211 CMR 65.00 LONG-TERM CARE INSURANCE

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65.01: Purpose

The purpose of 211 CMR 65.00 is to provide for full and fair disclosure of the provisions of long-term care insurance policies offered in Massachusetts and to promote the public interest by protecting applicants for long-term care insurance from unfair or deceptive sales and enrollment practices. 211 CMR 65.00 establishes minimum standards for individual and group long-term care insurance policies and minimum standards for disclosure, marketing and producer training for both individual long-term care insurance policies and group long-term care insurance policies that are not employment-based. 211 CMR 65.00 is intended to facilitate public understanding and comparison of long-term care policies, and to encourage flexibility and responsible innovation in the development of long-term care insurance.

65.02: Authority

211 CMR 65.00 is issued under the authority of M.G.L. Chs. 175, 176U and 176D.

65.03: Applicability and Scope

Except as otherwise specifically provided, 211 CMR 65.00 applies to all long-term care insurance policies, including qualified long-term care contracts and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in the commonwealth on or after the effective date by carriers. Additionally, this regulation is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if:

1. The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;

2. The disability income policy is advertised, marketed or offered as insurance for long-term care services; or

3. Benefits under the policy may commence after the policyholder has reached Social Security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

65.04: Definitions

No long-term care insurance policy delivered or issued for delivery in the commonwealth shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

Activities of daily living means at least eating, toileting, transferring, bathing, dressing and continence.

Acute condition means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

Adult day care means dementia day care or social day care, provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

Adult Foster Care means personal care and other related services provided in a family-like setting that are provided by programs approved by the Massachusetts Division of Medical Assistance or that meet the requirements of the state in which services are provided.

Alternate care benefits means benefits for services or other items not specified in the long-term care insurance policy, but to be covered as agreed to by the carrier, the insured, and the insured's caregiver. This includes, but is not limited to, payment for home modifications that allow the insured to continue living at home or a non-institutionalized setting and coverage of long-term care services that might not exist on the policy issue date.

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

Assisted Living Facility means a facility that has been certified as an assisted living residence by the Massachusetts Executive Office of Elder Affairs, or a facility meeting the requirements of the state in which services are provided.

Bathing means washing oneself by sponge bath in either a tub or shower, including the task of getting into or out of the tub or shower.

Benefit trigger, for the purposes of independent review, means a contractual provision in the insured's policy of long-term care insurance conditioning the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. For purposes of a tax-qualified long-term care insurance contract, as defined in section 7702B of the Internal Revenue Code of 1986, as amended, "benefit trigger" shall include a determination by a licensed health care practitioner that an insured is a chronically ill individual.

Care management means those procedures employed by a carrier to approve covered services and to determine the appropriate level of care.

Carrier means a commercial insurance company licensed to issue accident and sickness policies under M.G.L. 175: a fraternal benefit society licensed under M.G.L. 176: a nonprofit hospital service corporation authorized under chapter 176A; a nonprofit medical service corporation authorized under chapter 176B; or a health maintenance organization authorized under M.G.L. c. 176G.

Certificateholder means the holder of a certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery within the commonwealth.

Chore Care means non-medical services that are provided in the insured's home and are designed to maintain the insured's home so that it remains habitable, including at a minimum: vacuuming (including the moving of furniture); washing floors and walls; defrosting freezers; cleaning ovens; cleaning attics and basements to remove fire and health hazards; changing storm windows; performing heavy yardwork; shoveling snow; making minor home repairs.

Cognitive impairment means a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

Cold-lead advertising means making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that one of the purposes of the method of marketing is the solicitation of insurance and that contact will be made by a carrier or its producer.

Commissioner means the Commissioner of Insurance or his/her designee.

Community Care Benefits means those services provided to the insured in a home or community setting by a community-based service provider, including but not limited to personal care, home care and respite care.

Continence means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

Continuing Care Retirement Community (CCRC) means an entity that and meets the requirements set forth by the Executive Office of Elder Affairs, or a CCRC meeting the requirements of the state in which the CCRC is located.

Convertible means a policy feature that gives the insured the right to switch to another policy offered or sponsored by the carrier.

Custodial Care means non-medical care services provided by a nursing home or a home health care agency.

Daily maximum benefit means the maximum daily amount stated in the coverage that the long-term care insurance policy pays for specific services.

Deductible means the dollar amount stated in the coverage that is to be paid solely by the insured before the long-term care insurance policy begins to pay benefits.

Dementia Day Care means services provided by a dementia day care program operating in accordance with standards issued by the Executive Office of Elder Affairs, or a program meeting the requirements of the state in which the dementia care is being provided.

Disability means the functional or cognitive inability to engage in regular and customary activities of daily living without human assistance.

Dressing means putting on and taking off all items of clothing and any necessary braces,fasteners or artificial limbs.

Eating means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

Elimination period means the number of days stated in the policy during which covered services must be received by an insured before the long-term care insurance policy begins to pay benefits.

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

(a) an employer or labor organization or to a trust or to the trustees of a fund established by an employer or labor organization, or a combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of a labor organization;
(b) a professional, trade or occupational association for its members or former or retired members, or a combination thereof, if the association:
    1. is comprised of individuals all of whom are, or were, actively engaged in the same profession, trade or occupation; and
    2. has been maintained in good faith for purposes other than obtaining insurance;
(c) an association, or a trust or the trustees of a fund established, created or maintained for the benefit of members of any such association; provided, however, that before advertising, marketing or offering the policy within the commonwealth, the association, or the carrier of the association, shall file evidence with the commissioner that the association:
    1. has, at the outset, at least 100 persons;
    2. has been organized and maintained in good faith for purposes other than that of obtaining insurance;
    3. has been in active existence for at least 1 year; and
    4. has a constitution and by-laws that provide that:
        a. the association holds regular meetings not less than annually to further purposes of the members;
        b. except for credit unions, the association collects dues or solicits contributions from members; and
        c. the members have voting privileges and representation on the governing board and committees;

    provided further, that 30 days after the filing, the association shall be considered to have satisfied the organizational requirements unless the commissioner makes a finding that the association does not satisfy those organizational requirements; or
(d) a group other than those described in clauses (1) to (3), inclusive, subject to a finding by the commissioner that:
    1. the issuance of the group policy is not contrary to the best interests of the public;
    2. the issuance of the group policy would result in economies of acquisition or administration; and
    3. the benefits are reasonable in relation to the premiums charged.

Hands-on assistance means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.

High-pressure tactics means employing any method of marketing that has the effect of or tends to induce or recommend the purchase of any insurance policy through force, fright, threat (whether explicit or implied) or undue pressure.

Home Care means non-medical assistance with activities of daily living provided by a home care provider which are designed to maintain the insured's ability to live independently and include but are not limited to: shopping; planning meals; bringing home-delivered meals; and doing laundry, light house-cleaning and maintenance, including vacuuming, dusting, dry mopping, dishwashing, cleaning the kitchen/bathroom, and changing beds.

Home Care Provider means an entity that provides home care services and meets the provider requirements set forth by the Executive Office of Elder Affairs, or a program meeting the requirements of the state in which the home care services are provided.

Home Health Care Agency means an agency certified by the Massachusetts Department of Public Health, or an agency or program meeting the requirements of the state in which the home health care services are provided.
Home health care services means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences and shall include nursing, home health aide, rehabilitative therapy, and nutrition counseling services.

Hospice Care means those palliative services provided by a hospice to a patient deemed to be terminally ill.

Hospice means an agency or program licensed by the Massachusetts Department of Public Health, or an agency or program meeting the requirements of the state in which hospice services are provided.

Hospital means a facility licensed by the Massachusetts Department of Public Health, or facility meeting the requirements of the state in which the facility is located.

"*Incidental*," as used in 211 CMR 65.21(11), means that the value of the long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

Independent review organization means an organization that conducts independent reviews of long-term care benefit trigger decisions.

Individual policy means a policy issued by a carrier directly to an insured.

Insured means the named policyholder or certificate-holder under long-term care insurance coverage.

Intermediate Nursing Care means routine nursing services with the periodic availability of skilled nursing and rehabilitative services that are provided by a nursing home, a home health care agency, or by an adult day health program.

Licensed health care professional means an individual, qualified by education and experience in an appropriate field, to determine, by record review, an insured's actual functional or cognitive impairment.

Lifetime maximum benefit period means the maximum number of days of benefits stated in the policy that the carrier will pay for covered benefits after the satisfaction of any elimination period or deductible.

Lifetime maximum dollar amount means the maximum dollar amount stated in the policy that the carrier will pay for covered benefits after the satisfaction of any elimination period or deductible.

Long-term care insurance means an insurance policy or rider:

(a) advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis;

(b) for necessary or medically-necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, including home and community care service; and
(c) provided in a setting other than an acute care unit of a hospital.

Long-term care insurance shall include group and individual annuities and life insurance policies or riders that provide directly, or supplement, long-term care insurance; a policy or rider that provides for payments of benefits based upon cognitive impairment or the loss of functional capacity; and qualified long-term care insurance policies.

Long-term care insurance shall not include an insurance policy 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, long-term care shall not include life insurance policies that accelerate the death benefit specifically for any 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 provisions of this regulation, any other product advertised, marketed or offered as long-term insurance shall be subject to this regulation.

MassHealth Program (Medicaid) means the program of medical assistance within Massachusetts responsible to administer the Massachusetts Medicaid Program under Title XIX of the federal Social Security Act, 42 USCS §1396 *et seq.*, and M.G.L. 118E.

Medicare means “The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended,” or “Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof,” or words of similar import.

Medical necessity means that medical services have been found to be medically necessary for a person because of the following:

(a) they are in accordance with accepted standards of medical practice for the diagnosis and treatment of a condition,
(b) they are delivered, when possible, in the least intensive setting required by the insured's condition, and
(c) they are not solely for the convenience of the insured, the insured's family or the insured's health care provider.

Mental or nervous condition means a condition as described in the standard nomenclature of the American Psychiatric Association.

Nonforfeiture benefit means a benefit stated in the coverage that is provided to the insured in the event that the insured’s long-term care insurance policy lapses due to nonpayment of premium. Nonforfeiture benefits include, but are not limited to, return of premium and partial paid-up benefits.

Nurse means all nurses, including but not limited to registered nurses, licensed practical nurses, or licensed vocational nurses, who meet the appropriate licensing or registration requirements of the state in which the nurses are providing services.

Nursing Home means a facility that is primarily engaged in providing nursing care and related services on an inpatient basis under a license by the Department of Public Health or the appropriate licensing agency of the state in which it is located.

Personal care means services provided by a personal care provider to assist in activities of daily living, including but not limited to assistance with the following: bathing; bedpan routines; foot care; dressing; care of dentures; shaving and grooming; eating; and ambulating and transfers.

Personal Care Provider means a provider, program or agency that provides personal care services and meets the requirements set forth by the Executive Office of Elder Affairs, or a provider, program or agency that meets the requirements of the state in which the personal care services are being provided.

Policy means an individual or group policy, contract, subscriber agreement, rider or endorsement, as well as any policy applications, rider, amendments or other provisions that are attached to the policy that are delivered or issued for delivery in the commonwealth by an authorized Carrier.

Pre-existing condition means a medical condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within 6 months preceding the effective date of coverage of an insured person.

Producer means either

(a) a person licensed as an insurance producer under M.G.L. 175, §162I, or
(b) any other person legally authorized to represent a carrier in the marketing of long-term care insurance.

Qualified actuary means a member in good standing of the American Academy of Actuaries.

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 26 U.S.C. 7702B (b) as follows:

(a) the only insurance protection provided under the contract is coverage of qualified long-term care services; provided, however, that a contract shall not fail to satisfy the requirements of this clause 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 or would be so reimbursable but for the application of a deductible or coinsurance amount; provided, however, that the requirements of this clause shall not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payor; and provided further, that a contract shall not fail to satisfy the requirements of this clause 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 said 26 U.S.C. 7702B(b)(1)(C);
(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 clause (v);
(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 said 26 U.S.C. 7702B(g); and provided further, that "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" shall also include 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 said 26 U.S.C. 7702B(b) and 7702B(e) and as set forth in clauses (i) to (vi), inclusive.

Respite Care means services to temporarily relieve a caregiver of the daily stresses and demands of care for the insured, including but not limited to short-term placements in adult foster care, nursing facilities or rest homes, and home care, personal care and home health care provided in a home or community setting.

Similar policy forms means all of the long-term care insurance policies and certificates issued by a carrier in the same long-term care benefit classification. Certificates of groups that meet the definition of a group policy are not considered similar to certificates or policies otherwise issued as individual long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

Social Day Care means training, counseling and social services as defined by standards issued by the Executive Office of Elder Affairs, and includes assistance with the following: walking; grooming; eating; and planned recreational and social activities suited to the needs of the participants and designed to encourage physical and mental exercise and stimulate social interaction.

Toileting means getting to and from the toilet; getting on and off the toilet; and performing associated personal hygiene.

Transferring means moving into or out of a bed, chair or wheelchair.

Twisting means knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or carriers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any policy or to take out a policy with another carrier.

65.05: Policy Practices and Provisions

(1) Renewability. The terms “guaranteed renewable” and “noncancellable” shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of 211 CMR 65.07.
   (a) An individual policy shall not contain renewal provisions other than “guaranteed renewable” or “noncancellable.”
      1. The term “guaranteed renewable” may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the carrier has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the carrier on a class basis.
      2. The term “noncancellable” may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the carrier has no right to unilaterally make any change in any provision of the insurance or in the premium rate.
      3. The term “level premium” may only be used when the carrier does not have the right to change the premium.
   (b) In addition to the other requirements of this subsection, a federally-qualified long term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.
   (c) Carriers may not refuse to renew any individual policy, except in cases when the carrier is under receivership, rehabilitation or liquidation proceedings pursuant to M.G.L. c. 175 or 176, section 33, administrative supervision under M.G.L. c. 175J or comparable statutory requirements of another jurisdiction. A carrier may discharge its obligation to renew existing individual policies only upon a finding that the carrier has obtained coverage for existing insureds with equivalent benefits for value paid with another carrier.
   (d) A long-term care insurance policy shall not be cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder.

(2) Limitations and Exclusions.

(a) A long-term care insurance policy may not be delivered or issued for delivery in the commonwealth, if it

1. conditions long-term care benefits on the insured's prior hospitalization or prior receipt of services from any long-term care provider;
2. conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care;
3. conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement;
4. restricts or denies benefits because the insured is not eligible for Medicare;
5. conditions receipt of covered benefits on a requirement that the insured be making "steady improvement", have "recuperative potential" or have "returned to pre-morbid condition" or words of similar import;
6. excludes otherwise eligible policy benefits, because those benefits are also payable by a non-Medicare government agency or because the services are being received in a governmental facility;
7. conditions the receipt of any services, except medical services provided by a licensed medical professional, on any standard of medical necessity or
8. restricts benefit eligibility standards:
   a. for policies intended to be federally-qualified, it requires satisfaction of benefits eligibility standards that differ from what is required under standards set forth in the Internal Revenue Code and related federal regulations;
   b. for policies not intended to be federally-qualified, it requires satisfaction of benefits eligibility standards that are more stringent than requiring that the insured be unable to perform at least two Activities of Daily Living due to a loss of functional capacity or severe cognitive impairment.

(b) Long-term care insurance coverage may condition the receipt of medical benefits on the services being found to be medically necessary for an insured provided that any carrier using such a medical necessity standard discloses that standard within the coverage.

(c) A long-term care insurance policy may establish a care management system to manage the benefits provided under a policy, and plan benefits may be disallowed if specific care management standards and procedures are not met, provided that a carrier intending to use a care management system does the following:

1. establishes a needs assessment tool which measures functional ability;
2. files with the commissioner a description of its care management policy and procedures, as well as the mechanism by which the insured may appeal a care management decision, and file any and all updates to the management policy and procedures with the commissioner prior to implementation;
3. specifies the care management procedures within the policy, as well as the way to appeal whenever benefits are disallowed for failure to meet care management standards, and notify the insured about any changes to care management procedures included in the policy prior to implementation; and
4. discloses applicable care management standards to insureds upon request.

(d) A long-term care insurance policy may not limit or exclude coverage by type of illness, treatment, medical condition or accident, except as follows:

1. Pre-existing conditions or diseases, provided that all pre-existing condition limitations must (a) be identified on the front of the policy and in the outline of coverage and (b) may not apply for more than a six-month period from the effective date of the policy;
2. Illness, treatment or medical condition arising out of:
   a. War or act of war (whether declared or undeclared);
   b. Participation in a felony, riot or insurrection;
   c. Service in the armed forces or units auxiliary thereto;
   d. Suicide (sane or insane), attempted suicide or intentionally self inflicted injury; or
   e. Aviation (this exclusion applies only to non-fare-paying passengers).

(e) Services for which benefits are available under Medicare, any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services provided for alcohol or drug detoxification; services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

(f) Expenses for services or items available or paid under another long-term care insurance or health insurance policy;

(g) In the case of a federally-qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.

(h) 1. This subsection is not intended to prohibit exclusions and limitations by type of provider. However, no long-term care carrier may deny a claim because services are provided in a state other than the state of policy issued under the following conditions:

a. When the state other than the state of policy issue does not have the provider licensing, certification or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration; or

b. When the state other than the state of policy issue licenses, certifies or registers the provider under another name.

2. For purposes of this paragraph, "state of policy issue" means the state in which the individual policy or certificate was originally issued.

(3) Free Look Period. Long-term care insurance applicants may return the policy or certificate within 30 days of its delivery and have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached to the first page stating in substance that the applicant shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than an employment-based policy, the applicant is not satisfied for any reason. The requested refund shall be made within 30 days after the return of the policy.

(4) Rescissions

(a) For a policy or certificate that has been in force for less than 6 months, a carrier 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 of coverage.

(b) For a policy or certificate that has been in force for at least 6 months but less than 2 years a carrier 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 of coverage and which pertains to the condition for which benefits are sought.

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

(d) A long-term care insurance policy or certificate can be field issued if the compensation to the field issuer is not based on the number of policies or certificates issued. The term "field issued" shall mean a policy or certificate issued by a producer or third-party administrator under the underwriting authority granted to the producer or third party administrator by a carrier and using the carrier's underwriting guidelines.

(e) If a carrier has paid benefits under a long-term care insurance policy or certificate, the carrier shall not be entitled to recover the benefit payments if the policy or certificate is rescinded.

(f) In the event of the death of the insured, this section shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In that event, the remaining death benefits under such policy shall be governed by section 132 of chapter 175. In any other event, this section shall apply to life insurance policies that accelerate benefits for long-term care.

(a) Extension of Benefits.
If a policy is terminated while an insured is confined to a nursing home, benefits shall continue until the earliest of the following occurs:

1. The insured is discharged from the nursing home,
2. The policy lifetime maximum benefit period has expired, or
3. The insured has exhausted the lifetime maximum benefit amount for nursing home services.

(b) For the purposes of this section, the insured shall be considered to be continuously confined to a nursing home while being transferred to another nursing home, receiving another level of nursing care in any nursing home or being transferred back to a nursing home from a temporary/acute hospitalization.

(c) This section does not apply if coverage under the individual policy terminates because of failure of the policyholder to pay the premium within the time set forth in the policy.

(5) Continuation or Conversion of Group Coverage.

- (a) Group long-term care insurance issued in the commonwealth on or after the effective date of this section shall provide covered individuals with a basis for continuation or conversion of coverage.
- (b) For the purposes of this section, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.
- (c) For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the carrier under whose group policy he or she is covered, without evidence of insurability.
- (d) For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.
- (e) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the carrier not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.
- (f) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.
- (g) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:
  1. Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or
  2. The terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage:
     - a. Providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and
     - b. The premium for which is calculated in a manner consistent with the requirements of 211 CMR 65.05(6)(f).
- (h) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. The provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.
- (i) The converted policy shall not contain a provision establishing a new or other 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.

(j) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.
(k) Notwithstanding any other provision of this section, an insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.
(l) For the purposes of this section a "managed-care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

(6) Discontinuance and Replacement. If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding carrier shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the carrier and premiums charged to persons under the new group policy:
(a) Shall not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced;
(b) Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services; and
(c) Shall not contain a provision establishing a new waiting period, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder.

(7) Premium Charged
(a) The premium charged to an insured shall not increase due to either:
1. The increasing age of the insured at ages beyond sixty-five (65); or
2. The duration the insured has been covered under the policy.
(b) The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under 211 CMR 65.27, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.
(c) A reduction in benefits shall not be considered a premium change, but for purposes of the calculation required under 211 CMR 65.27, the initial annual premium shall be based on the reduced benefits.

(8) Benefit Requirements
(a) Individual Policy Benefits
1. Policies may not provide coverage for skilled nursing care only or provide significantly more coverage for skilled nursing care in a facility than coverage for lower levels of care.
2. Daily or monthly maximum benefit amounts for specific services must be clearly defined within the policy provisions. The daily maximum benefit may be limited by the carrier to the usual and customary cost of the service. If the service costs more than the maximum daily benefit and there is no law to the contrary, the insured is responsible for the amount over and above the daily maximum amount.
3. Lifetime maximum benefit periods may not cover fewer than 730 days beyond the policy's elimination period.
4. Individual policies may include a lifetime maximum benefit amount in lieu of the lifetime maximum benefit period, provided that the lifetime maximum benefit amount may not be less than the product of 730 multiplied by the highest daily maximum benefit amount covered in the policy.
(b) Elimination Periods
1. Individual policies may not include elimination periods of greater than 365 days, whether services are received within or away from the home.
2. At a minimum, carriers shall count each day that the insured receives any service that would be applied against the lifetime maximum benefit amount or maximum benefit period toward the satisfaction of an individual policy's elimination period. Individual policies may not require that elimination periods be satisfied within a specified period of time or that days be consecutive.
(c) Minimum benefit: Individual policies may not include any policy benefits that are so limited in scope that they are not likely to be of any substantial economic benefit to the insured.

(d) Alternate Care Benefits: Individual policies must include a provision that enables the insured to use policy benefits after satisfying policy benefit triggers, elimination periods and deductibles to cover long-term care treatments or expenses not specifically identified in the policy's described benefits. The alternate care benefits must be made available to the insured subject to the agreement of the carrier, the insured and the insured's health care practitioner.

(9) Electronic Enrollment for Group Policies

(a) In the case of a group policy, any requirement that a signature of an insured be obtained by an producer or carrier shall be deemed satisfied if:

(b) The consent is obtained by telephonic or electronic enrollment by the group policyholder or carrier. A verification of enrollment information shall be provided to the enrollee;

(c) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and

(d) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information as defined under M.G.L. c. 175I and the Federal Health Insurance Protection and Portability Act is maintained.

(e) The carrier shall make available, upon request of the commissioner, records that will demonstrate the carrier's ability to confirm enrollment and coverage amounts.

(10) Group Coverage

No group long-term care insurance policy shall be offered to a resident of the commonwealth under a group policy issued in another state to a group described in clause (4) of the definition of group long-term care insurance in 211 CMR 65.04 unless the commonwealth or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in the commonwealth has made a determination that the requirements of clause (4) have been met.

(11) Delivery of policy certificate. If an application for a long-term care insurance policy or certificate is approved, the carrier shall deliver the policy or certificate of insurance to the applicant not later than 30 days after the date of approval.

65.06: Unintentional Lapse

(1) Each carrier offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

(a) Notice before lapse or termination: No individual long-term care policy or certificate shall be issued until the carrier has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's *full name* and *home address*. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice." The carrier shall notify the insured of the right to change this written designation, no less often than once every two (2) years.

(b) When the policyholder or certificateholder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in 211 CMR 65.06(1)(a) need not be met until sixty (60) days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

(c) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the carrier, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing.

(2) Reinstatement. In addition to the requirement in 211 CMR 65.06(1), a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the carrier is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five (5) months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

65.07: Required Disclosure Provisions

(1) The policy, riders and all amendments, as well as the application, outline of coverage and other required disclosure materials distributed to any potential applicant must be presented in no less than 12-point type and must satisfy the readability standards of M.G.L. c. 175, §2B.

(2) First Page of the Policy

(a) If the policy does not provide coverage for care in a nursing home, a notation of the fact shall be prominently attached to the first page of the policy in no less than 18-point type font or in some other manner that distinguishes it from the print otherwise appearing in the policy.

(b) The following statement: "Notice to buyer: This policy may not cover all the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

(c) Renewability. Individual long-term care insurance policies shall include a renewability provision that shall be appropriately captioned using highlighted text that is prominently displayed that clearly states that the coverage is guaranteed renewable or noncancellable and whether it is being issued on other than an individual basis (policies providing conversion privileges must specify the benefits to be provided or must state that the converted coverage shall be on the policy form then being issued by the carrier for this purpose).

(d) Subject to rate increase: For policies that are not noncancellable, a statement must be prominently displayed that indicates that the company may apply for future rate increases if the projected future claims are higher than projected when rates were originally filed for regulatory approval.

(e) Qualification for Federal Income Tax Exemptions and Certain Massachusetts MassHealth (Medicaid) Exemptions:

1. All individual, group and employment-based group policies that are intended to qualify for certain federal income tax exemptions must comply with standards set forth in the federal Internal Revenue Code and related regulations.
2. All individual, group and employment-based policies issued on or after March 15, 1999 that are intended to qualify for exemptions from certain Massachusetts MassHealth (Medicaid) provisions including the financial eligibility exemption in M.G.L. c 118E, §25 and the liability exemption in M.G.L. c. 118E, §33, must comply with the individual policy requirements of 211 CMR 65.05 and the minimum coverage requirements of 130 CMR 515.014. All such policies issued prior to March 15, 1999, need only comply with the minimum standards and the limitations and exclusions provisions that were effective from April 1, 1989 through September 2, 1999. The provisions of 211 CMR 65.07(1), (2), (3) and (4) shall apply regardless of whether the policy is issued within or outside Massachusetts.
3. There shall be on the face of the policy or certificate, or a sticker attached to the first page of the policy or certificate, a notice that includes the following in substantially the same language and format:

> **FEDERAL INCOME TAX EXEMPTIONS**: This policy (**IS**)(**IS NOT**) intended to be a federally-qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended.
>
> **STATE MASSHEALTH (MEDICAID) EXEMPTIONS**: This policy (**IS**)(**IS NOT**) intended to satisfy Massachusetts' minimum long-term care insurance coverage requirements as of the policy's effective date for certain asset and liability exemptions under the Massachusetts MassHealth (Medicaid) Program. Please note that there may be other MassHealth (Medicaid) requirements to qualify for these exemptions.
>
> Please read your Options for Financing Long-Term Care: A Massachusetts Guide for important information about the federal and state exemptions. PLEASE NOTE THAT FEDERAL AND STATE LAWS ARE SUBJECT TO CHANGE AND THAT FEDERAL AND STATE EXEMPTIONS MAY NOT APPLY TO THIS POLICY AT A FUTURE DATE.

(3) All terms used in the policy must be fully explained so that the insured understands their relationship to the benefits covered. No misleading policy names may be used.

(4) Riders and Endorsements. Except for riders or endorsements by which the carrier effectuates a request made in writing by the insured under individual or group long-term care insurance coverage, all riders or endorsements added to a long-term care insurance policy after the date of issue, reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the coverage term must be agreed to in writing as signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider or endorsement.

(5) Policy Features

(a) Payment of Benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of these terms and an explanation of the terms in its accompanying outline of coverage.

(b) Preexisting Condition Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations." Other than for a policy or certificate issued to an employment-based group, no long-term care insurance policy shall use a definition of preexisting condition that is more restrictive than the definition in 211 CMR 65.04 and a long-term care insurance policy shall not exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within 6 months after the effective date of coverage for an insured person. The provision should state that a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period expires.

(c) Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in M.G.L. Chapter 176U shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits.

(d) Benefit Triggers. Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this section. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

(6) Other Disclosures

(a) Disclosure of Tax Consequences of Life Insurance Products. With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the request for an acceleration of death benefit is submitted that explains that the receipt of these accelerated death benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This subsection shall not apply to qualified long-term care insurance contracts.

(b) Outline of Coverage. No long-term care insurance policy may be delivered or issued for delivery in Massachusetts unless it contains an outline of coverage substantially similar to the one set forth in 211 CMR 65.34 The outline of coverage must be a document separate from the policy. Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring. The carrier or its producer must deliver the outline of coverage with the policy and must make it available at any time at the potential insured's request.

(c) Consumer Guide. No long-term care insurance policy may be delivered or issued for delivery in Massachusetts unless the potential insured receives *Your Options for Financing Long-Term Care: A Massachusetts Guide,* including any inserts, as prescribed by the commissioner, regarding changes to state or federal laws, no later than the first face-to-face contract between the potential insured and the producer, or in cases of direct response sales, at the time that the application or enrollment form is sent to the potential insured.

(d) Other Than Requested. If the policy is issued on a basis other than that applied for, a disclosure statement properly describing the actual policy terms must accompany the policy when it is delivered and must contain a statement substantially similar to the following: "NOTICE: Read this disclosure carefully. The coverage you originally applied for has not been issued. This policy is therefore not identical to the coverage you requested, but it differs in the following respects: [list].

(e) Required Disclosure Regarding Suitability Standards: If the carrier uses a worksheet or other marketing material to examine a potential applicant's financial situation, or uses any other marketing material that purports to provide guidance as to whether the applicant is suitable for long-term care insurance and subsequently notifies the applicant that the carrier finds the applicant to be suitable for long-term care insurance, the carrier shall provide the following disclosure notice: "Although [the carrier] may have determined that you meet [its] internal standards of suitability, there are other considerations that might influence your decision about whether this product is appropriate for you. [The company] uses the following standards to determine suitability for its long-term care insurance policies: [list] "Please note that you should not rely on this statement alone in making this purchase. You may want to contact a financial advisor for additional information."

(f) Required Disclosure Regarding Changes to MassHealth (Medicaid) Eligibiltiy and Recovery Exemptions under 130 CMR 515.014: If the carrier issued a policy that meets the standards of 130 CMR 515.014 and said standards are subsequently changed, the carrier shall notify all insureds whose policies will no longer satisfy the MassHealth (Medicaid) standards and shall offer all such insureds on a guaranteed issue basis the opportunity to purchase the needed benefits to meet the MassHealth (Medicaid) policy criteria. The rates for any change in beneifts shall be based upon the rate characteristics for the insured at the time of policy issue.

(g) Medicare eligible persons. Carriers shall provide the *Guide to Health Insurance for People with Medicare* and disclosure noted for Medicare-eligible applicants as required by 211 CMR 42.09(4).

(h) Annual disclosure. Carriers are to notify covered persons at least annually – including when they may be receiving an annual bill - of the right to reduce the level of benefits covered under a plan, including any change to the inflation coverage in a plan that may be at levels beyond the current rate of medical inflation in the Commonwealth.

(7) Group Policies: A certificate issued under a group long-term care insurance policy that is delivered or issued for delivery in the commonwealth shall include: (i) a description of the principal benefits and coverage provided in the policy; (ii) a statement of the principal exclusions, reductions and limitations contained in the policy; (iii) a statement that the group master policy determines governing contractual provisions; and (iv) a statement that the policy is available for viewing in the offices of the policyholder and will be copied for the certificate holder upon request at no cost.

65.08: Required Disclosure of Rating Practices to Consumers

(1) This section shall apply as follows:
   (a) This section applies to any long-term care policy or certificate issued in the commonwealth on or after July 1, 2014.
   (b) Notwithstanding 211 CMR 65.08(1)(a), for certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in 211 CMR 65.04, which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following July 1, 2014.

(2) Other than policies for which no applicable premium rate or rate schedule increases can be made, carriers shall provide all of the information listed in this subsection to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, a carrier shall provide all of the information listed in this section to the applicant no later than at the time of delivery of the policy or certificate.
   (a) A statement that the policy may be subject to rate increases in the future;
   (b) An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision;
   (c) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;
   (d) A general explanation for applying premium rate or rate schedule adjustments that shall include:
      1. A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and
      2. The right to a revised premium rate or rate schedule if the premium rate or rate schedule is changed;
   (e) 1. Information regarding each premium rate increase on this policy form or similar policy forms over the past ten (10) years for the commonwealth or any other state that, at a minimum, identifies:
         a. The policy forms for which premium rates have been increased;
         b. The calendar years when the form was available for purchase; and
         c. The amount or percentage of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.
      2. The carrier may, in a fair manner, provide additional explanatory information related to the rate increases.
      3. A carrier shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated carriers or the long-term care policies acquired from other nonaffiliated carriers when those increases occurred prior to the acquisition.
      4. If an acquiring carrier files for a rate increase on a long-term care policy form acquired from nonaffiliated carriers or a block of policy forms acquired from nonaffiliated carriers on or before the later of the effective date of this section or the end of a twenty-four-month period following the acquisition of the block or policies, the acquiring carrier may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with 211 CMR 65.08(2)(e)1.
      5. If the acquiring carrier files for a subsequent rate increase, even within the twenty-four-month period, on the same policy form acquired from nonaffiliated carriers or block of policy forms acquired from nonaffiliated carriers referenced in 211 CMR 65.08(2)(e)4, the acquiring carrier shall make all disclosures required by 211 CMR 65.08(2)(e), including disclosure of the earlier rate increase referenced in 211 CMR 65.08B(2)(e)4.

(3) An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the carrier made the disclosure required under 211 CMR 65.08(2)(a) and (e). If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

(4) A carrier shall use the forms in Appendices B and F to comply with the requirements of 211 CMR 65.08(2) and (3).

(5) A carrier shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least forty-five (45) days prior to the implementation of the premium rate schedule increase by the carrier. The notice shall include the information required by 211 CMR 65.08(2) when the rate increase is implemented.

65.09: Initial Filing Requirements

(1) This section applies to any long-term care policy issued in the commonwealth on or after July 1, 2014.

(2) A carrier shall provide the information listed in this subsection to the commissioner 30 days prior to making a long-term care insurance form available for sale.
  (a) A copy of all policy forms, including policies, outlines of coverage, applications, replacement forms, and disclosure documents, including those required in 211 CMR 65.07 and 211 CMR 65.08; and
  (b) A rate filing and an actuarial certification consisting of at least the following:
    1. A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;
    2. A statement that the policy design and coverage provided have been reviewed and taken into consideration;
    3. A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;
    4. A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:
      a. Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;
      b. A statement that the assumptions used for reserves contain reasonable margins for adverse experience;
      c. A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and
      d. A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur;
        i. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;
        ii. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under 211 CMR 65.09(3) based on a standard age distribution; and
    5. a. A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the carrier except for reasonable differences attributable to benefits; or
      b. A comparison of the premium schedules for similar policy forms that are currently available from the carrier with an explanation of the differences.

(3) (a) The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, or relevant and credible data from other studies, or both.
  (b) In the event the commissioner asks for additional information under this provision, the period in 211 CMR 65.09(2) does not include the period during which the carrier is preparing the requested information.

65.10: Prohibition Against Post-Claims Underwriting

(1) All applications for long-term care insurance policies or certificates, except those that are guaranteed issue, shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(2) (a) If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.
(b) If the medications listed in the application were known by the carrier, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

(3) Except for policies or certificates which are guaranteed issue:
(a) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:
"Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy."
(b) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:
"Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]."
(c) Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the carrier shall obtain one of the following:
1. A report of a physical examination;
2. An assessment of functional capacity;
3. An attending physician's statement; or
4. Copies of medical records.

(4) A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

(5) Every carrier, or other entity selling or issuing long-term care insurance benefits, shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and shall annually furnish this information in the format prescribed in Appendix A.

65.11: Minimum Standards for Home Health and Community Care Benefits in Long-Term Care Insurance Policies

(1) A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits:
(a) By requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;
(b) By requiring that the insured or claimant first or simultaneously receives nursing or therapeutic services, or both, in a home, community or institutional setting before home health care services are covered;
(c) By limiting eligible services to services provided by registered nurses or licensed practical nurses;
(d) By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;
(e) By excluding coverage for personal care services provided by a home health aide;
(f) By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;
(g) By requiring that the insured or claimant have an acute condition before home health care services are covered;
(h) By limiting benefits to services provided by Medicare-certified agencies or providers; or
(i) By excluding coverage for adult day care services.

(2) A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

65.12: Requirement to Offer Inflation Protection

(1) No carrier may offer a long-term care insurance policy unless the carrier also offers to the policyholder in addition to any other inflation protection the option to purchase a policy or rider to a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Carriers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:
  (a) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%);
  (b) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or
  (c) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(2) Where the policy is issued to a group, other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

(3) The offer in 211 CMR 65.12(1) above shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

(4) Carriers shall include the following information in or with the outline of coverage:
  (a) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period.
  (b) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(5) Inflation protection benefit increases under a policy which contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

(6) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the carrier expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(7) (a) Inflation protection as provided in 211 CMR 65.12(1)(a) of this section shall be included in a long-term care insurance policy unless a carrier obtains a rejection of inflation protection signed by the policyholder as required in this subsection. The rejection may be either in the application or on a separate form.
  (b) The rejection shall be considered a part of the application and shall state:
  "I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans ______, and I reject inflation protection."

65.13: Requirement to Offer Home Health Care Benefit

(1) A carrier shall make available, at the time of application, at least one policy covering home health care that is consistent with 211 CMR 65.11. A carrier may satisfy this requirement through the offer of an affiliated or non-affiliated carrier's product(s) as long as the arrangement is subject to a written contract filed with and approved by the commissioner.

(2) Where the policy is issued to a group, the required offer of a home health care benefit shall be made to the group policyholder; except, if the policy is issued to a group defined in 211 CMR 65.04 other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

65.14: Requirement to Offer Long-Term Care Benefits Qualifying the Insured for Exemptions from Certain Massachusetts MassHealth (Medicaid) Provisions

(1) A carrier shall make available, at the time of application, at least one policy that satisfies the requirements of 130 CMR 515.014. A carrier may satisfy this requirement through the offer of an affiliated or non-affiliated carrier's products, as long as the arrangement is subject to a written contract filed with and approved by the commissioner.

(2) The offer in 211 CMR 65.14(1) above shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

65.15: Requirements for Application Forms and Replacement Coverage

(1) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer, except where the coverage is sold without an producer, containing the questions may be used. With regard to a replacement policy issued to a group defined by 211 CMR 65.04, the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement.
   (a) Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?
   (b) Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months?
      1. If so, with which company?
      2. If that policy lapsed, when did it lapse?
   (c) Are you covered by MassHealth?
   (d) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

(2) Producers shall list any other health insurance policies they have sold to the applicant.
   (a) List policies sold that are still in force.
   (b) List policies sold in the past five (5) years that are no longer in force.

(3) Solicitations Other than Direct Response. Upon determining that a sale will involve replacement, a carrier; other than a carrier using direct response solicitation methods, or its producer; shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the carrier. The required notice shall be provided in the manner set forth in Appendix I.

(4) Direct Response Solicitations. Carriers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the manner set forth in Appendix J.

(5) Where replacement is intended, the replacing carrier shall notify, in writing, the existing carrier of the proposed replacement. The existing policy shall be identified by the carrier, name of the insured and policy number or address including zip code. Notice shall be made within five (5) working days from the date the application is received by the replacing carrier or the date the policy is issued, whichever is sooner.

(6) Life Insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the carrier shall comply with the replacement requirements of 211 CMR 34.00 If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing carrier shall comply with both the long-term care and the life insurance replacement requirements.

65.16 Reporting Requirements

(1) Carriers shall submit to the Commissioner annual reports by no later than June 30 of each year of the following experience for the past year.
  (a) Lapse Reporting
    1. Every carrier shall maintain records for each producer of that producer’s amount of replacement sales as a percent of the producer’s total annual sales and the amount of lapses of long-term care insurance policies sold by the producer as a percent of the producer’s total annual sales.
    2. Every carrier shall report annually the ten percent (10%) of its producers with the greatest percentages of lapses and replacements as measured by 211 CMR 65.16(1)(a)1 above. (Appendix G)
    3. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely producer activities regarding the sale of long-term care insurance.
    4. Every carrier shall report annually the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year. (Appendix G)
    5. Every carrier shall report annually the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year. (Appendix G)
  (b) Claims Denials
    1. Every carrier shall report annually by June 30, for long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. (Appendix E)
    2. For purposes of this section:
      a. “Policy” means only long-term care insurance;
      b. Subject to 211 CMR 65.16(1)(b)2c, “claim” means a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;
      c. “Denied” means the carrier refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and
      d. “Report” means on a statewide basis.
  (c) Experience Reporting
    1. General information reported in a format approved by the commissioner
    2. Individual long-term care insurance policies:
      a. As of the end of the prior year, a count of the number of persons covered listed by policy form, as well as a count of the number of persons covered under the policies according to 5-year age cohorts.
      b. Number of persons with newly issued policies during the prior calendar year
      c. Number of persons renewing during the prior calendar year
      d. Number of persons whose policies lapsed in the prior calendar year
      e. Premiums earned in the prior calendar year

f. Claims payments made in the prior calendar year
g. Actual loss ratio for the prior calendar year
h. Projected loss ratio for persons covered at the end of the prior calendar year.

3. Group long-term care insurance policies:
   a. As of the end of the prior year, a count of the number of groups and the persons with certificates under the group policies, as well as a count of the number of persons covered under the policies according to 5-year age cohorts.
   b. Number of persons with newly issued policies during the prior calendar year
   c. Number of persons renewing during the prior calendar year
   d. Number of persons whose policies lapsed in the prior calendar year
   e. Premiums earned in the prior calendar year
   f. Claims payments made in the prior calendar year
   g. Actual loss ratio for the prior calendar year
   h. Projected loss ratio for persons covered at the end of the prior calendar year
4. An actuarial certification consisting of at least the following:
   a. A statement that the premium rate schedule on file is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;
   b. A statement that the policy design and coverage provided have been reviewed and taken into consideration;
   c. A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;
   d. A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:
      i. Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;
      ii. A statement that the assumptions used for reserves contain reasonable margins for adverse experience;
      iii. A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and
      iv. A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur;
         I. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship; and
         II. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request an explanation under 211 CMR 65.09(3) based on a standard age distribution.
   e. i. A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the carrier except for reasonable differences attributable to benefits; or
      ii. A comparison of the premium schedules for similar policy forms that are currently available from the carrier with an explanation of the differences.
   f. An explanation of any concerns with the actuarial assumptions that were used in the original pricing of the product.

65.17: Producer Licensing and the Marketing of Long-Term Care Products

(1) (a) A producer shall not sell, solicit or negotiate long-term care insurance in the commonwealth unless the producer is licensed as an insurance producer for accident and sickness or life and has completed a one-time training course. The one-time training required shall not be less than 8 hours.
(b) In addition to the one-time training course required in 211 CMR 65.17(1)(a), a producer who sells, solicits or negotiates long-term care insurance shall complete ongoing training of not less than 4 hours every 24 months.

(2) (a) The training hours under this section shall be included as part of the required continuing education hours as set forth in M.G.L. c. 175 §177E(B).

(b) The training shall consist of topics related to long-term care insurance, long-term care services and the commonwealth's minimum long-term care coverage requirements for certain asset and liability exemptions under the MassHealth program, including:

1. state and federal regulations and requirements and the relationship between asset and liability exemptions under the MassHealth program and other public and private coverage of long-term care services, including MassHealth;
2. available long-term care services and providers;
3. changes or improvements in long-term care services or providers;
4. alternatives to the purchase of private long-term care insurance;
5. the effect of inflation on benefits and the importance of inflation protection;
6. consumer suitability standards and guidelines; and
7. marketing standards established under 211 CMR 40.00, especially associated with prohibitions on twisting, high-pressure tactics and cold-lead advertising.

(c) The required training shall not include training that is carrier or company product specific or that includes any sales or marketing information, materials or training other than those required by state or federal law.

(3) (a) Carriers shall obtain verification that a producer receives training required by this section before the producer shall be authorized to sell, solicit or negotiate the carrier's long-term care insurance products and shall maintain records subject to the laws relative to record retention requirements and make that verification available to the commissioner upon request.

(c) Carriers shall maintain records with respect to the training of its producers concerning the distribution of its policies intended to satisfy the commonwealth's minimum long-term care coverage requirements for certain asset and liability exemptions under the MassHealth program and file with the commissioner lists identifying those producers who have completed the training necessary to distribute its policies. This will allow the division of insurance to provide assurance to the department of medical assistance that producers have received the training required by this section and that producers have demonstrated an understanding of the policies and their relationship to public and private coverage of long-term care, including MassHealth, in the commonwealth. The records shall be maintained and shall be made available to the commissioner upon request.

(4) (a) The satisfaction of comparable training requirements in any state shall be deemed to satisfy the training requirements under this section, provided the training includes Massachusetts specific information. Non-resident producers who have satisfied comparable training requirements in another state must complete training on Massachusetts-specific information.

(b) All producers marketing a carrier's long-term care insurance shall clearly identify which plans being offered are individual products and which are group products. When marketing group products, the producer shall clearly identify the name of the group policyholder and any conditions that the eligible person must satisfy to join and remain a member of the group.

(c) All producers marketing a carrier's long-term care insurance shall disclose to potential applicants the name of the carrier that the producer represents in the sale. The carrier's name must be disclosed on any and all printed sales or appropriate materials provided, distributed or shown to potential applicants and/or during presentations made to potential applicants in association with a sale, whether part of a presentation or not.

(d) All producers marketing a carrier's long-term care insurance must disclose the fact that the producer receives compensation in connection with the sale or replacement of all long-term care insurance.

(e) All producers marketing a carrier's long-term care insurance shall not misrepresent their expertise, qualifications or training to potential clients and shall not comment on the legal or tax implications of purchasing long-term care insurance to the extent that they lack the training, qualification or license to provide such advice.

(f) A carrier whose producer fails to comply with any provisions of 211 CMR 65.00, including, but not limited to 211 CMR 65.17, will be deemed to have committed an unfair and deceptive act in the business of insurance subject to M.G.L. c. 176D.

65.18: Discretionary Powers of Commissioner

(1) The commissioner may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this regulation with respect to a specific long-term care insurance policy or certificate upon a written finding that:
   (a) The modification or suspension would be in the best interest of the insureds;
   (b) The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and
   (c) 1. The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or
      2. The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or
      3. The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

65.19. Reserve Standards

(1) When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with 211 CMR 29.00. Claim reserves shall also be established in the case when the policy or rider is in claim status.

(2) Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

(3) In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:
   (a) Definition of insured events;
   (b) Covered long-term care facilities;
   (c) Existence of home convalescence care coverage;
   (d) Definition of facilities;
   (e) Existence or absence of barriers to eligibility;
   (f) Premium waiver provision;
   (g) Renewability;
   (h) Ability to raise premiums;
   (i) Marketing method;
   (j) Underwriting procedures;
   (k) Claims adjustment procedures;
   (l) Waiting period;
   (m) Maximum benefit;
   (n) Availability of eligible facilities;
   (o) Margins in claim costs;
   (p) Optional nature of benefit;
   (q) Delay in eligibility for benefit;
   (r) Inflation protection provisions; and
   (s) Guaranteed insurability option.

(4) Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

65.20:. Loss Ratio

(1) This section shall apply to all long-term care insurance policies or certificates except those subject to 211 CMR 65.09 and 211 CMR 65.21.

(2) Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:
(a) Statistical credibility of incurred claims experience and earned premiums;
(b) The period for which rates are computed to provide coverage;
(c) Experienced and projected trends;
(d) Concentration of experience within early policy duration;
(e) Expected claim fluctuation;
(f) Experience refunds, adjustments or dividends;
(g) Renewability features;
(h) All appropriate expense factors;
(i) Interest;
(j) Experimental nature of the coverage;
(k) Policy reserves;
(l) Mix of business by risk classification; and
(m) Product features such as long elimination periods, high deductibles and high maximum limits.

(3) 211 CMR 65.20(2) shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:
(a) The interest credited internally to determine cash value accumulations, including long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
(b) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of M.G.L. 175, §144;
(c) At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy that provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the carrier shall deliver the policy summary upon the applicant's request; the carrier shall make delivery of the policy summary no later than at the time of delivery of the policy. In addition to complying with all applicable requirements, the summary shall include:
1. an explanation of how the long-term care benefit interacts with other components of the policy, including deductions from policy benefits;
2. an illustration of the amount of benefits, the length of benefits and the guaranteed lifetime benefits, if any, for each covered person;
3. any exclusions, reductions and limitations on benefits of long-term care insurance, including elimination or probationary periods and any preexisting condition limitations;
4. a statement indicating whether a long-term care inflation protection option required by law is available under the policy; and
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 related to long-term care costs or insurance charges.
c. Current and projected maximum lifetime benefit.

This policy summary may be incorporated into a basic illustration or into the life insurance policy summary which is required to be delivered to insureds.
(d) The policy meets the disclosure requirements of M.G.L. c.176U, sections 3(h), 3(i) and 3(j);
(e) There is a policy illustration that meets the applicable requirements of 211 CMR 28.00;
(f) 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: (i) any long-term care benefits paid out during the month; (ii) an explanation of any changes in the policy, including death benefits or cash values, due to the long-term care benefits being paid out; and (iii) the amount of long-term care benefits existing or remaining.

(g) An actuarial memorandum is filed with the insurance department that includes:

1. A description of the basis on which the long-term care rates were determined;
2. A description of the basis for the reserves;
3. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
4. A description and a table of each actuarial assumption used. For expenses, a carrier must include percent of premium dollars per policy and dollars per unit of benefits, if any;
5. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
6. The estimated average annual premium per policy and the average issue age;
7. A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
8. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

65.21: Premium Rate Schedule Increases

(1) This section shall apply as follows:

(a) Except as provided in Paragraph (2), this section applies to any rate increases impacting long-term care policies issued in the commonwealth that are filed with the Division on or after July 1, 2014.

(b) For certificates issued under a group long-term care insurance policy as defined in 211 CMR 65.04, which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply to rate increases impacting the policy on the policy anniversary following July 1, 2014.

(2) A carrier shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least [30] days prior to the notice to the policyholders and shall include:

(a) Information required by 211 CMR 65.08;

(b) Certification by a qualified actuary that:

1. If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;
2. The premium rate filing is in compliance with the provisions of this section;

(c) An actuarial memorandum justifying the rate schedule change request that includes:

1. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale, including the following;
   a. Annual values for the five (5) years preceding and the three (3) years following the valuation date shall be provided separately;
   b. An analysis of actual long-term care insurance claims experience for the past (5) years as compared to what was estimated in the most recent rate filing for the plan.
   c. The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;
   d. The projections shall demonstrate compliance with 211 CMR 65.21(3); and
   e. For exceptional increases,
      i. The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and
      ii. In the event the commissioner determines that offsets may exist, the carrier shall use appropriate net projected experience;

iii. Except as provided in 211 CMR 65.21, exceptional increases are subject to the same requirements as other premium rate schedule increases. *Exceptional increase* means only those increases filed by a carrier as exceptional for which the commissioner determines the need for the premium rate increase is justified:

I. Due to changes in laws or regulations applicable to long-term care coverage in the commonwealth; or

II. Due to increased and unexpected utilization that affects the majority of carriers of similar products.

iv. The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.

2. Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;
3. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;
4. A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and
5. In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the carrier will need to file composite rates reflecting projections of new certificates;

(d) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

(e) Sufficient information for review and approval of the premium rate schedule increase by the commissioner.

(f) The letter the carrier proposes to use to notify affected policyholders and certificateholders. The letter will make policyholders and certificateholder fully aware of the average increase in dollars per month or year, the basis for the rate increase, the carriers current estimate of future rate increase need based on moderately adverse experience, all available options to reduce plan benefits to lower plan premiums and the role of the Division of Insurance in reviewing long-term care insurance rates.

(3) All premium rate schedule increases shall be determined in accordance with the following requirements:

(a) Premium rate schedule increase are not to base any requested need on investment losses or a need to recoup past claims losses, as such items will not be considered reasonable and will be disapproved.

(b) Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(c) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

1. The accumulated value of the initial earned premium times fifty-eight percent (58%);
2. Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;
3. The present value of future projected earned premiums times fifty-eight percent (58%); and
4. Eighty-five percent (85%) of the present value of future projected premiums not in 211 CMR 65.21(3)(c)3 on an earned basis;

(d) In the event that a policy form has both exceptional and other increases, the values in 211 CMR 65.21(3)(c)2 and 4 will also include seventy percent (70%) for exceptional rate increase amounts; and

(e) All present and accumulated values used to determine rate increases shall use a valuation interest rate for contract reserves as disclosed in the actuarial memorandum. In addition, as part of the actuarial memorandum, the actuary shall disclose the use of any appropriate averages.

(4) Approved rate increases are valid for a 12-month period. If a carrier does not implement the rate change within 12 months, the approval will no longer be in effect and the carrier will be required to make a new filing before proceeding with any rate changes.

(5) For each rate increase that is implemented, the carrier shall file for review and approval by the commissioner updated projections, as defined in 211 CMR 65.21(2)(c)1, annually for the next three (3) years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in 211 CMR 65.21(12), the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

(6) Carriers shall only implement a single rate change at any one time. Carriers may not apply any rate increase to any policyholder or certificate holder for at least 12 months since the last applied rate increase.

(7) When a carrier is filing to increase the rates for "closed blocks of coverage", the carrier shall file the rates of all similar coverage that is being offered by the carrier or an affiliated carrier and demonstrate that the rates resulting from the rate increase will not be higher than the rates offered to similar newly enrolled individuals; any increase that will raise the rates for "closed blocks of coverage" beyond the rates charged to similar newly enrolled persons with similar coverage will not be considered reasonable and will be disapproved.

(8) If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in 211 CMR 65.21(2)(c)1, shall be filed for review by the commissioner every five (5) years following the end of the required period in 211 CMR 65.21(4). For group insurance policies that meet the conditions in 211 CMR 65.21(12), the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

(9) (a) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in 211 CMR 65.21(3), the commissioner may require the carrier to implement any of the following:
1. Premium rate schedule adjustments; or
2. Other measures to reduce the difference between the projected and actual experience.

(b) In determining whether the actual experience adequately matches the projected experience, consideration should be given to 211 CMR 65.21(2)(c)5, if applicable.

(10) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the carrier shall file:

(a) A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in 211 CMR 65.21(9) of this section; and

(b) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to 211 CMR 65.21(3) had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculations described in 211 CMR 65.21(3)(c)1 and 3.

(11) (a) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapsation has occurred or is anticipated:
1. The rate increase is not the first rate increase requested for the specific policy form or forms;
2. The rate increase is not an exceptional increase; and
3. The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(b) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the carrier following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the carrier to offer, without underwriting, to all in force insureds subject to the rate increase, the option to replace existing coverage with one or more reasonably comparable products being offered by the carrier or its affiliates.

1. The offer shall:
   a. Be subject to the approval of the commissioner;
   b. Be based on actuarially sound principles, but not be based on attained age; and
   c. Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.
2. The carrier shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:
   a. The maximum rate increase determined based on the combined experience; and
   b. The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%).

(12) If the commissioner determines that the carrier has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of 211 CMR 65.21(9), prohibit the carrier from either of the following:
(a) Filing and marketing comparable coverage for a period of up to five (5) years; or
(b) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

(13) 211 CMR 65.21(1) through (10) shall not apply to policies for which the long-term care benefits provided by the policy are incidental, if the policy complies with all of the following provisions:
(a) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
(b) The portion of the policy that provides insurance benefits other than long-term care coverage meets all regulatory nonforfeiture requirements, including but not limited to those in:
   1. M.G.L. 175, §144; and
   2. M.G.L. 175, §144A1/2;
(c) The policy meets the disclosure requirements of M.G.L. c.176U, sections 3(h), 3(i) and 3(j);
(d) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:
   1. Policy illustrations as required by 211 CMR 28.00;
   2. Disclosure requirements in 211 CMR 55.00; and
   3. Other appropriate disclosures for annuity products as designated by the commissioner.
(e) An actuarial memorandum is filed with the insurance department that includes:
   1. A description of the basis on which the long-term care rates were determined;
   2. A description of the basis for the reserves;
   3. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
   4. A description and a table of each actuarial assumption used. For expenses, a carrier must include percent of premium dollars per policy and dollars per unit of benefits, if any;
   5. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
   6. The estimated average annual premium per policy and the average issue age;
   7. A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
   8. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

(14) Subsections 211 CMR 65.21(7) and (9) shall not apply to group insurance policies as defined in 211 CMR 65.04 where:

(a) The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or
(b) The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed.

65.22: Filing Requirement

Prior to a carrier or similar organization offering group long-term care insurance to a resident of the commonwealth pursuant to M.G.L. c.176U, §2, it shall file with the commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in the commonwealth.

65.23: Filing Requirements for Advertising

(1) Every carrier, health care service plan or other entity providing long-term care insurance or benefits in the commonwealth shall provide a copy of any print long-term care insurance advertisement intended for use in the commonwealth to the Commissioner of Insurance review and approval. In addition all advertisements; print, radio, television and electronic shall be retained by the carrier, health care service plan or other entity for at least three (3) years from the date the advertisement was first used.

(2) The commissioner may exempt from these requirements any advertising form or material when, in the commissioner's opinion, this requirement may not be reasonably applied.

65.24: Standards for Marketing

(1) Every carrier, health care service plan or other entity marketing long-term care insurance coverage in the commonwealth, directly or through its producers, shall:
(a) Establish marketing procedures and producer training requirements to assure that:
1. Any marketing activities, including any comparison of policies, by its producers or other producers will be fair and accurate; and
2. Excessive insurance is not sold or issued.
(b) Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following:
"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."
(c) Provide copies of the disclosure forms set forth in Appendices B and F to the applicant.
(d) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required.
(e) Establish auditable procedures for verifying compliance with 211 CMR 65.24(1).
(f) At solicitation, provide written notice to the prospective policyholder and certificateholder that a senior counseling program is available and the name, address and telephone number of the program.
(g) For long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to 211 CMR 65.05(1)(a).
(h) Provide an explanation of contingent benefit upon lapse provided for in 211 CMR 65.29(4)(c) and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods as described in 211 CMR 65.29(4)(d).
(i) Establish auditable internal marketing procedures, methods for assuring compliance by producers, and prohibitions against twisting, high-pressure tactics and cold-lead advertising.

(2) In addition to the practices prohibited in M.G.L. c. 176D, the following acts and practices are prohibited:
(a) Twisting;

(b) High pressure tactics;
(c) Cold lead advertising; and
(d) Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

(3) (a) With respect to the obligations set forth in 211 CMR 65.24(3), the primary responsibility of the group sponsoring or endorsing a group insurance policy shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Groups, other than employment-based groups, shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such groups to ensure that members of such groups receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.
(b) The carrier shall file with the insurance department the following material:
1. The policy and certificate,
2. A corresponding outline of coverage, and
3. All advertisements requested by the insurance department.
(c) The group, other than an employment-based group, shall disclose in any long-term care insurance solicitation:
1. The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and
2. A brief description of the process under which the policies and the carrier issuing the policies were selected.
(d) If the group and the carrier have interlocking directorates or trustee arrangements, the group shall disclose that fact to its members.
(e) The board of directors of groups, other than employment-based groups, selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the carrier.
(f) The group, other than an employment-based group, shall also:
1. At the time of the group's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the carrier to conduct an examination of the policies, including their benefits, features, and rates and update the examination thereafter in the event of material change;
2. Actively monitor the marketing efforts of the carrier and its producers; and
3. Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.
4. 211 CMR 65.24(3)(f)1 through 3 shall not apply to qualified long-term care insurance contracts.
(g) No group long-term care insurance policy or certificate may be issued to a group other than an employment-based group unless the carrier files with the commissioner the information required in 211 CMR 65.24(3).
(h) The carrier shall not issue a long-term care policy or certificate to an group, other than an employment-based group, or continue to market such a policy or certificate unless the carrier certifies annually that the group has complied with the requirements set forth in this subsection.
(i) Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of M.G.L. c.176D.

65.25: Suitability

(1) This section shall not apply to life insurance policies that accelerate benefits for long-term care.

(2) Every carrier or other entity marketing long-term care insurance (the "carrier") shall:
(a) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;
(b) Train its producers in the use of its suitability standards; and
(c) Maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.

(3) (a) To determine whether the applicant meets the standards developed by the carrier, the producer and carrier shall develop procedures that take the following into consideration:
1. The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
2. The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and
3. The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

(b) The carrier, and where a producer is involved, the producer shall make reasonable efforts to obtain the information set out in 211 CMR 65.25(3)(a). The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the carrier shall contain, at a minimum, the information in the format contained in Appendix B, in not less than twelve (12) point type. The carrier may request the applicant to provide additional information to comply with its suitability standards. A copy of the carrier's personal worksheet shall be filed with the commissioner.

(c) A completed personal worksheet shall be returned to the carrier prior to the carrier's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

(d) The sale or dissemination outside the company or agency by the carrier or producer of information obtained through the personal worksheet in Appendix B is prohibited.

(4) The carrier shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

(5) Producers shall use the suitability standards developed by the carrier in marketing long-term care insurance.

(6) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix C, in not less than twelve (12) point type.

(7) If the carrier determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the carrier may reject the application. In the alternative, the carrier shall send the applicant a letter similar to Appendix D. However, if the applicant has declined to provide financial information, the carrier may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

(8) The carrier shall report annually to the commissioner the total number of applications received from residents of the commonwealth, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

65.26: Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates

If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing carrier shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

65.27: Availability of New Services or Providers

(1) A carrier shall notify policyholders of the availability of a new long-term policy series that provides coverage for new long-term care services or providers material in nature and not previously available through the carrier to the general public. The notice shall be provided within twelve (12) months of the date that the new policy series is made available for sale in the commonwealth.

(2) Notwithstanding 211 CMR 65.27(1), notification is not required for any policy issued prior to the effective date of 211 CMR 65.00 or to any policyholder or certificateholder who is currently eligible for benefits, within an elimination period or on a claim, or who previously had been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The carrier may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

(3) The carrier shall make the new coverage available in one of the following ways:
  (a) By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age;
  (b) By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits shall be based on premiums paid or reserves held for the prior policy or certificate;
  (c) By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or
  (d) By an alternative program developed by the carrier that meets the intent of 211 CMR 65.27(3) if the program is filed with and approved by the commissioner.

(4) A carrier is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of 211 CMR 65.27(4), "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders that purchased such a new proprietary policy shall be notified when a new long-term care policy series that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel.

(5) Policies issued pursuant to 211 CMR 65.27 shall be considered exchanges and not replacements. These exchanges shall not be subject to 211 CMR 65.15, 211 CMR 65.25 and the reporting requirements of 211 CMR 65.16(1)(a).

(6) Where the policy is offered through an employer, labor organization, professional, trade or occupational association, the required notification in 211 CMR 65.27(1) shall be made to the offering entity. However, if the policy is issued to a group defined 211 CMR 65.04, the notification shall be made to each certificateholder.

(7) Nothing in 211 CMR 65.27 shall prohibit a carrier from offering any policy, rider, certificate or coverage change to any policyholder or certificateholder. However, upon request, any policyholder may apply for currently available coverage that includes the new services or providers. The carrier may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

(8) 211 CMR 65.27 does not apply to life insurance policies or riders containing accelerated long-term care benefits.

65.28: Right to Reduce Coverage and Lower Premiums

(1) (a) Every long-term care insurance policy and certificate issued or renewed on and after July 1, 2014 shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:
    1. Reducing the maximum benefit; or
    2. Reducing the daily, weekly or monthly benefit amount.
  (b) The carrier may also offer other reduction options that are consistent with the policy or certificate design or the carrier's administrative processes.

(2) The provision shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

(3) The age to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force.

(4) The carrier may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.

(5) If a policy or certificate is about to lapse, the carrier shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by 211 CMR 65.06(1)(c).

(6) 211 CMR 65.28 does not apply to life insurance policies or riders containing accelerated long-term care benefits.

65.29: Nonforfeiture Benefit Requirement

(1) This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(2) Except for group policies, a long-term care insurance policy shall not be delivered or issued for delivery in the commonwealth unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate that includes a nonforfeiture benefit which may be in the form of a rider that is attached to the policy. For group policies, the nonforfeiture option for employment-based policies shall be made to the group policyholder and the nonforfeiture options for all other groups, other than to a continuing care retirement community or similar entity, shall be made to each proposed certificate holder.

(a) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in 211 CMR 65.29(5); and

(b) The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.

(3) If the offer is rejected, the carrier shall provide the contingent benefit upon lapse described in 211 CMR 65.29. Even if the offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in 211 CMR 65.29(4)(d) shall still apply.

(4) (a) After rejection of the offer required under 211 CMR 65.29 for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the carrier shall provide a contingent benefit upon lapse.

(b) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(c) A contingent benefit on lapse shall be triggered every time a carrier increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium as set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%

40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

(d) A contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period every time a carrier increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, when the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio in 211 CMR 65.29(4)(f)2 is forty percent (40%) or more. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

This provision shall be in addition to the contingent benefit provided by 211 CMR 65.29(4)(c) above and where both are triggered, the benefit provided shall be at the option of the insured.

(e) On or before the effective date of a substantial premium increase as defined in 211 CMR 65.29(4)(c), the carrier shall:
   1. Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;
   2. Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of 211 CMR 65.29(5). This option may be elected at any time during the 120-day period referenced in 211 CMR 65.29(4)(c); and
   3. Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in 211 CMR 65.29(4)(c) shall be deemed to be the election of the offer to convert in 211 CMR 65.29(4)(e)2 unless the automatic option in 211 CMR 65.29(4)(f)3 applies.

(f) On or before the effective date of a substantial premium increase as defined in 211 CMR 65.29(4)(d) above, the carrier shall:
   1. Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;
   2. Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent (90%) of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in 211 CMR 65.29(4)(d); and
   3. Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in 211 CMR 65.29(4)(d) shall be deemed to be the election of the offer to convert in 211 CMR 65.29D(4)(f)2 above if the ratio is forty percent (40%) or more.

(5) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with 211 CMR 65.29(4)(c) but not 211 CMR 65.29(4)(d), are described in this subsection:

(a) For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases with age at least one percent per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (50).

(b) For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in 211 CMR 65.29(5)(c).

(c) The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The carrier may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of 211 CMR 65.29(6).

(d) 1. The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three (3) years as well as thereafter.
   2. Notwithstanding Subparagraph (a), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:
      a. The end of the tenth year following the policy or certificate issue date; or
      b. The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(e) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(6) All benefits paid by the carrier while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.

(7) There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

(8) The requirements set forth in 211 CMR 65.29 shall become effective twelve (12) months after adoption of this provision and shall apply as follows:
   (a) Except as provided in 211 CMR 65.29(8)(b) and (c), the provisions of this section apply to any long-term care policy issued in the commonwealth on or after the effective date of this amended regulation.
   (b) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in 211 CMR 65.04, which policy was in force at the time this amended regulation became effective, the provisions of this section shall not apply.
   (c) The last sentence in 211 CMR 65.29(3) and 211 CMR 65.29(4)(d) and (4)(f) shall apply to any long-term care insurance policy or certificate issued in the commonwealth after six (6) months after their adoption, except new certificates on a group policy as defined in 211 CMR 65.04 one year after adoption.

(9) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of 211 CMR 65.20 or 211 CMR 65.21, whichever is applicable, treating the policy as a whole.

(10) To determine whether contingent nonforfeiture upon lapse provisions are triggered under 211 CMR 65.29(4)(c) or (4)(d), a replacing carrier that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another carrier shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original carrier.

(11) A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:
   (a) The nonforfeiture provision shall be appropriately captioned;
   (b) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying contracts approved by the commissioner for the same contract form; and
   (c) The nonforfeiture provision shall provide at least one of the following:
      1. Reduced paid-up insurance;
      2. Extended term insurance;
   (d) Shortened benefit period; or
   (e) Other similar offerings approved by the commissioner.

65.30: Standards for Benefit Triggers

(1) A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment.

(2) (a) Activities of daily living shall include at least the following as defined in 211 CMR 65.04 and in the policy:
      1. Bathing;
      2. Continence;
      3. Dressing;
      4. Eating;
      5. Toileting; and
      6. Transferring.
   (b) Carriers may use activities of daily living to trigger covered benefits in addition to those contained in 211 CMR 65.30(2)(a) as long as they are defined in the policy.

(3) A carrier may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in 211 CMR 65.30(1) and (2).

(4) For purposes of this section the determination of a deficiency shall not be more restrictive than:
   (a) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or
   (b) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

(5) Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

(6) Long term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

(7) The requirements set forth in this section shall be effective July 1, 2014 and shall apply as follows:
   (a) Except as provided in 211 CMR 65.30(7)(b), the provisions of this section apply to a long-term care policy issued in the commonwealth on or after the effective date of the amended regulation.
   (b) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in 211 CMR 65.04 that was in force at the time this amended regulation became effective, the provisions of this section shall not apply.

65.31: Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts

(1) For purposes of this section the following definitions apply:
   (a) "Qualified long-term care services" means services that meet the requirements of Section 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.
   (b) 1. "Chronically ill individual" has the meaning prescribed for this term by section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:
      a. Being unable to perform (without substantial assistance from another individual) at least two (2) activities of daily living for a period of at least ninety (90) days due to a loss of functional capacity; or
      b. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.
   2. The term "chronically ill individual" shall not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner has certified that the individual meets these requirements.
   (c) "Licensed health care practitioner" means a physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the Secretary of the Treasury.
   (d) "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

(2) A qualified long term care insurance contract shall pay only for qualified long term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(3) A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity or to severe cognitive impairment.

(4) Certifications regarding activities of daily living and cognitive impairment required pursuant to 211 CMR 65.31(3) shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury.

(5) Certifications required pursuant to 211 CMR 65.31(3) may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety-day period.

(6) Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

65.32: Appealing A Carrier's Determination That The Benefit Trigger Is Not Met

(1) For purposes of this section, "authorized representative" is authorized to act as the covered person's personal representative within the meaning of 45 CFR 164.502(g) promulgated by the Secretary under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act and means the following:
   (a) A person to whom a covered person has given express written consent to represent the covered person in an external review;
   (b) A person authorized by law to provide substituted consent for a covered person; or
   (c) A family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent.

(2) If a carrier determines that the benefit trigger of a long-term care insurance policy has not been met, it shall provide a clear, written notice to the insured and the insured's authorized representative, if applicable, of all of the following:
   (a) The reason that the carrier determined that the insured's benefit trigger has not been met;
   (b) The insured's right to internal appeal in accordance with 211 CMR 65.32(3), and the right to submit new or additional information relating to the benefit trigger denial with the appeal request; and
   (c) The insured's right, after exhaustion of the carrier's internal appeal process, to have the benefit trigger determination reviewed under the independent review process in accordance with 211 CMR 65.32(4).

(3) Internal Appeal. The insured or the insured's authorized representative may appeal the carrier's adverse benefit trigger determination by sending a written request to the carrier, along with any additional supporting information, within 120 calendar days after the insured and the insured's authorized representative, if applicable, receives the carrier's benefit determination notice. The internal appeal shall be considered by an individual or group of individuals designated by the carrier, provided that the individual or individuals making the internal appeal decision may not be the same individual or individuals who made the initial benefit determination. The internal appeal shall be completed and written notice of the internal appeal decision shall be sent to the insured and the insured's authorized representative, if applicable, within thirty (30) calendar days of the carrier's receipt of all necessary information upon which a final determination can be made.

   (a) If the carrier's original determination is upheld upon internal appeal, the notice of the internal appeal decision shall describe any additional internal appeal rights offered by the carrier. Nothing herein shall require the carrier to offer any internal appeal rights other than those described in this subsection.
   (b) If the carrier's original determination is upheld after the internal appeal process has been exhausted, and new or additional information has not been provided to the carrier, the carrier shall provide a written description of the insured's right to request an independent review of the benefit determination as described in 211 CMR 65.32(4) to the insured and the insured's authorized representative, if applicable.
   (c) As part of the written description of the insured's right to request an independent review, a carrier shall include the following, or substantially equivalent, language: "We have determined that the benefit eligibility criteria ("benefit trigger") of your [policy] [certificate] has not been met. You may have the right to an independent review of our decision conducted by long-term care professionals who are not associated with us. Please send a written request for independent review to us at [address]. You must inform us, in writing, of your election to have this decision reviewed within 120 days of receipt of this letter. Listed

below are the names and contact information of the independent review organizations approved or certified by your state insurance commissioner's office to conduct long-term care insurance benefit eligibility reviews. If you wish to request an independent review, please choose one of the listed organizations and include its name with your request for independent review. If you elect independent review, but do not choose an independent review organization with your request, we will choose one of the independent review organizations for you and refer the request for independent review to it."

(d) If the carrier does not believe the benefit trigger decision is eligible for independent review, the carrier shall inform the insured and the insured's authorized representative, if applicable, and the commissioner in writing and include in the notice the reasons for its determination of independent review ineligibility.

(e) The appeal process described in 211 CMR 65.32(3) is not deemed to be a 'new service or provider' as referenced in 211 CMR 65.27, Availability of New Services or Providers, and therefore does not trigger the notice requirements of that section.

(4) Independent Review of Benefit Trigger Determination.

(a) Request. The insured or the insured's authorized representative may request an independent review of the carrier's benefit trigger determination after the internal appeal process outlined in 211 CMR 65.32(3) has been exhausted. A written request for independent review may be made by the insured or the insured's authorized representative to the carrier within 120 calendar days after the carrier's written notice of the final internal appeal decision is received by the insured and the insured's authorized representative, if applicable.

(b) Cost. The cost of the independent review shall be borne by the carrier.

(c) Independent Review Process.

1. Within five (5) business days of receiving a written request for independent review, the carrier shall refer the request to the independent review organization that the insured or the insured's authorized representative has chosen from the list of certified or approved organizations the carrier has provided to the insured. If the insured or the insured's authorized representative does not choose an approved independent review organization to perform the review, the carrier shall choose an independent review organization approved or certified by the state. The carrier shall vary its selection of authorized independent review organizations on a rotating basis.

2. The carrier shall refer the request for independent review of a benefit trigger determination to an independent review organization, subject to the following:

    a. The independent review organization shall be on a list of certified or approved independent review organizations that satisfy the requirements of a qualified long-term care insurance independent review organization contained in this section;

    b. The independent review organization shall not have any conflicts of interest with the insured, the insured's authorized representative, if applicable, or the carrier; and

    c. Such review shall be limited to the information or documentation provided to and considered by the carrier in making its determination, including any information or documentation considered as part of the internal appeal process.

3. If the insured or the insured's authorized representative has new or additional information not previously provided to the carrier, whether submitted to the carrier or the independent review organization, such information shall first be considered in the internal review process, as set forth in 211 CMR 65.32(3).

    a. While this information is being reviewed by the carrier, the independent review organization shall suspend its review and the time period for review is suspended until the carrier completes its review.

    b. The carrier shall complete its review of the information and provide written notice of the results of the review to the insured and the insured's authorized representative, if applicable, and the independent review organization within five (5) business days of the carrier's receipt of such new or additional information.

    c. If the carrier maintains its denial after such review, the independent review organization shall continue its review, and render its decision within the time period specified in subparagraph (i) below. If the carrier overturns its decision following its review, the independent review request shall be considered withdrawn.

4. The carrier shall acknowledge in writing to the insured and the insured's authorized representative, if applicable, and the commissioner that the request for independent review has been received, accepted and forwarded to an independent review organization for review. Such notice will include the name and address of the independent review organization.
5. Within five (5) business days of receipt of the request for independent review, the independent review organization assigned pursuant to this paragraph shall notify the insured and the insured's authorized representative, if applicable, the carrier and the commissioner that it has accepted the independent review request and identify the type of licensed health care professional assigned to the review. The assigned independent review organization shall include in the notice a statement that the insured or the insured's authorized representative may submit in writing to the independent review organization, within seven (7) days following the date of receipt of the notice, additional information and supporting documentation that the independent review organization should consider when conducting its review.
6. The independent review organization shall review all of the information and documents received pursuant to 211 CMR 65.32(4)(c)5 that has been provided to the independent review organization. The independent review organization shall provide copies of any documentation or information provided by the insured or the insured's authorized representative to the carrier for its review, if it is not part of the information or documentation submitted by the carrier to the independent review organization. The carrier shall review the information and provide its analysis of the new information in accordance with 211 CMR 65.32(4)(c)8.
7. The insured or the insured's authorized representative may submit, at any time, new or additional information not previously provided to the carrier but pertinent to the benefit trigger denial. The carrier shall consider such information and affirm or overturn its benefit trigger determination. If the carrier affirms its benefit trigger determination, the carrier shall promptly provide such new or additional information to the independent review organization for its review, along with the carrier's analysis of such information.
8. If the carrier overturns its benefit trigger determination:
   a. The carrier shall provide notice to the independent review organization and the insured and the insured's authorized representative, if applicable, and the commissioner of its decision; and
   b. The independent review process shall immediately cease.
9. The independent review organization shall provide the insured and the insured's authorized representative, if applicable, the carrier and the commissioner written notice of its decision, within 30 calendar days from receipt of the referral referenced in 211 CMR 65.32(4)(c)2. If the independent review organization overturns the carrier's decision, it shall:
   a. Establish the precise date within the specific period of time under review that the benefit trigger was deemed to have been met;
   b. Specify the specific period of time under review for which the carrier declined eligibility, but during which the independent review organization deemed the benefit trigger to have been met; and
   c. For tax-qualified long-term care insurance contracts, provide a certification (made only by a licensed health care practitioner as defined in section 7702B(c)(4) of the Internal Revenue Code) that the insured is a chronically ill individual.

10. The decision of the independent review organization with respect to whether the insured met the benefit trigger will be final and binding on the carrier.
11. The independent review organization's determination shall be used solely to establish liability for benefit trigger decisions, and is intended to be admissible in any proceeding only to the extent it establishes the eligibility of benefits payable.
12. Nothing in this section shall restrict the insured's right to submit a new request for benefit trigger determination after the independent review decision, should the independent review organization uphold the carrier's decision.
13. The division shall utilize the criteria set forth in Appendix H, Guidelines for Long-Term Care Independent Review Entities, in certifying or approving entities to review long-term care insurance benefit trigger decisions.
14. The commissioner shall maintain and periodically update a list of approved independent review organizations.

(5) Certification of Long-Term Care Insurance Independent Review Organizations. The commissioner shall certify or approve a qualified long-term care insurance independent review organization, provided the independent review organization demonstrates to the satisfaction of the commissioner that it is unbiased and meets the following qualifications:
  (a) Have on staff, or contract with, a qualified and licensed health care professional in an appropriate field for determining an insured's functional or cognitive impairment (e.g. physical therapy, occupational therapy, neurology, physical medicine and rehabilitation) to conduct the review.
  (b) Neither it nor any of its licensed health care professionals may, in any manner, be related to or affiliated with an entity that previously provided medical care to the insured.
  (c) Utilize a licensed health care professional who is not an employee of the carrier or related in any manner to the insured.
  (d) Neither it nor its licensed health care professional who conducts the reviews may receive compensation of any type that is dependent on the outcome of the review.
  (e) Be state approved or certified to conduct such reviews if the state requires such approvals or certifications.
  (f) Provide a description of the fees to be charged by it for independent reviews of a long-term care insurance benefit trigger decision. Such fees shall be reasonable and customary for the type of long-term care insurance benefit trigger decision under review.
  (g) Provide the name of the medical director or health care professional responsible for the supervision and oversight of the independent review procedure.
  (h) Have on staff or contract with a licensed health care practitioner, as defined by section 7702B(c)(4) of the Internal Revenue Code of 1986, as amended, who is qualified to certify that an individual is chronically ill for purposes of a qualified long-term care insurance contract.

(6) Maintenance of Records and Reporting Obligations by Independent Review Organizations. Each certified independent review organization shall comply with the following:
  (a) Maintain written documentation establishing the date it receives a request for independent review, the date each review is conducted, the resolution, the date such resolution was communicated to the carrier and the insured, the name and professional status of the reviewer conducting such review in an easily accessible and retrievable format for the year in which it received the information, plus two (2) calendar years.
  (b) Be able to document measures taken to appropriately safeguard the confidentiality of such records and prevent unauthorized use and disclosures in accordance with applicable federal and state law.
  (c) Report annually to the commissioner, by June 1, in the aggregate and for each long-term care carrier all of the following:
    1. The total number of requests received for independent review of long-term care benefit trigger decisions;
    2. The total number of reviews conducted and the resolution of such reviews (i.e., the number of reviews which upheld or overturned the long-term care carrier's determination that the benefit trigger was not met);
    3. The number of reviews withdrawn prior to review;
    4. The percentage of reviews conducted within the prescribed timeframe set forth in 211 CMR 65.32(4)(c)9; and
    5. Such other information the commissioner may require.
  (d) Report immediately to the commissioner any change in its status which would cause it to cease meeting any of the qualifications required of an independent review organization performing independent reviews of long-term care benefit trigger decisions.

(7) Additional Rights. Nothing contained in this section shall limit the ability of a carrier to assert any rights a carrier may have under the policy related to:
  (a) An insured's misrepresentation;
  (b) Changes in the insured's benefit eligibility; and
  (c) Terms, conditions, and exclusions of the policy, other than failure to meet the benefit trigger.

(8) Applicability. The requirements of this Regulation apply to a benefit trigger request made on or after July 1, 2014 under a long-term care insurance policy.

(9) Conflict with Other Laws. The provisions of this section supersede any other external review requirements found in M.G.L. c. 176O.

65.33: Prompt Payment of Clean Claims

(1) For purposes of this section:
  (a) “Claim” means a request for payment of benefits under an in-force policy, regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.
  (b) “Clean claim” means a claim that has no defect or impropriety, including any lack of required substantiating documentation, such as satisfactory evidence of expenses incurred, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

(2) Within thirty (30) business days after receipt of a claim for benefits under a long-term care insurance policy or certificate, a carrier shall pay such claim if it is a clean claim, or send a written notice acknowledging the date of receipt of the claim and one of the following:
  (a) The carrier is declining to pay all or part of the claim and the specific reason(s) for denial; or
  (b) That additional information is necessary to determine if all or any part of the claim is payable and the specific additional information that is necessary.

(3) Within thirty (30) business days after receipt of all the requested additional information, a carrier shall pay a claim for benefits under a long-term care insurance policy or certificate if it is a clean claim, or send a written notice that the carrier is declining to pay all or part of the claim, and the specific reason or reasons for denial.

(4) In the event of a claim denial, the carrier, within 60 days after the date of a written request by the policyholder, or a representative, shall (a) provide a written explanation of the reasons for the denial and (b) make available all information directly related to the denial.

(5) If a carrier fails to comply with 211 CMR 65.33(2) or (3), such carrier shall pay interest at the rate of 1% per month on the amount of the claim that should have been paid but that remains unpaid forty-five (45) business days after the receipt of the claim with respect to 211 CMR 65.33(2) or all requested additional information with respect to 211 CMR 65.33(3). The interest payable pursuant to this subsection shall be included in any late reimbursement without requiring the person who filed the original claim to make any additional claim for such interest.

(6) The provisions of 211 CMR 65.33 shall not apply where the carrier has a reasonable basis supported by specific information that such claim was fraudulently submitted.

(7) Any violation of this regulation by a carrier if committed flagrantly and in conscious disregard of the provisions of this regulation or with such frequency as to constitute a general business practice shall be considered a violation of M.G.L. c. 176D.

(8) The provisions of 211 CMR 65.33 supersede any other claim payment requirement found in M.G.L. c.175, sections 108 and 110.

65.34: Standard Format Outline of Coverage

This section of the regulation implements, interprets and makes specific, the provisions of M.G.L. c.176U, section 3(f) in prescribing a standard format and the content of an outline of coverage.

(1) The outline of coverage shall be a free-standing document, using no smaller than ten-point type.

(2) The outline of coverage shall contain no material of an advertising nature.

(3) Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

(4) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

(5) Format for outline of coverage:

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE
[Policy Number or Group Master Policy and Certificate Number]

[The following three paragraphs must be included in substantially similar language at the top of the policy.]

FEDERAL INCOME TAX EXEMPTIONS: This policy (**IS**)(**IS NOT**) intended to be a federally-qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended.

STATE MASSHEALTH (MEDICAID) EXEMPTIONS: This policy (**IS**)(**IS NOT**) intended to satisfy Massachusetts' minimum long-term care insurance coverage requirements as of the policy's effective date for certain asset and liability exemptions under the Massachusetts MassHealth (Medicaid) Program. Please note that there may be other MassHealth (Medicaid) requirements to qualify for these exemptions.

Please read your Options for Financing Long-Term Care: A Massachusetts Guide for important information about the federal and state exemptions. PLEASE NOTE THAT STATE AND FEDERAL LAWS ARE SUBJECT TO CHANGE AND THAT FEDERAL AND STATE EXEMPTIONS MAY NOT APPLY TO THIS POLICY AT A FUTURE DATE.

1. This policy is [an individual policy of insurance]([a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]). THIS IS A LIMITED POLICY. This policy may not cover all the expenses associated with your long-term care needs.

   [Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

   Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

2. SUMMARY OF POLICY FEATURES
   This policy:
   1. is not a Medicare Supplement policy.
   2. is [guaranteed-renewable/noncancellable] for your lifetime.
   3. [is/is not] subject to premium increases as you get older.
   4. [may be/is not] subject to across the board premium increases for all policyholders in your class.
   5. [does/does not] offer an option to purchase inflation protection after the policy is issued without any medical underwriting.

6. [does/does not] offer an option to purchase nonforfeiture protection after the policy is issued without any medical underwriting.
7. [does/does not] contain special age limitations for purchase.
8. [does cover services due to pre-existing conditions (existing health problems for a period of ____ months from policy issue/does not have a waiting period before pre-existing conditions (existing health problems) are covered.]
9. [may have/has] an elimination period of ____ days before benefits are payable under the policy.
10. [offers a waiver of premium after ____ days of ___ benefits/does not offer a waiver of premium.]

3. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]
(c) [Describe waiver of premium provisions or state that there are not such provisions.]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return–"free look" provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) [For producers] Neither [insert company name] nor its producers represent Medicare, the federal government or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage 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, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductibles, waiting periods, elimination periods and benefit maximums.]
(b) [Institutional benefits, by skill level.]
(c) [Non-institutional benefits, by skill level.]
(d) Eligibility for Payment of Benefits
[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.]

[Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:
(a) Preexisting conditions;
(b) Non-eligible facilities and providers;
(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);
(d) Exclusions and exceptions;
(e) Limitations.
[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 9 above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:
    (a) That the benefit level will not increase over time;
    (b) Any automatic benefit adjustment provisions;
    (c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;
    (d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;
    (e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

    [Carriers must include the following information in or with the outline of coverage:
    (1) A graphic comparison of the benefit levels of a policy that increases benefits over the benefit period with the benefit levels of a policy that does not increase benefits. The graphic comparison must show benefit levels over at least a 20-year period.
    (2) Any expected premium increases or additional premiums to pay for automatic or optional benefit increase. A carrier may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.
    (3) Whether or not the benefit was chosen by the policyholder.]

12. Nonforfeiture Benefits. As an accident and sickness policy, this policy does not have a cash value associated with life insurance products. This policy does offer [for an additional charge (if applicable)] a nonforfeiture benefit that will continue until exhausted even if the policy lapses due to nonpayment of policy premiums. The following represents an example of how this benefit would apply to this policy: [As applicable, indicate the following:
    (1) a description of the benefits that would accrue at different periods of policy lapse.
    (2) Whether or not the benefit was chosen by the policyholder.

13. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.
    [State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

14. PREMIUM.
    (a) State the total annual premium for the policy;
    (b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]
    (c) Refer applicant to schedule page of the policy. For reference during the presentation, applicant may be referred to policy illustration form for the premium.

15. ADDITIONAL FEATURES.
    [(a) Indicate if medical underwriting is used;
    (b) Describe other important features.]

16. CONTACT THE SHINE PROGRAM OR YOUR PRODUCER IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

65.35: Requirement to Deliver Consumer Guide

(1) A consumer guide developed or approved by the commissioner shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

(a) In the case of producer solicitations, an producer must deliver the consumer's guide prior to the presentation of an application or enrollment form.
(b) In the case of direct response solicitations, the consumer's guide must be presented in conjunction with any application or enrollment form.

(2) Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish a policy summary in a format specified by the commissioner.

65.36: Penalties

In addition to any other penalties provided by the laws of the commonwealth, any carrier and any producer found to have violated any requirement of the commonwealth 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.

65.37: Severability

If any section or portion of 211 CMR 65.00, or the applicability thereof to any person or circumstance is held invalid by any Court of competent jurisdiction, the remainder of 211 CMR 65.00, or the applicability thereof to other persons or circumstances, shall not be affected thereby.

APPENDIX A: Form for Reporting Rescission of Long-Term Care Policies

The following form must be used by carriers to annually report rescissions.
RESCISSION REPORTING FORM FOR LONG-TERM CARE POLICIES FOR THE COMMONWEALTH OF MASSACHUSETTS FOR THE REPORTING YEAR 20[ ].
Company Name: ____________
Address: _______________
____
Phone Number: ____________
Due: March 1, annually
Instructions: The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission: ________
____
____
____
____
____

____
Signature

____
Name and Title (please type)

____
Date

APPENDIX B: Form of Personal Worksheet

The following form of personal worksheet must be used by carriers in the sale of long-term care insurance policies.

Long-Term Care Insurance
Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

The insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _______________

The premium for the coverage you are considering will be [$____ per month, or $____ per year,] [a one-time single premium of $____.]

Type of Policy (noncancellable or guaranteed renewable): _____________

The Company's Right to Increase Premiums: _____________________

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in the commonwealth.] [Carriers must use appropriate bracketed statement. Rate guarantees must not be shown on this form.]

Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in the commonwealth or any other state.] [The company has not raised its rates for this policy form or similar policy forms in the commonwealth or any other state in the last ten years.] [The company has raised its premium rates on this policy form or similar policy forms in the last ten years. Following is a summary of the rate increases.]

Questions Related to Your Income

How will you pay each year's premium?

□ From my Income □ From my Savings/Investments □ My Family will Pay

□ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

What is your annual income? (check one)

□ Under $10,000 □ $[10-20,000] □ $[20-30,000] □ $[30-50,000] □ Over $50,000

Note: The carrier may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)

□ No change □ Increase □ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) □ Yes □ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

□ From my Income □ From my Savings/Investments □ My Family will Pay

The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

Note: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.

What elimination period are you considering?

Number of days ____ Approximate cost $____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

□ From my Income □ From my Savings/Investments □ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

□ Under $20,000 □ $20,000-$30,000 □ $30,000-$50,000 □ Over $50,000

How do you expect your assets to change over the next ten years? (check one)
□ Stay about the same □ Increase □ Decrease
If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.
Disclosure Statement
□ The answers to the questions above describe my financial situation.
OR
□ I choose not to complete this information.
(Check one.)
□ I acknowledge that the carrier and/or its [producer] [insurance producer] (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** (This box must be checked).
Signed: _____________
(Applicant) (Date)
□ I explained to the applicant the importance of completing this information.
Signed: ________________________
(Insurance Producer) (Date)
Insurance Producer's Printed Name:______________]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.] [My [producer] [insurance producer] has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.
Signed: _____________]
(Applicant) (Date)

APPENDIX C : Disclosure Form

The following form of disclosure must be used in Massachusetts.

Things You Should Know Before You Buy Long-Term Care Insurance

Long-Term Care Insurance A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.

[You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare Medicare does **not** pay for most long-term care.

MassHealth MassHealth Program (Medicaid) will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for MassHealth.

Many people become eligible for MassHealth after they have used up their own financial resources by paying for long-term care services.

When MassHealth pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.

Your choice of long-term care services may be limited if you are receiving MassHealth. To learn more about MassHealth, contact your local or state Medicaid agency.

Consumer Guide Make sure the insurance company or producer gives you a copy of "*Your Options for Financing Long-Term Care: A Massachusetts Guide*." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Facilities Some long-term care insurance policies provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

APPENDIX D: Response Letter

The following form of response letter must be used in Massachusetts.

Long-Term Care Insurance Suitability Letter

Dear [Applicant]:
Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.
[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Your Options for Financing Long-Term Care: A Massachusetts Guide." Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]
[You chose not to provide any financial information for us to review.]
Note: Choose the paragraph that applies.
We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.
If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.
Please check one box and return in the enclosed envelope.
□ **Yes,** [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.
Note: Delete the phrase in brackets if the applicant did not answer the questions about income.
□ **No.** I have decided not to buy a policy at this time.

APPLICANT'S SIGNATURE ________________	DATE _____

Please return to [carrier] at [address] by [date].

APPENDIX E: Sample Claims Denial Reporting Form

The following form for reporting claims denials must be used in the commonwealth.
Claims Denial Reporting Form for Long-Term Care Insurance Due June 30th Annually
For the State of Massachusetts For the Reporting Year of________
Company Name: ________________________Company NAIC Number:____________
Company Address:____
Contact Person: ______________
Phone Number: _______________

Line of Business:	Individual	Group

Instructions
The purpose of this form is to report all long-term care claim denials under in-force long-term care insurance policies. "Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

		State Data	Nationwide Data[1]
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid Due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid Due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Long-Term Care Claims Denied Due to:		
8	• Long-Term Care Services Not Covered Under the Policy[2]		
9	• Provider/Facility Not Qualified Under the Policy[3]		
10	• Benefit Eligibility Criteria Not Met[4]		
11	• Other		

Footnotes:

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.
2. Example—Home health care claim filed under a nursing home only policy.
3. Example—A facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
4. Examples—A benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

APPENDIX F: Potential Rate Increase Disclosure Form

The following form must be used in the commonwealth to disclose a potential rate increase.
Instructions:
This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.
Carriers must provide all of the following information to the applicant:
Long-Term Care Insurance Potential Rate Increase Disclosure Form

1. **[Premium Rate] [Premium Rate Schedules]:** [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [filed] for an increase [is][are] [on the application][$____]
2. **The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.**
3. **Rate Schedule Adjustments:**

The company will provide a description of when premium rate or rate schedule adjustments will be **effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): __________.**

4. **Potential Rate Revisions:**

This Policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates CANNOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.
If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- ■ Pay the increased premium and continue your policy in force as is.
- ■ Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- ■ Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- ■ Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

***Contingent Nonforfeiture**
If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:
You will keep some long-term care insurance coverage, if:

- • Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- • You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.
Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.
Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.
Example:

- • You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.
- • In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).
- • Your "paid-up" policy benefits are $10,000 (provided you have a least $10,000 of benefits remaining under your policy.)

Contingent Nonforfeiture	
Cumulative Premium Increase Over Initial Premium	
That qualifies for Contingent Nonforfeiture	
(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)	
Issue Age	**Percent Increase Over Initial Premium**
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%

85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

[The following contingent nonforfeiture disclosure need only be included for those limited pay policies to which 211 CMR 65.29(4)(d) and (4)(f) are applicable].

In addition to the contingent nonforfeiture benefits described above, the following reduced "paid-up" contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced "paid-up" benefit AND the contingent benefit described above are triggered by the same rate increase, you can chose either of the two benefits.

You are eligible for the reduced "paid-up" contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below;

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect; AND

3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

a. The total lifetime amount of benefits your reduced paid up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.

- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy.

APPENDIX G: Replacement and Lapse Reporting Form

The following form must be used in the commonwealth to report replacements and lapses of long-term care insurance.
For the Commonwealth of Massachusetts For the Reporting Year of ____, Due June 30, Annually
Company Name: _____________Company NAIC Number: __________
Company Address: ____________
Contact Person: ____________ Phone Number: __________

Instructions

The purpose of this form is to report on a statewide basis information regarding long-term care insurance policy replacements and lapses. Specifically, every carrier must maintain records for each insurance producer on that insurance producer's amount of long-term care insurance replacement sales as a percent of the insurance producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the insurance producer as a percent of the insurance producer's total annual sales. The tables below should be used to report the ten percent of the carrier's insurance producers with the greatest percentages of replacements and lapses.

Listing of the 10% of Insurance Producers with the Greatest Percentage of Replacements

Insurance Producer's Name	Number of Policies Sold by This Insurance Producer	Number of Policies Replaced by This Insurance Producer	Number of Replacements as % of Number Sold by This Insurance Producer

Listing of the 10% of Insurance Producers with the Greatest Percentage of Lapses

Insurance Producer’s Name	Number of Policies Sold by This Insurance Producer	Number of Policies Lapsed by This Insurance Producer	Number of Lapses as % of Number Sold by This Insurance Producer

Company Totals

Percentage of Replacement Policies Sold to Total Annual Sales ___%
Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year)___%
Percentage of Lapsed Policies to Total Annual Sales___%
Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) ___%

APPENDIX H: Guidelines for Long-Term Care Independent Review Entities

In order for an organization to qualify as an independent review organization for long-term care insurance benefit trigger decisions, it shall comply with all of the following:

a. The independent review organization shall ensure that all health care professionals on its staff and with whom it contracts to provide benefit trigger determination reviews hold a current unrestricted license or certification to practice a health care profession in the UnitedStates.

b. The independent review organization shall ensure that any health care professional on its staff and with whom it contracts to provide benefit trigger determination reviews who is a physician holds a current certification by a recognized American medical specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

c. The independent review organization shall ensure that any health care professional on its staff and with whom it contracts to provide benefit trigger determination reviews, who is nota physician, holds a current certification in the specialty in which that person is licensed, by a recognized American specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

d. The independent review organization shall ensure that all health care professionals on its staff and with whom it contracts to provide benefit trigger determination reviews have no history of disciplinary actions or sanctions including, but not limited to, the loss of staff privileges or any participation restriction taken or pending by any hospital or state or federal government regulatory agency.

e. The independent review organization shall ensure that neither it, nor any of its employees, producers, or licensed health care professionals utilized for benefit trigger determination reviews, receives compensation of any type that is dependent on the outcome of the review.

f. The independent review organization shall ensure that neither it, nor any of its employees, producers, or licensed health care professionals it utilizes for benefit trigger determination reviews are in any manner related to, employed by or affiliated with the carrier, insured or with a person who previously provided medical care or long term care services to the insured.

g. The independent review organization shall provide a description of the qualifications of the reviewers retained to conduct independent review of long-term care insurance benefit trigger decisions, including the reviewers' current and past employment history, practice affiliations and a description of past experience with decisions relating to long-term care, functional capacity, dependency in activities of daily living, or in assessing cognitive impairment. Specifically, with regard to reviews of tax qualified long-term care insurance contracts, it must demonstrate the ability to assess the severity of cognitive impairment requiring substantial supervision to protect the individual from harm, or with assessing deficits in the ability to perform without substantial assistance from another person at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity.

h. The independent review organization shall provide a description of the procedures employed to ensure that reviewers conducting independent reviews are appropriately licensed, registered or certified; trained in the principles, procedures and standards of the independent review organization; and knowledgeable about the functional or cognitive impairments associated with the diagnosis and disease staging processes, including expected duration of such impairment, which is the subject of the independent review.

i. The independent review organization shall provide the number of reviewers retained by the independent review organization and a description of the areas of expertise available from such reviewers and the types of cases such reviewers are qualified to review (e.g., assessment of cognitive impairment or inability to perform activities of daily living due to a loss of functional capacity).

j. The independent review organization shall provide a description of the policies and procedures employed to protect confidentiality of protected health information, in accordance with federal and state law.

k. The independent review organization shall provide a description of its quality assurance program.

l. The independent review organization shall provide the names of all corporations and organizations owned or controlled by the independent review organization or which own or control the organization, and the nature and extent of any such ownership or control. The independent review organization shall ensure that neither it, nor any of its employees, producers, or licensed health care professionals utilized are not a subsidiary of, or owned or controlled by, a carrier or by a trade association of carriers of which the insured is a member.

m. The independent review organization shall provide the names and resumes of all directors, officers and executives of the independent review organization.

APPENDIX I:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY PRODUCER [BROKER OR OTHER REPRESENTATIVE]:
(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The carrier will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present carrier or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before your sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature of Producer or Other Representative)

[Typed Name and Address of Producer or Other Representative]
The above "Notice to Applicant" was delivered to me on:

______________________________ ________________________
(Applicant's Signature) (Date)

APPENDIX J:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your carrier will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present carrier or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.