SECOND REGULAR SESSION

SENATE BILL NO. 1180

91ST GENERAL ASSEMBLY

INTRODUCED BY SENATOR JACOB.

Read 1st time February 19, 2002, and 1,000 copies ordered printed.

TERRY L. SPIELER, Secretary.

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AN ACT

To repeal sections 376.951, 376.952, 376.955 and 376.957, RSMo, and to enact in lieu thereof nine new sections relating to long-term care insurance, with penalty provisions.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section A. Sections 376.951, 376.952, 376.955 and 376.957, RSMo, are repealed and nine new sections enacted in lieu thereof, to be known as sections 376.951, 376.952, 376.955, 376.957, 376.1121, 376.1124, 376.1127, 376.1130 and 376.1133, to read as follows:

376.951. 1. Sections 376.951 to 376.958 **and sections 376.1121 to 376.1133** may be known and cited as the "Long-term Care Insurance Act".

2. As used in sections 376.951 to 376.958 **and sections 376.1121 to 376.1133, unless the context requires otherwise,** the following terms mean:

(1) "Applicant":

(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;

(2) "Certificate", any certificate or evidence of coverage issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state;

(3) "Director", the director of the department of insurance of this state;

(4) "Group long-term care insurance", a long-term care insurance policy which is delivered or issued for delivery in this state and issued to:

(a) 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

EXPLANATION--Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organization; or

(b) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such 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

(c) An association or a trust or the trustee of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the director that the association or associations have at the outset a minimum of one hundred 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 which 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 days after such filing the association or associations shall be deemed to satisfy such organizational requirements, unless the director makes a finding that the association or associations do not satisfy those organizational requirements;

(d) A group other than as described in paragraph (a), (b) or (c) of subdivision (4) of this subsection, subject to a finding by the director 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;

(5) "Long-term care insurance", any **insurance** policy**[**, contract, certificate, evidence of coverage**]** or rider advertised, marketed, offered or designed to provide coverage for not less than twelve 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 of personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. **Long-term care insurance also**

includes qualified long-term care insurance contracts. Long-term care insurance may be issued by insurers; fraternal benefit societies; health services corporations; prepaid health plans; **[**and**]** 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 which 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, long-term care insurance 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 neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision of sections 376.951 to 376.958 and sections 376.1121 to 376.1133 to the contrary, any product advertised, marketed, or offered as long-term care insurance shall be subject to the provisions of sections 376.951 to 376.958 and sections 376.1121 to 376.1133**;

(6) "Policy", any policy, **[**contract, certificate, evidence of coverage,**]** subscriber agreement, rider or endorsement delivered or issued for delivery in this state by an insurer; fraternal benefit society; health services corporation; prepaid health plan or health maintenance organization**, or any similar organization;**

(7) "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract", the portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract that satisfies the requirements of Section 7702B(b) and (e) of the Internal Revenue Code of 1986, as amended. Qualified long-term care insurance contract also includes 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 paragraph 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 paragraph 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 paragraph 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 paragraph (e) of this subdivision;

(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 shall not 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.

376.952. 1. The provisions of sections 376.951 to 376.958 **and sections 376.1121 to 376.1133** shall apply to policies delivered or issued for delivery in this state on or after August 28, **[**1990**] 2002**. Sections 376.951 to 376.958 **and sections 376.1121 to 376.1133** are not intended to supersede the obligations of entities subject to the provisions of sections 376.951 to 376.958 **and sections 376.1122 to 376.1133** to comply with the substance of other applicable insurance laws insofar as they do not conflict with the provisions of sections 376.951 to 376.958 **and sections 376.1122 to 376.1133**, except that laws and regulations designed and intended to apply to medicare supplement insurance policies shall not be applied to long-term care insurance.

2. The purposes of the provisions of sections 376.951 to 376.958 **and sections 376.1122 to 376.1133** are 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.

3. Any policy or rider advertised, marketed or offered as long-term care or nursing home insurance shall comply with the provisions of sections 376.951 to 376.958 **and sections 376.1122 to 376.1133**.

376.955. 1. The director 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, nonduplication 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. Regulations adopted pursuant to sections 376.951 to 376.958 **and sections 376.1122 to 376.1133** shall be in accordance with the provisions of chapter 536, RSMo.

2. No long-term care insurance policy may:

(1) Be canceled, 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 for lower levels of care.

3. No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in paragraph (a) of subdivision (4) of subsection 2 of section 376.951:

(1) Shall use a definition of preexisting condition which 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 months preceding the effective date of coverage of an insured person;

(2) May exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six months following the effective date of coverage of an insured person.

4. The director may extend the limitation periods set forth in subdivisions (1) and (2) of subsection 3 of this section as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

5. The definition of preexisting condition provided in subsection 3 of this section 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 subdivision (2) of subsection 3 of this section 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 subdivision (2) of subsection 3 of this section.

6. No long-term care insurance policy may be delivered or issued for delivery in this state if such policy:

(1) Conditions eligibility for any benefits on a prior hospitalization requirement; or

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

(3) Conditions eligibility for any benefits **[**on a prior institutionalization requirement, except in the case of**] other than** waiver of premium, post-confinement, post-acute care or recuperative benefits **on a prior institutionalization requirement**.

7. 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.

8. A long-term care insurance policy or rider which conditions eligibility of noninstitutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty days.

9. No long-term care insurance policy or rider which 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 days after discharge from the institution.

10. The director 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.

11. Long-term care insurance applicants shall have the right to return the policy or certificate within thirty 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 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 paragraph (a) of subdivision (4) of subsection 2 of section 376.951, 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 days of the return or denial.**

376.957. 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 which prominently direct the attention of the recipient to the document and its purpose. The director shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an

outline of coverage. In the case of agent solicitations, an agent shall deliver the outline of coverage prior to the presentation of an applicant or enrollment form. In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form. **In the case of a policy issued to a group defined in section 376.951, an outline of coverage shall not be required to be delivered; provided that the information described in subdivisions (1) to (6) of subsection 2 of this section is contained in other materials relating to enrollment. Upon request, such other materials shall be made available to the director.**

2. The outline of coverage 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;

(3) 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 the premium. Continuation or conversion provisions of group coverage shall be specifically described;

(4) 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;

(5) A description of the terms under which the policy or certificate may be returned and premium refunded; **[**and**]**

(6) A brief description of the relationship of cost of care and benefits**; and**

(7) 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 under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

3. A certificate issued pursuant to a group long-term care insurance policy which 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.

4. **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 days after the date of approval.**

5. At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. 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 such 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; **[**and**]**

(4) **A statement that any long-term care inflation protection option that may be required by the laws of this state is not available under the policy; and**

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

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

(b) A disclosure of guarantees related to long-term care costs of insurance charges **[**or notice that such guarantees are included in the policy or rider; and**];**

(c) Current and projected maximum lifetime benefits**; and**

(d) The provisions of the policy summary listed in paragraphs (a) to (c) of this subdivision may be incorporated into a basic illustration required to be delivered in accordance with sections 375.1509, RSMo, or into the life insurance policy summary required to be delivered in accordance with section 376.706.

376.1121. If a claim under a long-term care insurance contract is denied, the issuer shall, within sixty days of the date of a written request by the policyholder or certificate holder, 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.

376.1124. 1. For a policy or certificate that has been in force less than six 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.

2. For a policy or certificate that has been in force for at least six months but less than two 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 both material to the acceptance of coverage and which pertains to the conditions for which benefits are sought.

3. After a policy or certificate has been in force for two years, such policy or certificate 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.

4. No long-term care insurance policy or certificate shall be field issued based on medical or health status. For purposes of this subsection, "field issued" means a policy or certificate issued by an agent or third-party administrator pursuant to the underwriting authority granted to the agent or third-party administrator by an insurer.

5. If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments shall not be recovered by the insurer if such policy or certificate is rescinded.

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

376.1127. 1. Except as provided in subsection 2 of this section, a long-term care insurance policy shall 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 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. If a policyholder or certificate holder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that will be available for a specified period of time following a substantial increase in premium rates.

2. When a group long-term care insurance policy is issued, the offer required in subsection 1 of this section shall be made to the group policyholder; except that, if the policy is issued as group long-term care insurance, as defined in section 376.951, other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificate holder.

3. The director shall promulgate rules 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 1 of this section.

376.1130. 1. The director shall promulgate reasonable rules to promote premium adequacy and to protect the policyholder in the event of substantial increases, and to establish minimum standards for marketing practices, agent compensation, agent testing, penalties, and reporting practices for long-term care insurance.

2. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in sections 376.1121 to 376.1133 shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2002, shall be invalid and void.

376.1133. In addition to any other penalty provided by state law, any insurer or agent found to have violated any requirement of state law 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 times the amount of any commissions paid for each policy involved in the violations or ten thousand dollars, whichever is greater.

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