

LONG-TERM CARE INSURANCE MODEL ACT

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Section 1. Purpose

The purpose of this Act is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

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

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

Section 2. Scope

The requirements of this Act shall apply to policies delivered or issued for delivery in this state on or after the effective date of this Act. This Act is not intended to supersede the obligations of entities subject to this Act to comply with the substance of other applicable insurance laws insofar as they do not conflict with this Act, except that laws and regulations designed and intended to apply to Medicare supplement insurance policies shall not be applied to long-term care insurance.

Drafting Note: See Section 6J.

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

Section 3. Short Title

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

Section 4. Definitions

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

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- A. “Long-term care insurance” means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. The term includes group and individual annuities and life insurance policies or riders that provide directly or supplement long-term care insurance. The term also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term shall also include qualified long-term care insurance contracts. Long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With regard to life insurance, this term does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision of this Act, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this Act.
- B. “Applicant” means:
- (1) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and
 - (2) In the case of a group long-term care insurance policy, the proposed certificate holder.
- C. “Certificate” means, for the purposes of this Act, any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.
- D. “Commissioner” means the Insurance Commissioner of this state.

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

- E. “Group long-term care insurance” means a long-term care insurance policy that is delivered or issued for delivery in this state and issued to:
- (1) One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations; or

- (2) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if the association:
 - (a) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and
 - (b) Has been maintained in good faith for purposes other than obtaining insurance; or
- (3) An association or a trust or the trustees of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering the policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the commissioner that the association or associations have at the outset a minimum of 100 persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws that provide that:
 - (a) The association or associations hold regular meetings not less than annually to further purposes of the members;
 - (b) Except for credit unions, the association or associations collect dues or solicit contributions from members; and
 - (c) The members have voting privileges and representation on the governing board and committees.

Thirty (30) days after the filing the association or associations will be deemed to satisfy the organizational requirements, unless the commissioner makes a finding that the association or associations do not satisfy those organizational requirements.
- (4) A group other than as described in Subsections E(1), E(2) and E(3), subject to a finding by the commissioner that:
 - (a) The issuance of the group policy is not contrary to the best interest of the public;
 - (b) The issuance of the group policy would result in economies of acquisition or administration; and
 - (c) The benefits are reasonable in relation to the premiums charged.

F. “Policy” means, for the purposes of this Act, any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this state by an insurer; fraternal benefit society; nonprofit health, hospital, or medical service corporation; prepaid health plan; health maintenance organization or any similar organization.

Drafting Note: This Act is intended to apply to the specified group and individual policies, contracts, and certificates whether issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization. In order to include such organizations, each state should identify them in accordance with its statutory terminology or by specific statutory citation. Depending upon state law,

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insurance department jurisdiction and other factors, separate legislation may be required. In any event, the legislation should provide that the particular terminology used by these plans and organizations may be substituted for, or added to, the corresponding terms used in this Act. The term “regulations” should be replaced by the terms “rules and regulations” or “rules” as may be appropriate under state law.

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

- G. (1) “Qualified long-term care insurance contract” or “federally tax-qualified long-term care insurance contract” means an individual or group insurance contract that meets the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as amended, as follows:
- (a) The only insurance protection provided under the contract is coverage of qualified long-term care services. A contract shall not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;
 - (b) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act, as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this subparagraph do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payor. A contract shall not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;
 - (c) The contract is guaranteed renewable, within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended;
 - (d) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in [insert reference to state law equivalent to Section 4G(1)(e) of the Long-Term Care Insurance Model Act];
 - (e) All refunds of premiums, and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract; and
 - (f) The contract meets the consumer protection provisions set forth in Section 7702B(g) of the Internal Revenue Code of 1986, as amended.

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

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

Section 5. Extraterritorial Jurisdiction—Group Long-Term Care Insurance

No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in Section 4E(4), unless this state or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met.

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

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

- A. The commissioner may adopt regulations that include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, non-duplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions and definitions of terms.

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

- B. No long-term care insurance policy may:
 - (1) 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; or
 - (2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or
 - (3) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.
- C. Preexisting condition.
 - (1) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4E(1) shall use a definition of “preexisting condition” that is more restrictive than the

following: Preexisting condition means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six (6) months preceding the effective date of coverage of an insured person.

- (2) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4E(1) may exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within six (6) months following the effective date of coverage of an insured person.
- (3) The commissioner may extend the limitation periods set forth in Sections 6C(1) and (2) above as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.
- (4) The definition of “preexisting condition” does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer’s established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in Section 6C(2) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in Section 6C(2).

D. Prior hospitalization/institutionalization.

- (1) No long-term care insurance policy may be delivered or issued for delivery in this state if the policy:
 - (a) Conditions eligibility for any benefits on a prior hospitalization requirement;
 - (b) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or
 - (c) Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.
- (2)
 - (a) A long-term care insurance policy containing post-confinement, post-acute care or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled “Limitations or Conditions on Eligibility for Benefits” such limitations or conditions, including any required number of days of confinement.
 - (b) A long-term care insurance policy or rider that conditions eligibility of non-institutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty (30) days.

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

- (3) No long-term care insurance policy or rider that provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related conditions within a period of less than thirty (30) days after discharge from the institution.

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

- E. The commissioner may adopt regulations establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the regulation.
- F. Right to return—free look. Long-term care insurance applicants shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in Section 4E(1) of this Act, the applicant is not satisfied for any reason. This subsection shall also apply to denials of applications and any refund must be made within thirty (30) days of the return or denial.
- G.
 - (1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose.
 - (a) The commissioner shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.
 - (b) In the case of agent solicitations, an agent shall deliver the outline of coverage prior to the presentation of an application or enrollment form.
 - (c) In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form.
 - (d) In the case of a policy issued to a group defined in Section 4E(1) of this Act, an outline of coverage shall not be required to be delivered, provided that the information described in Section 6G(2)(a) through (f) is contained in other materials relating to enrollment. Upon request, these other materials shall be made available to the commissioner.

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

- (2) The outline of coverage shall include:

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- (a) A description of the principal benefits and coverage provided in the policy;
 - (b) A statement of the principal exclusions, reductions and limitations contained in the policy;
 - (c) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;
 - (d) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;
 - (e) A description of the terms under which the policy or certificate may be returned and premium refunded;
 - (f) A brief description of the relationship of cost of care and benefits; and
 - (g) A statement that discloses to the policyholder or certificateholder whether the policy is intended to be a federally tax-qualified long-term care insurance contract under 7702B(b) of the Internal Revenue Code of 1986, as amended.
- H. A certificate issued pursuant to a group long-term care insurance policy that policy is delivered or issued for delivery in this state shall include:
- (1) A description of the principal benefits and coverage provided in the policy;
 - (2) A statement of the principal exclusions, reductions and limitations contained in the policy; and
 - (3) A statement that the group master policy determines governing contractual provisions.

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

- I. If an application for a long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than thirty (30) days after the date of approval.
- J. At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy that provides long-term care benefits within the policy or byrider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:
 - (1) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

- (2) An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;
 - (3) Any exclusions, reductions and limitations on benefits of long-term care;
 - (4) A statement that any long-term care inflation protection option required by [cite to state's inflation protection option requirement comparable to Section 11 of the Long-Term Care Insurance Model Regulation] is not available under this policy;
 - (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 of insurance charges; and
 - (c) Current and projected maximum lifetime benefits; and
 - (6) The provisions of the policy summary listed above may be incorporated into a basic illustration required to be delivered in accordance with [cite to state's basic illustration requirement comparable to Sections 6 and 7 of the Life Insurance Illustrations Model Regulation] or into the life insurance policy summary which is required to be delivered in accordance with [cite to state's life insurance policy summary requirement comparable to Section 5 of the Life Insurance Disclosure Model Regulation].
- K. Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include:
- (1) Any long-term care benefits paid out during the month;
 - (2) An explanation of any changes in the policy, e.g. death benefits or cash values, due to long-term care benefits being paid out; and
 - (3) The amount of long-term care benefits existing or remaining.
- L. If a claim under a long-term care insurance contract is denied, the issuer shall, within sixty (60) days of the date of a written request by the policyholder or certificateholder, or a representative thereof:
- (1) Provide a written explanation of the reasons for the denial; and
 - (2) Make available all information directly related to the denial.
- M. Any policy or rider advertised, marketed or offered as long-term care or nursing home insurance shall comply with the provisions of this Act.

Section 7. Incontestability Period

- A. For a policy or certificate that has been in force for less than six (6) months an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.
- B. For a policy or certificate that has been in force for at least six (6) months but less than two (2) years an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is *both* material to the acceptance for coverage *and* which pertains to the condition for which benefits are sought.
- C. After a policy or certificate has been in force for two (2) years it is not contestable upon the grounds of misrepresentation alone; such policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.
- D.
 - (1) A long-term care insurance policy or certificate may be field issued if the compensation to the field issuer is not based on the number of policies or certificates issued.
 - (2) For purposes of this section, "field issued" means a policy or certificate issued by a producer or a third-party administrator pursuant to the underwriting authority granted to the producer or third party administrator by an insurer and using the insurer's underwriting guidelines.
- E. If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.
- F. In the event of the death of the insured, this section shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies shall be governed by [cite to state's life insurance incontestability clause]. In all other situations, this section shall apply to life insurance policies that accelerate benefits for long-term care.

Section 8. Nonforfeiture Benefits

- A. Except as provided in Subsection B, a long-term care insurance policy may not be delivered or issued for delivery in this state unless the policyholder or certificateholder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. In the event the policyholder or certificateholder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates.

- B. When a group long-term care insurance policy is issued, the offer required in Subsection A shall be made to the group policyholder. However, if the policy is issued as group long-term care insurance as defined in Section 4E(4), other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificateholder.
- C. The commissioner shall promulgate regulations specifying the type or types of nonforfeiture benefits to be offered as part of long-term care insurance policies and certificates, the standards for nonforfeiture benefits, and the rules regarding contingent benefit upon lapse, including a determination of the specified period of time during which a contingent benefit upon lapse will be available and the substantial premium rate increase that triggers a contingent benefit upon lapse as described in Subsection A.

Section 9. Producer Training Requirements

- A.
 - (1) An individual may not sell, solicit or negotiate long-term care insurance unless the individual is licensed as an insurance producer for accident and health or sickness or life [include other lines of authority as applicable] and has completed a one-time training course. The training shall meet the requirements set forth in Subsection B.
 - (2) An individual already licensed and selling, soliciting or negotiating long-term care insurance on the effective date of this Act may not continue to sell, solicit or negotiate long term care insurance unless the individual has completed a one-time training course as set forth in Subsection B, within one year from [insert effective date of this legislation].
 - (3) In addition to the one-time training course required in Paragraphs (1) and (2) above, an individual who sells, solicits or negotiates long-term care insurance shall complete ongoing training as set forth in Subsection B.
 - (4) The training requirements of Subsection B may be approved as continuing education courses under [insert reference to applicable state law or regulation].
- B.
 - (1) The one-time training required by this Section shall be no less than eight (8) hours and the ongoing training required by this Section shall be no less than four (4) hours every 24 months.
 - (2) The training required under Paragraph (1) shall consist of topics related to long-term care insurance, long-term care services and, if applicable, qualified state long-term care insurance Partnership programs, including, but not limited to:
 - (a) State and federal regulations and requirements and the relationship between qualified state long-term care insurance Partnership programs and other public and private coverage of long-term care services, including Medicaid;
 - (b) Available long-term services and providers;
 - (c) Changes or improvements in long-term care services or providers;

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- (d) Alternatives to the purchase of private long-term care insurance;
 - (e) The effect of inflation on benefits and the importance of inflation protection; and
 - (f) Consumer suitability standards and guidelines.
- (3) The training required by this Section shall not include training that is insurer or company product specific or that includes any sales or marketing information, materials, or training, other than those required by state or federal law.
- C. (1) Insurers subject to this Act shall obtain verification that a producer receives training required by Subsection A before a producer is permitted to sell, solicit or negotiate the insurer's long-term care insurance products, maintain records subject to the state's record retention requirements, and make that verification available to the commissioner upon request.
- (2) Insurers subject to this Act shall maintain records with respect to the training of its producers concerning the distribution of its Partnership policies that will allow the state insurance department to provide assurance to the state Medicaid agency that producers have received the training contained in Subsection B(2)(a) as required by Subsection A and that producers have demonstrated an understanding of the Partnership policies and their relationship to public and private coverage of long-term care, including Medicaid, in this state. These records shall be maintained in accordance with the state's record retention requirements and shall be made available to the commissioner upon request.
- D. The satisfaction of these training requirements in any state shall be deemed to satisfy the training requirements in this state.

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

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

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

Section 10. Authority to Promulgate Regulations

The commissioner shall issue reasonable regulations to promote premium adequacy and to protect the policyholder in the event of substantial rate increases, and to establish minimum standards for producer education, marketing practices, producer compensation, producer testing, independent review of benefit determinations, penalties and reporting practices for long-term care insurance.

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

Section 11. Administrative Procedures

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

Section 12. Severability

If any provision of this Act or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 13. Penalties

In addition to any other penalties provided by the laws of this state, any insurer and any producer found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to \$10,000, whichever is greater.

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

Section 14. Effective Date

This Act shall be effective [insert date].

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

1987 Proc. I 11, 19, 655, 677-680, 700 (adopted).
1987 Proc. II 15, 23, 632-633, 727, 730-734 (amended and reprinted).
1988 Proc. I 9, 20-21, 629-630, 652, 661-665 (amended and reprinted).
1989 Proc. I 9, 24-25, 703, 754-755, 789-793 (amended).
1989 Proc. II 13, 23-24, 468, 476-477, 479-484 (amended and reprinted).
1990 Proc. I 6, 27-28, 477, 541-542, 556-561 (amended and reprinted).
1991 Proc. I 9, 17, 609-610, 662, 666-671 (amended and reprinted).
1993 Proc. I 8, 136, 819, 844, 845 (amended).

1993 Proc. 1st Quarter 3, 34, 267, 275, 276 (amended).
1994 Proc. 1st Quarter 4, 39, 446-447, 458 (amended).
1996 Proc. 2nd Quarter 10, 33, 731, 812, 823-824 (amended).
1997 Proc. 1st Quarter 54, 55, 56, 57, 700, 701-704 (amended).
1998 Proc. 1st Quarter 16, 17, 769, 801-804, 894 (amended).
1999 Proc. 4th Quarter 18, 929, 969, 972-978 (amended).
2006 Proc. 4th Quarter 44, 48-60 (amended, reprinted).
2007 Proc. 3rd Quarter 42-44 (amended).
2009 Proc. 3rd Quarter (amended).

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These charts are intended to provide the readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings which are related to the NAIC model. Such guidance provides the reader with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has made an interpretation of adoption or related state activity based on the definitions listed below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

This state page does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist the reader in targeting useful information. For further details, the laws cited should be consulted. The NAIC attempts to provide current information; however, due to the timing of our publication production, the information provided may not reflect the most up to date status. Therefore, readers should consult state law for additional adoptions and subsequent bill status.

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KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

RELATED STATE ACTIVITY: States that have citations identified in this column have **not** adopted the most recent version of the NAIC model in a substantially similar manner. Examples of Related State Activity include but are not limited to: An older version of the NAIC model, legislation or regulation derived from other sources such as Bulletins and Administrative Rulings.

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama		ALA. CODE §§ 27-19-100 to 27-19-110 (2000).
Alaska	ALASKA STAT. §§ 21.53.010 to 21.53.200 (1990/2011) (portions of model).	
American Samoa	NO CURRENT ACTIVITY	
Arizona		ARIZ. REV. STAT. ANN. §§ 20-1691 to 20-1691.11 (1987/2003).
Arkansas		ARK. CODE ANN. §§ 27-97-301 to 27-97-321 (2005).
California		CAL. INS. CODE §§ 10230 to 10237.6 (1989/2015).
Colorado		COLO. REV. STAT. §§ 10-19-101 to 10-19-115 (1990/2009); 3 COLO. CODE REGS. 702-4:4-4-4 (2013); BULLETIN B-1-20 (2007); BULLETIN B-4-27 (2007/2012); BULLETIN B-4-28 (2007); BULLETIN B-4.30 (2012).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Connecticut		CONN. GEN. STAT. § 38a-501 (1991/2014) (Commissioner shall develop regulations); <i>See also</i> CONN. ADMIN. CODE tit. 38a §§ 501-8 to 501-24 (1994).
Delaware		DEL. CODE ANN. tit. 18 §§ 7101 to 7108 (1990/1996); BULLETIN 23 (2006).
District of Columbia		D.C. CODE §§ 31-3601 to 31-3612 (2000/2005).
Florida		FLA. STAT. §§ 627.9401 to 627.9408 (1988/2013); FLA. ADMIN. CODE ANN. r. 690-157.001 to 690-157.023 (2003/2008); BULLETIN 88-224 (1988); Memorandum 2006-16; Memorandum 2007-011 (2007).
Georgia		GA. CODE ANN. §§ 33-42-1 to 33-42-7 (1988/2007) (previous version of model).
Guam	NO CURRENT ACTIVITY	
Hawaii	HAW. REV. STAT. 431:10H-101 to 431:10H-117 (2000/2011).	
Idaho		IDAHO CODE §§ 41-4601 to 41-4611 (1988/1999); <i>See</i> BULLETIN 2006-7; Bulletin 2007-8.
Illinois		215 ILL. COMP. STATS. 5/351A-1 to 5/351A-11 (1989/2001).
Indiana		IND. CODE §§ 27-8-12-1 to 27-8-12-18 (1987/2011); <i>See also</i> IND. CODE §§ 12-1-25-1 to 12-1-25-9 (1987/1991).
Iowa	IOWA CODE §§ 514G.102 to 514G.113 (2008/2015).	IOWA CODE §§ 514G.1 to 514G.10 (1987/2009); BULLETIN 2008-17 (2008); BULLETIN 2014-1 (2014).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Kansas		KAN. STAT. ANN. §§ 40-2225 to 2228 (1988/2002); § 40-2136 (2008/2009).
Kentucky		KY. REV. STAT. §§ 304.14-600 to 304.14-625 (1992/2010); KY. REV. STAT. § 304.14-560 (1990); 806 KY. ADMIN. REGS. 17:083 (2009).
Louisiana		LA. REV. STAT. ANN. §§ 22:1731 to 22:1737 (1989/2012); BULLETIN 9-5-2006; BULLETIN 06-03.
Maine		ME. REV. STAT. ANN. tit. 24-A §§ 5071 to 5083 (2000/2013) (previous version of model); ME. REV. STAT. ANN. tit. 36 § 2525 (1989) (Tax credit); BULLETIN 347 (2007); BULLETIN 381 (2011).
Maryland		MD. ANN. CODE, INS. § 18-101 to 18-120 (2008/2009) (portions of previous version of model); MD. ANN. CODE, INS. § 16-214 (1986/1997) (Life insurance riders); BULLETIN 13-2009 (2009).
Massachusetts	MASS. GEN. LAWS ch. 176U, §§ 1-9 (2013); 211 MASS. CODE REGS. §§ 65:01 to 65:16 (1989/2005) (portions of model); BULLETIN 2013-11 (2013).	
Michigan		MICH. COMP. LAWS §§ 500.3901 to 500.3955 (1992/2001) (Combines act and regulation).
Minnesota		MINN. STAT. §§ 62S.01 to 62S.33 (1997/2010) (Qualified policies); MINN. STAT. §§ 62A.46 to 62A.56 (1986/2003) (Non-qualified policies); BULLETIN 2007-4 (2007).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Mississippi		MISS. INS. REG. 90-102 (1990).
Missouri		MO. REV. STAT. §§ 376.951 to 376.958 (1990/2002); §§ 376.1121 to 376.1130 (2002).
Montana		MONT. CODE ANN. §§ 33-20-127 to 33-20-128 (1991/2007) (previous version of model); MONT. CODE ANN. §§ 33-22-1101 to 33-22-1121 (1989/1991);
Nebraska		NEB. REV. STAT. §§ 44-4501 to 44-4520 (1987/1999).
Nevada		NEV. ADMIN. CODE § 687B.010 to 687B.135 (1988/1994); <i>See</i> BULLETIN 2006-10.
New Hampshire		N.H. REV. STAT. ANN. §§ 415-D:1 to 415-D:11 (1990/2003).
New Jersey		N.J. REV. STAT. §§ 17B:27E-1 to 17B:27E-12 (2004); N.J. ADMIN. CODE §§ 11:3-34.1 to 11:3-34.13 (1989) (Includes parts of model law and regulation).
New Mexico		N.M. STAT. ANN. §§ 59A-23A-1 to 59A-23A-8 (1989/1993).
New York		N.Y. INS. LAW § 1117 (1986).
North Carolina		N.C. GEN. STAT. §§ 58-55-1 to 58-55-35 (1987/2007) (previous version of model); BULLETIN 2011-B-6 (2011).
North Dakota		N.D. CENT. CODE §§ 26.1-45-01 to 26.1-45-12 (1987/2003); BULLETIN 2007-4; BULLETIN 2007-3.

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY	
Ohio		OHIO REV. ANN. §§ 3923.41 to 3923.48 (1988/2013).
Oklahoma		OKLA. STAT. tit. 36 §§ 4421 to 4430 (1987/2008); BULLETIN 6-23-2008 (2008).
Oregon		OR. REV. STAT. §§ 743.650 to 743.656 (1989/2011) (previous version of model); OR. REV. STAT. § 743.138 (1987).
Pennsylvania		PA. UNCONS. STAT. §§ 40-39-701 to 40-39-715 (1993/2000); 40 P.S. 991.1110a (2007); Notice 2008-5
Puerto Rico	NO CURRENT ACTIVITY	
Rhode Island		R.I. GEN. LAW §§ 27-34.2-1 to 27-34.2-22 (1988/2013); BULLETIN 2007-10 (2007); BULLETIN 2011-2 (2011).
South Carolina		S.C. CODE ANN. §§ 38-72-10 to 38-72-100 (1988/2008) (previous version of model).
South Dakota		S.D. CODIFIED LAWS ANN. §§ 58-17B-1 to 58-17B-15 (1989/2007) (previous version of model); BULLETIN 89-3 (1989); BULLETIN 95-2 (1995); BULLETIN 2007-7.
Tennessee		TENN. CODE ANN. §§ 56-42-102 to 56-42-106 (2008) (previous version of model).
Texas		TEX. CODE ANN. § 1201.105 (2005); 1651.001 to 1651.056 (2005/2009); TEX. ADMIN. CODE §§ 3.3801 to 3.3838 (1990) (Portions of model); BULLETIN B-0020-12 (2012).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Utah		UTAH CODE ANN. §§ 31A-22-1401 to 31A-22-1410 (1991/2001).
Vermont		VT. STAT. ANN. tit. 8 §§ 8081 to 8099 (2005).
Virgin Islands	NO CURRENT ACTIVITY	
Virginia		V.A. CODE §§ 38.2-5200 to 38.2-5208 (1987/2002).
Washington		WASH. REV. CODE ANN. § 48 (2008) (previous version of model); WASH. REV. CODE ANN. §§ 48.84.010 to 48.84.910 (1988).
West Virginia	W. VA. CODE § 33-12-8a (2009).	W.VA. CODE §§ 33-15A-1 to 33-15A-7 (1989/2004).
Wisconsin		WIS. STAT. § 146.91 (1987); §§ 632.84, 600.03, 625.16 (1989/1990); WIS. ADMIN. CODE § INS. 3.46 (1991/2014).
Wyoming		WYO. STAT. §§ 26-38-101 to 26-38-111 (1988/1999).

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Section 1. Purpose

The first reported interest in developing a regulatory climate for the private financing of long-term care was in 1985, when conferences among regulators, legislators and industry representatives were held. Members of Congress were also interested in the area of nursing home insurance. **1986 Proc. I 681-682.**

The advisory committee appointed in 1986 reported a great deal of interest within the insurance industry in entering the long-term care market. They recommended that in order to develop private insurance as a viable financing mechanism for long-term care, the issue be considered as a whole. Piecemeal implementation would lessen the potential role of the insurance industry. **1986 Proc. II 707-709.**

The advisory committee's Long-Term Care Report suggested lack of consumer demand was the primary reason insurers had not developed long-term care insurance products. Many people remain unaware of the financial risks associated with nursing home care and erroneously believe Medicare and Medicare supplement insurance will address their long-term care needs. **1986 Proc. II 709.**

The Long-Term Care Report suggested that in order for the development of long-term care insurance to reach its fullest potential, the regulatory climate must be positive. Existing barriers to the growth and diversification of the marketplace must be addressed. **1986 Proc. II 711.**

Legislation was introduced in Congress during the 1989-90 session to regulate long-term care insurance at the federal level. One bill drew heavily on the NAIC Long-Term Care Insurance Model Act. Another bill afforded favorable tax treatment for the purchase of long-term care insurance. **1989 Proc. I 774.**

In testimony on a congressional bill, the NAIC indicated that more than two-thirds of the states have adopted the NAIC model act and/or regulation. States were urged to adopt the amendments also. The NAIC would withdraw its opposition to federal regulation if the states have not adopted the model act or regulation within two years. **1989 Proc. II 500.**

The industry advisory committee presented a report indicating the approach of adding long-term care benefit riders to life policies to a very valuable one and requested assistance from the NAIC in nurturing its development. It was the consensus of the working group that it was acceptable for a life product to contain a rider covering long-term care benefits. The reserving standards would need to be considered, so it was recommended that the Life Insurance (A) Committee and Life and Health Actuarial Technical Task Force become involved in this task. **1989 Proc. I 776.**

The working group recommended addition of a drafting note to the model act recognizing the viability of life insurance products offering long-term care insurance benefits. **1989 Proc. I 703.** An assignment for the future was to develop a regulatory scheme for non-illusory benefits. **1989 Proc. I 765.**

The definition of long-term care was revised in 1989 to include riders, and the footnote modified. **1989 Proc. II 479-480.**

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Section 2. Scope

By mid-1988 the long-term care working group had begun to consider the applicability of the Long-Term Care Insurance Model Act to home health care benefits and continuing care retirement communities. **1988 Proc. II 629.**

Recommendations from the subgroup on how to deal with the issue of continuing care retirement communities included developing a separate model act and regulation, developing a consumer's guide, monitoring federal proposals on retirement communities and/or nursing home requirements, and soliciting input from associations and consumers. **1989 Proc. I 765-766.**

A continuing care retirement community is a residential facility which provides residential, personal care and health care services (including long-term care) to people of retirement age. The central idea is that people live independently as long as their health permits, and, if necessary, transfer to a nursing home, usually located on the premises. **1989 Proc. I 770.**

The subgroup compiled information on CCRCs and found about half of the states had some sort of regulation. More than half of those require departments other than the insurance department to regulate CCRCs. Individual state regulation varies widely, with earlier legislation focused more on consumer protection, and more recent statutes regulating the financial aspects of CCRCs. **1989 Proc. I 771.**

In late 1995 an industry trade association contacted the NAIC because it was concerned about the regulatory oversight of life insurance used to fund long-term care. The association said some provisions in the Long-Term Care Insurance Model Act and Regulation should not apply to life/long-term care insurance. The Senior Issues Task Force agreed to consider the issue. **1996 Proc. 1st Quarter 712.**

Amendments adopted in 1997 were recommended by the life insurance industry because the models as constructed were not an exact fit for life insurance products with long-term care riders. **1997 Proc. 1st Quarter 699.**

Section 3. Title

Section 4. Definitions

A. Long-term care refers to the broad spectrum of medical and support services provided to persons who have lost some or all capacity to function on their own due to a chronic illness or condition and are expected to need such services over a prolonged period of time. **1986 Proc. II 709.**

The working group considered requiring that a policy marketed as long-term care insurance cover two years of benefits. The concern raised was that the regulatory process would not cover products offering benefits covering less than a two-year period. A move toward the two-year requirement

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Section 4A (cont.)

would create a loophole for substandard products. This loophole currently exists at the one-year level. If the model act is to apply to all products, the definition should be changed entirely. The working group did not reach a consensus on this issue and tabled the discussion. **1989 Proc. I 765.**

The drafters considered extensively the pros and cons of changing the definition from 12 to 24 months. There is definitely a need for products which offer coverage for less than two years, but perhaps they should not be referred to as “long-term.” The concern was raised that the model does not really mandate coverage for any specific length of time because of the terminology used. Upon further discussion it was decided that by mandating that any product marketed as long-term care insurance can’t be called anything else, the affect is to mandate coverage for 12 months in the current model. **1989 Proc. II 514.**

The definition was changed to include supplemental riders for life insurance and annuities. **1989 Proc. II 476.**

A definitional change was made in December 1989 to include policies or riders which provide for payment of benefits based on cognitive impairment or the loss functional capacity. **1990 Proc. I 542.**

A special joint committee was appointed to study the issue of accelerated benefits of life insurance policies used for long-term care. The committee’s task was to determine where these products would be regulated. The definition of long-term care was modified to make clear when products would have to meet the requirements of the Long-Term Care Act. Accelerated benefits products not authorized under the Accelerated Benefits Regulation, which otherwise fit the definition of long-term care, would be regulated under the Long-Term Care Insurance Model Act and Regulation. Life insurance products which accelerate to provide monthly nursing home benefits only as long as the insured remains confined would be subject to the Long-Term Care Insurance Model Act. Benefits not conditioned on the receipt of long-term care are excluded from the Long-Term Care Insurance Model Act. **1991 Proc. IB 687.**

G. In 1998 the Senior Issues Task Force was charged with the task of reviewing the Long-Term Care Insurance Model Act and Regulation for compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **1998 Proc. 2nd Quarter II 882.**

HIPAA created tax-qualified plans so the task force needed to determine how the NAIC models needed to be adjusted to clearly accommodate such plans. **1998 Proc. 2nd Quarter II 882.**

The chair of the working group asked interested parties how many companies still wrote a substantial percent of policies that were not tax-qualified. An association representative responded that her association had recently compiled results of a survey showing 80-90% of long-term care insurance business was in policies qualifying for favorable tax treatment under HIPAA. **1998 Proc. 4th Quarter II 765.**

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Section 4G (cont.)

Regulators discussed whether they should refer to “qualified” plans or “tax-qualified” plans. The working group agreed to use “tax-qualified” in the parts of the model that set standards for what to disclose to consumers. An interested party commented that some states have tax benefits and suggested use of the term “federally tax-qualified.” A regulator suggested that the model clarify that the terms are synonymous. **1999 Proc. 1st Quarter 612.**

Subsection G contained a definition of a qualified long-term care insurance contract. Paragraph (2) applied to life riders. **1998 Proc. 3rd Quarter 719.**

Section 5. Extraterritorial Jurisdiction—Group Long-Term Care Insurance

The advisory committee expressed the opinion that the provision authorizing the Commissioner to extend extra-territorial jurisdiction over all long-term care insurance issued to residents of the state went significantly further than other existing model laws. The advisory group spoke against allowing each state to extend jurisdiction over the certificates because it would cause an employee benefit plan to be structured differently according to the regulation of each state where the employer was located. The task force chose to retain the provision in the final draft. **1987 Proc. I 705-706.**

The title of this section was changed to its present form when a footnote was added in December of 1987 to clarify the intent of the drafters that this provision regarding discretionary groups not limit jurisdiction over other health policies. **1988 Proc. I 663.**

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

A. In June of 1987, the model was amended to grant the commissioner the authority to make regulations on continuation and conversion. This had not been included in the initial model. **1987 Proc. II 729, 732.**

It was suggested when the regulation was being amended in 1989, to include the words “inflation protection” to authorize the states to promulgate regulations, because without this some states might have difficulty implementing the section on inflation protection in their regulation. The committee chair expressed concern that the suggestion implies that states do not have jurisdiction to promulgate this type of benefit enhancement without an act by the legislature. Inflation protection is a part of the minimum standards and is consistent with the actions directed in the Long-Term Care Insurance Model Act. The task force rejected the proposal. **1990 Proc. I 542.**

B. The task force subgroup recommended that long-term care insurance products must be guaranteed renewable and non-cancellable. The advisory committee said this would give the insurer no option to cancel an entire block of business if it didn’t meet necessary business expectations, and would preclude the spirit of innovation and flexibility. The language adopted provides the policy could not be terminated due to the deterioration of health or increased age of the insured individual. **1987 Proc. I 706.**

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Section 6B (cont.)

An amendment to the model added a prohibition against issuing coverage for skilled nursing care only or coverage that provides significantly more skilled care in a facility than coverage for lower levels of care. The intention of this section is to prohibit a type of policy which would offer a benefit which is illusory to the long-term care risk. **1987 Proc. II 729, 732.**

After adoption of a clarifying amendment in December of 1987, the model now reads “significantly more *coverage for skilled care.*” **1988 Proc. I 663.**

C. As adopted in December of 1986, the model contained a preexisting condition limitation period of six months for coverage of a person age 65 or older and a 24-month limitation for an insured person under the age of 65. The rationale for this decision was the concern that, as long-term care products become available, they would attract high-risk segments of the insurable population. The preexisting condition limitation recognized the untested nature of long-term care coverage, and would serve to help control policy costs by avoiding adverse selection. **1987 Proc. I 707.**

In June of 1987, the NAIC voted to make several modifications to the preexisting condition portion of the model. Preexisting condition restrictions were removed for insurance sold as group employment benefit policies. Another amendment changed the limitation period to a uniform six months, with no distinction based on age. Finally, the definition of preexisting condition was changed. The model initially defined the term as “preexisting condition means *the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment for a condition for which medical advice or treatment was recommended by, or received from a provider of health care services.*” The underlined portion of the definition was deleted. **1987 Proc. II 730, 732.** Clarifying changes were made to this amendment in December of 1987 to change the wording from “employer’s group policy” to “policy issued to a group.” **1988 Proc. I 664.**

The subgroup was urged by the advisory committee to reinstate the provisions with regard to preexisting conditions and return to the earlier definition, but the group decided against such changes. Both provisions as they now exist in the model closely parallel the similar provisions in Medicare policies. **1988 Proc. I 710.**

The subgroup considered deleting Subsection C(3) but at the urging of the advisory committee allowed it to remain part of the model. The major purpose of this provision was to allow maximum flexibility in the product so as to encourage variation, thereby meeting the needs of the greater number of insurance consumers. With long-term care products on the drawing boards of many health insurers, a crystal ball would be necessary to foresee all the variations in product design that will emerge. **1987 Proc. I 707.**

The advisory committee suggested language for Subsection C(4) which would have allowed an insurer the right to exclude from coverage named diseases or physical conditions of the applicant. The purpose of that section was to encourage insurers to accept these persons who would otherwise be denied insurance because of certain chronic preexisting conditions and thereby make available

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Section 6C (cont.)

limited coverage to such persons. **1987 Proc. I 707-708.** The subgroup rejected the suggestion in favor of a broader coverage, which was adopted in June of 1987 as an amendment to Subsection C(4). **1987 Proc. II 730, 733.**

D. As adopted in 1986, the model permitted policies which conditioned benefits on admission to a facility for the same or related condition within a period of less than 30 days after discharge from an institution. The advisory committee suggested a minimum period of 14 days. They pointed out that increasing the period to 30 days would increase an insurer's potential liability, which would in turn be reflected in increased policy costs. By way of compromise, the language was modified to add a requirement that the 30-day period apply to institutionalization for the same or related condition. **1987 Proc. I 679, 708.**

The subgroup recommended an amendment to the section to prohibit a prior hospitalization requirement for any benefit, with a one-year effective date, and dual option language contained in a drafting note. **1989 Proc. I 761.**

Industry supported a prohibition against prior hospitalization and a prohibition against conditioning receipt of benefits for lower levels of care upon higher levels of care, provided lead time was given to execute the changes. A survey was taken which indicated that the majority of policies offered did condition benefits on a prior hospital stay. **1989 Proc. I 764-765, 769-770.** Six months later the one-year effective date was removed because most policies introduced no longer had the three-day prior hospitalization requirement and it was not needed. **1989 Proc. II 477.**

In 1988 an amendment was added regarding home health care benefits. The proposed amendment did not rule out the home health care benefit, it just prohibited conditioning of benefits advertised or marketed as a home care benefit with a prior institutionalization requirement. It limited the prior institutionalization stay to no more than 30 days for a policy that continued care at home after institutionalization. **1989 Proc. I 761.** Working group members discussed the possibility of developing a regulatory scheme for home health care benefit products. **1989 Proc. I 765.**

The working group considered what stance the NAIC should take to assure that the home health care benefit was not illusory. An extensive skilled nursing home requirement prior to eligibility is illusory if not fully explained in the sales approach. Another issue is composition of the home health care benefit, i.e., whether the services are what the family usually provides or whether it is keyed to medical need. If not medical need, it is more difficult to focus on when a person is entitled to the benefit. A definition of home health care is needed. **1989 Proc. I 781-782.**

The amendments adopted in December 1989 allowed a prior institutionalization requirement in waiver of premium situations and for post-acute care, post-confinement and post-recuperative type benefits or riders. **1990 Proc. I 544.**

F. As originally contemplated, the model had the free look provision in the accompanying regulation. Some states require this type of provision to be statutory, so the provision was moved to the model act. **1987 Proc. I 708.**

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Section 6F (cont.)

The earlier revisions of the model contained separate free look provisions for agent solicited and for direct response solicited policies. The direct response solicited policies had a 30-day free look period and the agent solicited policies had a 10-day free look period. This was changed to made the 30-day free look period uniform. **1989 Proc. II 476.**

A sentence was added at the end of Subsection F in 1999 to clarify that this subsection also applied to denials of applications. **1999 Proc. 4th Quarter 976.**

G. A provision was added to require an outline of coverage in a specified format. The regulation contains the specified format. The working group considered the issue of specifying a size of type for printing, and decided to explore the issue of readability of type, size and font. **1989 Proc. I 761.**

A small subgroup was created to study disclosure issues. **1993 Proc. 3rd Quarter 798.**

The subgroup looked at all the disclosure requirements to determine if they had the intended effect and whether they were applicable to group long-term care products. A member of the group opined that the disclosure requirements are aimed at agents. He suggested that some of these requirements should not apply in the group market since there is no agent meeting with potential enrollees. **1995 Proc. 4th Quarter 894.**

The subgroup agreed to recommend changes to the model to give more flexibility in group settings so the material distributed was not duplicative. **1995 Proc. 4th Quarter 894.**

An inquiry was made as to the meaning of “other materials related to enrollment.” A regulator responded that this language was added to provide insurance departments with the ability to review and disapprove, if necessary, the marketing materials insurers used, based upon the filing requirements in each state. The drafting note further addressed this idea. **1996 Proc. 2nd Quarter 823.**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required that an outline of coverage must disclose to the policyholder or certificateholder that the policy was intended to be a qualified long-term care insurance product under the Internal Revenue Code. The working group discussed whether there should also be a parallel statement that a nonqualified plan was not intended to be tax-qualified. **1999 Proc. 1st Quarter 611-612.**

I. Subsection I was added as part of the HIPAA amendments. A regulator questioned whether an early draft created an implication that there were different standards for qualified and nonqualified plans. The working group agreed that the same standard should apply to both types of contracts. **1999 Proc. 1st Quarter 612.**

J. This section was added in the modifications adopted in June of 1989. It specifies time for delivery of a policy summary. **1989 Proc. II 484.**

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Section 6J (cont.)

When considering amendments relative to life/long-term care issues, a trade association representative said that currently life insurers offering long-term care benefits must deliver two policy summaries: one for the life insurance policy and one for the long-term care benefits. The task force discussed adding language to Subsection J to state that the information required in the long-term care regulation could be incorporated in the life insurance policy summary, if not provided separately. **1996 Proc. 2nd Quarter 811.**

An industry trade association suggested that two provisions in the model needed to be amended. First, the inflation protection option should not be required in a life insurance policy that accelerates benefits for long-term care. Secondly, the policy summary may be incorporated into a basic illustration or into the life insurance policy summary. **1996 Proc. 3rd Quarter 1018.**

K. This subsection was added in June of 1989 after specific authority was added to Section 4 for life insurance or annuities to provide long-term care insurance benefits. A monthly report to policyholders receiving long-term care benefits via acceleration of the death benefit is required when benefits are being paid. **1989 Proc. II 484.**

M. Revisions to this section broadened its scope so that any policy or rider advertised or marketed as long-term care or nursing home insurance would have to comply with the Act. **1989 Proc. II 484.**

Some of the policies available on the market contain inflation adjusters. The options were discussed, including a mandated offer, permitting selection of an increased benefit without underwriting, an annual offer, disclosure and more. The committee decided to address the issue and have language ready for action in December 1989. **1989 Proc. II 515.**

Section 7. Incontestability Period

This section was added to the model in December 1992. **1993 Proc. IB 845.**

Initially the drafters planned to include this section in the regulation, but after further consideration, the task force decided to make the provision part of the model act. Most states do not have the ability to implement this provision by regulation. **1993 Proc. IB 851.**

A. While considering amendments to the post-claims underwriting section of the regulation, the task force members considered whether that was the preferred approach, or whether the contestability period should be shortened from two years to six months. The chair commented that the disadvantage is that fraudulent applicants will get coverage. Another meeting attendee added that shortening the contestability period forces companies to underwrite up front. The chair suggested that it was appropriate to either move to a six-month contestability provision (with its attendant problems) or tighten up the medical underwriting provisions in the regulation. **1992 Proc. IIB 686.**

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Section 7A (cont.)

After some discussion the task force agreed that a six-month approach would be cleaner, simpler and easier to administer. The task force felt it was important to insert a provision on incontestability in the model. The discussion draft imposed a six-month standard for material misrepresentation related to acceptance of coverage, a two-year contestability for misrepresentations that are material to the acceptance of coverage *and* pertaining to the condition for which benefits are sought, and allowed insurers to contest a policy after two years only if the insured knowingly and intentionally misrepresented relevant facts related to the insurer's health. **1993 Proc. IB 854.**

B. When exploring the possibilities for revision of the post-claims underwriting section of the regulation, one regulator suggested a hybrid approach, that is a six-month contestability provision with an accompanying two-year contestability provision relating to medical conditions. **1992 Proc. IIB 686.**

C. The task force consensus was to combine the shortening of the contestability period to six months with strengthening the prohibition against rescission for fraud and material misrepresentation relating to health conditions of applicants. **1992 Proc. IIB 688.**

D. A definition of field issued was added to the draft shortly before adoption by the task force. **1993 Proc. IB 851.**

An industry spokesperson suggested that third-party administrators should be removed from the section. He also asked how policies printed in an agent's home office were to be handled. The task force responded that the printing of a policy in the home office may not constitute "field issued" because the definition means policies issued pursuant to the *underwriting* authority granted by the insurer to the agent. **1993 Proc. IB 844.**

E. The task force decided to move forward with adoption of Section 7 after adding language creating a presumption that once a company had paid a claim, it cannot reject claims in the future or rescind a policy thereafter. **1993 Proc. IB 852.**

F. When discussing amendments relative to life insurance policies that accelerate benefits for long-term care, an industry spokesperson said one example of an unintended result of life/long-term care insurance is that an insured may receive long-term care benefits from a life insurance policy during the uncontestable period, and then the insured would die. Upon review of the death claim, the insurance company could find evidence of a material misrepresentation that would have given the insurer the right to rescind the policy. In this case the insurer would be unable to recover the amount of long-term care claims paid. The task force agreed to consider this issue. **1996 Proc. 1st Quarter 712.**

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An industry representative suggested that life/long-term care insurance should be exempt from the incontestability requirements of this model. A consumer representative suggested two separate incontestability periods, one for the life insurance portion of the policy and one for the long-term care portion. An industry representative responded that the morbidity costs and the mortality costs are different. Another interested party commented that having incontestability provisions is vitally important to life insurers. The task force agreed to consider language to address this concern. **1996 Proc. 2nd Quarter 811.**

Section 8. Nonforfeiture Benefits

When the consumer protection amendments to the Long-Term Care Insurance Model Act and Regulation were being considered, one of the protections discussed was the development of a provision for nonforfeiture benefits. Both the federal government and consumer organizations had expressed an interest in the topic. An insurance department actuary indicated that nonforfeiture benefits would increase the cost of the product and he also expressed concern about solvency and payout when claims came in. The chair of the task force asked the actuary to review the nonforfeiture issue. The chair indicated that the cash inside buildup would create a new class of products which might have federal tax implications. More discussion would be needed on the issue. **1989 Proc. II 515.**

The actuary concluded that nonforfeiture values of the paid-up type are appropriate. An insurance company's actuaries also looked at the issue and chose extended term over the paid-up type because it can result in significant amounts being distributed and they thought it was more meaningful to provide 100 percent of a benefit for a certain period of time. The department actuary commented that it would be more difficult to offer the extended type and that the reduced paid-up type offered more advantages as a required benefit. **1990 Proc. IB 566.**

The department actuary prepared a study which argued against cash values, quantified the cost impact on premiums of certain types of nonforfeiture values, supported required nonforfeiture values of the reduced paid-up type, and offered suggestions on whether policies should include nonforfeiture benefits. His study concluded that the potential for loss of value on the part of the insurance consumer was great in the long-term care insurance market. Nonforfeiture values were one way of diminishing the loss. Although nonforfeiture values have a cost, the study indicated that the cost was not necessarily a barrier to their requirement. **1990 Proc. IB 567.**

By December of 1990, a first draft of a provision on nonforfeiture had been crafted. It was contemplated as a section of the model regulation, and as a requirement to *offer* nonforfeiture protection. **1991 Proc. IB 655.**

The following March a hearing was held where a number of individuals presented their views on nonforfeiture benefits. The participants were asked to address three questions: (1) should there be mandatory nonforfeiture benefits, (2) should there be a mandated offer of nonforfeiture benefits, and if the answer to (1) or (2) is yes, (3) what form should the benefits take: reduced paid-up, extended term, cash surrender value or another form. **1991 Proc. IIB 828.**

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Section 8 (cont.)

The testimony received was outlined extensively in the task force minutes. The following are a few of the comments received: The issue for the task force is what happens to the reserves that have been built up when a long-term care insurance policy lapses. The choices are two-fold: (1) use these reserves for the benefit of the policyholders who continue to pay premiums, or (2) use the reserves for the benefit of the particular policyholder that lapsed his/her policy. Under scenario 1, the company would take lapses into account at time of pricing. Under scenario 2, the company could offer a nonforfeiture benefit to the policyholder who lapses his coverage. Either reduced paid-up or extended term are the most feasible types of nonforfeiture benefits. The task force should not preclude the offering of cash values, but cash values should not be required. The advantages of extended term are: simple to understand, protection is in proportion to premiums paid, the method lends itself to uniform percentages applicable to all insurers, the method is equally applicable to home care benefits, and it can be required at early durations and minimum terms set at levels that force insurers to minimize sales and issue expenses. Reduced paid-up benefits meet most of the public policy objections. Premium loans are another form of nonforfeiture benefit that would allow some policies to be maintained in force that would otherwise lapse. The task force should consider a life annuity as a viable alternative. This type of alternative should not be as expensive as a cash value on a lump sum basis. Nonforfeiture benefits should be roughly equal to 80 percent of the projected reserve accumulations. The purpose of nonforfeiture benefits should be to protect consumers. If high lapse rates continue, a much larger issue is that the long-term care insurance product is completely indefensible. Although nonforfeiture benefits are not the best solution, they may be a way to mitigate the problems of high lapses. The root causes of lapse rates should be addressed. **1991 Proc. IIB 828-832.**

A report was prepared by an advisory group of actuaries, addressing the issue of nonforfeitures. The group was asked to investigate the effect on premiums of providing nonforfeiture benefits. **1991 Proc. IIB 775-828.**

The task force noted that the NAIC's goal to implement a recommendation within one year may have been unrealistic, given the substantive and technical aspects of the issue. Appropriate reserve tables must be developed. The NAIC Life and Health Actuarial (Technical) Task Force upgraded nonforfeiture benefits in long-term care insurance to a number one priority project. The NAIC staff drew up a list of points for discussion. **1991 Proc. IIB 766-769.**

One of the challenges in developing a nonforfeiture benefit is that there are no morbidity tables that can be relied upon in fashioning such a benefit. **1992 Proc. IB 989.**

One of the nonforfeiture benefit issues that was discussed was whether the nonforfeiture benefit should be available, or whether there should be an offer of the benefit, or whether inclusion should be mandated. **1992 Proc. IB 990.**

In the discussions of the task force and the interested parties at the meetings, there did not seem to be a consensus on the appropriate type of nonforfeiture benefit. There was also disagreement about whether the type of benefit should be specified. One person commented that there should not be too many variations on the type of nonforfeiture benefit offered because that confused the purchaser. One regulator suggested that if each company had its own proposal to offer the consumer, there was no ability to comparison shop. **1992 Proc. IB 990.**

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At a later meeting, a revised draft of proposals was circulated for comment. The focus of the discussion was on whether the benefit should be mandated. One consumer representative was of the opinion that it was not in the consumers' best interest to force them to purchase nonforfeiture benefits. Another consumer advocate favored a mandatory nonforfeiture benefit to inspire more realistic pricing and to prevent lapses. It was suggested the assumptions as to why individuals buy and then lapse should be tested before a type of nonforfeiture benefit is chosen. A state regulator found little merit in the argument that regulators could not move forward on nonforfeiture benefits because the impact was unknown. He asked companies and actuaries to bring forward any information they had in this area. A representative from another association stated that it appeared irresponsible to mandate a benefit without knowing the cost; mandating a benefit limits consumer choice. **1992 Proc. IB 985.**

The task force also considered *when* to start the nonforfeiture benefit. The draft under consideration provided that the nonforfeiture benefit would begin after one full year. One person in attendance suggested that requiring nonforfeiture benefits in the second year was too soon, and recommended three to five years. **1992 Proc. IB 987.**

A regulator suggested that mandatory nonforfeiture might not be appropriate for some ages. It was also pointed out that the draft should be clear whether it applies to both individual and group policies. **1992 Proc. IB 987.**

The task force identified a number of related questions that needed to be answered before a position on nonforfeiture benefits could be finalized:

1. Should the basic benefit be reduced paid-up, return of premium, traditional cash value, extended term, or some combination of the above?
2. Does the policyholder have to be given the option of adding a nonforfeiture provision at times other than when the policy is issued?
3. Can the nonforfeiture benefit be changed after the policy is issued? If yes, at what times?
4. Is there a minimum level below which it is not reasonable to require nonforfeiture benefits?
5. What is the task force's perception of equity relative to:
 - a) terminating vs. continuing policyholders?
 - b) differing issue ages?
 - c) policyholders with differing claims experience?
6. Should the nonforfeiture benefit be a "mandated benefit" or a "mandated offer"?

The threshold question is whether the benefit should be mandated or whether an offer of a benefit should be mandated. **1992 Proc. IB 984.**

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An ad hoc actuarial group offered to develop a report on nonforfeiture benefits. The group's consensus was that no one form of nonforfeiture benefit was more workable than the others studied. The task force chair said he believed the task force preferred a shortened benefit period as the type of nonforfeiture benefit to be considered. One of the consumer representatives present said he believed all consumer representatives would favor a shortened benefit period. The chair said he believed the results of the nonforfeiture report did not lend support for allowing *alternative* nonforfeiture benefits. **1992 Proc. IIB 683-684.**

He suggested that one idea to be explored was mandating benefits in the nature of a shortened benefit period and allowing the commissioner discretion to approve others. The task force agreed that it would direct further study of the shortened benefit period approach. The chair stated that the task force had previously expressed a preference for mandating a nonforfeiture benefit, and he believed it did not make sense to study the issues further without considering the benefit a mandate. **1992 Proc. IB 984.**

At the next meeting of the task force, the chair asked task force members and advisory committee members to comment on the current direction of the task force which was a mandatory nonforfeiture benefit of the shortened benefit period type. One advisory committee member said he thought individuals with a nonforfeiture benefit of the shortened benefit type would end up with less equity protection than before. He explained that if the residual benefit was short, agents would key in on selling insurance to cover short stays. However, a staff member with the NAIC disagreed with those conclusions. **1993 Proc. IB 854-855.**

An extensive report was prepared by the ad hoc actuarial group which elaborated on the shortened benefit period form in the earlier report. The conclusions reached included observations that:

1. The effect on the premium of providing a shortened benefit period is substantial.
2. The increase in premiums needed to provide a particular benefit scale varies by issue age and benefit period.
3. The implementation should be coordinated with other issues, such as policy upgrades and rate stabilization. **1993 Proc. IB 850.**

The ad hoc actuarial group identified several issues which the NAIC would need to resolve before resolution of the debate could be achieved:

1. To what degree should persisters and lapsed be cross subsidized?
2. How much equity is reasonable to give up in the name of simplicity?
3. Should the scales that are developed be fixed or minimum?
4. Should the benefit be mandatory for all policies or mandated to be offered?

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5. Should standard scales be adopted only with more knowledge of standard tables that would be used for these benefits and reserves? **1993 Proc. IB 850.**

One of the task force members stated that he believed the questions to be asked were: (1) what is the price impact of nonforfeiture, and (2) who would benefit? He expressed concern over whether a mandated nonforfeiture benefit which impacts premiums substantially would reach only a limited number of people because of the number of lapses. The task force discussed the fact that the price impact makes clear that high lapse assumptions are integrated into the product. **1993 Proc. IB 850.**

A consumer representative commented that the central issue is why seniors buy this product. Another consumer advocate added that he believed the addition of nonforfeiture benefits would result in structural changes that would reflect: (1) an investment, (2) an incentive to persist, and (3) assistance in reducing lapses. He therefore believed the benefit was worth the additional cost. **1993 Proc. IB 850.**

Three points were made by one of the members of the task force: (1) because the long-term care insurance product is substantially prefunded, when a person gets nothing back, it raises questions of fairness, (2) high lapses in this product in the initial years constitute a substantial concern; and (3) a serious question is raised by the fact that individuals are purchasing the product with less than adequate financial means. **1993 Proc. IB 850.**

At the September 1992 task force meeting, the chair summarized the efforts of the group during the previous two years. She said the issue had been very troubling because the need for protection was clear but there was an impact on price that must be considered. She believed that the price implications are a manifestation of the unacceptably high lapse rates that plague the product and that the task force should move forward to address both the lapse rates and nonforfeiture protection. **1993 Proc. IB 844.**

After distribution of a draft which mandated nonforfeiture benefits in all long-term care insurance policies, a consultant listed several disadvantages he saw to mandated nonforfeiture benefits: (1) affordability and access to coverage by middle-income seniors, (2) impact on affordability of inflation benefits, (3) discouragement of younger buyers, (4) encouragement of replacements, (5) weakness of the shortened benefit period approach, (6) impact on rate increases, (7) impact on solvency, (8) over-emphasis on the issue of equity, and (9) inconsistency with other regulatory initiatives. **1993 Proc. IB 842.**

In December the task force deferred final action to allow time for discussion by all the insurance commissioners. **1993 Proc. IB 824.**

In March 1993 the task force adopted a draft which mandated nonforfeiture benefits and gave the commissioner authority to specify the type or types of nonforfeiture benefits and the standards for the benefits. **1993 Proc. 1st Quarter 274.**

One issue which was not addressed in the draft was the application of the nonforfeiture mandate to life insurance policies with long-term care benefits. Since nonforfeiture benefits are already present in life insurance policies, one task force member suggested the task force should consider this and

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any differences between the products. He said there might be some modifications that need to be made to accommodate any inherent differences in the products. **1993 Proc. 1st Quarter 277.**

One insurer representative suggested that the draft should make clear that only the master policy needs to comply with the mandate in a particular state and that the individual certificates do not. The consensus of the task force was not to address that issue at this time. **1993 Proc. 1st Quarter 277.**

Before final adoption of the provision for mandating nonforfeiture benefits, an extensive discussion took place at the Executive Committee meeting. The Long-Term Care Insurance Task Force chair explained that the mandate would ensure that consumers receive benefits for which they have paid because long-term care policies historically have a high lapse rate. She explained that inappropriate or ineffective sales practices frequently result in sales to consumers who will not have sufficient income to continue to pay premiums. The Long-Term Care Insurance Task Force concluded that mandated benefits would resolve this problem. Another commissioner said that the real problem was not the absence of mandated benefits, but rather the inappropriate or ineffective sales practices that result in sales of the policies to consumers who cannot afford them over the long-term. **1993 Proc. 1st Quarter 34.**

The NAIC began a discussion of alternatives to mandatory nonforfeiture in 1997. (See a discussion of details in the nonforfeiture section of the regulation.) Near the end of the discussion the task force reviewed its progress. A regulator opined the proposal was better than the mandatory nonforfeiture in the model. He stated the task force would be giving up mandatory nonforfeiture, which no state had adopted. Another regulator said he believed incremental change was appropriate. A third regulator agreed contingent nonforfeiture was a good first step and the group could go back later and attack other problems. **1997 Proc. 4th Quarter 940.**

The proposal adopted by the task force included elimination of the mandatory nonforfeiture benefit, which was replaced by a mandatory offer of nonforfeiture. If the mandatory offer was rejected, the policy should provide for contingent nonforfeiture on lapse. The contingent benefit on lapse would be triggered by a substantial increase in premium rates, which would be defined in the regulation. The rate increases can be cumulative or a single rate increase. **1998 Proc. 1st Quarter 768, 802.**

Section 9. Authority to Promulgate Regulations

This section was added in December 1990 when the consumer protective amendments were adopted. The task force considered whether to provide authority to promulgate regulations on agents compensation or agent testing and penalties. Not desiring to limit a state's authority to promulgate regulations in general, the draft was modified to contain both. **1991 Proc. IB 664.**

In June 1994 an amendment to this section was finalized that gave the authority to include regulations on premium rate stabilization. **1994 Proc. 1st Quarter 457-458.**

The premium rate stabilization language was changed as a result of discussion that occurred during 1997. During the discussion a consumer advocate commented on how far discussion has come during

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the past six years. She stated that the initial premium is a stretch for many people, and they are being sold benefits they cannot afford. She suggested carriers needed to design benefits the consumer could afford, and proper agent education was critical. **1997 Proc. 4th Quarter 937.**

Section 10. Administrative Procedures

Section 11. Severability

Section 12. Penalties

The imposition of penalties was an alternative suggested to the levelization of commissions for agents. **1991 Proc. IB 654.**

Section 13. Effective Date

Chronological Summary of Actions

December 1986: Model Act adopted.

June 1987: Amendment adopted which provided that no long-term care insurance policy could cover skilled care only or provide higher benefits for skilled care than for lower levels of care. Waivers could not be used to reduce coverage for specifically named conditions beyond the waiting period for preexisting conditions. The preexisting condition definition was changed and the elimination period made a uniform six months.

December 1987: Technical amendment adopted regarding the exclusion of employer groups from preexisting condition requirements, and footnote was added on extraterritoriality.

December 1988: Prohibitions against a prior hospitalization requirement and conditioning receipt of institutional benefits on a prior institutionalization added. The requirements for the outline of coverage were changed, and a footnote added recognizing the viability of life insurance riders. Provision on continuation and conversion added.

June 1989: Model now provides that any policy marketed as long-term care must comply with the provisions of the Act. Authority for life insurance riders added. Free-look period made a uniform 30 days. One-year grace period for prior hospitalization prohibition removed.

December 1989: Eliminated language prohibiting prior hospital stays for home health care benefits.

December 1990: Changed definition to clarify distinction between regulation of long-term care insurance and accelerated benefits. Eliminated drafting note on prior hospitalization. Added sections providing statutory authority to promulgate regulations and impose penalties.

December 1992: Added Section 7 to provide for an incontestability period.

June 1993: Added new Section 8 to provide for nonforfeiture benefits.

June 1994: Added phrase to Section 9 to give authority to promulgate regulations on premium rate stabilization.

September 1996: Amended Section 6G to say that an outline of coverage is not required in group sales if similar information is contained in other enrollment materials.

September 1997: Adopted amendments to Section 6 and 7 relative to life insurance that accelerates benefits to cover long-term care expense.

June 1998: Changed requirement for mandated nonforfeiture to a mandated offer of a nonforfeiture benefit. Reference in Section 9 was changed from premium rate stabilization to regulations designed to protect the policyholder in the event of substantial rate increases.

March 2000: Model was amended to comply with the requirements of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).