulations including: standards for full and fair disclosures of policy terms and conditions, terms of renewability, initial and subsequent conditions of eligibility,
non-duplication, preexisting conditions, and coverage limitations.

The department is also required to adopt rules setting forth standards for the advertising and sale of long-term care policies, in order to protect consumers from deceptive practices. The insurer is required to file advertising material with the department at least 30 days before use in this state. The department may disapprove an advertisement at any time and enter orders requiring advertisements to be discontinued, if it determines there has been a violation of the Unfair Insurance Trade Practices Act of ch. 626, F.S., the provisions of this act, or any rule of the department.

Currently, the department has the authority under the Unfair Insurance Trade Practices Act to order a violator to cease engaging in an unlawful practice, which includes misrepresentations and false advertising of insurance policies. This section departs from existing law in that it requires all advertising materials to be pre-filed before use.

This section prohibits the insurer from cancelling or refusing to renew a policy based on the age or deterioration of the health of the insured. The department may, however, authorize non-renewal for an insurer on a statewide basis if the insurer demonstrates that renewal will jeopardize solvency or that substantial and unexpected loss cannot be mitigated or remedied. Many of the insurers offering coverage today offer optionally renewable policies, either because they feel guaranteeing renewability is too risky, or because they regard their policies as experimental. Others oppose offering coverage in this market that is not guaranteed renewable, arguing that it is against public policy to cancel coverage for elderly people who have faithfully paid their premiums and therefore have a right to expect continued coverage as risk increases with age.

Long-term care insurance policies vary in terms of the number of days insured must wait before they are eligible to collect benefits. Waiting periods are the equivalent of a deductible, requiring the insured to incur a specified number of days of expenses before coverage will begin. This section prohibits insurers from establishing a new waiting period when existing coverage is replaced by new coverage within the same company, except with respect to an increase in benefits selected by the insured. This requirement reduces the incentive for an insurer to "twist" a policyholder out of an existing policy, thereby subjecting him to a new deductible.

This section also prohibits an insurer from limiting coverage to care only in nursing homes, or from providing significantly more coverage for such care than for lower levels of care. Dr. Sutton's survey indicated that of the policies offered in Florida, 94 percent offered skilled nursing care as its principle component, which creates a bias toward more expensive care. Only 58 percent of the policies offered coverage for home health care. Many elderly individuals in need of long-term care do not require skilled nursing care. Additionally, this section requires policies to provide coverage for at least 24 consecutive months. The NAIC model act only requires policies marketed as long-term care insurance to provide coverage for one year. The bill departs from the model in this respect. According to a study by Dr. Nancy Sutton of Florida State University, only 37 percent of the insurers who covered skilled nursing care offered protection for more than one year. Only 18 percent of the insurers offering home health care provided coverage for over 1 year. Many of the products covered services for periods of less than 1 year and, therefore, do not meet the NAIC definition of long-term care. Additionally, the GAO reported that 91 percent of
all nursing home residents spend an average of 2.5 years in the nursing home. The 2-year coverage requirement of this bill aligns the length of coverage with the average length of stay for most nursing home residents.

Regarding preexisting conditions, this section prohibits an insurer from defining "preexisting condition" more restrictively than a condition for which medical advice was received from a health care provider or the existence of symptoms which would cause an ordinarily prudent person to seek treatment, within 6 months preceding the effective date of coverage. Additionally, coverage for care required as a result of a preexisting condition may not be excluded unless the care begins within 6 months after the effective date of coverage. This definition of preexisting condition provides uniformity among policies, and prohibits an insurer from excluding an insured from benefits due to an overly broad definition of "preexisting condition." The department is given the authority to extend the restrictions on preexisting condition limitations to specific age categories in specific policy forms. An insurer may still issue application forms to elicit the complete health history of the applicant, and may underwrite in accordance with the insurer's established standards. The preexisting condition limitations do not apply to employee or labor organization groups.

Many policies contain restrictive clauses that attempt to establish medical necessity in order for the services to be covered. These clauses tend to reduce the likelihood that policies will pay benefits, especially for custodial care, which is often based more on the need for assistance in performing activities of daily living, than on the need for medical care. This section prohibits policies which provide benefits only following institutionalization from conditioning the benefits upon admission to a facility within a period of less than 30 days after discharge from the previous institutionalization. This prevents an insured from being subject to an inadequate period of time within which to locate and enter an institution in order to be compensated under his policy. A time period of fewer than 30 days may also result in the insured being placed in an institution at an inappropriate level of care.

Two additional provisions in this section which are not included in the NAIC model prohibit a policy from conditioning benefits upon a length of stay in a facility for more than 3 days, and require an insurer to offer to each applicant, a policy which does not condition benefits upon prior institutionalization. While 73 percent of the products in Florida required prior hospitalization for benefits, 85 percent of these products required hospitalization for 3 fewer days. Therefore, the 3 day prior institutionalization limitation would not affect the majority of the policies offered in Florida today. Optional coverage without a prior institutionalization requirement will be subject to an appropriate additional premium. Since prior hospitalization is a method used by insurers to control insurance-induced demand for services, it will be difficult for insurers to adequately assess the utilization of this benefit; therefore, the premium for this type of coverage may be prohibitive.

Loss ratios are the proportion of gross premiums that must be returned to the policyholder as benefits. Minimum loss ratios are currently used in the regulation of Medicare supplement policies. Since long-term care insurance is a relatively new product, the availability of actuarially sound data for evaluating the risk is not yet available. Additionally, in this market there is the potential for adverse selection and insurance-induced demand. Insurers are concerned that regulation limiting the premium to a specified percent of the losses would not provide a fair profit margin and adequate
reserves for future loss. Realizing the difficulty of setting an appropriate loss ratio, the NAIC recommended that the department adopt a loss ratio at a level where benefits are reasonable in relation to premiums and calculated to provide adequate reserves. This section requires the department to set an appropriate loss ratio, and allows the department flexibility to adjust the loss ratio by rule as more actuarial data becomes available with respect to the long-term care risk.

Finally, this section sets forth specific consumer protections including the right to return the policy within 30 days, requiring long-term care insurance policies to carry a stamp stating that the policy meets the requirements of Florida law, and requiring insurers to provide applicants with an outline of the benefits, limitations, exclusions, and renewal provisions contained in the policy. The "stamp of approval" was not recommended by the NAIC. Certificates issued for group long-term care policies shall include a statement similar to the outline required for individual policies.

Section 627.9408, F.S., gives the department rulemaking authority with respect to the provisions of this act.

The act takes effect on October 1, 1988, and will apply only to policies issued on or after that date. The act is scheduled for Sunset review and repeal on October 1, 1992.

II. ECONOMIC IMPACT AND FISCAL NOTE:

A. Public:

It is estimated that the average cost of a long-term care policy meeting the minimum standards ranges from $600 to $1,700 annually, depending upon the age of the policyholder and the benefits provided. Policies that provide lower benefits covered by a long-term care policy but which fall short of the minimum standards are obviously cheaper, and can be as low as $85 to $200 annually.

Insurance products are targeted to individuals for whom the cost of the premium represents less than 5 to 7 percent of total income. Persons with $12,000 in income may be able to afford minimum standard policies at younger ages ($600 or less in premiums), and persons with at least $34,000 in income may be able to afford the more costly policies at older age groups ($1,700 or less in premiums). Today an estimated 21 percent of the elderly should be able to afford coverage in the future. In Florida, this represents about 460,000 persons over 65 years of age, which may be understated since Florida elderly tend to have higher incomes than the national average.

Persons buying insurance marketed as a long-term care policy to meet their long-term health care needs will receive the benefit of the minimum standards provided under this bill.

B. Government:

The department advises that the workload impact of this bill can be absorbed by existing resources.
III. COMMENTS:
   None.

IV. AMENDMENTS:
   None.
SENATE BILL 606 (CHAPTER 88- ) creates the Long-Term Care Insurance Act, as a new part of ch. 627, F.S. The act is based upon the National Association of Insurance Commissioners Model Act of 1987. Long-term care insurance is defined as insurance marketed or offered to provide coverage for necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services provided in a setting other than in an acute care unit of a hospital. The bill requires the Department of Insurance to establish standards for long-term care insurance by adopting regulations including: standards for full and fair disclosures of policy terms and conditions, terms of renewability, initial and subsequent conditions of eligibility, non-duplication, preexisting conditions, and coverage limitations. The department is also required to adopt rules setting forth standards for the advertising and sale of long-term care policies, in order to protect consumers from deceptive practices. All advertising materials must be pre-filed with the Department of Insurance before use.

The bill also prohibits an insurer from limiting coverage to care only in nursing homes, or from providing significantly more coverage for at least 24 consecutive months.

Specific consumer protections are set forth, including the right to return the policy within 30 days, requiring long-term care insurance policies to carry a stamp stating that the policy meets the requirements of Florida law, and requiring insurers to provide applicants with an outline of the benefits, limitation, exclusions, and renewal provisions contained in the policy.
I. SUMMARY:

This bill sets forth minimum standards for long-term care insurance policies.

A. PRESENT SITUATION:

Long-term care is prolonged assistance with daily living activities required by individuals who are dependent upon others as a result of some physical or mental disability. Long-term care ranges from non-medical support in the home to intense, continuous monitoring and services in skilled nursing facilities.

Four levels of long-term care services are:

1. Skilled nursing home care - nursing and rehabilitative services given by skilled medical personnel on a daily basis under the orders of a physician;

2. Intermediate nursing home care - skilled nursing care provided on an occasional basis;

3. Custodial nursing home care - assistance in requirements of daily living such as eating and bathing, which can be provided by persons without medical skills (also referred to as personal care); and

4. Home care - a variety of services provided in the home, including skilled nursing care, speech, physical and occupational therapy, social work, personal care, and homemaker services.

Eighty to 90 percent of all long-term care needs are in the form of non-institutional personal care. The need for long-term care is of particular significance to Florida, since 23 percent of
the population is over 60 years of age. The Health Insurance Association of America estimates that by 1990, 7.7 million elderly people will need long-term care and one out of every four will enter a nursing home.

Long-term care costs range between $20,000-36,000 per year for nursing home care and $1,000-16,000 per year for home health care, depending on the severity of the disability.

Medicare, the federal health insurance program for the elderly and disabled, provides only short term physician, hospital, and rehabilitative care for acute disorders. Medicare will only cover a maximum of 100 days in a skilled nursing home, under special circumstances and subject to co-payments by the individual. A survey by the American Association of Retired Persons indicated that 80 percent of the elderly people believed medicare covered long-term care. Medicare Supplement Insurance, which is health insurance offered by insurers to individuals entitled to medicare, provides reimbursement for medical expenses which are not covered by medicare due to deductibles, co-payments, and other limitations imposed by medicare. Seldom do these policies cover long-term care to any extent.

Medicaid is the federal and state health insurance for the poor. To qualify for Medicaid an individual must have no more than $1,800 in assets, and must have income of no more than $918 monthly. Medicaid will cover extended nursing home stays, but only after the individual has qualified by exhausting his assets. The United States General Accounting Office reported that seven out of 10 elderly individuals exhaust their life savings after 13 weeks in a nursing home. Only one percent of the total nursing home costs in 1987 were paid by private long-term care insurance.

Currently, 59 companies are marketing some form of long-term care insurance in Florida, offering 112 policies. These policies vary widely in terms of indemnity payments per day, maximum benefits offered, age limitations, deductibles, waiting periods, level of care covered, pre-existing conditions, illnesses excluded, prior hospitalization requirements, and renewability. There are currently no laws specifically regulating the form, content and manner of sale of these policies. State regulations addressing health insurance and medicare supplement insurance were not designed to regulate long-term care insurance, which differs in scope from other types of insurance, and are therefore inappropriate and ineffective for this purpose.

In June of 1987, the National Association of Insurance Commissioners (NAIC) adopted model legislation setting forth a definition of long-term care insurance, its scope and purpose, minimum benefit standards and specific consumer protections. Of the 112 policies offered in Florida, only 45 percent qualify as long-term care policies under the NAIC definition. Ten states have adopted legislation based on this model.
B. EFFECT OF PROPOSED CHANGES:

This bill creates the Long-Term Care Insurance Act, as a new part of chapter 627, Florida Statutes. This act is based on the NAIC Model Act of 1987. The purpose of the Long-Term Care Insurance Act, as set forth in s. 627.9402, F.S., is to establish standards for long-term care insurance, promote its availability, protect consumers from unfair trade practices, and facilitate flexibility and innovation in the development of coverage.

In a report to the U.S. House of Representatives Select Committee on Aging, the General Accounting Office (GAO) concluded that the lack of uniform standards and marketing requirements result in consumers having little protection against substandard policies and sales abuses. They also reported that the same abusive marketing practices prevalent in the marketing of medicare supplement insurance also exist in the long-term care market. GAO also reported that many companies have not been in the market long enough to experience sufficient claims to build actuarially sound data for determining long-term care risks. In order to assure the availability of this type of insurance, minimum standards must balance the needs of the insurer with the needs of the consumer. The NAIC model attempts to strike this balance.

Application of the act (s. 627.9403, F.S.) The provisions of this act will apply to all long-term care policies issued for delivery in this state and to policies issued for delivery outside this state as provided for in s. 627.906, F.S., by an insurer, fraternal benefit society, health care services plan, health maintenance organization, prepaid health clinic, and multiple-employer welfare arrangement. Policies marketed as both long-term care and medicare supplement policies must meet the requirements of this act and the Florida Medicare Supplement Reform Act. To the extent the requirements of these acts are inconsistent, the policy is subject to the requirement which is more favorable to the policyholder.

Definitions (s. 627.9404, F.S.) Long-term care insurance is defined as insurance marketed or offered to provide coverage for at least two years for necessary diagnostic, preventative, therapeutic, rehabilitative or personal care services provided in a setting other than in an acute care unit of a hospital. A policy which is not advertised, marketed or offered as long-term care insurance is not required to comply with this act. The NAIC model act only requires policies marketed as long-term care insurance to provide coverage for one year. The bill departs from the model in this respect. According to a study by Dr. Nancy Sutton of Florida State University, only 37 percent of the insurers who covered skilled nursing care offered protection for more than one year. Only 18 percent of the insurers offering home health care provided coverage for over one year. Many of the products covered services for periods of less than one year.
and, therefore, do not meet even the NAIC definition of long-term care. Additionally, the GAO reported that 91 percent of all nursing home residents spend an average of 2.5 years in the nursing home. The two year coverage requirement of this bill aligns the length of coverage with the average length of stay for most nursing home residents.

For the purposes of this act, "applicant" is defined as the person who contracts for coverage, or in the case of a group policy, the certificate holder.

Authorized Groups (s. 627.9405, F.S.) This section allows group insurance to be delivered or issued for delivery in this state only to the following groups: employer, labor organization, professional or trade association composed of individuals who are or were engaged in the same occupation and have been maintained for purposes other than obtaining insurance, an association which in addition to other requirements has at the outset 100 members, has been in existence for one year for purposes other than obtaining insurance, other groups if the department determines the issuance of the group policy is in the best interests of the public, would result in economies of administration, and has reasonable benefits in relation to premiums.

Prior to marketing a group policy in this state, the insurer must demonstrate that the policy will be issued to one of the groups authorized by this section. If the department does not disapprove the issuance of the policy within 30 days, the issuance to the group will be deemed approved. The department may extend the period within which it may disapprove issuance of the policy an additional 15 days.

Additionally, an insurer may not issue a policy to one of these groups unless all members are declared eligible and acceptable to the insurer at the time the policy is issued. This prevents the practice of individual underwriting in the group market, which is also prohibited with respect to employer and labor organization group health insurance under ss. 627.653 and 627.654, F.S. There is no similar requirement in the NAIC model, because not all states prohibit individual underwriting with respect to group policies.

Out-of-State Groups (s. 627.9406, F.S.) This section prohibits a group long-term care insurance policy from being offered to a resident in this state under a group policy issued in another state, unless it meets the requirements of this act, or meets the requirements of a state having long-term care insurance requirements substantially similar to those adopted in this state.

An insurer issuing a policy in a state without minimum standards for long-term care insurance may not offer a long-term care
policy to a resident of this state under a group policy unless the policy meets the requirements of this act.

This section applies to association and discretionary groups only. Out-of-state group policies offered to residents of this state under a group policy issued in another state to an employee or labor organization are not required to comply with this act.

Restrictions (s. 627.9407, F.S.) Permits the department to adopt regulations including: standards for full and fair disclosures of policy terms and conditions, terms of renewability, initial and subsequent conditions of eligibility, non-duplication, preexisting conditions, and coverage limitations.

This section prohibits the insurer from cancelling or refusing to renew a policy based on the age or deterioration of the health of the insured. The department may, however, authorize non-renewal for an insurer on a statewide basis if the insurer demonstrates that renewal will jeopardize solvency or that substantial and unexpected loss cannot be mitigated or remedied. Many of the insurers offering coverage today offer optionally renewable policies, either because they feel guaranteeing renewability is too risky, or because they regard their policies as experimental. Others oppose offering coverage in this market that is not guaranteed renewable, arguing that it is against public policy to cancel coverage for elderly people who have faithfully paid their premiums and therefore have a right to expect continued coverage as risk increases with age.

Long-term care insurance policies vary in terms of the number of days insured must wait before they are eligible to collect benefits. Waiting periods are the equivalent of a deductible, requiring the insured to incur a specified number of days of expenses before coverage will begin. This section prohibits insurers from establishing a new waiting period when existing coverage is replaced by new coverage within the same company, except with respect to an increase in benefits selected by the insured. This requirement reduces the incentive for an insurer to "twist" a policyholder out of an existing policy, thereby subjecting him to a new deductible.

This section also prohibits an insurer from limiting coverage to skilled nursing care only, or from providing significantly more coverage for skilled care in a facility than for lower levels of care. Dr. Sutton's survey indicated that of the policies offered in Florida, 94 percent offered skilled nursing care as its principle component, which creates a bias toward more expensive care. Only 58 percent of the policies offered coverage for home health care. Many elderly individuals in need of long-term care do not require skilled nursing care.

Regarding preexisting conditions, this section prohibits an insurer from defining "preexisting condition" more restrictively than a condition for which medical advice was received from a
health care provider within 6 months preceding the effective date of coverage. Additionally, coverage for care required as a result of a preexisting condition may not be excluded unless the care begins within 6 months after the effective date of coverage. This definition of preexisting condition provides uniformity among policies, and prohibits an insurer from excluding an insured from benefits due to an overly broad definition of "preexisting condition." The department is given the authority to extend the restrictions on preexisting condition limitations as to specific age categories in specific policy forms. An insurer may still use application forms to elicit the complete health history of the applicant, and may underwrite in accordance with the insurer's established standards. The preexisting condition limitations do not apply to employee or labor organization groups.

Many policies contain restrictive clauses that attempt to establish medical necessity in order for the services to be covered. These clauses tend to reduce the likelihood that policies will pay benefits, especially for custodial care, which is often based more on the need for assistance in performing activities of daily living, than on the need for medical care. This section prohibits policies which provide benefits only following institutionalization from conditioning the benefits upon admission to a facility within a period of less than 30 days after discharge from the previous institutionalization. This prevents an insured from being subject to an inadequate period of time within which to locate and enter an institution in order to be compensated under his policy. A time period of fewer than 30 days may also result in the insured being placed in an institution at an inappropriate level of care.

Two additional provisions in this section which are not included in the NAIC model prohibit a policy from conditioning benefits upon a length of stay in a facility for more than three days, and require an insurer to offer to each applicant, a policy which does not condition benefits upon prior institutionalization. While 73 percent of the products in Florida required prior hospitalization for benefits, 85 percent of these products required hospitalization for three or fewer days. Therefore, the three day prior institutionalization limitation would not affect the majority of the policies offered in Florida today. Optional coverage without a prior institutionalization requirement will be subject to an appropriate additional premium. Since prior hospitalization is a method used by insurers to control insurance-induced demand for services, it will be difficult for insurers to adequately assess the utilization of this benefit, therefore, the premium for this type of coverage may be prohibitive.

Loss ratios are the proportion of gross premiums that must be returned to the policyholder as benefits. Minimum loss ratios are currently used in the regulation of medicare supplement policies. Since long-term care insurance is a relatively new product, the availability of actuarially sound data for evaluating the risk is not yet available. Additionally, in this
market there is the potential for adverse selection and insurance induced demand. Insurers are concerned that regulation limiting the premium to a specified percent of the losses would not provide a fair profit margin and adequate reserves for future loss. Realizing the difficulty of setting an appropriate loss ratio, the NAIC recommended that the department adopt a loss ratio at a level where benefits are reasonable in relation to premiums and calculated to provide adequate reserves. This allows the department flexibility to adjust the loss ratio by rule as more actuarial data becomes available with respect to the long-term care risk. This section adopts this approach to setting the appropriate loss ratio.

Finally, this section sets forth specific consumer protections including the right to return the policy within 30 days, requiring long-term care insurance policies to carry a stamp stating that the policy meets the requirements of Florida law, and requiring insurers to provide applicants with an outline of the benefits, limitation, exclusions, and renewal provisions contained in the policy. The "stamp of approval" was not recommended by the NAIC. Certificates issued for group long-term care policies shall include a statement similar to the outline required for individual policies.

Section 627.9408, F.S., gives the department rulemaking authority with respect to the provisions of this act.

The act takes effect on October 1, 1998, and will apply only to policies issued on or after that date. The act is scheduled to sunset on October 1, 1992.

C. SECTION-BY-SECTION ANALYSIS:

See B. above

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring or First Year Start-Up Effects:
   None

2. Recurring or Annualized Continuation Effects:
   None

3. Long Run Effects Other Than Normal Growth:
   None

4. Appropriations Consequences:
   None
B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring or First Year Start-Up Effects:
   None

2. Recurring or Annualized Continuation Effects:
   None

3. Long Run Effects Other Than Normal Growth:
   None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

   It is estimated that the average cost of a long-term care policy meeting the minimum standards ranges from $600 to $1,700 annually, depending upon the age of the policyholder and the benefit provided. Policies that provide lower benefits covered by a long-term care policy but which fall short of the minimum standards are obviously cheaper, and can be as low as $85 to $200 annually.

   Insurance products are targeted to individuals for whom the cost of the premium represents less than 5 to 7 percent of total income. Persons with $12,000 in income may be able to afford minimum standard policies at younger ages ($600 or less in premiums), and persons with at least $34,000 in income may be able to afford the more costly policies at older age groups ($1,700 or less in premiums). Today an estimated 21 percent of elderly fall into the latter category. Forty-five to 50 percent of the elderly should be able to afford coverage in the future. In Florida, this represents about 460,000 persons over 65 years of age, which may be understated since Florida elderly tend to have higher incomes than the national average.

2. Direct Private Sector Benefits:

   Persons buying insurance marketed as a long-term care policy to meet their long-term health care needs will receive the benefit of the minimum standards provided under this bill.

3. Effects on Competition, Private Enterprise, and Employment Markets:

   Currently most policies do not meet the minimum standards of this bill, however, such policies would not be prohibited. Policies not meeting the minimum standards could not be marketed as "long-term care policies" and would be expected to be at a competitive disadvantage to long-term care policies meeting the minimum standards.
Bill #: HB 478  
Date: 04/11/88

D. FISCAL COMMENTS:

The department advises that the workload impact of this bill can be absorbed by existing resources.

III. LONG RANGE CONSEQUENCES:

The effect of this bill is to regulate an area of insurance previously without minimum standards and guidelines. Policies offered after the effective date of this act will be more uniform as a result. A larger proportion of the elderly will purchase long-term care policies as the population of elderly individuals increases in Florida.

IV. COMMENTS:

A similar bill has been filed in the Senate (SB 606). The Senate bill also sets forth requirements with regard to advertising long-term care insurance.

V. AMENDMENTS:

VI. SIGNATURES:

INSURANCE COMMITTEE:
Prepared by: Debbi Zappi
Staff Director: William Leary

FINANCE & TAXATION:
Prepared by: Staff Director:

APPROPRIATIONS:
Prepared by: Staff Director:
I. SUMMARY:

This bill sets forth minimum standards for long-term care insurance policies including provisions relating to advertising, renewability, waiting periods, required coverage, preexisting conditions, prior institutionalization, loss ratios, and consumer protection.

A. PRESENT SITUATION:

Long-term care is prolonged assistance with daily living activities required by individuals who are dependent upon others as a result of some physical or mental disability. Long-term care ranges from non-medical support in the home to intense, continuous monitoring and services in skilled nursing facilities.

Four levels of long-term care services are:

1. Skilled nursing home care - nursing and rehabilitative services given by skilled medical personnel on a daily basis under the orders of a physician;

2. Intermediate nursing home care - skilled nursing care provided on an occasional basis;

3. Custodial nursing home care - assistance in requirements of daily living such as eating and bathing, which can be provided by persons without medical skills (also referred to as personal care); and

4. Home care - a variety of services provided in the home, including skilled nursing care, speech, physical and occupational therapy, social work, personal care, and homemaker services.
Eighty to 90 percent of all long-term care needs are in the form of non-institutional personal care. The need for long-term care is of particular significance to Florida, since 23 percent of the population is over 60 years of age. The Health Insurance Association of America estimates that by 1990, 7.7 million elderly people will need long-term care and one out of every four will enter a nursing home.

Long-term care costs range between $20,000-36,000 per year for nursing home care and $1,000-16,000 per year for home health care, depending on the severity of the disability.

Medicare, the federal health insurance program for the elderly and disabled, provides only short term physician, hospital, and rehabilitative care for acute disorders. Medicare will only cover a maximum of 100 days in a skilled nursing home, under special circumstances and subject to co-payments by the individual. A survey by the American Association of Retired Persons indicated that 80 percent of the elderly people believed medicare covered long-term care. Medicare Supplement Insurance, which is health insurance offered by insurers to individuals entitled to medicare, provides reimbursement for medical expenses which are not covered by medicare due to deductibles, co-payments, and other limitations imposed by medicare. Seldom do these policies cover long-term care to any extent.

Medicaid is the federal and state health insurance for the poor. To qualify for Medicaid an individual must have no more than $1,800 in assets, and must have income of no more than $918 monthly. Medicaid will cover extended nursing home stays, but only after the individual has qualified by exhausting his assets. The United States General Accounting Office reported that seven out of 10 elderly individuals exhaust their life savings after 13 weeks in a nursing home. Only one percent of the total nursing home costs in 1987 were paid by private long-term care insurance.

Currently, 59 companies are marketing some form of long-term care insurance in Florida, offering 112 policies. These policies vary widely in terms of indemnity payments per day, maximum benefits offered, age limitations, deductibles, waiting periods, level of care covered, pre-existing conditions, illnesses excluded, prior hospitalization requirements, and renewability. There are currently no laws specifically regulating the form, content and manner of sale of these policies. State regulations addressing health insurance and medicare supplement insurance were not designed to regulate long-term care insurance, which differs in scope from other types of insurance, and are therefore inappropriate and ineffective for this purpose.

In June of 1987, the National Association of Insurance Commissioners (NAIC) adopted model legislation setting forth a definition of long-term care insurance, its scope and purpose, minimum benefit standards and specific consumer protections. Of the 112 policies offered in Florida, only 45 percent qualify as
long-term care policies under the NAIC definition. Ten states have adopted legislation based on this model.

**B. EFFECT OF PROPOSED CHANGES:**

This bill creates the Long-Term Care Insurance Act, as a new part of chapter 627, Florida Statutes. This act is based on the NAIC Model Act of 1987. The purpose of the Long-Term Care Insurance Act, as set forth in s. 627.9402, F.S., is to establish standards for long-term care insurance, promote its availability, protect consumers from unfair trade practices, and facilitate flexibility and innovation in the development of coverage.

In a report to the U.S. House of Representatives Select Committee on Aging, the General Accounting Office (GAO) concluded that the lack of uniform standards and marketing requirements result in consumers having little protection against substandard policies and sales abuses. They also reported that the same abusive marketing practices prevalent in the marketing of medicare supplement insurance also exist in the long-term care market. GAO also reported that many companies have not been in the market long enough to experience sufficient claims to build actuarially sound data for determining long-term care risks. In order to assure the availability of this type of insurance, minimum standards must balance the needs of the insurer with the needs of the consumer. The NAIC model attempts to strike this balance.

**Application of the act (Page 2, line 6)** The provisions of this act will apply to all long-term care policies issued for delivery in this state and to policies issued for delivery outside this state as provided for in s. 627.906, F.S., by an insurer, fraternal benefit society, health care services plan, health maintenance organization, prepaid health clinic, and multiple-employer welfare arrangement. Policies marketed as both long-term care and medicare supplement policies must meet the requirements of this act and the Florida Medicare Supplement Reform Act. To the extent the requirements of these acts are inconsistent, the policy is subject to the requirement which is more favorable to the policyholder.

**Definitions (Page 2, line 23)** Long-term care insurance is defined as insurance marketed or offered to provide coverage for necessary diagnostic, preventative, therapeutic, rehabilitative or personal care services provided in a setting other than in an acute care unit of a hospital. A policy which is not advertised, marketed or offered as long-term care insurance is not required to comply with this act.

For the purposes of this act, "applicant" is defined as the person who contracts for coverage, or in the case of a group policy, the certificate holder.
Authorized Groups (Page 3, line 21) This section allows group insurance to be delivered or issued for delivery in this state only to the following groups: employer, labor organization, professional or trade association composed of individuals who are or were engaged in the same occupation and have been maintained for purposes other than obtaining insurance, an association which in addition to other requirements has at the outset 100 members, has been in existence for one year for purposes other than obtaining insurance, other groups if the department determines the issuance of the group policy is in the best interests of the public, would result in economics of administration, and has reasonable benefits in relation to premiums.

Prior to marketing a group policy in this state, the insurer must demonstrate that the policy will be issued to one of the groups authorized by this section. If the department does not disapprove the issuance of the policy within 30 days, the issuance to the group will be deemed approved. The department may extend the period within which it may disapprove issuance of the policy an additional 15 days.

Additionally, an insurer may not issue a policy to one of these groups unless all members are declared eligible and acceptable to the insurer at the time the policy is issued. This prevents the practice of individual underwriting in the group market, which is also prohibited with respect to employer and labor organization group health insurance under ss. 627.653 and 627.654, F.S. There is no similar requirement in the NAIC model, because not all states prohibit individual underwriting with respect to group policies.

Out-of-State Groups (Page 5, line 16) This section prohibits a group long-term care insurance policy from being offered to a resident in this state under a group policy issued in another state, unless it meets the requirements of this act, or meets the requirements of a state having long-term care insurance requirements substantially similar to those adopted in this state.

An insurer issuing a policy in a state without minimum standards for long-term care insurance may not offer a long-term care policy to a resident of this state under a group policy unless the policy meets the requirements of this act.

This section applies to association and discretionary groups only. Out-of-state group policies offered to residents of this state under a group policy issued in another state to an employee or labor organization are not required to comply with this act.

Advertising (Page 6, line 8) The department is also required to adopt rules setting forth standards for the advertising and sale of long-term care policies, in order to protect consumers from
deceptive practices. The insurer is required to file advertising material with the department at least 30 days before use in this state. The department may disapprove an advertisement at any time and enter orders requiring advertisements to be discontinued, if it determines there has been a violation of the Unfair Insurance Trade Practices Act of chapter 626, F.S., the provisions of this act, or any rule of the department.

Currently, the department has the authority under the Unfair Insurance Trade Practices Act to order a violator to cease engaging in an unlawful practice, which includes misrepresentations and false advertising of insurance policies. This section departs from existing law in that it requires all advertising materials to be pre-filed before use.

Restrictions (Page 6, line 26) Requires the department to adopt regulations including: standards for full and fair disclosures of policy terms and conditions, terms of renewability, initial and subsequent conditions of eligibility, non-duplication, preexisting conditions, and coverage limitations.

Renewability (Page 6, line 28) This section prohibits the insurer from cancelling or refusing to renew a policy based on the age or deterioration of the health of the insured. The department may, however, authorize non-renewal for an insurer on a statewide basis if the insurer demonstrates that renewal will jeopardize solvency or that substantial and unexpected loss cannot be mitigated or remedied. Many of the insurers offering coverage today offer optionally renewable policies, either because they feel guaranteeing renewability is too risky, or because they regard their policies as experimental. Others oppose offering coverage in this market that is not guaranteed renewable, arguing that it is against public policy to cancel coverage for elderly people who have faithfully paid their premiums and therefore have a right to expect continued coverage as risk increases with age.

Waiting Periods (Page 7, line 7) Long-term care insurance policies vary in terms of the number of days insured must wait before they are eligible to collect benefits. Waiting periods prohibit an insured from collecting any benefits before a specified period of time has passed. This section prohibits insurers from establishing a new waiting period when existing coverage is replaced by new coverage within the same company, except with respect to an increase in benefits selected by the insured. This requirement reduces the incentive for an insurer to "twist" a policyholder out of an existing policy, thereby subjecting him to a new waiting period.

Coverage (Page 7, line 12) This section also prohibits an insurer from limiting coverage to nursing home care only, or
from providing significantly more coverage for nursing home care than for lower levels of care. Dr. Sutton's survey indicated that of the policies offered in Florida, 94 percent offered skilled nursing care as its principle component, which creates a bias toward more expensive care. Only 58 percent of the policies offered coverage for home health care. Many elderly individuals in need of long-term care do not require skilled nursing care.

Additionally, this section requires policies to provide coverage for at least 24 consecutive months. The NAIC model act only requires policies marketed as long-term care insurance to provide coverage for one year. The bill departs from the model in this respect. According to a study by Dr. Nancy Sutton of Florida State University, only 37 percent of the insurers who covered skilled nursing care offered protection for more than one year. Only 18 percent of the insurers offering home health care provided coverage for over one year. Many of the products covered services for periods of less than one year and, therefore, do not meet even the NAIC definition of long-term care. Additionally, the GAO reported that 91 percent of all nursing home residents spend an average of 2.5 years in the nursing home. The two year coverage requirement of this bill aligns the length of coverage with the average length of stay for most nursing home residents.

The bill prohibits an elimination period of longer than 120 days. Elimination periods are the equivalent of a deductible, requiring the insured to incur a specified number of days of expenses before coverage will begin. The May 1988 edition of Consumer Reports found elimination periods ranging from 20-100 days in the 55 long-term care policies it reviewed. This provision was not recommended by the NAIC.

Preexisting Conditions (Page 7, line 25) Regarding preexisting conditions, this section prohibits an insurer from defining "preexisting condition" more restrictively than a condition for which medical advice was received from a health care provider or the existence of symptoms which would cause an ordinarily prudent person to seek treatment, within 6 months preceding the effective date of coverage. Additionally, coverage for care required as a result of a preexisting condition may not be excluded unless the care begins within 6 months after the effective date of coverage. This definition of preexisting condition provides uniformity among policies, and prohibits an insurer from excluding an insured from benefits due to an overly broad definition of "preexisting condition." The department is given the authority to extend the restrictions on preexisting condition limitations as to specific age categories in specific policy forms. An insurer may still use application forms to elicit the complete health history of the applicant, and may underwrite in accordance with the insurer's established standards. The preexisting condition limitations do not apply to employee or labor organization groups.
Prior Institutionalization (Page 9, line 1) Many policies contain restrictive clauses that attempt to establish medical necessity in order for the services to be covered. These clauses tend to reduce the likelihood that policies will pay benefits, especially for custodial care, which is often based more on the need for assistance in performing activities of daily living, than on the need for medical care. This section prohibits policies which provide benefits only following institutionalization from conditioning the benefits upon admission to a facility within a period of less than 30 days after discharge from the previous institutionalization. This prevents an insured from being subject to an inadequate period of time within which to locate and enter an institution in order to be compensated under his policy. A time period of fewer than 30 days may also result in the insured being placed in an institution at an inappropriate level of care.

Two additional provisions in this section which are not included in the NAIC model prohibit a policy from conditioning benefits upon a length of stay in a facility for more than three days, and require an insurer to offer to each applicant, a policy which does not condition benefits upon prior institutionalization. While 73 percent of the products in Florida required prior hospitalization for benefits, 85 percent of these products required hospitalization for three or fewer days. Therefore, the three day prior institutionalization limitation would not affect the majority of the policies offered in Florida today. Optional coverage without a prior institutionalization requirement will be subject to an appropriate additional premium. The May 1988 edition of Consumer Reports indicated that 61 percent of nursing home patients are admitted without being hospitalized beforehand. Presumably, almost 40 percent of these patients have the need for nursing home services but have not had prior hospitalization. Since prior hospitalization is a method used by insurers to control insurance-induced demand for services, it will be difficult for insurers to adequately assess the utilization of this benefit, therefore, the premium for this type of coverage may be prohibitive.

Loss Ratios (Page 9, line 17) Loss ratios are the proportion of gross premiums that must be returned to the policyholder as benefits. Minimum loss ratios are currently used in the regulation of medicare supplement policies. Since long-term care insurance is a relatively new product, the availability of actuarially sound data for evaluating the risk is not yet available. Additionally, in this market there is the potential for adverse selection and insurance induced demand. Insurers are concerned that regulation limiting the premium to a specified percent of the losses would not provide a fair profit margin and adequate reserves for future loss. Realizing the difficulty of setting an appropriate loss ratio, the NAIC recommended that the department adopt a loss ratio at a level where benefits are reasonable in relation to premiums and calculated to provide adequate reserves. This section requires
the department to set an appropriate loss ratio, and allows the department flexibility to adjust the loss ratio by rule as more actuarial data becomes available with respect to the long-term care risk.

**Consumer Protection** (Page 9, line 25) Finally, this section sets forth specific consumer protections including the right to return the policy within 30 days, requiring long-term care insurance policies to carry a stamp stating that the policy meets the requirements of Florida law, and requiring insurers to provide applicants with an outline of the benefits, limitations, exclusions, and renewal provisions contained in the policy. The "stamp of approval" was not recommended by the NAIC. Additionally, the NAIC recommended a 10-day free look period for individual policies, and a 30-day free look period for policies issued pursuant to a direct response solicitation. Certificates issued for group long-term care policies shall include a statement similar to the outline required for individual policies.

Section 627.9408, F.S., gives the department rulemaking authority with respect to the provisions of this act.

The act takes effect on October 1, 1998, and will apply to policies issued or renewed on or after that date. The act is scheduled to sunset on October 1, 1992.

**C. SECTION-BY-SECTION ANALYSIS:**

See B. above

**II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:**

**A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:**

1. **Non-recurring or First Year Start-Up Effects:**
   None

2. **Recurring or Annualized Continuation Effects:**
   None

3. **Long Run Effects Other Than Normal Growth:**
   None

4. **Appropriations Consequences:**
   None
B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring or First Year Start-Up Effects:
   None

2. Recurring or Annualized Continuation Effects:
   None

3. Long Run Effects Other Than Normal Growth:
   None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

   It is estimated that the average cost of a long-term care policy meeting the minimum standards ranges from $600 to $1,700 annually, depending upon the age of the policyholder and the benefit provided. Policies that provide lower benefits covered by a long-term care policy but which fall short of the minimum standards are obviously cheaper, and can be as low as $85 to $200 annually.

   Insurance products are targeted to individuals for whom the cost of the premium represents less than 5 to 7 percent of total income. Persons with $12,000 in income may be able to afford minimum standard policies at younger ages ($600 or less in premiums), and persons with at least $34,000 in income may be able to afford the more costly policies at older age groups ($1,700 or less in premiums). Today an estimated 21 percent of elderly fall into the latter category. Forty-five to 50 percent of the elderly should be able to afford coverage in the future. In Florida, this represents about 460,000 persons over 65 years of age, which may be understated since Florida elderly tend to have higher incomes than the national average.

2. Direct Private Sector Benefits:

   Persons buying insurance marketed as a long-term care policy to meet their long-term health care needs will receive the benefit of the minimum standards provided under this bill.

3. Effects on Competition, Private Enterprise, and Employment Markets:

   Currently most policies do not meet the minimum standards of this bill, however, such policies would not be prohibited. Policies not meeting the minimum standards could not be marketed as "long-term care policies" and would be expected
D. FISCAL COMMENTS:

The department advises that the workload impact of this bill can be absorbed by existing resources.

III. LONG RANGE CONSEQUENCES:

The effect of this bill is to regulate an area of insurance previously without minimum standards and guidelines. Policies offered after the effective date of this act will be more uniform as a result. A larger proportion of the elderly will purchase long-term care policies as the population of elderly individuals increases in Florida.

IV. COMMENTS:

A similar bill has been filed in the Senate (SB 606).

V. AMENDMENTS:

VI. SIGNATURES:

INSURANCE COMMITTEE:
Prepared by:  
Debbi Zagar

FINANCE & TAXATION:
Prepared by:  

APPROPRIATIONS:
Prepared by:  

Staff Director:

William Leary