

LONG-TERM CARE INSURANCE MODEL ACT

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Section 1. 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.

Drafting Note: The purpose clause evidences legislative intent to protect the public while recognizing the need to permit flexibility and innovation with respect to long-term care insurance coverage.

Drafting Note: The Task Force recognizes the viability of a long-term care product funded through a life insurance vehicle, and this Act is not intended to prohibit approval of this product. Section 4 now specifically addresses this product. However, states must examine their existing statutes to determine whether amendments to other code sections such as the definition of life insurance and accident and health reserve standards and further revisions are necessary to authorize approval of the product.

Section 2. Scope

The requirements of this Act shall apply to policies delivered or issued for delivery in this state 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.

Drafting Note: See Section 6J.

Drafting Note: This section makes clear that entities subject to the Act must continue to comply with other applicable insurance legislation not in conflict with this Act.

Section 3. Short Title

This Act may be known and cited as the “Long-Term Care Insurance Act.”

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The language in Section 1 is not adequate for today’s marketplace. The current description of the purpose fails to include language to reflect the full scope of financial products that are being marketed to consumers as providing benefits for long-term care. Free standing long-term care insurance products are currently being sold by only a very few companies. These products have been replaced with a wide variety of life insurance and annuity products that include LTC benefits in a variety of ways.

Commented [TD2]: FROM THE CONSUMER REPRESENTATIVES:

The thought expressed in the drafting note to Section 1, Purpose language, should not be left to a drafting note, but expressly incorporated in the Purpose in Section 1.

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Scope requires insurers to comply with all other applicable statutes. There is now a short term LTCI model and reference to that model should be included.

Section 4. Definitions

Unless the context requires otherwise, the definitions in this section apply throughout this Act.

- A. “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; prepaid health plans; health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. 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.
- B. “Applicant” means:
 - (1) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and
 - (2) In the case of a group long-term care insurance policy, the proposed certificate holder.
- C. “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 this state.
- D. “Commissioner” means the Insurance Commissioner of this state.

Drafting Note: Where the word “commissioner” appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted.

- E. “Group long-term care insurance” means a long-term care insurance policy that is delivered or issued for delivery in this state and issued to:
 - (1) 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
 - (2) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if the association:
 - (a) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and
 - (b) Has been maintained in good faith for purposes other than obtaining insurance; or

Commented [TD4]: FROM THE CONSUMER REPRESENTATIVES:

There are no definitions, reference to, or description of an RBO, or of the full scope and range of RBOs that might be offered to policyholders.

While there is some language in the Model Regulation about the right to reduce benefits, there isn't anything in either the Act or the Regulation that describes or defines all of the potential options insurers can give policyholders as a way to reduce the effect of a rate increase. Nor is there anything that specifies how, when, or under what circumstances these options have to be offered.

- (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. Prior to advertising, marketing or offering the policy within this state, 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:
- (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.
- 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.
- (4) A group other than as described in Subsections E(1), E(2) and E(3), subject to a finding by the commissioner that:
- (a) The issuance of the group policy is not contrary to the best interest of the public;
 - (b) The issuance of the group policy would result in economies of acquisition or administration; and
 - (c) The benefits are reasonable in relation to the premiums charged.
- F. “Policy” means, for the purposes of this Act, any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this state by an insurer; fraternal benefit society; nonprofit health, hospital, or medical service corporation; prepaid health plan; health maintenance organization or any similar organization.

Drafting Note: This Act is intended to apply to the specified group and individual policies, contracts, and certificates whether issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization. In order to include such organizations, each state should identify them in accordance with its statutory terminology or by specific statutory citation. Depending upon state law, insurance department jurisdiction and other factors, separate legislation may be required. In any event, the legislation should provide that the particular terminology used by these plans and organizations may be substituted for, or added to, the corresponding terms used in this Act. The term “regulations” should be replaced by the terms “rules and regulations” or “rules” as may be appropriate under state law.

The definition of “long-term care insurance” under this Act is designed to allow maximum flexibility in benefit scope, intensity and level, while assuring that the purchaser’s reasonable expectations for a long-term care insurance policy are met. The Act is intended to permit long-term care insurance policies to cover either diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, or any combination thereof, and not to mandate coverage for each of these types of services. Pursuant to the definition, long-term care insurance may be either a group or individual insurance policy or a rider to such a policy, e.g., life or accident and sickness. The language in the definition concerning “other than an acute care unit of a hospital” is intended to allow payment of benefits when a portion of a hospital has been designated for, and duly licensed or certified as a long-term care provider or swing bed.

- G. (1) “Qualified long-term care insurance contract” or “federally tax-qualified long-term care insurance contract” means 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 [insert reference to state law equivalent to Section 4G(1)(e) of the Long-Term Care Insurance Model Act];
 - (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.

Drafting Note: The definition of “qualified long-term care insurance contract” has been added to assist states in regulating long-term care insurance policies that are federally tax-qualified. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Section 7702B of the Internal Revenue Code, as amended, provide a definition of this term and clarify federal income tax treatment of premiums and benefits. Treasury Regulations 1.7702B-1 and 1.7702B-2, and Notice 97-31 issued by the Internal Revenue Service, further address these issues.

Section 5. Extraterritorial Jurisdiction—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 Section 4E(4), unless this state or another 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.

Drafting Note: By limiting extraterritorial jurisdiction to “discretionary groups,” it is not the drafters’ intention that jurisdiction over other health policies should be limited in this manner.

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

- A.** The commissioner may adopt 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, 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, recurrent conditions and definitions of terms.

Drafting Note: This subsection permits the adoption of regulations establishing disclosure standards, renewability and eligibility terms and conditions, and other performance requirements for long-term care insurance. Regulations under this subsection should recognize the developing and unique nature of long-term care insurance and the distinction between group and individual long-term care insurance policies.

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Extraterritorial Jurisdiction for Group LTC should be revisited and clarified. If a group policy is issued in State A and offered in other states, which state is responsible for rate increases? Is State A responsible for a rate increase request for all other states in which the group policy is offered? Or are individual states responsible for their state’s rate increase even though the group policy was filed and approved in one state?

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We suggest that Disclosure and Performance Standards be two different sections. Significant thought must be given to **what and how** disclosures are made.

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Options to reduce premium increases must be added to this section to comply with the drafting note and state’s ability to adopt regulations.

- B. No long-term care insurance policy may:
- (1) Be cancelled, non-renewed or otherwise terminated on the grounds of the age, gender 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. Preexisting condition.
- (1) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4E(1) 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 thereunder issued to a group as defined in Section 4E(1) may exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins 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 6C(1) and (2) above 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 waiting period described in Section 6C(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 Section 6C(2).
- D. Prior hospitalization/institutionalization.
- (1) No long-term care insurance policy may be delivered or issued for delivery in this state if the policy:
 - (a) Conditions eligibility for any benefits on a prior hospitalization requirement;
 - (b) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or
 - (c) Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.
 - (2) A long-term care insurance policy or rider shall not condition eligibility for non-institutional benefits on the prior or continuing receipt of skilled care services.

Drafting Note: The amendment to the section is primarily intended to require immediate and clear disclosure where a long-term care insurance policy or rider conditions eligibility for non-institutional benefits on prior receipt of institutional care.

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- (3) No long-term care insurance policy or rider that 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 thirty (30) days after discharge from the institution.

Drafting Note: Section 6D(3) is language from the original model act which did not prohibit prior institutionalization. The drafters intended that Section 6D(3) would be eliminated after adoption of the amendments to this section which prohibit prior institutionalization. States should examine their Section 6 carefully during the process of adoption or amendment of this Act.

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. (1) Long-term care insurance applicants shall have the right to return the policy, certificate or rider to the company or an agent/insurance producer of the company within thirty (30) days of its receipt and to have the premium refunded if, after examination of the policy, certificate or rider, the applicant is not satisfied for any reason.

(2) Long-term care insurance policies, certificates and riders shall have a notice prominently printed on the first page or attached thereto including specific instructions to accomplish a return. This requirement shall not apply to certificates issued pursuant to a policy issued to a group defined in Section 4E(1) of this Act. The following free look statement or language substantially similar shall be included:

“You have 30 days from the day you receive this policy, certificate or rider to review it and return it to the company if you decide not to keep it. You do not have to tell the company why you are returning it. If you decide not to keep it, simply return it to the company at its administrative office. Or you may return it to the agent/insurance producer that you bought it from. You must return it within 30 days of the day you first received it. The company will refund the full amount of any premium paid within 30 days after it receives the returned policy, certificate or rider. The premium refund will be sent directly to the person who paid it. The policy, certificate or rider will be void as if it had never been issued.”

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 shall 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 4E(1) of this Act, an outline of coverage shall not be required to be delivered, provided that the information described in Section 6G(2)(a) through (h) is contained in other materials relating to enrollment. Upon request, these other materials shall be made available to the commissioner.

Drafting Note: States may wish to review specific filing requirements as they pertain to the outline of coverage and these other materials.

(2) The outline of coverage shall include:

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

(b) A description of the eligibility triggers for benefits and how those triggers are met;

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

(d) 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;
- (e) 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;
 - (f) A description of the terms under which the policy or certificate may be returned and premium refunded;
 - (g) A brief description of the relationship of cost of care and benefits; and
 - (h) A statement that discloses to the policyholder or certificateholder 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 policy 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.

Drafting Note: The above provisions are deemed appropriate due to the particular nature of long-term care insurance, and are consistent with group insurance laws. Specific standards would be contained in regulations implementing this Act.

- 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 or annuity 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;
- (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 benefits;
- (4) A statement that any long-term care inflation protection option required by [cite to state's inflation protection option requirement comparable to Section 11 of the Long-Term Care Insurance Model Regulation] is not available under this policy. If inflation protection was not required to be offered, or if inflation protection was required to be offered but was rejected, a statement that inflation protection is not available under the policy that provides long-term care benefits, and an explanation of other options available under the policy, if any, to increase the funds available to pay for the long-term care benefits;

Commented [TD8]: FROM THE CONSUMER REPRESENTATIVES:

Subsections 1 through 6 may not be adequate to address the full range of insurance platforms that life insurance policies and annuities use to provide LTC benefits.

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- (5) 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, fees or other costs related to long-term care costs of insurance charges in the base policy and any riders; and
 - (c) Current and projected periodic and maximum lifetime benefits; and
- (6) The provisions of the policy summary listed above may be incorporated into a basic illustration required to be delivered in accordance with [cite to state's basic illustration requirement comparable to Sections 6 and 7 of the Life Insurance Illustrations Model Regulation] or into the life insurance policy summary which is required to be delivered in accordance with [cite to state's life insurance policy summary requirement comparable to Section 5 of the Life Insurance Disclosure Model 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) Any costs or changes that apply or will apply to the policy or any riders;
 - (3) 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
 - (4) 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 certificateholder, 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, certificate or rider advertised, marketed or offered as long-term care or nursing home insurance, as defined in Section 4A of the NAIC Long-Term Care Insurance Model Act, shall comply with the provisions of this Act.

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.

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Section 6L gives the insurer up to 60 days following a written request for an explanation of a benefit denial. A policyholder should not have to wait 60 days for an explanation to contest an unreasonable benefit denial.

- 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 [cite to state’s life insurance incontestability clause]. 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 Subsection B, a long-term care insurance policy may not be delivered or issued for delivery in this state unless the policyholder or certificateholder 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 certificateholder 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 Subsection A shall be made to the group policyholder. However, if the policy is issued as group long-term care insurance as defined in Section 4E(4), other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificateholder.
- C. The commissioner shall 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 Subsection A.

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 health or sickness or life [include other lines of authority as applicable] and has completed a one-time training course. The training shall meet the requirements set forth in Subsection B.
- (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 Subsection B, within one year from [insert effective date of this legislation].
- (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 Subsection B.
- (4) The training requirements of Subsection B may be approved as continuing education courses under [insert reference to applicable state law or regulation].
- 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.

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The Contingent Benefit on Lapse (CBL) is an important consumer protection. There is no definition in the Act of a substantial increase in premium. The term “substantial” increase is apparently the current formulaic process of tying the amount of premium increase to both a percentage of premium increase since purchase and the issue age of the policyholder specified in the Regulation. Limiting CBL to a substantial increase unfairly penalizes policyholders who are unable to continue funding an ever increasing premium.

The option of CBL should not be limited only to a substantial premium increase. The option of CBL should be added to the list of options in the Regulation that policyholders can choose based on their needs at any time it’s needed. As people live to advanced ages they are often faced with changing economic choices. Preserving coverage, even limited coverage, should always be an option.

Commented [TD11]: FROM THE CONSUMER REPRESENTATIVES:

This section highlights the problem with the term “long term care insurance” and the definition of this term. Does the term include benefits in life and annuity products for the purposes of this section? Are agents and brokers selling products containing benefits that are regulated under 702(b) included in this section and those selling 101(g) excluded? Are agents and brokers selling products providing benefits for critical illness events included or excluded? Knowing and being able to explain the difference between free standing products for long term care and life as annuity based products should be included in the topics listed in B(2) for agents and brokers selling life or annuity based products.

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- (2) The training required under Paragraph (1) 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 Act shall obtain verification that a producer receives training required by Subsection A 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 Act 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 Subsection B(2)(a) as required by Subsection A 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 this state. These records shall be maintained in accordance with the state's record retention requirements and shall be made available to the commissioner upon request.
- D. The satisfaction of these training requirements in any state shall be deemed to satisfy the training requirements in this state.

Drafting Note: Guidance on the implementation of the Deficit Reduction Act of 2005 (DRA), Pub. L. 109-171, provided by the Centers for Medicare & Medicaid Services in the July 27, 2006 State Medicaid Director Letter (SMDL #06-019) states that "[t]he State insurance department must provide assurance to the State Medicaid agency that anyone who sells a policy under the Partnership receives training and demonstrates an understanding of Partnership policies and their relationship to public and private coverage of [long term care]." There is no guidance as to how the State insurance department is to accomplish this requirement. This drafting note provides information to the State insurance departments with respect to achieving the aforementioned requirements.

Section 9C of the NAIC Long-Term Care Insurance Model Act requires insurers to obtain and maintain records verifying that producers who sell, solicit or negotiate long-term care insurance products on their behalf have received the training required in this Section and to make such records available to the State insurance department. In addition, Section 9C(2) requires insurers to obtain and maintain records concerning the training of their agents for Partnership policies. Insurers are to maintain records that verify its producers have received the training required for Partnership policies and that they demonstrate an understanding of the policies and their relationship to public and private long-term care coverage.

State insurance departments, in order to meet the standards contained in the DRA concerning producer training should consider developing a process to communicate with the State Medicaid agency on how the DRA requirements will be met. They should develop a process to verify insurance company compliance with these requirements including, as an audit step, the verification of compliance with the above requirements as part of a market conduct examination. In addition, State insurance departments should consider performing annual, random verifications of insurance company compliance. Finally, consideration may be given to deeming those training programs, specifically approved by the State for Partnership policy training that qualify for Continuing Education, as meeting the requirements contained in Section 9C(2).

Section 10. Authority to Promulgate Regulations

The commissioner shall issue reasonable regulations to 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, independent review of benefit determinations, penalties and reporting practices for long-term care insurance.

Drafting Note: Each state should examine its statutory authority to promulgate regulations and revise this section accordingly so that sufficient rulemaking authority is present and that unnecessary duplication of unfair practice provisions does not occur.

Section 11. Administrative Procedures

Regulations adopted pursuant to this Act shall be in accordance with the provisions of [cite section of state insurance code relating to the adoption and promulgation of rules and regulations or cite the state's administrative procedures act, if applicable].

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 thereby.

Section 13. Penalties

In addition to any other penalties provided by the laws of this state, any insurer and any producer found to have violated any requirement of this state 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.

Drafting Note: The intention of this section is to authorize separate fines for both the insurer and the producer in the amounts suggested above.

Section 14. Effective Date

This Act shall be effective [insert date].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1987 Proc. 111, 19, 655, 677-680, 700 (adopted).
1987 Proc. II 15, 23, 632-633, 727, 730-734 (amended and reprinted).
1988 Proc. 19, 20-21, 629-630, 652, 661-665 (amended and reprinted).
1989 Proc. 19, 24-25, 703, 754-755, 789-793 (amended).
1989 Proc. II 13, 23-24, 468, 476-477, 479-484 (amended and reprinted).
1990 Proc. 16, 27-28, 477, 541-542, 556-561 (amended and reprinted).
1991 Proc. 19, 17, 609-610, 662, 666-671 (amended and reprinted).
1993 Proc. 18, 136, 819, 844, 845 (amended).
1993 Proc. 1st Quarter 3, 34, 267, 275, 276 (amended).
1994 Proc. 1st Quarter 4, 39, 446-447, 458 (amended).
1996 Proc. 2nd Quarter 10, 33, 731, 812, 823-824 (amended).
1997 Proc. 1st Quarter 54, 55, 56, 57, 700, 701-704 (amended).
1998 Proc. 1st Quarter 16, 17, 769, 801-804, 894 (amended).
1999 Proc. 4th Quarter 18, 929, 969, 972-978 (amended).
2006 Proc. 4th Quarter 44, 48-60 (amended, reprinted).
2007 Proc. 3rd Quarter 42-44 (amended).
2009 Proc. 3rd Quarter Vol. 195-102, 114-119, 205-210, 312-315 (amended).
2016 Proc. 3rd Quarter (amended).

Commented [TD12]: FROM THE CONSUMER REPRESENTATIVES:

This section should be reviewed to determine whether these penalties continue to be sufficient and adequate for the situation. The penalties described are far too low when violations can potentially result in thousands of dollars of harm to policyholders and their families.