HOUSE BILL NO. 156

INTRODUCED BY E. FRANKLIN

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING LONG-TERM CARE INSURANCE LAWS; REVISING DEFINITIONS; REVISING PROVISIONS RELATING TO NONFORFEITURE BENEFITS; EXPANDING RULEMAKING AUTHORITY FOR THE COMMISSIONER OF INSURANCE; REVISING PROVISIONS RELATING TO DELIVERY OF POLICY SUMMARIES; REVISING PROVISIONS RELATING TO BENEFIT TRIGGERS; PROVIDING ADDITIONAL STANDARDS FOR LONG-TERM CARE INSURANCE CONTRACTS; REQUIRING TRAINING FOR INSURANCE PRODUCERS IN THE LONG-TERM CARE FIELD; PROVIDING PENALTIES; AMENDING SECTIONS 33-20-127, 33-20-128, 33-22-1107, 33-22-1111, 33-22-1115, 33-22-1116, 33-22-1119, 33-22-1121, 33-22-1123, 33-22-1124, AND 33-22-1125, MCA; AND PROVIDING AN EFFECTIVE DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 33-20-127, MCA, is amended to read:

"33-20-127. Life insurance policy with long-term care provision or accelerated benefits provision -- summary required. At the time of policy delivery, a summary must be delivered to the insured for an individual life insurance policy that provides ~~long-term care benefits or~~ accelerated benefits within the policy or by rider. An individual life insurance policy that provides long-term care benefits must provide a summary as described in 33-22-1123. In the case of direct response solicitations, the insurer shall deliver the summary upon the applicant's request but ~~no~~ not later than the time of policy delivery. In addition to complying with all applicable requirements, the summary must also include:

(1) an explanation of how the long-term care benefits or accelerated benefits interact with other components of the policy, including deductions from death benefits;

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

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

(4) if applicable to the policy type:

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

(b) a disclosure of guaranties related to long-term care costs of insurance charges; and

(c) current and projected maximum lifetime benefits."

Section 2. Section 33-20-128, MCA, is amended to read:

"33-20-128. Life insurance policy paying long-term benefits -- monthly report. When 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 must be provided to the policyholder as provided for in 33-22-1123 and this section. The report must include the following information for the month for which the report is issued:

(1) the amount of long-term care benefits paid out during the month;

(2) an explanation of any changes in the policy, including without limitation death benefits or cash values, resulting from long-term care benefits having been paid out; and

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

NEW SECTION. **Section 3. Scope.** This part is not intended to supersede the obligations of entities subject to this part to comply with the substance of other applicable insurance laws insofar as they do not conflict with this part. However, laws and regulations designed and intended to apply to medicare supplement insurance policies may not be applied to long-term care insurance.

Section 4. Section 33-22-1107, MCA, is amended to read:

"33-22-1107. Definitions. As used in this part, the following definitions apply:

(1) "Activities of daily living" means:

(a) eating;

(b) toileting;

(c) transferring;

(d) bathing;

(e) dressing; and

(f) continence.

(2) "Applicant" means:

(a) in the case of an individual long-term care insurance policy, the person who seeks to contract for

benefits; and

(b) in the case of a group long-term care insurance policy, the proposed certificate holder.

(3) "Appropriate sale criteria" means the set of conditions that an insurance company is required to address with an applicant that help to determine whether or not a particular insurance policy or contract offered for sale is appropriate to the applicant. These conditions must include but are not limited to any insurance premium involved in the policy, the income of the applicant, and the savings and investments of the applicant.

(4) "Certificate" means a certificate issued under a group long-term care insurance policy that has been delivered or issued for delivery in this state.

(5) "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:

(a) (i) ~~an employer~~ one or more employers;

(ii) a labor organization;

(iii) a trust established by an employer or labor organization; or

(iv) a trustee of a fund established by ~~an employer or labor organization~~ one or more employers or labor organizations or a combination of employers and labor organizations for:

(A) employees or former employees or a combination of employees and former employees; or

(B) members or former members of the labor organization or a combination of members and former members;

(b) ~~a~~ any professional, trade, or occupational association for its current, former, or retired members or a combination of current, former, and retired members if the association:

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

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

(c) an association, a trust, or the trustee of a fund established, created, or maintained for the benefit of members of one or more associations.

(i) Prior to advertising, marketing, or offering the policy within this state, the association or the insurer of the association shall file evidence with the commissioner that the association has:

(A) a minimum of 100 persons at the outset;

(B) been organized and maintained in good faith for purposes other than obtaining insurance;

(C) been in active existence for at least 1 year; and

(D) a constitution and bylaws requiring that the association hold regular meetings at least annually to further purposes of the membership; except for credit unions, the association collects dues or solicits contributions from members; and the members have voting privileges and representation on the governing board and committees.

(ii) Thirty days after filing, the association ~~is~~ must be considered ~~as having~~ to have satisfied the organizational requirements unless the commissioner finds ~~after hearing~~ that the association does not satisfy the organizational requirements.

(d) a group other than as described in subsections (5)(a) through (5)(c) if the commissioner determines that the:

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

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

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

(6) (a) "Long-term care insurance":

(i) means ~~a~~ any insurance policy ~~or certificate~~ that is advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for ~~a~~ each covered person, on an expense-incurred, indemnity, prepaid, or other basis, for ~~a~~ one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, or maintenance or personal-care ~~service~~ services provided in a setting other than an acute care unit of a hospital;

(ii) may be issued by an insurer, fraternal benefit society, nonprofit health service corporation, prepaid health plan, health maintenance organization, or similar organization to the extent that ~~it~~ the organization is otherwise authorized to issue life or health insurance;

(iii) includes group and individual annuities and life insurance policies ~~or riders~~ that provide directly or that supplement long-term care insurance;

(iv) includes any product advertised, marketed, or offered as long-term care insurance regardless of any exceptions to the definition included in this section;

(v) includes a policy ~~or rider~~ that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity; and

(vi) includes qualified long-term care insurance contracts.

(b) Long-term care insurance does not include:

(i) ~~an~~ 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; or

(ii) 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 in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

(c) An 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 protection coverage, accident-only coverage, specified disease or specified accident coverage, or limited benefit health coverage and that also contains long-term care insurance benefits of a duration of at least 6 months is not required to meet the requirements of this part unless the premium allocable to the long-term care insurance benefits contained in the policy is greater than 25% of the total policy premium.

(7) "Policy" means a any policy, certificate, contract, membership contract, subscriber agreement, health care services agreement, rider, or endorsement delivered or issued for delivery in this state by an insurer, fraternal benefit society, health service corporation, prepaid health plan, health maintenance organization, or similar organization.

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

(9) "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means:

(a) an individual or group insurance contract that meets the requirement of section 7702B of the Internal Revenue Code, 26 U.S.C. 7702B, if:

(i) the only insurance protection provided under the contract is coverage of qualified long-term care services;, as defined in [section13]. A contract may also satisfy the requirements of this subsection (9)(a) if payments are made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(ii) the contract does not pay or reimburse expenses incurred for services or items to the extent that the

expenses are reimbursable under 42 U.S.C. 1395 or would be reimbursable but for the application of a deductible or coinsurance amount~~;~~. The requirements of this subsection (9)(a) do not apply to expenses that are reimbursable under 42 U.S.C. 1395 only as a secondary payor. A contract may also satisfy the requirements of this subsection (9)(a) if payments are made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(iii) the contract is guaranteed renewable within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code, 26 U.S.C. 7702B(b)(1)(C);

(iv) 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. 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. However, a refund of the aggregate premium paid under the contract may be allowed in the event of death of the insured or a complete surrender or cancellation of the contract.

(v) the contract contains the consumer protection provisions set forth in section 7702B(g) of the Internal Revenue Code, 26 U.S.C. 7702B(g); or

(b) a life insurance contract that provides long-term care coverage by rider or as a part of the contract as long as the contract complies with section 7702B(b) and (e) of the Internal Revenue Code, 26 U.S.C. 7702B(b) and (e).

~~(10) (a) "Qualified long-term care services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services and maintenance for personal-care services for which an insured is eligible under a qualified long-term care insurance contract and that are provided pursuant to a plan of care prescribed by a licensed health care practitioner.~~

~~(b) For the purposes of this subsection (10), "licensed health care practitioner" means any of the following individuals when licensed in this state:~~

~~(i) a physician, as defined in 42 U.S.C. 1395x(r)(1);~~

~~(ii) a registered professional nurse;~~

~~(iii) a licensed social worker; or~~

~~(iv) another individual as determined by rules of the commissioner adopted for purposes of compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.~~

~~(11)~~(10) "Transferring" means moving into or out of a bed, chair, or wheelchair."

Section 5. Section 33-22-1111, MCA, is amended to read:

"33-22-1111. Outline of coverage. (1) (a) An insurer shall deliver an outline of coverage as approved by the commissioner 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.

(b) The commissioner shall prescribe a standard format, including style, arrangement, and overall appearance, and the content of the outline of coverage.

(c) In the case of insurance producer solicitations, an insurance producer shall deliver the outline of coverage prior to the presentation of an application or enrollment form.

(d) In the case of direct response solicitations, the insurer shall deliver the outline of coverage upon the earlier of the applicant's request or the delivery of the policy.

(2) The outline of coverage must include:

(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 premiums. Continuation or conversion provisions of a group policy must be specifically described.

(d) a statement that the outline of coverage is only a summary of the policy issued or applied for, 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 the premium refunded; ~~and~~

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

(g) a statement that discloses to the policyholder or certificate holder whether the policy is intended to be a federally tax-qualified long-term care insurance contract.

(3) The outline of coverage:

(a) must prominently display the name of the insurer;

(b) must be a freestanding document not dependent for purposes of reader comprehension upon any other document;

(c) must use no smaller than 12-point type; and

(d) may not contain material of an advertising nature."

Section 6. Section 33-22-1115, MCA, is amended to read:

"33-22-1115. Prior hospitalization or institutionalization. (1) A long-term care insurance policy may not be delivered or issued for delivery in Montana if the policy conditions eligibility for a benefit:

(a) on a prior hospitalization requirement;

(b) provided in an institutional care setting on the receipt of a higher level of institutional care; or

(c) other than waiver of premium, postconfinement benefits, postacute care benefits, or recuperative benefits, on a prior institutionalization requirement.

(2) A long-term care insurance policy containing a limitation or condition for eligibility other than those prohibited in subsection (1) must clearly label, in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits", the limitations or conditions, including ~~the~~ any required number of days of confinement.

(3) A long-term care insurance policy that contains a benefit advertised, marketed, or offered as a home health care benefit may not condition receipt of a benefit on a prior institutionalization requirement.

(4) A long-term care insurance policy that conditions eligibility of noninstitutional benefits on the prior receipt of institutional care may not require a prior institutional stay of more than 30 days ~~for which benefits are paid~~.

(5) A long-term care insurance policy that provides ~~a benefit~~ benefits only following institutionalization may not condition the ~~benefit~~ benefits upon admission to a facility for the same or a related condition within a period of less than 30 days after discharge from the institution."

Section 7. Section 33-22-1116, MCA, is amended to read:

"33-22-1116. Nonforfeiture benefits -- ~~availability~~ offer requirement. ~~An insurance company offering~~ (1) Except as provided in subsection (3), a long-term care insurance policy ~~or certificate shall offer to each prospective purchaser the choice between a policy that includes nonforfeiture benefits to the defaulting or surrendering policyholder or certificate holder and one that does not include nonforfeiture benefits~~ may not be delivered or issued for delivery in this state unless the policyholder or certificate holder has been offered the option of purchasing a policy that includes a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy.

(2) If a policyholder or certificate holder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that must be available for a specified period of time following a substantial increase

in premium rates.

(3) When a group long-term care insurance policy is issued, the offer required in subsection (1) must be made to the group policyholder. However, if the policy is issued as group long-term care insurance as defined in 33-22-1107(5)(d), other than to a continuing care retirement community or other similar entity, the offer must be made to each proposed certificate holder."

Section 8. Section 33-22-1119, MCA, is amended to read:

"33-22-1119. Right to return policy -- free look -- refunds upon denial of application. (1) ~~A person insured under an individual long-term care insurance policy has~~ A long-term care insurance applicant and insured has the right to return the policy within 30 days of ~~its~~ the policy's delivery and to have the premium refunded if, after ~~examining~~ examination of the policy, the applicant or insured is not satisfied for any reason. ~~An individual~~ A long-term care insurance policy must have a notice prominently printed on the first page of the policy or attached to ~~it~~ the policy stating that the applicant or insured has the right to return the policy within 30 days of ~~its~~ the policy's delivery and to have the premium refunded if, after ~~examining~~ examination of the policy, other than a certificate issued to a group defined in 33-22-1107(5)(a), the applicant or insured is not satisfied for any reason.

(2) ~~A~~ An applicant or a person insured under a long-term care insurance policy issued pursuant to a direct response solicitation has the right to return the policy ~~or certificate~~ within 30 days of its delivery and to have the premium refunded if, after ~~examining~~ examination of the policy, the applicant or the insured is not satisfied for any reason. A long-term care insurance policy ~~or certificate~~ issued pursuant to a direct response solicitation must have a notice prominently printed on the first page or attached to it stating that the applicant or the insured has the right to return the policy within 30 days of its delivery and to have the premium refunded if, after ~~examining~~ examination of the policy, the applicant or the insured is not satisfied for any reason.

(3) If the application of a person for long-term care insurance is denied, any refund due the person must be refunded within 30 days of the denial or return of the application."

Section 9. Section 33-22-1121, MCA, is amended to read:

"33-22-1121. Rules. The commissioner may adopt rules necessary to implement this part, including but not limited to rules that:

(1) establish loss ratio standards for long-term care insurance policies;

(2) promote premium adequacy and protect the policyholder in the event of substantial rate increases;

(3) establish minimum standards for insurance producer training, marketing practices, compensation, and testing;

(4) establish penalties and reporting practices for long-term care insurance;

~~(2)~~(5) specify ~~the requirements for offering the sale of a policy with nonforfeiture benefits and~~, with respect to nonforfeiture benefits and contingent benefits:

(a) the type or types of nonforfeiture benefits to be offered as part of long-term care insurance policies;

(b) the standards for nonforfeiture benefits;

(c) the rules regarding contingent benefits upon lapse, including:

(i) a determination of the specified period of time during which a contingent benefit upon lapse will be available;

(ii) the substantial premium rate increase that triggers a contingent benefit upon lapse as described in 33-22-1116; and

(d) the types of appropriate sale criteria to be communicated at the time of application;

~~(3)~~(6) establish a requirement for the mandatory triggering of policy benefits based upon the number of activities of daily living that an individual is capable or incapable of performing; and

~~(4)~~(7) are necessary to implement a determination made by the secretary of health and human services pursuant to ~~Public Law 104-191~~ 45 CFR, parts 160 and 164, as to who is a licensed health care practitioner."

Section 10. Section 33-22-1123, MCA, is amended to read:

"33-22-1123. Delivery of policy ~~or certificate~~ -- policy summary -- monthly reports. (1) If an application for a long-term care insurance policy ~~or a certificate meeting the requirements of Public Law 104-191~~ is approved, the ~~health insurance~~ issuer ~~of the policy or certificate~~ shall deliver the policy ~~or certificate~~ to the applicant~~,~~ or policyholder~~, or certificate holder~~ not later than 30 days after the date of ~~issue~~ approval.

(2) (a) At the time of delivery of an individual life insurance policy that provides long-term care benefits within the policy or by rider, a policy summary must be provided to the insured.

(b) In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, and whether or not a request is made, a policy summary must be delivered not later than at the time the policy is delivered.

(c) In addition to complying with any other applicable requirements, the summary must include:

(i) an explanation of how the long-term care benefit interacts with other components of the policy,

including deductions from death benefits;

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

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

(iv) a statement that any long-term care inflation protection option required by the Administrative Rules of Montana is or is not available under this policy;

(d) If applicable to the policy type, the summary must also include:

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

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

(iii) current and projected maximum lifetime benefits.

(3) The required provisions of the policy summary may be incorporated into a basic illustration required to be delivered in accordance with administrative rules or into the life insurance policy summary.

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

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

(b) an explanation of any changes in the policy, such as to death benefits or cash values, due to long-term care benefits being paid out; and

(c) the amount of long-term care benefits existing or remaining."

Section 11. Section 33-22-1124, MCA, is amended to read:

"33-22-1124. Denial of claims. If a claim under a long-term care insurance policy ~~or certificate meeting the requirements of Public Law 104-191~~ is denied, the ~~health insurance~~ issuer shall, not later than 60 days after ~~the receipt of~~ the date of a written request by the ~~policy holder~~ policyholder, certificate holder, or the representative of either of them:

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

(2) provide all information possessed by the ~~health insurance~~ issuer relating to the denial."

Section 12. Section 33-22-1125, MCA, is amended to read:

"33-22-1125. Benefit triggers. (1) A long-term care insurance policy ~~or certificate~~ may not be delivered

or issued for delivery in this state unless it complies with the requirements of this section and applicable rules~~, as established by rules of the commissioner,~~ for the triggering of mandatory provision of benefits.

(2) (a) A ~~qualified~~ long-term care insurance ~~contract~~ policy must condition the payment of benefits on a determination of the insured's inability to perform activities of daily living or on cognitive impairment. ~~for an expectation of at least 90 days because of a loss of level of disability described under regulations adopted by the U.S. secretary of the treasury and because of:~~

~~(a) a loss of functional capacity requiring the substantial assistance of another person to perform the prescribed activities of daily living; or~~

~~(b) a severe cognitive impairment requiring substantial supervision, including verbal cueing, by another person to protect the insured from harming the insured or others for from threats to the insured's health or safety.~~

~~(3) An insured meets a condition of payment if, within the preceding 12-month period, a licensed health care practitioner has certified that the insured has met the requirements and the practitioner has prescribed the qualified long-term care insurance services pursuant to a plan of care.~~

(b) Eligibility for the payment of benefits may not be more restrictive than requiring a deficiency in the ability to perform not more than three of the activities of daily living or requiring the presence of cognitive impairment.

(c) Insurers may use activities of daily living to trigger covered benefits that are in addition to those contained in the definition under 33-22-1107 or rules as long as they are defined in the policy.

(3) An insurer may use additional provisions for the determination of when benefits are payable under a policy. However, the provisions may not restrict or be in lieu of the requirements contained in subsections (1) and (2).

(4) For purposes of this section, the determination of a deficiency may not be more restrictive than:

(a) requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

(b) if the deficiency is due to the presence of a cognitive impairment, the need for supervision or verbal cueing by another person in order to protect the insured or others.

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

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

NEW SECTION. **Section 13. Additional standards for qualified long-term care contracts -- definitions.** (1) For the purposes of this section, the following definitions apply:

(a) (i) "Chronically ill individual" has the meaning provided by section 7702B(c)(2) of the Internal Revenue Code, 26 U.S.C. 7702B(c)(2), and means any individual who has been certified by a licensed health care practitioner as:

(A) being unable to perform without substantial assistance from another individual at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity; or

(B) requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

(ii) The term may not include an individual otherwise meeting the requirements of subsections (1)(a)(i)(A) or (1)(a)(i)(B) unless within the preceding 12-month period a licensed health care practitioner has certified that the individual meets the requirements of subsections (1)(a)(i)(A) or (1)(a)(i)(B).

(b) "Licensed health care practitioner" means a physician, as defined in section 1861(r)(1) of the Social Security Act, 42 U.S.C. 1395x(r)(1), a registered professional nurse, licensed social worker, or other individual who meets the requirements prescribed by the secretary of the treasury.

(c) "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual, including the protection from threats to health and safety due to severe cognitive impairment.

(d) "Qualified long-term care services" means services that meet the requirements of section 7702(c)(1) of the Internal Revenue Code, 26 U.S.C. 7702(c)(1), and that:

(i) provide necessary diagnostic, preventative, therapeutic, curative, treatment, mitigation, and rehabilitative services;

(ii) provide maintenance or personal care services that are required by a chronically ill individual; and

(iii) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

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

(3) Certifications regarding activities of daily living and cognitive impairment required pursuant to subsection (2) must be performed by the following licensed or certified professionals:

(a) physicians or registered professional nurses;

(b) licensed social workers; or

(c) other individuals who meet the requirements prescribed by the secretary of the treasury.

(4) Certifications required pursuant to subsection (2) may be performed by a licensed health care professional at the direction of the insurer as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the 90-day period.

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

NEW SECTION. **Section 14. Incontestability period.** (1) Upon a showing of misrepresentation that is material to the acceptance for coverage, a policy that has been in force for less than 6 months may be rescinded by the insurer or the insurer may deny an otherwise valid long-term care insurance claim.

(2) Upon a showing of misrepresentation that is both material to the acceptance for coverage and that pertains to the condition for which benefits are sought, a policy that has been in force for at least 6 months but less than 2 years may be rescinded by the insurer or the insurer may deny an otherwise valid long-term care insurance claim.

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

(4) (a) A long-term care insurance policy may be field-issued if the compensation to the field issuer is not based on the number of policies sold.

(b) For purposes of this subsection (A), "field-issued" means a policy 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.

(5) If an insurer has paid benefits under the long-term care insurance policy, the benefit payments may not be recovered by the insurer if the policy is rescinded.

(6) In the event of the death of the insured, this section may not be applied to the remaining death benefit

of a life insurance policy that accelerates benefits for long-term care. In that situation, the remaining death benefits under the policy must be governed by Title 33, chapter 20. In all other situations, this section applies to life insurance policies that accelerate benefits for long-term care.

NEW SECTION. **Section 15. Insurance producer training requirements.** (1) An individual may not sell, solicit, or negotiate long-term care insurance unless the individual is licensed as an insurance producer for disability or life insurance, has completed a one-time training course on or before July 1, 2008, and completes ongoing training within every 24-month period following July 1, 2008.

(2) The training requirements of this section may be approved as continuing education courses under Title 33, chapter 17, part 12.

(3) The one-time training course required by this section may not be less than 8 hours, and the ongoing training required by this section may not be less than 4 hours for each 24-month period.

(4) (a) The training must consist of topics related to long-term care insurance, long-term care services, and, if applicable, qualified state long-term care insurance partnership programs.

(b) The training must address but is not limited to:

(i) 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;

(ii) available long-term care services and providers;

(iii) changes or improvements in long-term care services or providers;

(iv) alternatives to the purchase of private long-term care insurance;

(v) the effect of inflation on benefits and the importance of inflation protection; and

(vi) consumer suitability standards and guidelines.

(5) The training required by this section may not include training that is specific to the insurer or a company product or that includes any sales or marketing information, materials, or training, other than those required by state or federal law.

(6) (a) An insurer subject to this section shall obtain verification that an insurance producer acting on the insurer's behalf receives the training required by this section before the insurance producer is permitted to sell, solicit, or negotiate the insurer's long-term care insurance products.

(b) The insurer shall maintain records subject to this state's record retention requirements and make the

verification of the insurance producer's compliance with training requirements available to the commissioner upon request.

(7) (a) An insurer subject to this section shall maintain records with respect to the training of its insurance producers concerning the distribution of its policies that will allow the commissioner to provide assurance to the department of public health and human services that insurance producers have received the required training and that the insurance producers have demonstrated an understanding of the insurer's policies and the relationship of the policies to public and private coverage of long-term care, including medicaid, in this state.

(b) The records must be maintained in accordance with this state's record retention requirements and must be made available to the commissioner upon request.

(8) The satisfaction of the training requirements required by this section in any state must be considered to satisfy the training requirements in this state.

NEW SECTION. **Section 16. Penalties.** In addition to any other penalty provided for in Title 33, an insurer or an insurance producer found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of long-term care insurance is subject to a fine of up to three times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

NEW SECTION. **Section 17. Codification instruction.** [Sections 3 and 13 through 16] are intended to be codified as an integral part of Title 33, chapter 22, part 11, and the provisions of Title 33, chapter 22, part 11, apply to [sections 3 and 13 through 16].

NEW SECTION. **Section 18. Effective date.** [This act] is effective July 1, 2007.

- END -