

# SENATE NO. 613

## **AN ACT** TO PROMOTE ACCESS TO HIGH QUALITY, AFFORDABLE LONG TERM CARE FOR MASSACHUSETTS CITIZENS

*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. The General Laws are hereby amended by inserting after chapter 111M the following  
2 chapter:—

### CHAPTER 111N.

#### INDIVIDUAL LONG TERM CARE COVERAGE

5 Section 1. As used in this chapter, the following words shall, unless the context clearly requires  
6 otherwise, have the following meanings:—

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

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

12 “Commissioner”, the commissioner of insurance.

13 “Creditable coverage”, long term care insurance coverage of an individual under any of the  
14 following plans or as a named beneficiary receiving coverage on another’s plan with no lapse of

15 coverage for more than 63 days and which provides for the equivalent value of 30 or more  
16 consecutive months of nursing home costs at the private duty rate with inflation adjustments: (a) an  
17 individual or group long term care insurance plan; (b) an individual or group annuities and life  
18 insurance policy or rider that provides directly, or supplements, long term care insurance coverage;  
19 (c) a savings or investment plan such as an IRA or a 401K; (d) a plan provided under the  
20 commonwealth long term care insurance program; (e) 10 U.S.C. 55; (f) a medical care program of  
21 the Indian Health Service or of a tribal organization; (g) a health plan offered under 5 U.S.C. 89; (h)  
22 an individual or group policy or rider that provides for payment of benefits based upon cognitive  
23 impairment or the loss of functional capacity; (i) qualified long term care insurance contract.

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

26 (1) one or more employers or labor organizations, or to a trust or to the trustees of a fund  
27 established by 1 or more employers or labor organizations, or a combination thereof, for employees  
28 or former employees, or a combination thereof, or for members or former members, or a  
29 combination thereof, of the labor organizations; or

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

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

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

35 (3) an association, or a trust, or the trustees of a fund established, created or maintained for the  
36 benefit of members of one or more associations; but, before advertising, marketing or offering the  
37 policy within the commonwealth, the association, or the insurer of the association, shall file

38 evidence with the commissioner that the association has at the outset a minimum of 100 persons  
39 and has been organized and maintained in good faith for purposes other than that of obtaining  
40 insurance; has been in active existence for at least 1 year; and have a constitution and bylaws that  
41 provide that:

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

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

44 and

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

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

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

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

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

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

54 “Long-term care insurance”, any insurance policy or rider: (1) advertised, marketed, offered or  
55 designed to provide coverage for not less than 12 consecutive months for each covered person on an  
56 expense incurred, indemnity, prepaid or other basis; (2) for one or more necessary or medically  
57 necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services;  
58 and (3) provided in a setting other than an acute care unit of a hospital including, but not limited to,  
59 an assisted living facility, a residential care facility or home health care. The term includes group  
60 and individual annuities and life insurance policies or riders that provide directly, or supplement,

61 long-term care insurance. The term also includes a policy or rider that provides for payment of  
62 benefits based upon cognitive impairment or the loss of functional capacity. The term shall also  
63 include qualified long-term care insurance contracts. Long-term care insurance shall not include any  
64 insurance policy that is offered primarily to provide basic Medicare supplement coverage, basic  
65 hospital expense coverage, basic medical-surgical expense coverage, hospital confinement  
66 indemnity coverage, major medical expense coverage, disability income or related asset-protection  
67 coverage, accident only coverage, specified disease or specified accident coverage, or limited  
68 benefit health coverage. With regard to life insurance, this term shall not include life insurance  
69 policies that accelerate the death benefit specifically for 1 or more of the qualifying events of  
70 terminal illness, medical conditions requiring extraordinary medical intervention or permanent  
71 institutional confinement, and that provide the option of a lump-sum payment for those benefits and  
72 where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-  
73 term care. Notwithstanding any other provision of this chapter, any product advertised, marketed or  
74 offered as long-term care insurance shall be subject to this chapter.

75 “Policy”, any policy, contract, subscriber agreement, rider or endorsement delivered or issued for  
76 delivery within the commonwealth by an insurer authorized to issue policies upon the lives of  
77 persons in the commonwealth or to provide accident and health insurance under chapter 175; a  
78 fraternal benefit society authorized under chapter 176; a nonprofit hospital service corporation  
79 authorized under chapter 176A, a nonprofit medical service corporation authorized under chapter  
80 176B or a health maintenance organization authorized under chapter 176G.

81 (1) “Qualified long-term care insurance contract” or “federally tax-qualified long-term care  
82 insurance contract” an individual or group insurance contract that meets the requirements of Section  
83 7702B(b) of the Internal Revenue Code of 1986, as amended, as follows:

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

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

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

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

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

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

105 (2) “Qualified long-term care insurance contract” or “federally tax-qualified long term care  
106 insurance contract” also means the portion of a life insurance contract that provides long-term care

107 insurance coverage by rider or as part of the contract and that satisfies the requirements of Sections  
108 7702B(b) and (e) of the Internal Revenue Code of 1986, as amended.

109 “Resident”, a person who has:—

110 (1) obtained an exemption under clause Seventeenth, Seventeenth C, Seventeenth C ½,  
111 Seventeenth D, Eighteenth, Twenty-second, Twenty-second A, Twenty-second B, Twenty-second  
112 C, Twenty-second D, Twenty-second E, Thirty- seventh, Thirty-seventh A, Forty-first, Forty-first  
113 A, Forty-first B, Forty- first C, Forty-second or Forty-third of section 5 of chapter 59;

114 (2) obtained an exemption under section 5C of said chapter 59;

115 (3) filed a Massachusetts resident income tax return under chapter 62;

116 (4) obtained a rental deduction under subparagraph (9) of paragraph (a) of Part B of section 3 of  
117 chapter 62;

118 (5) declared in a home mortgage settlement document that the mortgaged property located in the  
119 commonwealth would be occupied as his principal residence;

120 (6) obtained homeowner's liability insurance coverage on property that was declared to be occupied  
121 as a principal residence;

122 (7) filed a certificate of residency and identified his place of residence in a city or town in the  
123 commonwealth in order to comply with a residency ordinance as a prerequisite for employment  
124 with a governmental entity;

125 (8) paid on his own behalf or on behalf of a child or dependent of whom the person has custody,  
126 resident in-state tuition rates to attend a state-sponsored college, community college or university;

127 (9) applied for and received public assistance from the commonwealth for himself or his child or  
128 dependent of whom he has custody;

129 (10) has a child or dependent, of whom he has custody, who is enrolled in a public school in a city  
130 or town in the commonwealth, unless the cost of such education is paid for by him, such child or  
131 dependent, or by another education jurisdiction;

132 (11) is registered to vote in the commonwealth;

133 (12) obtained any benefit, exemption, deduction, entitlement, license, permit or privilege by  
134 claiming principal residence in the commonwealth; or

135 (13) is a resident under any other written criteria under which the commissioner of revenue may  
136 determine residency in the commonwealth.

137 Section 2. (a) As of July 1, 2009, the following individuals age 35 and over shall obtain and  
138 maintain creditable coverage so long as it is deemed affordable under the schedule set by the board  
139 of the connector, established by chapter 176Q: (1) residents of the commonwealth; or (2)  
140 individuals who become residents of the commonwealth within 63 days, in the  
141 aggregate. Residents who within 63 days have terminated any prior creditable coverage, shall  
142 obtain and maintain creditable coverage within 63 days of such termination. If, at any time,  
143 because of retirement or disability, such individuals can no longer afford the premium, the  
144 connector shall establish a sliding scale reimbursement based on earned income only.

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148 (b) Every person, age 35 and over, who files an individual income tax return as a resident of the  
149 commonwealth, either separately or jointly with a spouse, shall indicate on the return, in a manner  
150 prescribed by the commissioner of revenue, whether such person (i) had creditable coverage in  
151 force for each of the 12 months of the taxable year for which the return is filed as required under

152 paragraph (a) whether covered as an individual or as a named beneficiary of a policy covering  
153 multiple individuals, (ii) claims an exemption under section 3, or (iii) had a certificate issued under  
154 section 3 of chapter 176Q. If the person fails to indicate or indicates that he did not have such  
155 coverage in force, then a penalty shall be assessed on the return. If the person indicates that he had  
156 such coverage in force but the commissioner determines, based on the information available to him,  
157 that such requirement of paragraph (a) was not met, then the commissioner shall assess the  
158 penalty. If in any taxable year, in whole or in part, a taxpayer does not comply with the  
159 requirement of paragraph (a), the commissioner shall retain any amount overpaid by the taxpayer  
160 for purposes of making payments described in paragraph (c); provided, however, that the amount  
161 retained shall not exceed 50 per cent of the minimum insurance premium for creditable coverage for  
162 which the individual would have qualified during the previous year. The penalty shall be assessed  
163 for each of the months the individual did not meet the requirement of paragraph (a); provided, that  
164 any lapse in coverage of 63 days or less shall not be counted in calculating the penalty; and,  
165 provided further, that nothing in this paragraph shall be considered to authorize the commissioner to  
166 retain any amount for such purposes that otherwise would be paid to a claimant agency or agencies  
167 as debts described in clauses (i) to (vii), inclusive, of section 13 of chapter 62D. If the amount  
168 retained is insufficient to meet the penalty assessed, the commissioner shall notify the taxpayer of  
169 the balance due on the penalty and related interest. The commonwealth shall have all enforcement  
170 and collection procedures available under chapter 62C to collect any penalties assessed under this  
171 section.

172 (c) The commissioner shall deposit all penalties collected into the Commonwealth Long Term Care  
173 Trust Fund, established by section 32A of chapter 118E.

174 Section 3. An individual shall be exempt from section 2(a) if he files a sworn affidavit with his  
175 income tax return stating that he did not have creditable coverage and that his sincerely held  
176 religious beliefs are the basis of his refusal to obtain and maintain creditable coverage during the 12  
177 months of the taxable year for which the return was filed. Any individual who claimed an  
178 exemption but received long term care during the taxable year for which the return is filed shall be  
179 liable for providing or arranging for full payment for the medical health care and be subject to the  
180 penalties in subsection (b) of section 2.

181 Section 4. An individual subject to section 2(a), who disputes the determination of applicability or  
182 affordability, as enforced by the department of revenue, may seek a review of this determination  
183 through an appeal established by the board of the commonwealth health insurance connector, under  
184 chapter 176Q; provided, however, that no additional penalties shall be enforced against an  
185 individual seeking review until the review is complete and any subsequent appeals are exhausted.

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

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

197 reductions, elimination periods, requirements for replacement, offer of inflation protection,  
198 recurrent conditions and definitions of terms.

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

- 200 (1) be cancelled, non-renewed or otherwise terminated on the grounds of the age or the  
201 deterioration of the mental or physical health of the insured individual or certificate holder;  
202 (2) contain a provision establishing a new waiting period in the event existing coverage is converted  
203 to, or replaced by, a new or other form within the same company, except with respect to an increase  
204 in benefits voluntarily selected by the insured individual or group policyholder; or  
205 (3) provide coverage for skilled nursing care only or provide significantly more coverage for skilled  
206 care in a facility than coverage for lower levels of care.

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

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

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

220 underwrite in accordance with that insurer's established underwriting standards. Unless otherwise  
221 provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on  
222 the application need not be covered until the waiting period described in subsection (2) expires. No  
223 long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to  
224 exclude, limit or reduce coverage or benefits for specifically named or described preexisting  
225 diseases or physical conditions beyond the waiting period described in subsection (2).

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

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

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

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

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

236 (f) Long-term care insurance applicants shall have the right to return the policy or certificate within  
237 30 days of its delivery and to have the premium refunded if, after examination of the policy or  
238 certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and  
239 certificates shall have a notice prominently printed on the first page or attached thereto stating in  
240 substance that the applicant shall have the right to return the policy or certificate within 30 days of  
241 its delivery and to have the premium refunded if, after examination of the policy or certificate, other  
242 than a certificate issued pursuant to a policy issued to a group defined in clause (1) of the definition

243 of "Group long-term care" of section (4), the applicant is not satisfied for any reason. This  
244 subsection shall also apply to denials of applications and any refund must be made within 30 days  
245 of the return or denial.

246 (g) (1) An outline of coverage shall be delivered to a prospective applicant for long-term care  
247 insurance at the time of initial solicitation through means that prominently direct the attention of the  
248 recipient to the document and its purpose. In the case of producer solicitations, an insurance  
249 producer shall deliver the outline of coverage prior to the presentation of an application or  
250 enrollment form. In the case of direct response solicitations, the outline of coverage shall be  
251 presented in conjunction with any application or enrollment form. In the case of a policy issued to a  
252 group defined in clause (1) of the definition of "Group long-term care", an outline of coverage shall  
253 not be required to be delivered, provided that the information described in clauses (i) to (vi),  
254 inclusive, of paragraph (2) is contained in other materials relating to enrollment. Upon request,  
255 these other materials shall be made available to the commissioner.

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

- 258 (i) a description of the principal benefits and coverage provided in the policy or certificate;
- 259 (ii) a statement of the principal exclusions, reductions and limitations contained in the policy or  
260 certificate;
- 261 (iii) a statement of the terms under which the policy or certificate, or both, may be continued in  
262 force or discontinued, including any reservation in the policy of a right to change premium;  
263 continuation or conversion provisions of group coverage shall be specifically described;
- 264 (iv) a statement that the outline of coverage is a summary only, not a contract of insurance, and that  
265 the policy or group master policy contains governing contractual provisions;

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

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

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

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

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

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

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

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

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

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

289 (2) an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime  
290 benefits if any, for each covered person;  
291 (3) any exclusions, reductions and limitations on benefits of long-term care;  
292 (4) a statement indicating whether any long term care inflation protection option required by law is  
293 available under this policy;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

331 (f) In the event of the death of the insured, this section shall not apply to the remaining death benefit  
332 of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining  
333 death benefits under these policies shall be governed by section 132 of chapter 175 of the General

334 Laws. In all other situations, this section shall apply to life insurance policies that accelerate  
335 benefits for long-term care.

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

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

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

354 Section 9. The commissioner shall promulgate reasonable regulations in accordance with chapter  
355 30A to promote premium adequacy and to protect the policyholder in the event of substantial rate

356 increases, and to establish minimum standards for marketing practices, agent compensation, agent  
357 testing, penalties and reporting practices for long term care insurance.

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

363 Section 11. The commissioner of revenue, in consultation with the board of the commonwealth  
364 health insurance connector, established by chapter 176Q, shall promulgate such rules and  
365 regulations, as necessary, to carry out this chapter.

366 SECTION 2. Chapter 118E of the General Laws is hereby amended by replacing section 32A with  
367 following section:—

368 Commonwealth Long Term Care Trust Fund

369 Section 32A. There is hereby established and set up on the books of the commonwealth a separate  
370 fund to be known as the Commonwealth Long Term Care Trust Fund, in this section called the trust  
371 fund. There shall be credited to the trust fund: (a) any transfers from the Health Safety Net Trust  
372 Fund, established by section 57 of chapter 118E, and (b) revenue deposited pursuant to penalties  
373 collected under chapter 111N. The Secretary of Health and Human Services shall develop and seek  
374 a demonstration grant from CMS to determine the cost savings to the Medicaid program resulting  
375 from the long term care insurance coverage mandate, and those savings shall also be credited to the  
376 fund.

377 Amounts credited to the trust fund shall be expended without further appropriation for programs  
378 designed to increase health coverage, including a program of subsidized long term care insurance

379 provided to low-income residents of the commonwealth under chapter 118H and rate increases to  
380 certain Medicaid providers and supplemental payments to certain publicly operated or public-  
381 service hospital entities, as determined by law. Not later than January 1, the comptroller shall  
382 report an update of revenues for the current fiscal year and prepare estimates of revenues to be  
383 credited to the trust fund in the subsequent fiscal year. The comptroller shall file this report with  
384 the secretary of administration and finance, the office of Medicaid, the joint committee on health  
385 care financing, and the house and senate committees on ways and means. If revenues credited to  
386 the trust fund are less than the amounts estimated to be credited to the trust fund, the comptroller  
387 shall duly notify the secretary, office and committees that this revenue deficiency shall require  
388 proportionate reductions in expenditures from the revenues available to support programs  
389 appropriated from the trust fund.

390 SECTION 3. Chapter 32A of the General Laws is hereby amended by inserting after section 10E,  
391 as appearing in the 2004 Official Edition, the following section:-

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

399 SECTION 4. Paragraph (b) of Part B of section 3 of chapter 62 of the General Laws, as so  
400 appearing, is hereby amended by adding the following subparagraph:-

401 (6) In the case of an individual who purchases a qualified long-term care insurance policy, as  
402 defined by chapter 111N , including both nursing facility and home health benefits, an amount  
403 equal to 100 per cent of the individual's cost of any annual premium of the insurance policy not to  
404 exceed \$5,000; if the policy has been approved for sale in the commonwealth by the division of  
405 insurance. Married individuals filing jointly or separately are each entitled to an exemption from  
406 taxable income equal 100 per cent of the couple's cost of the annual premium but not more than  
407 \$5,000.

408 SECTION 5. The General Laws are hereby amended by inserting after chapter 118H the following  
409 chapter:-

#### 410 CHAPTER 118I

#### 411 COMMONWEALTH LONG TERM CARE INSURANCE PROGRAM

412 Section 1. This chapter shall apply to policies delivered, or issued for delivery, in the  
413 commonwealth on or after January 1, 2007. This chapter is not intended to supersede the  
414 obligations of entities subject to this chapter to comply with applicable insurance laws insofar as  
415 they do not conflict with this chapter, except that laws and regulations designed and intended to  
416 apply to Medicare supplement insurance policies shall apply to long-term care insurance.

417 Section 2. For the purpose of promoting equal choice of long term care pursuant to the provision of  
418 chapter 211 of the Acts of 2006, there shall be a commonwealth long term care insurance program  
419 within the commonwealth health insurance connector, established by chapter 176Q. The program  
420 shall be administered by the board of the connector, in consultation with the office of Medicaid and  
421 the department of elder affairs. The program shall provide subsidies to assist eligible individuals in  
422 purchasing long term care insurance, provided that subsidies shall only be paid on behalf of an  
423 eligible individual who is enrolled in a long term care plan that has been procured by the

424 commonwealth health insurance connector under said chapter 176Q, and shall be made under a  
425 sliding-scale premium contribution payment schedule for enrollees, as determined by the board of  
426 the connector. Eligibility for premium assistance payments under this section shall be determined  
427 in coordination with and using the procedures of the office of Medicaid. After consultation with the  
428 director of the office of Medicaid, representatives of any carrier eligible to receive premium subsidy  
429 payments under this chapter, representatives of long term care providers, and representatives of  
430 senior citizen advocacy organizations, the board shall develop a plan for outreach and education  
431 that is designed to reach low-income uninsured residents and maximize their enrollment in the  
432 program.

433 Section 3. (a) An individual shall be eligible to participate in the program if:—

- 434 (1) an individual's or family's household income does not exceed 400 per cent of the federal  
435 poverty level;
- 436 (2) the individual has been a resident of the commonwealth for the previous 6 months;
- 437 (3) the individual is not eligible for any MassHealth program or for Medicare;
- 438 (4) has attained the age of thirty-five;

439 Section 4. All residents shall have the right to apply for the program established by this chapter,  
440 the right to receive written determination detailing denial of eligibility, and the right to appeal any  
441 eligibility decision, provided such appeal is conducted pursuant to the process established by the  
442 board of the commonwealth health insurance connector, established by chapter 176Q. Applicants  
443 for said program shall be eligible for subsequent appeals subject to chapter 30A. Notwithstanding  
444 any general or special law to the contrary, all eligible individuals on whose behalf premium  
445 assistance payments are made under this section shall be entitled to consumer protections as  
446 described in chapter 176O.

447 Section 5. Premium assistance payments shall be made under a schedule set annually by the board,  
448 in consultation with the office of Medicaid and the department of elder affairs; provided that this  
449 schedule shall be published on or before September 30, starting in 2009. Premium assistance  
450 payments shall not be subject to appropriation from the fund, established by section 2SSS of  
451 chapter 29, and shall be made directly by the connector to eligible long term care insurance plans,  
452 under chapter 176Q. If the director determines that amounts in the fund are insufficient to meet the  
453 projected costs of enrolling new eligible individuals, the director shall impose a cap on enrollment  
454 in the program.

455 Section 6. (a) There shall be established a program for any resident with a household income that  
456 does not exceed 100 percent of the federal poverty level, in which the board of the connector shall  
457 procure long term care insurance plans that include, but are not limited to: (1) skilled nursing  
458 facility services; (2) assisted living services; (3) home care services (4) outpatient services and  
459 preventative care by participating providers; (5) prescription drugs as provided under the  
460 Prescription Advantage formulary; (6) medically necessary inpatient and outpatient mental health  
461 services and substance abuse services; and (7) medically necessary dental services, including  
462 preventative and restorative procedures.

463 (b) Enrollees with a household income that does not exceed 100 percent of the federal poverty level  
464 shall only be responsible for a co-payment toward the purchase of each pharmaceutical product and  
465 for use of emergency room services in acute care hospitals for non-emergency conditions equal to  
466 that required of enrollees in the MassHealth program, as described in clause (5) of section 25 of  
467 chapter 118E. The board may waive co-payments upon a finding of substantial financial or medical  
468 hardship. No other premium, deductible, or other cost sharing shall apply to enrollees under this  
469 program.

470 SECTION 6. The General Laws are hereby amended by inserting after section 17 in chapter 175  
471 the following section:-

472 Section 17A. The commissioner shall each year compute the reserve required of long term care  
473 insurance companies for outstanding losses under long term care insurance in accordance with  
474 accounting practices and procedures prescribed or allowed by the commissioner. The commissioner  
475 shall require that value of the reserves be computed in accordance with the Accounting Practices  
476 and Procedures Manual of the National Association of Insurance Commissioners, unless modified  
477 by the commissioner as the commissioner considers appropriate.

478 SECTION 39. The provisions of sections 2-3 of this act shall take effect on January 1, 2010

479 SECTION 41. The remaining sections shall be effective on July 1, 2008.