

# SENATE NO. 575

## AN ACT TO ESTABLISH 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:*

1 SECTION 1. Chapter 32A of the General Laws is hereby amended by inserting after section 10E, as  
2 appearing in the 2002 Official Edition, the following section:-

3 Section 10F. The commission shall establish a plan of long term care insurance on the terms and  
4 conditions it considers to be in the best interest of the commonwealth and its employees. With respect  
5 to any long term care insurance which is in effect for an employee there shall be withheld from the  
6 salary or wages of the employee the premium for the insurance and the commonwealth shall make no  
7 contribution to the premium. The commission shall use its best efforts to ensure that all premium  
8 payments by employees are eligible for favorable tax treatment available under federal or state law.

9 SECTION 2. Paragraph (b) of Part B of section 3 of chapter 62 of the General Laws, as so appearing,  
10 is hereby amended by adding the following subparagraph:-

11 (6) In the case of an individual who purchases a qualified long-term care insurance policy, as defined  
12 by chapter 176Q, including both nursing facility and home health benefits, an amount equal to 100 per  
13 cent of the annual premium of the insurance policy not to exceed \$5,000. Married individuals filing

14 jointly or separately are each entitled to an exemption from taxable income equal to 100 per cent of the  
15 annual premium but not more than \$5,000.

16 SECTION 2A . Chapter 118E of the General Laws is hereby amended by striking out Section 33, as so  
17 appearing, and inserting in place thereof the following section:-

18 Section 33. No claim for costs of a nursing facility and other long-term care services may be made by  
19 the division under section 31 or 32 if the individual receiving medical assistance was permanently  
20 institutionalized, had notified the division that he had no intention to return home and, on the date of  
21 admission to the nursing facility or other medical institution, had long-term care insurance that, when  
22 purchased, met the requirements of 211 C.M.R. 65.00.

23 SECTION 3. The General Laws are hereby amended by inserting after chapter 176P the following  
24 chapter:-

25 CHAPTER 176Q

26 LONG TERM CARE INSURANCE

27 Section 1. The purpose of this chapter is to promote the public interest and the availability of long-  
28 term care insurance policies, to protect applicants for long-term care insurance from unfair or  
29 deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate  
30 public understanding and comparison of long-term care insurance policies, and to promote flexibility  
31 and innovation in the development of long-term care insurance coverage.

32 Section 2. This chapter shall apply to policies delivered, or issued for delivery, in the commonwealth  
33 on or after January 1, 2009. This chapter is not intended to supersede the obligations of entities subject  
34 to this chapter to comply with applicable insurance laws insofar as they do not conflict with this

35 chapter, except that laws and regulations designed and intended to apply to Medicare supplement  
36 insurance policies shall apply to long-term care insurance.

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

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

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

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

45 “Commissioner”, the commissioner of insurance.

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

48 (1) one or more employers or labor organizations, or to a trust or to the trustees of a fund established  
49 by 1 or more employers or labor organizations, or a combination thereof, for employees or former  
50 employees, or a combination thereof, or for members or former members, or a combination thereof, of  
51 the labor organizations; or

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

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

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

57 (3) an association, or a trust, or the trustees of a fund established, created or maintained for the benefit  
58 of members of one or more associations; but, before advertising, marketing or offering the policy  
59 within the commonwealth, the association, or the insurer of the association, shall file evidence with the  
60 commissioner that the association has at the outset a minimum of 100 persons and has been organized  
61 and maintained in good faith for purposes other than that of obtaining insurance; has been in active  
62 existence for at least 1 year; and have a constitution and bylaws that provide that:

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

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

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

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

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

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

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

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

74 “Long-term care insurance”, any insurance policy or rider: (1) advertised, marketed, offered or  
75 designed to provide coverage for not less than 12 consecutive months for each covered person on an  
76 expense incurred, indemnity, prepaid or other basis; (2) for one or more necessary or medically  
77 necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services;  
78 and (3) provided in a setting other than an acute care unit of a hospital. The term includes group and  
79 individual annuities and life insurance policies or riders that provide directly, or supplement, long-term  
80 care insurance. The term also includes a policy or rider that provides for payment of benefits based  
81 upon cognitive impairment or the loss of functional capacity. The term shall also include qualified  
82 long-term care insurance contracts. Long-term care insurance shall not include any insurance policy  
83 that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense  
84 coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major  
85 medical expense coverage, disability income or related asset-protection coverage, accident only  
86 coverage, specified disease or specified accident coverage, or limited benefit health coverage. With  
87 regard to life insurance, this term shall not include life insurance policies that accelerate the death  
88 benefit specifically for 1 or more of the qualifying events of terminal illness, medical conditions  
89 requiring extraordinary medical intervention or permanent institutional confinement, and that provide  
90 the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility  
91 for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision  
92 of this chapter, any product advertised, marketed or offered as long-term care insurance shall be  
93 subject to this chapter.

94 “Policy”, any policy, contract, subscriber agreement, rider or endorsement delivered or issued for  
95 delivery within the commonwealth by an insurer authorized to issue policies upon the lives of persons  
96 in the commonwealth or to provide accident and health insurance under chapter 175; a fraternal benefit  
97 society authorized under chapter 176; a nonprofit hospital service corporation authorized under chapter  
98 176A, a nonprofit medical service corporation authorized under chapter 176B or a health maintenance  
99 organization authorized under chapter 176G.

100 (1) “Qualified long-term care insurance contract” or “federally tax-qualified long-term care insurance  
101 contract” an individual or group insurance contract that meets the requirements of Section 7702B(b) of  
102 the Internal Revenue Code of 1986, as amended, as follows:

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

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

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

116 (d) The contract does not provide for a cash surrender value or other money that can be paid, assigned,  
117 pledged as collateral for a loan, or borrowed except as provided in paragraph (e);

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

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

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

128 Section 5. No group long-term care insurance policy may be offered to a resident of the  
129 commonwealth under a group policy issued in another state to a group described in clause (4) of the  
130 definition of "Group long-term care insurance" of section 4, unless the commonwealth or another state  
131 having statutory and regulatory long-term care insurance requirements substantially similar to those  
132 adopted in the commonwealth has made a determination that the requirements set forth in said clause  
133 (4) have been met.

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

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

142 (1) be cancelled, non-renewed or otherwise terminated on the grounds of the age or the deterioration of  
143 the mental or physical health of the insured individual or certificate holder;

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

147 (3) provide coverage for skilled nursing care only or provide significantly more coverage for skilled  
148 care in a facility than coverage for lower levels of care.

149 (c) (1) A long-term care insurance policy, or certificate other than a policy or certificate thereunder,  
150 issued to a group as defined in clause (1) of the definition of "Group long-term care" of section (4)  
151 shall not use a definition of "preexisting condition" that is more restrictive than the following:  
152 Preexisting condition means a condition for which medical advice or treatment was recommended by,  
153 or received from a provider of health care services, within 24 months preceding the effective date of  
154 coverage of an insured person.

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

159 (3) Notwithstanding this subsection (c), an insurer may use an application form designed to elicit the  
160 complete health history of an applicant, and, on the basis of the answers on that application,  
161 underwrite in accordance with that insurer's established underwriting standards. Unless otherwise  
162 provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on  
163 the application need not be covered until the waiting period described in subsection (2) expires. No  
164 long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to  
165 exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases  
166 or physical conditions beyond the waiting period described in subsection (2).

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

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

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

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

174 (e) The commissioner may adopt regulations establishing loss ratio standards for long-term care  
175 insurance policies provided that a specific reference to long-term care insurance policies is contained  
176 in the regulation.

177 (f) Long-term care insurance applicants shall have the right to return the policy or certificate within 30  
178 days of its delivery and to have the premium refunded if, after examination of the policy or certificate,  
179 the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall  
180 have a notice prominently printed on the first page or attached thereto stating in substance that the  
181 applicant shall have the right to return the policy or certificate within 30 days of its delivery and to  
182 have the premium refunded if, after examination of the policy or certificate, other than a certificate  
183 issued pursuant to a policy issued to a group defined in clause (1) of the definition of "Group long-  
184 term care" of section (4), the applicant is not satisfied for any reason. This subsection shall also apply  
185 to denials of applications and any refund must be made within 30 days of the return or denial.

186 (g) (1) An outline of coverage shall be delivered to a prospective applicant for long-term care  
187 insurance at the time of initial solicitation through means that prominently direct the attention of the  
188 recipient to the document and its purpose. In the case of producer solicitations, an insurance producer  
189 shall deliver the outline of coverage prior to the presentation of an application or enrollment form. In  
190 the case of direct response solicitations, the outline of coverage shall be presented in conjunction with  
191 any application or enrollment form. In the case of a policy issued to a group defined in clause (1) of  
192 the definition of "Group long-term care" of section 4, an outline of coverage shall not be required to  
193 be delivered, provided that the information described in clauses (i) to (vi), inclusive, of paragraph (2)  
194 is contained in other materials relating to enrollment. Upon request, these other materials shall be  
195 made available to the commissioner.

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

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

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

201 (iii) a statement of the terms under which the policy or certificate, or both, may be continued in force  
202 or discontinued, including any reservation in the policy of a right to change premium; continuation or  
203 conversion provisions of group coverage shall be specifically described;

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

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

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

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

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

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

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

216 (3) a statement that the group master policy determines governing contractual provisions and that the  
217 policy is available for viewing in the offices of the policyholder and will be copied for the certificate  
218 holder upon request at no cost.

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

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

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

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

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

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

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

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

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

237 (iii) current and projected maximum lifetime benefits; and

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

240 (k) Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of  
241 the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder.

242 The report shall include:

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

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

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

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

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

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

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

253 Section 7. (a) For a policy or certificate that has been in force for less than 6 months an insurer may  
254 rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care  
255 insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.

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

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

263 (d) A long-term care insurance policy or certificate shall not be field issued based on medical or health  
264 status. For purposes of this subsection the term "field issued" means a policy or certificate issued by  
265 an agent or a third-party administrator pursuant to the underwriting authority granted to the agent or  
266 third party administrator by an insurer.

267 (e) If an insurer has paid benefits under the long-term care insurance policy or certificate, the insurer  
268 may not recover the benefit payments if the policy or certificate is rescinded.

269 (f) In the event of the death of the insured, this section shall not apply to the remaining death benefit of  
270 a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining

271 death benefits under these policies shall be governed by section 132 of chapter 175 of the General  
272 Laws. In all other situations, this section shall apply to life insurance policies that accelerate benefits  
273 for long-term care.

274 Section 8. (a) Except as provided in subsection (b), a long-term care insurance policy shall not be  
275 delivered or issued for delivery in this state unless the policyholder or certificate holder has been  
276 offered the option of purchasing a policy or certificate that includes a non-forfeiture benefit. The offer  
277 of a non-forfeiture benefit may be in the form of a rider that is attached to the policy. In the event the  
278 policyholder or certificate holder declines the non-forfeiture benefit, the insurer shall provide a  
279 contingent benefit upon lapse that shall be available for a specified period of time following a  
280 substantial increase in premium rates.

281 (b) When a group long-term care insurance policy is issued, the offer required in subsection (a) shall  
282 be made to the group policyholder. However, if the policy is issued as group long-term care insurance  
283 to a group defined in clause (4) the definition of "Group long-term care" of section 4, other than to a  
284 continuing care retirement community or other similar entity, the offering shall be made to each  
285 proposed certificate holder.

286 (c) The commissioner shall promulgate regulations specifying the type or types of non-forfeiture  
287 benefits to be offered as part of long-term care insurance policies and certificates, the standards for  
288 non-forfeiture benefits, and the rules regarding contingent benefit upon lapse, including a  
289 determination of the specified period of time during which a contingent benefit upon lapse will be  
290 available and the substantial premium rate increase that triggers a contingent benefit upon lapse as  
291 described in subsection a.

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

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

301 SECTION 4. Notwithstanding any general of special law to the contrary the Division of Insurance,  
302 after prior consultation with states with experience with long-term care insurance partnership plans,  
303 other appropriate state agencies, issuers of long-term care insurance policies, representatives of  
304 consumers of long-term care insurance policies, long-term care providers including the Massachusetts  
305 Extended Care Federation, Inc., Massachusetts Aging Services Association shall submit a state plan  
306 amendment to the Secretary of the federal office of Health and Human Services (HHS) providing for a  
307 Long Term Care Insurance Partnership Program. Such a program shall, for purposes of determining  
308 financial eligibility for MassHealth services, disregard assets or resources in an amount equal to the  
309 insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a  
310 qualified long-term care insurance policy. The plan amendment shall comply with the requirements of  
311 all relevant state and federal statutes and regulations including Subchapter B, Section 6021, of the  
312 federal 2005 Deficit Reduction Act, and 211 Code of Massachusetts Regulations (CMR) 65.00,  
313 Massachusetts' Long-Term Care Insurance Regulations. Upon approval by HHS of the state plan

314 amendment, the Division of Insurance shall develop regulations to implement and administer the  
315 Partnership Program consistent with state plan approval.