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

**HOUSE . . . . . . . . . . . . . . No.**

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The Commonwealth of Massachusetts

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PRESENTED BY:

**John P. Fresolo**

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*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 establishing standards for long term care insurance.

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PETITION OF:

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| --- | --- |
| Name: | District/Address: |
| John P. Fresolo | 16th Worcester |

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE HOUSE, NO. 3927 OF 2007-2008.]

The Commonwealth of Massachusetts

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**In the Year Two Thousand and Nine**

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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.