HOUSE DOCKET, NO. 3395 FILED ON: 1/14/2009

HOUSE . . . . . No. 2740

The Commonwealth of Massachusetts

In the Year Two Thousand Nine

An Act establishing standards for 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:

SECTION 1. The purpose of this act is to promote the public interest and 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 promote flexibility and innovation in the development of long term care insurance coverage.

SECTION 2. Ch. 32A OF THE General Laws is hereby amended by inserting after section 10E, the following section:-

Section 10F. The commission shall establish a plan of long term care insurance on the terms and conditions it considers to be in the best interest of the commonwealth and its employees. With respect to any long term care insurance which is in effect for an employee there shall be withheld from the salary or wages of the employee the premium for the insurance and the

commonwealth shall make no contribution to the premium. The commission shall use its best efforts to ensure that all premium payments by employees are eligible for favorable tax treatment available under federal or state law.

SECTION 3. Paragraph (b) of Part B of section 3 of chapter 62 of the General Laws, as so appearing, is hereby amended by adding the following subparagraph:-

(6) In the case of an individual who purchases a qualified long-term care insurance policy, as defined by chapter 176Q, including both nursing facility and home health benefits, an amount equal to 100 per cent of the annual premium of the insurance policy not to exceed $5,000, if the policy has been approved for sale in the commonwealth by the division of insurance. Married individuals filing jointly or separately are each entitled to an exemption from taxable income equal to 100 per cent of the annual premium but not more than $5,000.

SECTION 4. The General Laws are hereby amended by inserting after chapter 176P the following chapter:-

CHAPTER 176Q

LONG TERM CARE INSURANCE

Section 1. The purpose of this chapter is to promote the public interest and 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 promote flexibility and innovation in the development of long-term care insurance coverage.

Section 2. This chapter shall apply to policies delivered, or issued for delivery, in the commonwealth on or after January 1, 2005. This chapter is not intended to supersede the obligations of entities subject to this chapter to comply with applicable insurance laws insofar as they do not conflict with this chapter, except that laws and regulations designed and intended to apply to Medicare supplement insurance policies shall apply to long-term care insurance.

Section 3. This chapter may be known and cited as the "Long-Term Care Insurance Act."

Section 4. Unless the context requires otherwise, the following words and phrases as used in this chapter shall have the following meanings.

"Applicant", in the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; or, in the case of a group long-term care insurance policy, the proposed certificate holder.

"Certificate", a certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery within the commonwealth.

"Commissioner", the commissioner of insurance.

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

(1) one or more employers or labor organizations, or to a trust or to the trustees of a fund established by 1 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

(2) any professional, trade or occupational association for its members or former or retired members, or combination thereof, if the association:

(i) is composed of individuals all of whom are, or were, actively engaged in the same profession, trade or occupation; and

(ii) has been maintained in good faith for purposes other than obtaining insurance; or

(3) 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; but, before advertising, marketing or offering the policy within the commonwealth, the association, or the insurer of the association, shall file evidence with the commissioner that the association has at the outset a minimum of 100 persons and has been organized and maintained in good faith for purposes other than that of obtaining insurance; has been in active existence for at least 1 year; and have a constitution and bylaws that provide that:

(i) the association holds regular meetings not less than annually to further purposes of the members;

(ii)except for credit unions, the association collects dues or solicits contributions from members; and

(iii) the members have voting privileges and representation on the governing board and committees.

Thirty days after the filing, the association shall be considered to have satisfied the organizational requirements, unless the commissioner makes a finding that the association does not satisfy those organizational requirements.

(4)A group other than those described in paragraphs (1), (2) and (3), subject to a finding by the commissioner that:

(i) the issuance of the group policy is not contrary to the best interest of the public;

(ii) the issuance of the group policy would result in economies of acquisition or administration; and

(iii) the benefits are reasonable in relation to the premiums charged.

"Long-term care insurance", any insurance policy or rider: (1) advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; (2) for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services; and (3) 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 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 shall not include life insurance policies that accelerate the death benefit specifically for 1 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 chapter, any product advertised, marketed or offered as long-term care insurance shall be subject to this chapter.

"Policy", any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery within the commonwealth by an insurer authorized to issue policies upon the lives of persons in the commonwealth or to provide accident and health insurance under chapter 175; a fraternal benefit society authorized under chapter 176; a nonprofit hospital service corporation authorized under chapter 176A, a nonprofit medical service corporation authorized under chapter 176B or a health maintenance organization authorized under chapter 176G.

(1) "Qualified long-term care insurance contract" or "federally tax- qualified long-term care insurance contract" 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:

(a) 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;

(b) 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;

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

(e) 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

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

(2) "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. No group long-term care insurance policy may be offered to a resident of the commonwealth under a group policy issued in another state to a group described in clause (4) of the definition of "Group long-term care insurance" of section 4, unless the commonwealth 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 the requirements set forth in said clause (4) have been met.

Section 6. (a) The commissioner shall promulgate regulations that include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long-term care insurance policies and certificates, terms of renewability, initial and subsequent conditions of eligibility, non-duplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, offer of inflation protection, recurrent conditions and definitions of terms.

(b) A long-term care insurance policy shall not:

(1) be cancelled, non-renewed 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;

(2) 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

(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) (1) A long-term care insurance policy, or certificate other than a policy or certificate thereunder, issued to a group as defined in clause (1) of the definition of "Group long-term care" of section (4) shall not 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 24 months preceding the effective date of coverage of an insured person.

(2) A long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in clause (1) of the definition of "Group long-term care" of section (4) shall not exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within 6 months following the effective date of coverage of an insured person.

(3) Notwithstanding this subsection (c), an insurer may use an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, underwrite 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 subsection (2) 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 subsection (2).

(d) A long-term care insurance policy shall not be delivered or issued for delivery in this state if the policy:

(1) conditions eligibility for any benefits on a prior hospitalization requirement;

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

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

(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) Long-term care insurance applicants shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant 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 applicant shall have the right to return the policy or certificate within 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 clause (1) of the definition of "Group long-term care" of section (4), the applicant is

not satisfied for any reason. This subsection shall also apply to denials of applications and any refund must be made within 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. In the case of producer solicitations, an insurance producer shall deliver the outline of coverage prior to the presentation of an application or enrollment form. In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form. In the case of a policy issued to a group defined in clause (1) of the definition of "Group long-term care" of section 4, an outline of coverage shall not be required to be delivered, provided that the information described in subsections (i) to (vi) of this section, inclusive, is contained in other materials relating to enrollment. Upon request, these other materials shall be made available to the commissioner.

(2) The commissioner shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage. The outline of coverage shall include:

(i) a description of the principal benefits and coverage provided in the policy or certificate;

(ii) a statement of the principal exclusions, reductions and limitations contained in the policy or certificate;

(iii) 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;

(iv) 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;

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

(vi) a brief description of the relationship of cost of care and benefits; and

(vii) 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 this state 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 and that the policy is available for viewing in the offices of the policyholder and will be copied for the certificate holder upon request at no cost.

(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 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) a statement indicating whether any long term care inflation protection option required by law is available under this policy;

(5) if applicable to the policy type, the summary shall also include:

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

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

(iii) current and projected maximum lifetime benefits; and

(6) the policy summary listed above may be incorporated into a basic illustration or into the life insurance policy summary which is required to be delivered in accordance with applicable regulation.

(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 report shall include:

(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 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. (a) For a policy or certificate that has been in force for less than 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 6 months but less than 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 2 years it is not contestable upon the grounds of misrepresentation alone; the 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) A long-term care insurance policy or certificate shall not be field issued based on medical or health status. For purposes of this

subsection the term "field issued" means a policy or certificate issued by an agent or a third-party administrator pursuant to the underwriting authority granted to the agent or third party administrator by an insurer.

(e) If an insurer has paid benefits under the long-term care insurance policy or certificate, the insurer may not recover the benefit payments if 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 section 132 of chapter 175 of the General Laws. In all other situations, this section shall apply to life insurance policies that accelerate benefits for long-term care.

Section 8. (a) Except as provided in subsection (b), a long-term care insurance policy shall not be delivered or issued for delivery in this state unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate that includes a non-forfeiture benefit. The offer of a non-forfeiture 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 non-forfeiture 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 subsection (a) shall be made to the group policyholder. However, if the policy is issued as group long-term care insurance to a group defined in clause (4) the definition of "Group long-term care" of section 4, 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 shall promulgate regulations specifying the type or types of non-forfeiture benefits to be offered as part of long-term care insurance policies and certificates, the standards for non-forfeiture 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 subsection a.

Section 9. The commissioner shall promulgate reasonable regulations in accordance with chapter 30A to promote premium adequacy and to protect the policyholder in the event of substantial rate increases, and to establish minimum standards for marketing practices, agent compensation, agent testing, penalties and reporting practices for long term care insurance.

Section 10. In addition to the penalties provided in chapters 175 and 176D, any insurer and any insurance producer found to have violated any requirement of this chapter or any regulations promulgated hereunder, relating to the regulation of long-term care insurance or the marketing of such insurance, shall be subject to a fine of up to 3 times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.