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HOUSE . . . . . No. 979

The Commonwealth of Massachusetts

PRESENTED BY:

Ronald Mariano

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act to Protect Consumers in the Purchase of Long-Term Care Insurance.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Ronald Mariano	3rd Norfolk

The Commonwealth of Massachusetts

In the Year Two Thousand and Nine

AN ACT TO PROTECT CONSUMERS IN THE PURCHASE OF LONG-TERM CARE INSURANCE.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

The General Laws, as appearing in the 2006 Official Edition, are hereby amended by inserting after chapter 176R the following chapter: –

CHAPTER 176S

LONG-TERM CARE INSURANCE

Section 1. Short Title

This act may be cited as the Long-Term Care Insurance Act or the Act.

Section 2. Purpose

The purpose of this Act is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance, as defined, 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.

Section 3. Scope

The requirements of this Act shall apply to policies delivered or issued for delivery in the commonwealth on or after the effective date of this Act. This Act is not intended to supersede the obligations of entities subject to this Act to comply with the substance of other applicable insurance laws insofar as they do not conflict with this Act, except that laws and regulations designed and intended to apply to Medicare Supplement insurance policies shall not be applied to long-term care insurance.

Section 4. Definitions

As used in this chapter, the following words shall, unless the context clearly requires otherwise, have the following meanings: -

"Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) 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. The term includes group and individual annuities and life insurance policies or riders that provide directly or supplement long-term care insurance. The term also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term shall also include qualified long-term care insurance contracts. Long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations. Long-term care insurance shall not include any insurance policy that 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 or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With regard to life insurance, this term does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision of this Act, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this Act.

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

"Certificate" means, for the purposes of this Act, any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in the commonwealth.

"Commissioner" means the insurance commissioner, appointed pursuant to section six of chapter 26, or his/her designee.

"Division of Medical Assistance" means the state agency responsible for administering programs of medical assistance in the commonwealth pursuant to chapter 118E.

"Effective date of coverage" means the date on which an insurance policy goes into force.

"Group long-term care insurance" means a long-term care insurance policy that is delivered or issued for delivery in the commonwealth and issued to:

(a) One or more employers or labor organizations, or to a trust or to 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 the labor organizations; or

(b) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if the 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; or

(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. Prior to advertising, marketing or offering the policy within the commonwealth, the association or associations, or the insurer of the association or associations, shall file evidence with the commissioner that the association or associations have at the outset a minimum of 100 persons and have

been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws that provide that:

(1) The association or associations hold regular meetings not less than annually to further purposes of the members;

(2) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(3) The members have voting privileges and representation on the governing board and committees. Thirty (30) days after the filing the association or associations will be deemed to satisfy the organizational requirements, unless the commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

(d) A group other than as described in subsections (a), (b) and (c), subject to a finding by the commissioner 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.

"Policy" means, for the purposes of this Act, any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in the commonwealth by an insurer; fraternal benefit society; nonprofit health, hospital, or medical service corporation.

"Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means

(a) an individual or group insurance contract that meets the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as amended, as follows:

(1) The only insurance protection provided under the contract is coverage of qualified long-term care services. A contract shall not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

(2) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act, as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this subparagraph do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payor. A contract shall not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

(3) The contract is guaranteed renewable, within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended;

(4) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in this chapter;

(5) All refunds of premiums, and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract; and

(6) The contract meets the consumer protection provisions set forth in Section 7702B(g) of the Internal Revenue Code of 1986, as amended.

(b) "Qualified long-term care insurance contract" or "federally tax-qualified long term care insurance contract" also means the portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of Sections 7702B(b) and (e) of the Internal Revenue Code of 1986, as amended.

Section 5. Extraterritorial Jurisdiction – Group Long-Term Care Insurance

No group long-term care insurance coverage may be offered to a resident of the commonwealth under a group policy issued in another state to a group defined in section 4 of this chapter, unless the Division of Insurance has determined that it meets all relevant statutory and regulatory

requirements, or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in the commonwealth has made a determination that such requirements have been met.

Section 6. Disclosure and Performance Standards for Long-Term Care Insurance

(a) The commissioner may adopt regulations that include, but are not limited to, standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, benefit requirements, non-duplication of coverage provisions, coverage of dependents, preexisting conditions, recurrent conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exclusions, exceptions, reductions, elimination periods, requirements for replacement, mandatory benefit offers, form and rate filing procedures, requirements for agent training and marketing and definitions of terms.

(b) No long-term care insurance policy may:

(1) Be cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder; or

(2) Contain a provision establishing a new preexisting condition limitation period in the event an 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

(3) 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.

(c) Preexisting Condition

(1) No long-term care insurance policy or certificate, other than a policy or certificate issued to a group as defined in section 4 of this chapter, shall use a definition of "preexisting condition" that 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 six (6) months preceding the effective date of coverage of an insured person.

(2) No long-term care insurance policy or certificate, other than a policy or certificate issued to a group as defined in section 4 of this chapter, may exclude coverage for any covered benefit for which an insured person seeks coverage that is the result of a preexisting condition unless the covered care occurs within six (6) months following the effective date of coverage of an insured person.

(3) The commissioner may extend the limitation periods set forth in sections 6(c)(1) and (2) of this chapter as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(4) The definition of "preexisting condition" 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 preexisting condition limitation period described in section 6(c)(2) of this chapter 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 preexisting condition limitation period described in section 6(c)(2) of this chapter.

(d) Prior hospitalization/institutionalization.

No long-term care insurance policy may be delivered or issued for delivery in the commonwealth if the policy:

(1) Conditions eligibility for benefits or services on:

(A) a requirement that the insured is making a "steady improvement," has "recuperative potential" or has "returned to a pre-morbid condition;"

(B) a prior hospitalization requirement or prior receipt of services from any long-term care provider;

(C) any standard of medical necessity, except for medical services provided by a licensed professional; or

(D) a care management system that disallows plan benefits if specific care management standards and procedures are not met, unless specifically approved by the commissioner and properly disclosed to the insured;

(2) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutionalized care;

(3) Conditions eligibility for any benefits, other than waiver of premium, post-confinement, post-acute care or recuperative benefits, on a prior institutionalization requirement; or

(4) Restricts or denies benefits because the insured is not eligible for Medicare.

(e) The commissioner may adopt regulations 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 regulation.

(f) Right to return—free look. Long-term care insurance insureds shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the insured shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in section four of this chapter, the insured is not satisfied for any reason. This subsection shall also apply to denials of applications and any refund must be made within thirty (30) days of the return or denial.

(g) (1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose.

(A) The commissioner may prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.

(B) In the case of agent solicitations, an agent shall deliver the outline of coverage prior to the presentation of an application or enrollment form.

(C) In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form.

(D) In the case of a policy issued to a group defined in section 4 of this chapter, an outline of coverage shall not be required to be delivered, provided that the information described in sections 6(g)(2)(A) through (F) of this chapter is

contained in other materials relating to enrollment. Upon request, these other materials shall be made available to the commissioner.

(2) The 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 terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;

(D) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(E) A description of the terms under which the policy or certificate may be returned and premium refunded;

(F) A brief description of the relationship of cost of care and benefits; and

(G) A statement that discloses to the policyholder or certificate holder whether the policy is intended to be a federally tax-qualified long-term care insurance contract under 7702B(b) of the Internal Revenue Code of 1986, as amended.

(h) A certificate issued pursuant to a group long-term care insurance policy that is delivered or issued for delivery in the commonwealth shall include:

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

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

(3) A statement that the group master policy determines governing contractual provisions.

(i) If an application for a long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than thirty (30) days after the date of approval.

(j) At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy that provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

(1) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(2) An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;

(3) Any exclusions, reductions and limitations on benefits of long-term care;

(4) If applicable to the policy type, the summary shall also include:

(A) A disclosure of the effects of exercising other rights under the policy;

(B) A disclosure of guarantees related to long-term care costs of insurance charges; and

(C) Current and projected maximum lifetime benefits.

(k) Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. The commissioner may adopt regulations that identify the content and format of this monthly report, which shall include, but not be limited to:

(1) Any long-term care benefits paid out during the month;

(2) An explanation of any changes in the policy, e.g., death benefits or cash values, due to long-term care benefits being paid out; and

(3) The amount of long-term care benefits existing or remaining.

(l) If a claim under a long-term care insurance contract is denied, the issuer shall, within sixty (60) days of the date of a written request by the policyholder or certificate holder, or a representative thereof:

(1) Provide a written explanation of the reasons for the denial; and

(2) Make available all information directly related to the denial.

(m) Any policy or rider advertised, marketed or offered as long-term care or nursing home insurance shall comply with the provisions of this chapter.

Section 7. Incontestability Period

(a) For a policy or certificate that has been in force for less than six (6) months an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.

(b) For a policy or certificate that has been in force for at least six (6) months but less than two (2) years an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is *both* material to the acceptance for coverage *and* which pertains to the condition for which benefits are sought.

(c) After a policy or certificate has been in force for two (2) years it is not contestable upon the grounds of misrepresentation alone; such policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

(d) (1) A long-term care insurance policy or certificate may be field issued if the compensation to the field issuer is not based on the number of policies or certificates issued.

(2) For purposes of this section, "field issued" means a policy or certificate issued by a producer or a third-party administrator pursuant to the underwriting authority granted to the producer or third party administrator by an insurer and using the insurer's underwriting guidelines.

(e) If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

(f) In the event of the death of the insured, this section shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies shall be governed by sections 132 and 134 of chapter 175. In all other situations, this section shall apply to life insurance policies that accelerate benefits for long-term care.

Section 8. Nonforfeiture Benefits

(a) Except as provided in section 8(b) of this chapter, a long-term care insurance policy may not be delivered or issued for delivery in the commonwealth unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. In the event the policyholder or certificate holder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates.

(b) When a group long-term care insurance policy is issued, the offer required in section 8(a) of this chapter shall be made to the group policyholder. However, if the policy is issued as group long-term care insurance as defined in section 4 of this chapter, other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificate holder.

(c) The commissioner may promulgate regulations specifying the type or types of nonforfeiture benefits to be offered as part of long-term care insurance policies and certificates, the standards for nonforfeiture benefits, and the rules regarding contingent benefit upon lapse, including a determination of the specified period of time during which a contingent benefit upon lapse will be available and the substantial premium rate increase that triggers a contingent benefit upon lapse as described in section 8(a) of this chapter.

Section 9. Producer Training Requirements

(a) (1) An individual may not sell, solicit or negotiate long-term care insurance unless the individual is licensed as an insurance producer for accident and sickness or life and has completed a one-time training course. The training shall meet the requirements set forth in section 9(b) of this chapter.

(2) An individual already licensed and selling, soliciting or negotiating long-term care insurance on the effective date of this Act may not continue to sell, solicit or negotiate long term care insurance unless the individual has completed a one-time training course as set forth in section 9(b) of this chapter, within one year from the effective date of this Act.

(3) In addition to the one-time training course required in Paragraphs (1) and (2) above, an individual who sells, solicits or negotiates long-term care insurance shall complete ongoing training as set forth in section 9(b) of this chapter.

(4) The training requirements of section 9(b) of this chapter may be approved as continuing education courses under section 177E of chapter 175.

(b) (1) The one-time training required by this Section shall be no less than eight (8) hours and the ongoing training required by this Section shall be no less than four (4) hours every 24 months.

(2) The training required under section 9(b)(1) of this chapter shall consist of topics related to long-term care insurance, long-term care services and, if applicable, qualified state long-term care insurance Partnership programs, including, but not limited to:

(A) State and federal regulations and requirements and the relationship between qualified state long-term care insurance Partnership programs and other public and private coverage of long-term care services, including Medicaid;

(B) Available long-term services and providers;

(C) Changes or improvements in long-term care services or providers;

(D) Alternatives to the purchase of private long-term care insurance;

(E) The effect of inflation on benefits and the importance of inflation protection; and

(F) Consumer suitability standards and guidelines.

(3) The training required by this Section shall not include training that is insurer or company product specific or that includes any sales or marketing information, materials, or training, other than those required by state or federal law.

(c) (1) Insurers subject to this chapter shall obtain verification that a producer receives training required by section 9(a) of this chapter before a producer is permitted to sell, solicit or

negotiate the insurer's long-term care insurance products, maintain records subject to the state's record retention requirements, and make that verification available to the commissioner upon request.

(2) Insurers subject to this chapter shall maintain records with respect to the training of its producers concerning the distribution of its Partnership policies that will allow the state insurance department to provide assurance to the state Medicaid agency that producers have received the training contained in section 9(b)(2)(A) as required by section 9(a) of this chapter and that producers have demonstrated an understanding of the Partnership policies and their relationship to public and private coverage of long-term care, including Medicaid, in the commonwealth. These records shall be maintained in accordance with the state's record retention requirements and shall be made available to the commissioner upon request.

Section 10. Authority to Promulgate Regulations

The commissioner may issue regulations to monitor and promote premium adequacy and to protect the policyholder in the event of substantial rate increases, and to establish minimum standards for producer education, marketing practices, producer compensation, producer testing, penalties and reporting practices for long-term care insurance.

Section 11. Administrative Procedures

Regulations adopted pursuant to this chapter shall be in accordance with the provisions of chapters 30A, 118E, 176D, and section 108 of chapter 175.

Section 12. Severability

If any provision of this Act or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected.

Section 13. Penalties

In addition to any other penalties provided by the laws of the commonwealth, any insurer and any producer found to have violated any requirement of the commonwealth relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.