

ALASKA LEGISLATURE COMMITTEE FILES, 1989-1990 8672

6265 SENATE HEALTH, EDUCATION AND SOCIAL SERVICES

009

- (c) An estimate of total charges for administering the plan;
 - (d) The insurer's ability to administer the pool in a cost efficient manner.
- (2)
- (a) The administering insurer shall serve for a period of 3 years subject to removal for cause.
 - (b) At least 1 year prior to the expiration of each 3-year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer to submit bids to serve as the administering insurer for the succeeding 3-year period. Selection of the administering insurer for the succeeding period shall be made at least 6 months prior to the end of the current 3-year period.
- (3)
- (a) The administering insurer shall perform all eligibility and administrative claims payment functions relating to the pool.
 - (b) The administering insurer shall establish a premium billing procedure for collection of premium from insured persons. Billings shall be made on a periodic basis as determined by the board.
 - (c) The administering insurer shall perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:
 - 1. Making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission shall be made;
 - 2. Evaluating the eligibility of each claim for payment by the pool.
 - (d) The administering insurer shall submit regular reports to the board regarding the operation of the pool. The frequency, content, and form of the report shall be as determined by the board.
 - (e) Following the close of each calendar year, the administering insurer shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the Board and the Department on a form as prescribed by the Commissioner.
 - (f) The administering insurer shall be paid as provided in the plan of operation for its expenses incurred in the performance of its services.

Section 5. Assessments.

- (1) Following the close of each fiscal year, the pool administrator shall determine the net premiums (premiums less administrative expense allowances), the pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Health insurance premiums and benefits paid by an insurance arrangement that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments.
- (a) Each insurer's assessment shall be determined by multiplying the total cost of pool operation by a fraction, the numerator of which equals that insurer's premium and subscriber contract charges for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges written in the state and 110% of all claims paid

- by insurance arrangements in the state during the preceding calendar year.
- (b) Each insurance arrangement's assessment shall be determined by multiplying the total cost of pool operation by a fraction, the numerator of which equals 110% of the benefits paid by that insurance arrangement on behalf of insureds in this state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges and 110% of all benefits paid by insurance arrangements made on behalf of insured in this state during the preceding calendar year. Insurance arrangements shall report to the board claims payments made in this state on an annual basis on a form prescribed by the Commissioner.
- (2) If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" includes reserves for incurred by not reported claims.
 - (3) (a) Each member's proportion of participation in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the member with it.
(b) Any deficit incurred by the pool shall be recouped by assessments apportioned under subsection (1) of this Section by the board among members.
 - (4) The board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in subsection (1) of this Section. The member receiving such abatement or deferment shall remain liable to the pool for the deficiency for 4 years.

Drafting Note - Section 6

Section 6 deals with the coverage to be issued by the pool. The original draft bill established a comprehensive and specific plan of coverage. However, this plan may not be appropriate to the needs of all states. Thus, the model bill provides two alternative approaches to Section 6. Alternative 1 specifically establishes a broad, comprehensive plan of coverage in the form of a detailed schedule of benefits, exclusions, limits, deductibles and coinsurance factors.

Alternative 2 vests authority in the Commissioner to promulgate, with the advice and recommendations of the pool members, a level of pool coverage determined to be commensurate with those typically provided by a representational number of large employers in the state. It should be pointed out that most carriers will be members of the pools in more than one, and perhaps all, of the states that enacted pooling legislation. The administration of these pools will be greatly facilitated if those provisions of the model bill dealing with pool formation, operation and administration remain uniform. This uniformity will allow each state pool to benefit from the operational experience of the others and will facilitate monitoring of the efficiency of pooling mechanisms. There is not the same necessity, however, regarding the actual plan benefits or coverage and the scope of coverage could vary according to individual state needs.

ALTERNATIVE 1

Section 6. Minimum Benefits - Availability.

- (1) The pool shall offer major medical expense coverage to every eligible person who is not eligible for Medicare. Major medical expense coverage offered by the pool shall pay an eligible person's covered expenses, subject to limits on the deductible and coinsurance payments authorized under paragraph (4) (d) of this Section, up to a life time limit of \$1,000,000 per covered individual. The maximum limit under this paragraph shall not be altered by the Board, and no actuarial equivalent benefit may be substituted by the Board.

- (2) **Covered Expenses.** Covered expenses shall be the prevailing charge in the locality for the following services and articles when prescribed by a physician and determined by the pool to be medically necessary:
- (a) Hospital services;
 - (b) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, which are rendered by a physician, or by other licensed professionals at his direction;
 - (c) Drugs requiring a physician's prescription;
 - (d) Services of a licensed skilled nursing facility for not more than 120 days during a policy year;
 - (e) Services of a home health agency up to a maximum of 270 services per year;
 - (f) Use of radium or other radioactive materials;
 - (g) Oxygen;
 - (h) Anesthetics;
 - (i) Prostheses other than dental;
 - (j) Rental of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the conditions for which is prescribed;
 - (k) Diagnostic x-rays and laboratory tests;
 - (l) Oral surgery for excision of partially or completely unerupted, impacted teeth or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;
 - (m) Services of a physical therapist;
 - (n) Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;
 - (o) Services for diagnosis and treatment of mental and nervous disorders, provided that an insured shall be required to make a 50 percent copayment, and that the payment of the pool shall not exceed \$4,000 for outpatient psychiatric treatment.
- (3) **Exclusions.** Covered expenses shall not include the following:
- (a) Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect to restore normal bodily functions;
 - (b) Care which is primarily for custodial or domiciliary purposes;

- (c) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician;
 - (d) That part of any charge for services rendered or articles prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality or for any charge not medically necessary;
 - (e) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles;
 - (f) Any expense incurred prior to the effective date of coverage by the pool for the person on whose behalf the expense is incurred;
 - (g) Dental care except as provided in subsection (3) (l) of this section;
 - (h) Eyeglasses and hearing aids;
 - (i) Illness or injury due to acts of war;
 - (j) Services of blood donors and any fee for failure to replace the first 3 pints of blood provided to an eligible person each policy year;
 - (k) Personal supplies or services provided by a hospital or nursing home, or any other nonmedical or nonprescribed supply or service.
- (4) Premiums, Deductibles, and Coinsurance.
- (a) Premiums charged for coverages issued by the pool may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage.
 - (b) Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks.
 - (c) The pool shall determine the standard risk rate by calculating the average individual standard rate charged by the five largest insurers offering coverages in the state comparable to the pool coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for pool coverage shall not be less than 150% of rates established as applicable for individual standards risks. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall pool rates exceed 200% of rates applicable to individual standard risks. All rates and rate schedules shall be submitted to the Commissioner for approval.
 - (d) The pool coverage defined in Section 6. shall provide optional deductibles of \$500 or \$1,500 per annum per individual, and coinsurance of 20%, such coinsurance and deductibles in the aggregate not to exceed \$3,500 per individual nor \$5,000 per family per annum. The deductibles and coinsurance factors may be adjusted annually according to the Medical Component of the Consumer Price Index.
- (5) Preexisting Conditions. Pool coverage shall exclude charges or expenses incurred during the first twelve months following the effective date of coverage as to any condition, which

during the six month period immediately preceding the effective date of coverage, (i) had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or (ii) for which medical advice, care or treatment was recommended or received. Such preexisting condition exclusions shall be waived to the extent to which similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated; provided, that application for pool coverage is made not later than thirty-one (31) days following such involuntary termination and, in such case, coverage in the pool shall be effective from the date on which such prior coverage was terminated.

(6) **Nonduplication of Benefits.**

- (a) Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or Federal law or program except Medicaid.
- (b) The insurer or the pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not coverage expenses. Benefits due from the pool may be reduced or refused as a set-off against any amount recoverable under this paragraph.

ALTERNATIVE 2

Section 6. Minimum Benefits - Availability.

- (1) The pool shall offer major medical expense coverage to every eligible person who is not eligible for Medicare. The coverage to be issued by the pool, its schedule of benefits, exclusions and other limitations, shall be established through regulations promulgated by the Commissioner taking into consideration the advice and recommendations of the pool members.
- (2) In establishing the pool coverage, the Commissioner shall take into consideration the levels of health insurance provided in the state, medical economic factors as may be deemed appropriate and promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with health insurance provided through a representative number of large employers in the state.
- (3) Pool coverage established under this Section shall provide both an appropriate "high" and a "low" deductible to be selected by the pool applicant. The deductibles and coinsurance factors may be adjusted annually according to the Medical Component of the Consumer Price Index.
- (4) **Premiums and Assessments.**
 - (a) Premiums charged for pool coverage may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing the coverage. Separate schedules of premium rates based on age, sex and geographical location may apply for individual risks.
 - (b) The pool shall determine the standard risk rate by calculating the average individual standard rate charged by the five largest insurers offering coverages in the

state comparable to the pool coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for pool coverage shall not be less than 150% of rates established as applicable for individual standard risks. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall pool rates exceed 200% of rates applicable to individual standard risks. All rates and rate schedules shall be submitted to the Commissioner for approval.

- (5) **Preexisting Conditions.** Pool coverage shall exclude charges or expenses incurred during the first twelve months following the effective date of coverage as to any condition, which during the six month period immediately preceding the effective date of coverage, (i) had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or (ii) for which medical advice, care or treatment was recommended or received as to such condition. Such preexisting condition exclusions shall be waived to the extent to which similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated; provided, that application for pool coverage is made not later than thirty-one (31) days following such involuntary termination and, in such case, coverage in the pool shall be effective from the date on which such prior coverage was terminated.
- (6) **Nonduplication of Benefits.**
 - (a) Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or Federal law or program except Medicaid.
 - b) The insurer or the pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a set-off against any amount recoverable under this paragraph.

Section 7. Collective Action.

Neither the participation in the pool as members, the establishment of rates, forms or procedures nor any other joint or collective action required by this Act shall be the basis of any legal action, criminal or civil liability or penalty against the pool or any of its members.

Section 8. Taxation.

The pool established pursuant to this Act shall be exempt from any and all taxes.

Drafting Note - Optional Section

A state may wish to provide for some form of offset against applicable taxes in the amount of the assessments incurred by the members of the pool. If so, such a provision should allow appropriate reductions in assessments as to pool members not subject to the taxes against which offsets are allowed.

Section 9. Effective Date.

The provisions of this Act shall become effective _____

Legislative History (all references are to the Proceedings of the NAJC).

1983 Proc. II 16, 22, 638, 693, 698-712 (adopted).

1984 Proc. I 6, 31, 576, 585, 590-592 (adopted The Health Insurance Act of 1983 as NAJC Policy).

54304 Schedule 2/26/90

The Uninsurables

Coghill's bill would create high-risk pool

By IMRE NEMETH

Uninsurable is a label branded on more and more people. As health care costs rise, insurance providers are looking for ways to cover themselves in a very volatile business.

People with heart conditions, cancer, other serious illnesses or just an all-around broken-down body don't fit into the system.

foot of calamity. Thus, it's good for the rest but, due to economic concerns, cancels out anybody else.

A bill Sen. Jack Coghill (R-Nenana) introduced this session would give these uninsurables another option.

Senate bill No. 304 would create a risk pool for this group. It would provide "access to disability insurance

Rather than place high-risk individuals in the same group as others taking out plans or having them face exclusion, this would incorporate every individual into one pool. The risk for this wouldn't be the concentrated responsibility of a single insurer but spread evenly among all the insurance firms providing health coverage in the state.

"We as an industry would be picking up the tab," Moore said. "I think it's important that our industry do what it can to support this big problem. It's a very positive solution."

Under the bill, which according to Moore was written to include as many hypothetical situations as possible, those in the pool wouldn't pay any more than 50 percent more than the

average health insurance premium.

The bill is modeled after a similar program in Washington state. So far 17 states have adopted legislation creating like programs.

The problem of the uninsurable is fairly large. There is the possibility that employers may refrain from hiring somebody who would cause their health plans problems in the future.

Moore said there seems to be quite a bit of support this time around for the high-risk pool.

"The concern is what if the losses become too high?" he said. "What if the 50 percent premium cap is not adequate?"

These are questions nobody yet knows the answers to. It isn't even known yet how many people are out there who would be eligible.



Lucky enough to fit under the umbrella of a corporate health plan, those who have had some major medical catastrophe in their past are able to get coverage. Unfortunately, a large group of castaways seems to fit in the individual category.

In this area, it's easy for an insurer to print "rejected" on an applicant's form. It enhances competitiveness and keeps costs down for people who don't get sick or trampled under the

coverage to all residents of the state who are denied adequate disability insurance coverage for any reason or who are otherwise considered uninsurable."

Insurance agent Bruce Moore, president of the Southern Alaska Life Underwriters, considers the bill one of his pet projects. He feels the issue is of grand importance not only to his industry but to clients of his that fall under this category.

KIRA BROKERAGE AND AFFILIATES

"Your Leasing Specialist"

- ★ Automatic approval for Medical Practitioners (starting from \$10,000 and up)
- Sell-Buy Lease Backs
- Direct Leasing
- Vendor programs available

SB 304

25 Apr 1989

ORIGINAL COMMITTEE REFERRALS:
Labor & Commerce, Health, Education & Social Services and Finance

ORIGINAL SPONSORS:
Coghill

"An Act relating to disability insurance; and providing for an effective date."

This bill would create a nonprofit, incorporated, legal entity known as the "Comprehensive Disability Insurance Association." Its membership would consist of all licensed hospital or medical service corporations in the state offering subscriber contracts for major medical coverage and all insurers licensed to transact disability insurance in the state that offer policies for major medical coverage on an expense-incurred basis. Membership in this association would be a condition of doing disability insurance business, or being able to offer subscriber contracts for major medical coverage in the state.

The stated purpose of this association is to provide a state plan of health and disability insurance for those who are denied adequate coverage for any reason or who are otherwise considered uninsurable. Maximum premiums for this insurance plan could not exceed 150 percent of the premiums that would be required for a similar actuarially sound plan for persons who are a standard risk. The losses due to claims expenses would be shared by each member of the association in proportion to the amount of business they transact in the state.

SB 305

27 Apr 1989

ORIGINAL COMMITTEE REFERRALS:
Resources and Finance

ORIGINAL SPONSORS:
Coghill

"An Act relating to utilization of fish caught by subsistence fishermen, waste of fish, and management of and planning for certain salmon stocks; and providing for an effective date."

According to this bill the state would develop plans and programs for rehabilitation and enhancement of salmon stocks that spawn in terminal

areas to meet the needs of subsistence, personal use, sport, and commercial fishermen who utilize those salmon stocks.

This bill would increase from 6 months to 1 year, the maximum term of imprisonment for those who intentionally, knowingly, or with reckless disregard waste not only salmon but fish in general.

This bill would allow the commercial utilization of fish parts from subsistence-caught fish.

SB 306

3 May 1989

ORIGINAL COMMITTEE REFERRALS:
Finance

ORIGINAL SPONSORS:
Finance Committee

"An Act making, amending, transferring, and repealing capital and operating appropriations; and providing for an effective date."

This bill makes 200 separate modifications in prior capital projects and operating expense appropriations.

SB 307

27 Apr 1989

ORIGINAL COMMITTEE REFERRALS:
Community & Regional Affairs and Labor & Commerce

ORIGINAL SPONSORS:
Pearce

"An Act relating to property foreclosed upon by a municipality."

Currently the owner at the time of a property tax foreclosure may within 10 years repurchase the property if it has not already been sold by the municipality. However, according to this bill, the repurchase price would have to include the "costs of maintaining and managing the property incurred by the municipality including insurance, repairs, association dues, and management fees, that exceed amounts received by the municipality for the use of the property."

Currently if the property is sold at a tax foreclosure sale, the former owner is entitled to the portion of the sale proceeds that exceeds the unpaid taxes, the accumulated taxes, penalties, interest, and the costs of foreclosing and selling the property. However, according to this bill, the "costs to the municipality of maintaining and

managing the property that exceed as received by the municipality for the use of property" would also be deducted from former owner's share of the proceeds.

SB 308

27 Apr

ORIGINAL COMMITTEE REFERRAL:
Community & Regional Affairs and Labor & Commerce

ORIGINAL SPONSORS:
Pearce

"An Act relating to taxation of certain property by municipalities; and providing for an effective date."

According to this bill the real property taxes of the following would be subject to municipal taxation:

- Teachers Retirement System
- Public Employees Retirement System
- Alaska Industrial Development Authority

SB 309

28 Apr

ORIGINAL COMMITTEE REFERRAL:
Labor & Commerce

ORIGINAL SPONSORS:
Frank, Duncan, Zharoff, Fischer, Binkley, Uehling and Faiks

"An Act relating to excluding a named person from a motor vehicle insurance policy providing for an effective date."

According to this bill, except for state automobile liability insurance policies:

"An insurer may not refuse to exclude a person from coverage under an automobile insurance policy on the basis of the claim experience or driving record of the person if the exclusion would have justified cancellation, nonrenewal, or an increase in the premium. A premium charge for a policy that excludes a person from coverage does not reflect the claims, experience, or driving record of the excluded person."

"An automobile insurance policy providing coverage for a named person is excluded from coverage may also exclude that the insurer is not liable for damages arising out of use or operation of the automobile by the excluded person."

SENATE CONCURRENT RESOLUTIONS

SCR 29

3 Apr 1989

ORIGINAL COMMITTEE REFERRALS:
Labor & Commerce and Finance

ORIGINAL SPONSORS:
Senate Special Committee on Banking & Economic Development

"Relating to the investment of the state's public trust funds."

This resolution encourages the managers of the state's public trust funds to consider placing a portion of their investment portfolios in sound, diversified venture capital funds and that all such investments be accompanied by appropriate

terms and conditions that encourage the venture capital fund managers to actively pursue investment opportunities in the state.

SCR 30

5 Apr 1989

ORIGINAL COMMITTEE REFERRALS:
Oil & Gas and Resources

ORIGINAL SPONSORS:
Rodey and Szymanski

"Urging coordinated research and development of technology and programs for prevention and cleanup of oil discharges."

This resolution requests the Governor to direct the Science and Engineering Advisory

Commission and the Alaska Science and Technology Foundation to explore additional ways to coordinate their activities and the activities of other state agencies in order to achieve development of better prevention and techniques related to oil discharges."

This resolution also requests the Governor to "consider the possibility of having Alaska hold a future conference at which the attendance of worldwide experts could be focused on prevention, consequences, and lessons learned from charge disasters like the one at Prince Sound."

SCR 31

ORIGINAL COMMITTEE REFERRAL:
Rules

S B

314



Senate Health, Education and Social Services Committee

Senator Paul Fischer, Chairman

Senator:

A number of Hospitals are concerned about the impact this bill will have upon them. They would like to set up a teleconference next week.
(Wednesday)

Also, the Court system may be fiscally impacted by this bill. They are working on a fiscal note. They have stated that they "Have no idea of how many new cases this will bring in".

Perhaps public safety ^{may} ~~will~~ be impacted as well.

DCM 3/14

SENATE COMMITTEE REPORT

FIRST COMMITTEE OF REFERRAL

Date of 5-DAY NOTICE _____
IN ACCORDANCE WITH UNIFORM RULE 23

FURTHER

SA

**FISCAL NOTE(S) MUST BE ATTACHED
IN ACCORDANCE WITH AS 24.08.035

5/2/89

DATE TURNED INTO OFFICE _____

Mr. President:

HESS

Committee considered

SB 314

limiting the right to receive medical benefits under the public employees' retirement system and the teachers' retirement system simultaneously

and recommended:

- replace with CS _____ same title
- attached amendment(s) and new title
- _____ letter of intent adopted
- do pass
- do not pass
- no recommendation
- individual recommendations
- further referral to _____

FISCAL NOTE(S) attached zero fiscal impact
 appropriation no FN attached Gov. FN introduced w/ bill

MEMBERS SIGNING DO PASS

OTHER RECOMMENDATIONS

[Signature]

Al Adams

Tom Kelly

Jim Duncan - No Rec

Paul Frink (Do Pass)

 Chair : signature and recommendation

Committee backup attached

Alaska State Legislature

Irman
Chairman



P.O. BOX
ROOM 1
STATE CAPITOL
(907) 465-37

Senate Committee on Health, Education and Social Services

TO: MEMBERS OF THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE.

FROM: SENATOR PAUL FISCHER, CHAIRMAN

DATE: JANUARY 22, 1990

RE: SENATE BILL 314 - LIMITING PERS AND TRS MEDICAL BENEFITS.

DURING TESTIMONY BEFORE THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE, IT WAS DETERMINED THAT SOME INDIVIDUALS ARE ELIGIBLE TO RECEIVE 100 % MEDICAL COVERAGE WHEN THEY RETIRE UNDER BOTH PERS AND TRS.

THIS POSES AN UNFAIR ADVANTAGE NOT SHARED BY THOSE WHO RETIRE UNDER ONE SYSTEM ONLY. IT IS THE INTENT OF THIS BILL TO LIMIT RETIREMENT BENEFITS FOR MEDICAL COVERAGE TO 80%. THIS WILL KEEP THE SYSTEM IN A MORE EQUITABLE POSITION.

THE MAIN PROVISION OF THIS BILL IS TO PROHIBIT A PERSON WHO RECEIVES BENEFITS UNDER BOTH PERS AND TRS FROM RECEIVING MAJOR MEDICAL BENEFITS SIMULTANEOUSLY FROM BOTH SYSTEMS. THE BENEFIT RECIPIENT MUST SELECT WHETHER TO RECEIVE BENEFITS UNDER PERS OR TRS.

THIS BILL WILL RESULT IN A NET SAVINGS TO THE STATE IN THE RANGE OF \$70,000.

CORRECTION

**THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY**

Alaska State Legislature

SENATOR PAUL FISCHER, Chairman
SENATOR JIM DUNCAN, Vice Chairman
SENATOR AL ADAMS
SENATOR LLOYD JONES
SENATOR TIM KELLY



P.O. BOX V
ROOM 508
STATE CAPITOL
(907) 465-3762

Senate Committee on Health, Education and Social Services

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FROM: SENATOR PAUL FISCHER, CHAIRMAN

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THIS BILL WILL RESULT IN A NET SAVINGS TO THE STATE IN THE RANGE OF \$70,000.

STATE OF ALASKA
THE LEGISLATURE

POUCH Y STATE CAPITOL
JUNEAU, ALASKA 99811
907 465 3800

LEGISLATIVE AFFAIRS AGENCY

M E M O R A N D U M

January 22, 1990

SUBJECT: Sectional Analysis of SB 314
(Medical benefits under PERS and TRS)

TO: Senator Paul Fischer
Chairman, HESS Committee

FROM: Teresa B. Cramer *TBC*
Legislative Counsel

You have requested a sectional analysis of the above described bill.

As a preliminary matter, note that a sectional analysis or summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

Sections 1 and 2 make technical amendments in the Teachers' Retirement System (TRS) statute concerning major medical benefits to reflect the addition, by bill section 3, of a new subsection.

Sec. 3 prohibits a person who receives benefits under both TRS and the Public Employees' Retirement System (PERS) from receiving major medical benefits simultaneously from both systems. The benefit recipient must select whether to receive benefits under PERS or under TRS.

Secs. 4 and 5 make technical amendments in the PERS statute concerning major medical benefits to reflect the addition, by bill section 6, of a new subsection.

Sec. 6 prohibits a person who receives benefits under both PERS and TRS from receiving major medical benefits simultaneously from both systems. The benefit recipient must select whether to receive benefits under PERS or under TRS.

If I may be of further assistance, please advise.

TC:lmb
L9/068

FISCAL NOTE

REQUEST:

Revision Date: _____
 Title: An Act Limiting Benefits Under the PERS and TRS Agency Affected: University of Alaska
BRU: UAF, UAA, UAS
 Sponsor: Senate HESS Components: _____
 Requestor: Senate HESS

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0

CAPITAL						
---------	--	--	--	--	--	--

REVENUE						
---------	--	--	--	--	--	--

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS : (Attach a separate page if necessary)

Senate Bill SB 314 would eliminate dual health insurance coverage under the PERS and TRS. Since current active or retired members of the systems would not be affected, only new hires, no immediate savings, would be recognized. Future fiscal impact is not expected to be measurable on the contribution rate or the funding ratios for the PERS

Prepared by: Marsha Hubbard Phone: 474-7593 or TRS.
 Division: Statewide Budget Date: 2/7/90

Approved by Commissioner: Brian Rogers Date: 2/7/90
 Agency: University of Alaska

Distribution (by preparer):
 Legislative Finance
 Legislative Sponsor
 Requestor
 Office of Management and Budget
 Impacted Agency(ies)

FISCAL NOTE

REQUEST:

Revision Date: _____ Agency Affected: Department of Administration
 Title: An Act limiting medical benefits BRU: Retirement and Benefits
under the PERS and TRS.
 Sponsor: (S) HESS Components: Retirement and Benefits
 Requestor: Senate HESS

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: (Attach a separate page if necessary)

See attached fiscal implications.

Prepared by: Sally Smith *Sally Smith* Phone: 465-4470
 Division: Retirement and Benefits Date: 01/22/90
 Approved by Commissioner: Frank S. Baxter *Frank S. Baxter* Date: 1/23/90
 Agency: Department of Administration

Distribution (by preparer):
 Legislative Finance
 Legislative Sponsor
 Requestor
 Office of Management and Budget
 Impacted Agency(ies)

Senate Bill 314
Analysis of Financial Implications on the Retirement Systems
Prepared by Division of Retirement & Benefits
Department of Administration
January 22, 1990

Analysis: Senate Bill 314 would eliminate dual health insurance coverage under the Public Employees' and Teachers' Retirement Systems. Since current active or retired members of the systems would not be affected, only new hires, no immediate savings would be recognized. Though this provision could save the systems \$75,000 annually, the amount is insufficient to impact the funding of the systems; therefore, this bill would have no measurable impact on the contribution rate or the funding ratios of either the PERS or TRS.

given twenty years of part-time service to retire under the teacher's retirement system with a twenty year retirement. Their benefit was based on their actual accumulated service.

Senator Fischer asked if the person was working part-time for the school district and part-time for another government agency and they would qualify for early retirement and only one agrees, what would happen? Mr. Stalnaker said if a member became vested under both systems by this legislation, then their participation under the RIP would be totally dependent upon the employer that designated them to participate. If both employers designated the person then they would be able to participate under both systems. If one employer designated them, they could retire under one system but couldn't retire under the other system until they were eligible to retire. He said the benefit that is accumulated under each system would be totally independent of the other.

Senator Fischer asked if a person could retire early from TRS and still work for PERS. Mr. Stalnaker said currently, under the PERS system, a new employee can't retire until they reach the age of sixty and can early retire at fifty-five. Currently, under the teacher's system, normal retirement is age fifty-five and early retirement is fifty.

Senator Duncan referred to the RIP program and said if a person retires from PERS and they go to work for TRS or visa versa, the person would have to pay a penalty.

Senator Jones asked how many people would this legislation affect. Mr. Stalnaker said presently there isn't a way to compare who is working or who could potentially work under both systems because they are two different systems and that data isn't maintained. He said it would probably be less than ten. Senator Duncan said just because these people happen to work for two different employers, they shouldn't be penalized.

Number 614

Jackie Lorensen, Education Specialist, Alaska State Museum, said last year she had taken a half-time position at Gastineau School to teach. She stated she is half-time under PERS and half-time under the Teacher Retirement Program. She said in November, 1988, she found out that she couldn't contribute to both retirement systems. Senator Jones asked her which plan she chose. Ms. Lorensen said she chose the Teacher Retirement Program.

Senator Kelly referred to the medical benefits and asked when a person retires, do they have to choose one or the other or do they receive medical benefits under both

systems. Mr. Stalnaker said at the present time a person can't participate under both systems. A person in this situation would make an election as to which system they want and when that person retires they would get the medical benefits under the system. This legislation enables them to accumulate service under each system. There is a conditional benefit that says if a member has worked under the PERS and is vested under the program and goes to work under TRS for two years, they get a conditional benefit which includes everything provided under TRS.

TAPE 1, SIDE 2
Number 025

Senator Duncan said there is a difference in medical benefits between a working employee. Retirees are at 80 percent. In PERS workers are at 90 percent. Senator Duncan asked if there are people who are presently getting 100 percent coverage. Mr. Stalnaker said there are. Senator Duncan asked if it has any impact on the retirees premium costs. Mr. Stalnaker said it has the net effect of actually reducing the cost of health. There will be people who will retire under other systems. There is a situation that exists for married people that both retire under one system. They are both eligible for full health benefits, but because under the retirement system, the benefit also includes a benefit for the spouse. The system isn't being charged for two full health plans because they coordinate between themselves.

Senator Fischer said this may be an unfair advantage to people who are single as they wouldn't be getting 100 percent. Mr. Stalnaker said a person who works through one system their entire career would get the health benefit from provided by the system which is currently 80 percent.

Senator Duncan noted this legislation doesn't create a problem as the problem already exists. There was continued discussion regarding this matter.

Senator Duncan made a motion to move SB 163 out of the Senate HESS Committee. Senator Fischer asked if there were any objections to moving the bill out of committee, hearing none, the bill moved with individual recommendations.

Number 312

Senator Fischer adjourned the meeting at 5:15 p.m.

S B

315

Gordon Evans is
sick and will not
be here today.

Supports the

HESS CS SB 315

Alaska State Legislature

SENATOR PAUL FISCHER, Chairman
SENATOR JIM DUNCAN, Vice Chairman
SENATOR AL ADAMS
SENATOR LLOYD JONES
SENATOR TIM KELLY



P.O. BOX V
ROOM 508
STATE CAPITOL
(907) 465-3762

Senate Committee on Health, Education and Social Services

TO: MEMBERS OF THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE.

FROM: SENATOR PAUL FISCHER, CHAIRMAN

DATE: JANUARY 22, 1990

RE: SB 315 - LONG TERM CARE INSURANCE.

THIS BILL IS BASED UPON A MODEL ACT DEVELOPED BY THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS. IT ESSENTIALLY ALLOWS PROVIDERS TO DELIVER LONG TERM CARE INSURANCE IN THE STATE OF ALASKA. ~~CERTAIN REQUIREMENTS MUST BE MET~~ IN ORDER TO BE ALLOWED TO DO THIS.

TO DATE, 38 STATES HAVE DEVELOPED SIMILAR VERSIONS OF THIS MODEL ACT. SEVERAL OTHER STATES HAVE THIS UNDER CONSIDERATION.

ESSENTIALLY, THIS BILL PROVIDES A METHOD FOR OUR CITIZENRY TO MEET THE NEEDS OF AN AGING POPULATION. MEDICARE CURRENTLY PROVIDES ALMOST NO COVERAGE FOR LONG TERM CARE. MOST COVERAGE FOR LONG TERM CARE COMES OUT OF MEDICAID.

THIS BILL PROVIDES A PRIVATE SECTOR ALTERNATIVE FOR INDIVIDUALS IN NEED OF LONG TERM CARE. IT WOULD ALSO HELP REDUCE PRESSURES ON THE MEDICAID BUDGET.

A ZERO FISCAL NOTE IS ATTACHED.

STATE OF ALASKA
THE LEGISLATURE

POUCH Y STATE CAPITOL
JUNEAU, ALASKA 99811
907 465 3800

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM

January 22, 1990

SUBJECT: Long-term disability insurance - SB 315
TO: Senator Paul Fischer
FROM: Michael F. Ford *M.F.*
Legislative Counsel

The following is a section by section analysis of SB 315:

Section 1 - Purpose section.

Section 2 - Adds a new chapter to Title 21, concerning long term disability insurance.

Sec. 21.53.010 - Prohibits the sale or delivery of a long-term disability insurance policy unless the policy complies with AS 21.53.

Sec. 21.53.020 - Establishes certain disclosure and performance standards that must be included in each long-term disability insurance policy.

Sec. 21.53.030 - Establishes requirements for exclusion of a preexisting condition from coverage in a long-term disability insurance policy.

Sec. 21.53.040 - Provides that a policy cannot condition eligibility on certain prior hospital or institutional care, and that a limitation or condition not prohibited must be clearly set out in the policy.

Sec. 21.53.050 - Establishes the right of a policyholder to return the policy and to receive a refund. Requires insurers to provide an outline of coverage to a prospective applicant and establishes certain items that must be included in the outline.

Sec. 21.53.060 - Prohibits long-term disability insurance being offered under a group policy issued in another state,

Senator Paul Fischer
Page 2
January 22, 1990

unless the state in which the policy is issued has substantially similar statutory or regulatory provisions.

Sec. 21.53.070 - Provides that an insurer may not issue a long-term group disability insurance policy to an association, unless the association meets the requirements of this section.

Sec. 21.53.080 - Definitions.

Section 3 - Delayed effective date for the prohibition on prior hospital or institutional care conditions.

Section 4 - Effective date.

MFF:lmb
L9/065

STATE OF ALASKA
THE LEGISLATURE

POUCH Y STATE CAPITOL
JUNEAU ALASKA 99811
907-465 3800

LEGISLATIVE AFFAIRS AGENCY

M E M O R A N D U M

February 14, 1990

SUBJECT: Long-term care disability insurance -
CSSB 315(HESS)

TO: Senator Paul Fischer

FROM: Michael F. Ford *M.F.*
Legislative Counsel

The following is a sectional analysis of CSSB 315(HESS):

Section 1 - Purpose section.

Section 2

Sec. 21.53.010 - Prohibits sale or marketing unless the insurance complies with the provision of this charter and other applicable provisions of law.

Sec. 21.53.020 - Provides disclosure and performance standards for long-term disability insurance.

Sec. 21.53.030 - Establishes criteria for excluding coverage as a result of a preexisting condition.

Sec. 21.53.040 - Prohibits conditioning eligibility on prior hospital or institutional care. Allows limitations or conditions on eligibility, if not prohibited and if clearly set out in a separate paragraph of the policy.

Sec. 21.53.050 - Provides that an insured has the right to return a policy within 30 days after delivery. Requires the insurer to deliver an outline of coverage to a prospective applicant. Establishes items that must be included in the outline of coverage.

Sec. 21.53.060 - Requires a policy summary be included with an individual life insurance policy, if the policy provides long-term care disability insurance benefits. Establishes

Senator Paul Fischer

Page 2

February 14, 1990

items that must be included in the summary. Requires a report of benefits paid, if the benefits are paid by acceleration of the policy death benefit. Establishes items that must be included in the report.

Sec. 21.53.070 - Provides that group long-term care disability insurance cannot be offered to a resident of this state, under a group policy in another state, unless the state in which the policy is offered has similar statutory or regulatory provisions.

Sec. 21.53.080 - Prohibits group long-term care disability insurance being offered to an association, unless the association meets the requirements of this section.

Sec. 21.53.090 - Requires the director of the division of insurance to adopt certain regulations.

Sec. 21.53.200 - Definitions.

Section 3 - Provides that AS 21.53 applies to fraternal benefit societies.

Section 4 - Provides that AS 21.53 applies to hospital or medical service corporations.

Section 5 - Effective date.

MFF:pl
WKP2/046

SB 315: An Act relating to long-term disability insurance; and providing for an effective date.

This bill establishes a specific regulatory framework for insurance contracts that provide for long-term care benefits. It establishes certain standardized contract provisions in order to require certain minimum benefits and to facilitate public understanding and comparison shopping.

Funding of long-term care is a critical issue throughout the nation that impacts all third-party and out-of-pocket payers of medical care for older persons. "Long-term care" is the term that pertains to a continuum of care that ranges from some assistance in the home to the extreme of 24-hour skilled care in a medical facility. Our average population is getting older and is living longer, thus, increasing the likelihood of more people requiring some form of long-term care. Medicare currently provides almost no coverage for long-term care. Medicaid provides the majority of the funding for long-term care nationwide and provides for nearly all of the funding for skilled nursing service care in Alaska. Most Americans are not financially prepared to meet the cost of long-term care in their later years. This results in those people spending down both assets and income in order to qualify for public assistance primarily through Medicaid.

The insurance industry has been slow to develop insurance products to cover this risk. The most important reason for this is the lack of reliable statistical data on which to base rates, coupled with the fact that correct projection of costs far into the future is required and is extremely difficult to accomplish. Although this attitude is changing, the general population has held the misperception that there is little or no need for such coverage, and also that, if long-term care is needed, Medicare would provide the necessary benefits.

Without mechanisms such as insurance products to prefund long-term care, publicly-funded care is expected to increase, perhaps to a point beyond that which public resources can readily bear. It is important to encourage the growth of insurance products to help finance long-term care needs. However, this needs to be done in a manner that provides appropriate elements of consumer protection.

SB 315 is based on the National Association of Insurance Commissioners (NAIC) Model Long-Term Care Act. The NAIC is encouraging the adoption of this model by the various states in lieu of federal intervention. Abuses have occurred in other states with a large senior population. These abuses have received Congressional scrutiny, with indications that the federal government should regulate long-term care if the states do not.

Since the introduction of SB 315, the NAIC has amended its model act. The department supports the legislation with inclusion of the NAIC amendments.

Proposed amendments:

1. The term "long-term disability insurance" should be changed to "long-term care disability insurance" whenever it appears in the bill. This will avoid confusion with long-term disability income replacement coverage.

AS is deleted
AS 21.53.030(e) (page 3) needs to be amended in order to clarify the sponsor's intent. Subsection (e) of this section exempts group long-term care contracts from limiting the preexisting condition definition and the waiting period for benefits to that prescribed in subsections (a) and (b). The NAIC model does not exempt group contracts from these provisions. It is not clear whether the intent of this Act is to prohibit any preexisting condition or waiting period provisions, or to allow all possible provisions with any kind of definition or any length waiting period.

3. The effective date clauses (page 8) need review. *Not needed* Section 3 allows for a one-year phase-in of the requirements found in AS 21.53.040. Amendment to the NAIC model eliminates this one-year phase-in provision. The model was amended because two-thirds of the states have previously adopted the model and insurers in the marketplace do not need this lead time in other jurisdictions as contracts have already been developed to comply with these requirements.

4. AS 21.53.050 (page 4) needs to be amended to include a 30-day right to return the contract for all types of contracts providing long-term care. We recommend wording used in the amended NAIC model.

5. AS 21.53.060 (page 6) needs to be amended to have this provision apply only to stationary groups as defined in AS 21.53.100(3)(D).

HIAA
6. AS 21.53.100 (page 6) needs to be amended to include a definition of the term "insurer" to include hospital or medical service corporations and fraternal benefit associations. Also, the term "policy" should be amended to include subscriber contracts issued by a hospital or medical service corporation.

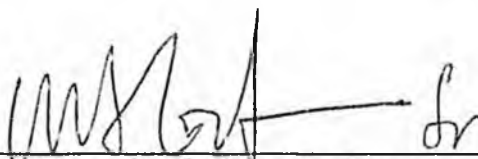
7. AS 21.87.340 needs to be amended to include a reference to AS 21.53.010-100. Otherwise, hospital or medical service corporations will not be subject to this Act.

8. AS 21.84.590 needs to be amended to include reference to AS 21.53.010-100. Otherwise, fraternal benefit associations will not be subject to this Act.

9. A new provision, perhaps AS 21.53.080, needs to be added to specifically authorize the director to adopt regulations to establish the format for the required disclosures, outlines of coverage, and for the establishment of loss ratio standards. The language for this authority is found in the NAIC model at Section 6-A and Section 6-E. Also, the NAIC model act contemplates a regulation to be promulgated following enactment of the model act.
10. A new provision, perhaps AS 21.53.055, needs to be added to reorganize long-term care benefits provided through life insurance contracts. We recommend the language used in the amended NAIC model act identified in Section 6-I and Section 6-J. Benefits can be provided via the nonforfeiture benefits or by accelerated death benefits. In other words, the amount of death benefit is reduced by any amounts utilized for long-term care benefits. Most often these types of benefits provided through life insurance contracts are provided for terminally ill people. This would also require that AS 21.53.010 be amended to provide for compliance with AS 21.45 and AS 21.18. AS 21.12.040 needs to be amended to recognize that life insurance contracts may be utilized to offer such benefits. ✓

6E
IJK

I have attached the sections of the Model Act referenced above for your consideration.



Larry Mercurieff, Commissioner
Date: 16 Jan 90

LM/LW/dgl6113D
11690b
Attachments

Dubin

FISCAL NOTE

REQUEST:

Revision Date: _____
Title : An Act relating to long-term disability insurance
Sponsor : HESS Committee
Requestor : Senate HESS Committee

Agency Affected : Commerce & Economic Dev. Insurance
BRU : _____
Components : Operations

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS : (Attach a separate page if necessary)

Prepared by : Don Koch, Chief of Market Surveillance *DAC* Phone : 465-2577
Division : Insurance Date : 1-12-90
Approved by Commissioner : Larry Merculieff *LM* Date : 1/1/90
Agency : Department of Commerce and Economic Development

Distribution (by preparer) :
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: An Act relating to long-term disability insurance
Sponsor: HESS Committee
Requestor: Senate HESS Committee

Agency Affected: Commerce & Economic Dev. Insurance
BRU: _____
Components: Operations

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS : (Attach a separate page if necessary)

Prepared by: Don Koch, Chief of Market Surveillance *DK* Phone: 465-2577
Division: Insurance Date: 1-12-90
Approved by Commissioner: Larry Merculieff *LM* Date: 1/11/90
Agency: Department of Commerce and Economic Development

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

page _____ of _____

*Adopted/Passed
out*

6-1217E
Ford
2/5/90

Original sponsor(s): HESS Committee

1 IN THE SENATE

BY THE HESS COMMITTEE

2 CS FOR SENATE BILL NO. 315 (HESS)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 SIXTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to long-term care disability insur-
7 ance; and providing for an effective date."

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

9 * Section 1. PURPOSE. The purpose of this Act is to promote the public
10 interest and the availability of long-term care disability insurance poli-
11 cies, to protect applicants for long-term care disability insurance from
12 unfair or deceptive sales or enrollment practices, to establish standards
13 for long-term care disability insurance, to facilitate public understanding
14 and comparison of long-term care disability insurance policies, and to
15 facilitate flexibility and innovation in the development of long-term care
16 disability insurance coverage.

17 * Sec. 2. AS 21 is amended by adding a new chapter to read:

18 CHAPTER 53. LONG-TERM CARE DISABILITY INSURANCE.

19 Sec. 21.53.010. PROHIBITED SALE OR ADVERTISING. An insurer,
20 hospital or medical service corporation, or a fraternal benefit soci-
21 ety may not advertise, market, sell, deliver, or offer for delivery a
22 long-term care disability insurance policy unless the policy complies
23 with this chapter, AS 21.18, AS 21.45, the disability insurance re-
24 quirements imposed under AS 21.51, and, if a group policy, the group
25 disability insurance requirements imposed under AS 21.54.

26 Sec. 21.53.020. DISCLOSURE AND PERFORMANCE STANDARDS. An insur-
27 er, hospital or medical service corporation, or a fraternal benefit

1 (1) cancel, fail to renew, or otherwise terminate the
2 policy on the grounds of age or deterioration of the mental or phys-
3 ical health of the insured or certificate holder;

4 (2) include a provision requiring a new waiting period in
5 the event existing coverage is converted to or replaced by a new or
6 another form of disability insurance within the same company, unless
7 there is an increase in benefits voluntarily selected by the insured;
8 or

9 (3) provide coverage only for skilled nursing care, or
10 provide significantly more coverage for skilled care in a facility
11 than is provided for coverage for lower levels of care; evaluation of
12 the coverage provided under this paragraph must be based on the number
13 of days of coverage provided for lower levels of care, when compared
14 to the number of days of coverage provided for skilled care.

15 Sec. 21.53.030. PREEXISTING CONDITIONS. (a) An insurer, hospi-
16 tal or medical service corporation, or a fraternal benefit society
17 may not include, in a long-term care disability insurance policy or
18 certificate, a definition of "preexisting condition" that is more
19 restrictive than the following: preexisting condition means the
20 existence of symptoms that would cause an ordinarily prudent person to
21 seek diagnosis, care, or treatment, or a condition for which medical
22 advice or treatment was recommended by, or received from a provider of
23 health care services, within six months preceding the effective date
24 of coverage of an insured person.

25 (b) In a long-term care disability insurance policy or certifi-
26 cate an insurer, hospital or medical service corporation, or a frater-
27 nal benefit society may not exclude coverage for a loss or confinement
28 that is the result of a preex. ing condition, unless the loss or
29 confinement begins within six months following the effective date of

1 coverage of an insured person.

2 (c) The director may extend the limitation periods established
3 under (a) and (b) of this section for specific age group categories or
4 specific policy forms, if the director finds that the extension is in
5 the best interest of the public.

6 (d) This section does not prohibit an insurer, hospital or
7 medical service corporation, or a fraternal benefit society from using
8 an application form designed to elicit the complete health history of
9 an applicant, and, on the basis of the answers on the application,
10 from applying that insurer's, hospital or medical service corpora-
11 tion's, or fraternal benefit society's established underwriting stan-
12 dards. Unless otherwise provided in the policy or certificate, a
13 preexisting condition, regardless of whether it is disclosed on the
14 application, need not be covered until the waiting period described in
15 (b) of this section expires. A long-term care disability insurance
16 policy or certificate may not exclude, limit, or reduce, or use waiv-
17 ers or riders of any kind to exclude, limit, or reduce coverage or
18 benefits for specifically named or described preexisting diseases or
19 physical conditions after the waiting period described in (b) of this
20 section, unless the waiver or rider has been specifically approved by
21 the director.

22 Sec. 21.53.040. PRIOR HOSPITAL OR INSTITUTIONAL CARE CONDITIONS
23 PROHIBITED. (a) A long-term care disability insurance policy may not
24 be delivered or issued for delivery in this state if the policy condi-
25 tions eligibility

- 26 (1) on a prior hospitalization requirement;
27 (2) on the receipt of a higher level of institutional care,
28 when care is provided in an institutional setting;
29 (3) for noninstitutional benefits on a prior institutional

1 stay of more than 30 days for which benefits are paid; or

2 (4) on admission to an institutional care facility for the
3 same or a related condition within a period of less than 30 days after
4 discharge from the institution, if the policy provides benefits only
5 following institutionalization.

6 (b) A long-term care disability insurance policy may contain a
7 limitation or condition on eligibility for benefits, not prohibited in
8 (a) of this section, if the limitation or condition is clearly set out
9 in a separate paragraph of the policy or certificate.

10 Sec. 21.53.050. RIGHT OF RETURN; OUTLINE OF COVERAGE. (a) A
11 long-term care disability insurance applicant may return a policy
12 within 30 days after delivery and have the premium refunded if, after
13 examination of the policy, the applicant is not satisfied with the
14 policy. A long-term care disability insurance policy must have a
15 notice prominently printed on the first page of the policy or sepa-
16 rately attached stating that the applicant has the right to return the
17 policy within 30 days of its delivery and to have the premium refunded
18 if, after examination of the policy, the applicant is not satisfied
19 with the policy.

20 (b) An insurer, hospital or medical service corporation, or a
21 fraternal benefit society shall deliver an outline of coverage to a
22 prospective applicant for long-term care disability insurance at the
23 time of initial solicitation by a means that prominently directs the
24 attention of the recipient to the document and its purpose. In the
25 case of agent solicitations, an agent shall deliver the outline of
26 coverage before the presentation of an application or enrollment form.
27 In the case of direct response solicitations, the outline of coverage
28 must be presented in conjunction with an application or enrollment
29 form. The outline of coverage must include

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

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

5 (3) a statement of the terms under which the policy or
6 certificate, or both, may be continued in force or discontinued,
7 including a reservation in the policy of a right to change the pre-
8 mium; continuation or conversion provisions of group coverage must be
9 specifically described;

10 (4) a statement that the outline of coverage is a summary
11 only, not a contract of insurance, and that the policy or group master
12 policy contain governing contractual provisions;

13 (5) a description of the terms under which the policy or
14 certificate may be returned and premium refunded; and

15 (6) a brief description of the relationship between the
16 cost of care and benefits.

17 (c) A certificate issued under a group long-term care disability
18 insurance policy that is delivered or issued for delivery in this
19 state must include

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

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

24 (3) a statement that the group master policy establishes
25 the governing contractual provisions.

26 Sec. 21.53.060. GROUP LONG-TERM CARE BENEFITS UNDER LIFE INSUR-
27 ANCE POLICIES. (a) In addition to the requirements of AS 21.45, at
28 the time of policy delivery, a policy summary shall be included with
29 an individual life insurance policy if the policy or policy rider

1 provides long-term care disability benefits. In the case of direct
2 response solicitations, the insurer shall deliver the policy summary
3 upon the applicant's request, but regardless of request shall deliver
4 a policy summary not later than the time of policy delivery. The
5 summary must include

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

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

11 (3) an explanation of each exclusion, reduction, and limi-
12 tation on long-term care disability benefits; and

13 (4) if applicable to the policy type,

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

16 (B) disclosure of guarantees related to the long-term
17 care disability costs of insurance charges; and

18 (C) current and projected maximum lifetime benefits.

19 (b) If a long-term care disability benefit is paid under a life
20 insurance policy by the acceleration of the policy death benefit, and
21 is in benefit payment status, a monthly report shall be provided to
22 the policyholder. The report must include

23 (1) long-term care disability benefits paid out during the
24 month;

25 (2) an explanation of changes in the policy, including
26 changes in death benefits or cash values, due to long-term care dis-
27 ability benefits being paid out; and

28 (3) the amount of long-term care disability benefits re-
29 maining.

1 Sec. 21.53.070. GROUP LONG-TERM CARE DISABILITY INSURANCE.
2 Group long-term care disability insurance coverage may not be offered
3 to a resident of this state under a group policy issued in another
4 state, unless the state in which the policy is issued has statutory or
5 regulatory provisions applicable to group long-term care disability
6 insurance that are substantially similar to this chapter and the
7 director determines that the issuance of the group policy is not
8 contrary to the best interest of the public, results in economies of
9 acquisition or administration, and the benefits are reasonable in
10 relation to the premiums charged.

11 Sec. 21.53.080. ORGANIZATIONAL REQUIREMENTS OF ASSOCIATIONS. An
12 insurer, hospital or medical service corporation, or a fraternal
13 benefit society may not issue group long-term care disability insur-
14 ance to an association or a trust or the trustee of a fund estab-
15 lished, created, or maintained for the benefit of members of one or
16 more associations, unless the association or the insurer of the asso-
17 ciation files evidence with the director that the association has

- 18 (1) a minimum of 100 members;
- 19 (2) been organized and maintained in good faith for pur-
20 poses other than that of obtaining insurance;
- 21 (3) been in active existence for at least one year; and
- 22 (4) a constitution and by-laws that require
- 23 (A) the association to hold regular meetings not less
24 than annually to further purposes of the members;
- 25 (B) except for credit unions, the association to
26 collect dues or solicit contributions from members; and
- 27 (C) the members to have voting privileges and repre-
28 sentation on the governing board and committees.

29 Sec. 21.53.090. REQUIRED REGULATIONS. The director shall adopt

1 regulations regarding the sale of long-term care disability insurance
2 that provide standards for

- 3 (1) terms of renewability;
- 4 (2) initial and subsequent conditions of eligibility;
- 5 (3) nonduplication of coverage provisions;
- 6 (4) coverage of dependents;
- 7 (5) preexisting conditions;
- 8 (6) termination of insurance;
- 9 (7) continuation or conversion;
- 10 (8) probationary periods, limitations, exceptions, reduc-
11 tions, elimination periods, and requirements for replacement.

12 Sec. 21.53.200. DEFINITIONS. In this chapter,

13 (1) "applicant" means in the case of an individual long-
14 term care disability insurance policy, the person who seeks to con-
15 tract for benefits, and in the case of a group long-term care disabili-
16 ty insurance policy, the proposed certificate holder;

17 (2) "certificate" means a certificate issued under a group
18 long-term care disability insurance policy that has been delivered or
19 issued for delivery in this state;

20 (3) "group long-term care disability insurance" means a
21 long-term care disability insurance policy, subscriber's contract, or
22 fraternal benefit society certificate that is delivered or issued for
23 delivery in this state and issued to

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

1 (B) a professional, trade, or occupational association
2 for its members or former or retired members, or combination of
3 them, if the association is composed of individuals all of whom
4 are or were actively engaged in the same profession, trade, or
5 occupation, and has been maintained in good faith for purposes
6 other than obtaining insurance;

7 (C) an association or a trust or the trustee of a fund
8 established, created, or maintained for the benefit of members of
9 one or more associations;

10 (D) a group other than described in this paragraph if
11 the director determines that the issuance of the group policy is
12 not contrary to the best interest of the public, would result in
13 economies of acquisition or administration, and the benefits are
14 reasonable in relation to the premiums charged;

15 (4) "long-term care disability insurance" means an indi-
16 vidual or group insurance policy, including group and individual life
17 insurance or annuities, a subscriber's contract, fraternal benefit
18 society certificate, or rider advertised, marketed, offered, or de-
19 signed to provide coverage for not less than 12 consecutive months for
20 each covered person on an expense incurred, indemnity, prepaid, or
21 other basis, for one or more necessary or medically necessary diagnos-
22 tic, preventive, therapeutic, rehabilitative, maintenance, or personal
23 care services that are provided in a setting other than an acute care
24 unit of a hospital, and includes a policy or rider that provides for
25 payment of benefits based on cognitive impairment or loss of func-
26 tional capacity; "long-term care disability insurance" does not in-
27 clude an insurance policy, subscriber's contract, or fraternal benefit
28 society certificate that is offered primarily to provide basic Medi-
29 care supplement coverage, basic hospital expense coverage, basic

1 medical-surgical expense coverage, hospital confinement indemnity
2 coverage, major medical expense coverage, disability income and relat-
3 ed asset protection coverage, catastrophic coverage, comprehensive
4 coverage, accident only coverage, specified disease or specified
5 accident coverage, or limited benefit health coverage;

6 (5) "policy" means a contract, subscriber agreement, rider,
7 or endorsement delivered or issued for delivery in this state by an
8 insurer, fraternal benefit society, nonprofit health, hospital or
9 medical service corporation, prepaid health plan, or health mainte-
10 nance organization.

11 * Sec. 3. AS 21.84.590 is amended to read:

12 Sec. 21.84.590. OTHER PROVISIONS APPLICABLE. In addition to the
13 provisions contained in this chapter, the following provisions of this
14 title apply to fraternal benefit societies to the extent applicable
15 and not in conflict with the express provisions of this chapter and
16 the reasonable implications of this chapter:

- 17 (1) AS 21.03
18 (2) AS 21.06
19 (3) AS 21.09.050 and 21.09.100
20 (4) AS 21.33
21 (5) AS 21.36
22 (6) AS 21.42.290 and 21.42.355
23 (7) AS 21.53
24 (8) AS 21.69.370 and 21.69.640
25 (9) [(8)] AS 21.78
26 (10) [(9)] AS 21.89.060.

27 * Sec. 4. AS 21.87.340 is amended to read:

28 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the
29 provisions contained or referred to previously in this chapter, the

1 following chapters and provisions of this title also apply with re-
2 spect to service corporations to the extent applicable and not in
3 conflict with the express provisions of this chapter and the reason-
4 able implications of the express provisions, and for the purposes of
5 the application the corporations shall be considered to be mutual
6 "insurers":

- 7 (1) AS 21.03
8 (2) AS 21.06
9 (3) AS 21.09, except AS 21.09.090
10 (4) AS 21.18.010
11 (5) AS 21.18.030
12 (6) AS 21.18.040
13 (7) AS 21.18.120
14 (8) AS 21.21.321
15 (9) AS 21.36
16 (10) AS 21.53
17 (11) AS 21.69.400
18 (12) [(11)] AS 21.69.520
19 (13) [(12)] AS 21.69.600, 21.69.620, and 21.69.630
20 (14) [(13)] AS 21.78
21 (15) [(14)] AS 21.90
22 (16) [(15)] AS 21.42.345 - 21.42.365
23 (17) [(16)] AS 21.89.040
24 (18) [(17)] AS 21.89.060.

25 * Sec. 5. This Act takes effect July 1, 1990.
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29

1 IN THE SENATE

BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

2

SENATE BILL NO. 315

3

IN THE LEGISLATURE OF THE STATE OF ALASKA

4

SIXTEENTH LEGISLATURE - FIRST SESSION

5

A BILL

6 For an Act entitled: "An Act relating to long-term disability insurance;
7 and providing for an effective date."

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

9 * Section 1. PURPOSE. The purpose of this Act is to promote the public
10 interest and the availability of long-term disability insurance policies,
11 to protect applicants for long-term disability insurance from unfair or
12 deceptive sales or enrollment practices, to establish standards for long-
13 term disability insurance, to facilitate public understanding and compari-
14 son of long-term disability insurance policies, and to facilitate flexibil-
15 ity and innovation in the development of long-term disability insurance
16 coverage.

17 * Sec. 2. AS 21 is amended by adding a new chapter to read:

18 CHAPTER 53. LONG-TERM DISABILITY INSURANCE.

19 Sec. 21.53.010. PROHIBITED SALE OR ADVERTISING. An insurer may
20 not advertise, market, sell, deliver, or offer for delivery a long-
21 term disability insurance policy unless the policy complies with this
22 chapter as well as the disability insurance requirements imposed under
23 AS 21.51, and, if a group policy, the group disability insurance
24 requirements imposed under AS 21.54.

25 Sec. 21.53.020. DISCLOSURE AND PERFORMANCE STANDARDS. An insur-
26 er who delivers or issues for delivery a long-term disability insur-
27 ance policy may not

28 (1) cancel, fail to renew, or otherwise terminate the
29 policy on the grounds of age or deterioration of the mental or

1 physical health of the insured or certificate holder;

2 (2) include a provision requiring a new waiting period in
3 the event existing coverage is converted to or replaced by a new or
4 another form of disability insurance within the same company, unless
5 there is an increase in benefits voluntarily selected by the insured;
6 or

7 (3) provide coverage only for skilled nursing care, or
8 provide significantly more coverage for skilled care in a facility
9 than is provided for coverage for lower levels of care; evaluation of
10 the coverage provided under this paragraph must be based on the number
11 of days of coverage provided for lower levels of care, when compared
12 to the number of days of coverage provided for skilled care.

13 Sec. 21.53.030. PREEXISTING CONDITIONS. (a) An insurer may not
14 include, in a long-term disability insurance policy or certificate, a
15 definition of "preexisting condition" that is more restrictive than
16 the following: preexisting condition means the existence of symptoms
17 that would cause an ordinarily prudent person to seek diagnosis, care,
18 or treatment, or a condition for which medical advice or treatment was
19 recommended by, or received from a provider of health care services,
20 within six months preceding the effective date of coverage of an
21 insured person.

22 (b) In a long-term disability insurance policy or certificate an
23 insurer may not exclude coverage for a loss or confinement that is the
24 result of a preexisting condition, unless the loss or confinement
25 begins within six months following the effective date of coverage of
26 an insured person.

27 (c) The director may extend the limitation periods established
28 under (a) and (b) of this section for specific age group categories or
29 specific policy forms, if the director finds that the extension is in

1 the best interest of the public.

2 (d) This section does not prohibit an insurer from using an
3 application form designed to elicit the complete health history of an
4 applicant, and, on the basis of the answers on the application, from
5 applying that insurer's established underwriting standards. Unless
6 otherwise provided in the policy or certificate, a preexisting condi-
7 tion, regardless of whether it is disclosed on the application, need
8 not be covered until the waiting period described in (b) of this
9 section expires. A long-term disability insurance policy or certifi-
10 cate may not exclude, limit, or reduce, or use waivers or riders of
11 any kind to exclude, limit, or reduce coverage or benefits for specif-
12 ically named or described preexisting diseases or physical conditions
13 after the waiting period described in (b) of this section, unless the
14 waiver or rider has been specifically approved by the director.

15 (e) Subsections (a) and (b) of this section do not apply to
16 group long-term disability insurance.

17 Sec. 21.53.040. PRIOR HOSPITAL OR INSTITUTIONAL CARE CONDITIONS
18 PROHIBITED. (a) A long-term disability insurance policy may not be
19 delivered or issued for delivery in this state if the policy condi-
20 tions eligibility

21 (1) on a prior hospitalization requirement;

22 (2) on the receipt of a higher level of institutional care,
23 when care is provided in an institutional setting;

24 (3) for noninstitutional benefits on a prior institutional
25 stay of more than 30 days for which benefits are paid; or

26 (4) on admission to an institutional care facility for the
27 same or a related condition within a period of less than 30 days after
28 discharge from the institution, if the policy provides benefits only
29 following institutionalization.

1 (b) A long-term disability insurance policy may contain a limi-
2 tation or condition on eligibility for benefits, not prohibited in (a)
3 of this section, if the limitation or condition is clearly set out in
4 a separate paragraph of the policy or certificate.

5 Sec. 21.53.050. RIGHT OF RETURN; OUTLINE OF COVERAGE. (a)
6 Individual long-term disability insurance policyholders may return a
7 policy within 10 days after delivery and have the premium refunded if,
8 after examination of the policy, the policy holder is not satisfied
9 with the policy. An individual long-term disability insurance policy
10 must have a notice prominently printed on the first page of the policy
11 or separately attached stating that the policyholder has the right to
12 return the policy within 10 days of its delivery and to have the
13 premium refunded if, after examination of the policy, the policyholder
14 is not satisfied with the policy.

15 (b) A person insured under a long-term disability insurance
16 policy issued under a direct response solicitation has the right to
17 return the policy within 30 days of its delivery and to have the
18 premium refunded if, after examination, the insured person is not
19 satisfied with the policy. Long-term disability insurance policies
20 issued under a direct response solicitation must have a notice promi-
21 nently printed on the first page or attached to the policy stating in
22 substance that the insured person has the right to return the policy
23 within 30 days of its delivery and to have the premium refunded if
24 after examination the insured person is not satisfied with the policy.

25 (c) An insurer shall deliver an outline of coverage to a pro-
26 spective applicant for long-term disability insurance at the time of
27 initial solicitation by a means that prominently directs the attention
28 of the recipient to the document and its purpose. In the case of
29 agent solicitations, an agent shall deliver the outline of coverage

1 before the presentation of an application or enrollment form. In the
2 case of direct response solicitations, the outline of coverage must be
3 presented in conjunction with an application or enrollment form. The
4 outline of coverage must include

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

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

9 (3) a statement of the terms under which the policy or
10 certificate, or both, may be continued in force or discontinued,
11 including a reservation in the policy of a right to change the pre-
12 mium; continuation or conversion provisions of group coverage must be
13 specifically described;

14 (4) a statement that the outline of coverage is a summary
15 only, not a contract of insurance, and that the policy or group master
16 policy contain governing contractual provisions;

17 (5) a description of the terms under which the policy or
18 certificate may be returned and premium refunded; and

19 (6) a brief description of the relationship between the
20 cost of care and benefits.

21 (d) A certificate issued under a group long-term disability
22 insurance policy that is delivered or issued for delivery in this
23 state must include

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

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

28 (3) a statement that the group master policy establishes
29 the governing contractual provisions.

1 Sec. 21.53.060. GROUP LONG-TERM DISABILITY INSURANCE. Group
2 long-term disability insurance coverage may not be offered to a resi-
3 dent of this state under a group policy issued in another state,
4 unless the state in which the policy is issued has statutory or regu-
5 latory provisions applicable to group long-term disability insurance
6 that are substantially similar to this chapter.

7 Sec. 21.53.070. ORGANIZATIONAL REQUIREMENTS OF ASSOCIATIONS. An
8 insurer may not issue group long-term disability insurance to an
9 association or a trust or the trustee of a fund established, created,
10 or maintained for the benefit of members of one or more associations,
11 unless the association or the insurer of the association files evi-
12 dence with the director that the association has

13 (1) a minimum of 100 members;

14 (2) been organized and maintained in good faith for pur-
15 poses other than that of obtaining insurance;

16 (3) been in active existence for at least one year; and

17 (4) a constitution and by-laws that require

18 (A) the association to hold regular meetings not less
19 than annually to further purposes of the members;

20 (B) except for credit unions, the association to
21 collect dues or solicit contributions from members; and

22 (C) the members to have voting privileges and repre-
23 sentation on the governing board and committees.

24 Sec. 21.53.100. DEFINITIONS. In this chapter,

25 (1) "applicant" means in the case of an individual long-
26 term disability insurance policy, the person who seeks to contract for
27 benefits, and in the case of a group long-term disability insurance
28 policy, the proposed certificate holder;

29 (2) "certificate" means a certificate issued under a group

1 long-term disability insurance policy that has been delivered or
2 issued for delivery in this state;

3 (3) "group long-term disability insurance" means a long-
4 term disability insurance policy that is delivered or issued for
5 delivery in this state and issued to

6 (A) one or more employers or labor organizations, or
7 to a trust or to the trustees of a fund established by one or
8 more employers or labor organizations, or a combination of them,
9 for employees or former employees or a combination of them, or
10 for members or former members or a combination of them, of the
11 labor organization;

12 (B) a professional, trade, or occupational association
13 for its members or former or retired members, or combination of
14 them, if the association is composed of individuals all of whom
15 are or were actively engaged in the same profession, trade, or
16 occupation, and has been maintained in good faith for purposes
17 other than obtaining insurance;

18 (C) an association or a trust or the trustee of a fund
19 established, created, or maintained for the benefit of members of
20 one or more associations;

21 (D) a group other than described in this paragraph if
22 the director determines that the issuance of the group policy is
23 not contrary to the best interest of the public, would result in
24 economies of acquisition or administration, and the benefits are
25 reasonable in relation to the premiums charged;

26 (4) "long-term disability insurance" means an individual or
27 group insurance policy or rider advertised, marketed, offered, or
28 designed to provide coverage for not less than 12 consecutive months
29 for each covered person on an expense incurred, indemnity, prepaid, or

1 other basis, for one or more necessary or medically necessary
2 diagnostic, preventive, therapeutic, rehabilitative, maintenance, or
3 personal care services that are provided in a setting other than an
4 acute care unit of a hospital; "long-term disability insurance" does
5 not include an insurance policy that is offered primarily to provide:
6 basic Medicare supplement coverage, basic hospital expense coverage,
7 basic medical-surgical expense coverage, hospital confinement indem-
8 nity coverage, major medical expense coverage, disability income
9 protection coverage, catastrophic coverage, comprehensive coverage,
10 accident only coverage, specified disease or specified accident cover-
11 age, or limited benefit health coverage.

12 * Sec. 3. AS 21.53.040, enacted in sec. 2 of this Act, takes effect
13 July 1, 1990.

14 * Sec. 4. Except for AS 21.53.040, enacted in sec. 2 of this Act, this
15 Act takes effect July 1, 1989.

Original sponsor(s): HESS Committee

1 IN THE SENATE

BY THE HESS COMMITTEE

2 CS FOR SENATE BILL NO. 315 (HESS)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 SIXTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to long-term care disability insur-
7 ance; and providing for an effective date."

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

9 * Section 1. PURPOSE. The purpose of this Act is to promote the public
10 interest and the availability of long-term care disability insurance poli-
11 cies, to protect applicants for long-term care disability insurance from
12 unfair or deceptive sales or enrollment practices, to establish standards
13 for long-term care disability insurance, to facilitate public understanding
14 and comparison of long-term care disability insurance policies, and to
15 facilitate flexibility and innovation in the development of long-term care
16 disability insurance coverage.

17 * Sec. 2. AS 21 is amended by adding a new chapter to read:

18 CHAPTER 53. LONG-TERM CARE DISABILITY INSURANCE.

19 Sec. 21.53.010. PROHIBITED SALE OR ADVERTISING. An insurer,
20 hospital or medical service corporation, or a fraternal benefit soci-
21 ety may not advertise, market, sell, deliver, or offer for delivery a
22 long-term care disability insurance policy unless the policy complies
23 with this chapter, AS 21.18, AS 21.45, the disability insurance re-
24 quirements imposed under AS 21.51, and, if a group policy, the group
25 disability insurance requirements imposed under AS 21.54.

26 Sec. 21.53.020. DISCLOSURE AND PERFORMANCE STANDARDS. An insur-
27 er, hospital or medical service corporation, or a fraternal benefit
28 society that delivers or issues for delivery a long-term care disabil-
29 ity insurance policy may not

1 (1) cancel, fail to renew, or otherwise terminate the
2 policy on the grounds of age or deterioration of the mental or phys-
3 ical health of the insured or certificate holder;

4 (2) include a provision requiring a new waiting period in
5 the event existing coverage is converted to or replaced by a new or
6 another form of disability insurance within the same company, unless
7 there is an increase in benefits voluntarily selected by the insured;
8 or

9 (3) provide coverage only for skilled nursing care, or
10 provide significantly more coverage for skilled care in a facility
11 than is provided for coverage for lower levels of care; evaluation of
12 the coverage provided under this paragraph must be based on the number
13 of days of coverage provided for lower levels of care, when compared
14 to the number of days of coverage provided for skilled care.

15 Sec. 21.53.030. PREEXISTING CONDITIONS. (a) An insurer, hospi-
16 tal or medical service corporation, or a fraternal benefit society
17 may not include, in a long-term care disability insurance policy or
18 certificate, a definition of "preexisting condition" that is more
19 restrictive than the following: preexisting condition means the
20 existence of symptoms that would cause an ordinarily prudent person to
21 seek diagnosis, care, or treatment, or a condition for which medical
22 advice or treatment was recommended by, or received from a provider of
23 health care services, within six months preceding the effective date
24 of coverage of an insured person.

25 (b) In a long-term care disability insurance policy or certifi-
26 cate an insurer, hospital or medical service corporation, or a frater-
27 nal benefit society may not exclude coverage for a loss or confinement
28 that is the result of a preexisting condition, unless the loss or
29 confinement begins within six months following the effective date of

1 coverage of an insured person.

2 (c) The director may extend the limitation periods established
3 under (a) and (b) of this section for specific age group categories or
4 specific policy forms, if the director finds that the extension is in
5 the best interest of the public.

6 (d) This section does not prohibit an insurer, hospital or
7 medical service corporation, or a fraternal benefit society from using
8 an application form designed to elicit the complete health history of
9 an applicant, and, on the basis of the answers on the application,
10 from applying that insurer's, hospital or medical service corpora-
11 tion's, or fraternal benefit society's established underwriting stan-
12 dards. Unless otherwise provided in the policy or certificate, a
13 preexisting condition, regardless of whether it is disclosed on the
14 application, need not be covered until the waiting period described in
15 (b) of this section expires. A long-term care disability insurance
16 policy or certificate may not exclude, limit, or reduce, or use waiv-
17 ers or riders of any kind to exclude, limit, or reduce coverage or
18 benefits for specifically named or described preexisting diseases or
19 physical conditions after the waiting period described in (b) of this
20 section, unless the waiver or rider has been specifically approved by
21 the director.

22 Sec. 21.53.040. PRIOR HOSPITAL OR INSTITUTIONAL CARE CONDITIONS
23 PROHIBITED. (a) A long-term care disability insurance policy may not
24 be delivered or issued for delivery in this state if the policy condi-
25 tions eligibility

- 26 (1) on a prior hospitalization requirement;
27 (2) on the receipt of a higher level of institutional care,
28 when care is provided in an institutional setting;
29 (3) for noninstitutional benefits on a prior institutional

1 stay of more than 30 days for which benefits are paid; or

2 (4) on admission to an institutional care facility for the
3 same or a related condition within a period of less than 30 days after
4 discharge from the institution, if the policy provides benefits only
5 following institutionalization.

6 (b) A long-term care disability insurance policy may contain a
7 limitation or condition on eligibility for benefits, not prohibited in
8 (a) of this section, if the limitation or condition is clearly set out
9 in a separate paragraph of the policy or certificate.

10 Sec. 21.53.050. RIGHT OF RETURN; OUTLINE OF COVERAGE. (a) A
11 long-term care disability insurance applicant may return a policy
12 within 30 days after delivery and have the premium refunded if, after
13 examination of the policy, the applicant is not satisfied with the
14 policy. A long-term care disability insurance policy must have a
15 notice prominently printed on the first page of the policy or sepa-
16 rately attached stating that the applicant has the right to return the
17 policy within 30 days of its delivery and to have the premium refunded
18 if, after examination of the policy, the applicant is not satisfied
19 with the policy.

20 (b) An insurer, hospital or medical service corporation, or a
21 fraternal benefit society shall deliver an outline of coverage to a
22 prospective applicant for long-term care disability insurance at the
23 time of initial solicitation by a means that prominently directs the
24 attention of the recipient to the document and its purpose. In the
25 case of agent solicitations, an agent shall deliver the outline of
26 coverage before the presentation of an application or enrollment form.
27 In the case of direct response solicitations, the outline of coverage
28 must be presented in conjunction with an application or enrollment
29 form. The outline of coverage must include

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

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

5 (3) a statement of the terms under which the policy or
6 certificate, or both, may be continued in force or discontinued,
7 including a reservation in the policy of a right to change the pre-
8 mium; continuation or conversion provisions of group coverage must be
9 specifically described;

10 (4) a statement that the outline of coverage is a summary
11 only, not a contract of insurance, and that the policy or group master
12 policy contain governing contractual provisions;

13 (5) a description of the terms under which the policy or
14 certificate may be returned and premium refunded; and

15 (6) a brief description of the relationship between the
16 cost of care and benefits.

17 (c) A certificate issued under a group long-term care disability
18 insurance policy that is delivered or issued for delivery in this
19 state must include

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

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

24 (3) a statement that the group master policy establishes
25 the governing contractual provisions.

26 Sec. 21.53.060. GROUP LONG-TERM CARE BENEFITS UNDER LIFE INSUR-
27 ANCE POLICIES. (a) In addition to the requirements of AS 21.45, at
28 the time of policy delivery, a policy summary shall be included with
29 an individual life insurance policy if the policy or policy rider

1 provides long-term care disability benefits. In the case of direct
2 response solicitations, the insurer shall deliver the policy summary
3 upon the applicant's request, but regardless of request shall deliver
4 a policy summary not later than the time of policy delivery. The
5 summary must include

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

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

11 (3) an explanation of each exclusion, reduction, and limi-
12 tation on long-term care disability benefits; and

13 (4) if applicable to the policy type,

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

16 (B) disclosure of guarantees related to the long-term
17 care disability costs of insurance charges; and

18 (C) current and projected maximum lifetime benefits.

19 (b) If a long-term care disability benefit is paid under a life
20 insurance policy by the acceleration of the policy death benefit, and
21 is in benefit payment status, a monthly report shall be provided to
22 the policyholder. The report must include

23 (1) long-term care disability benefits paid out during the
24 month;

25 (2) an explanation of changes in the policy, including
26 changes in death benefits or cash values, due to long-term care dis-
27 ability benefits being paid out; and

28 (3) the amount of long-term care disability benefits re-
29 maining.

1 Sec. 21.53.070. GROUP LONG-TERM CARE DISABILITY INSURANCE.
2 Group long-term care disability insurance coverage may not be offered
3 to a resident of this state under a group policy issued in another
4 state, unless the state in which the policy is issued has statutory or
5 regulatory provisions applicable to group long-term care disability
6 insurance that are substantially similar to this chapter and the
7 director determines that the issuance of the group policy is not
8 contrary to the best interest of the public, results in economies of
9 acquisition or administration, and the benefits are reasonable in
10 relation to the premiums charged.

11 Sec. 21.53.080. ORGANIZATIONAL REQUIREMENTS OF ASSOCIATIONS. An
12 insurer, hospital or medical service corporation, or a fraternal
13 benefit society may not issue group long-term care disability insur-
14 ance to an association or a trust or the trustee of a fund estab-
15 lished, created, or maintained for the benefit of members of one or
16 more associations, unless the association or the insurer of the asso-
17 ciation files evidence with the director that the association has

- 18 (1) a minimum of 100 members;
- 19 (2) been organized and maintained in good faith for pur-
20 poses other than that of obtaining insurance;
- 21 (3) been in active existence for at least one year; and
- 22 (4) a constitution and by-laws that require
- 23 (A) the association to hold regular meetings not less
24 than annually to further purposes of the members;
- 25 (B) except for credit unions, the association to
26 collect dues or solicit contributions from members; and
- 27 (C) the members to have voting privileges and repre-
28 sentation on the governing board and committees.

29 Sec. 21.53.090. REQUIRED REGULATIONS. The director shall adopt

1 regulations regarding the sale of long-term care disability insurance
2 that provide standards for

- 3 (1) terms of renewability;
- 4 (2) initial and subsequent conditions of eligibility;
- 5 (3) nonduplication of coverage provisions;
- 6 (4) coverage of dependents;
- 7 (5) preexisting conditions;
- 8 (6) termination of insurance;
- 9 (7) continuation or conversion;
- 10 (8) probationary periods, limitations, exceptions, reduc-
11 tions, elimination periods, and requirements for replacement.

12 Sec. 21.53.200. DEFINITIONS. In this chapter,

13 (1) "applicant" means in the case of an individual long-
14 term care disability insurance policy, the person who seeks to con-
15 tract for benefits, and in the case of a group long-term care disabil-
16 ity insurance policy, the proposed certificate holder;

17 (2) "certificate" means a certificate issued under a group
18 long-term care disability insurance policy that has been delivered or
19 issued for delivery in this state;

20 (3) "group long-term care disability insurance" means a
21 long-term care disability insurance policy, subscriber's contract, or
22 fraternal benefit society certificate that is delivered or issued for
23 delivery in this state and issued to

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

1 (B) a professional, trade, or occupational association
2 for its members or former or retired members, or combination of
3 them, if the association is composed of individuals all of whom
4 are or were actively engaged in the same profession, trade, or
5 occupation, and has been maintained in good faith for purposes
6 other than obtaining insurance;

7 (C) an association or a trust or the trustee of a fund
8 established, created, or maintained for the benefit of members of
9 one or more associations;

10 (D) a group other than described in this paragraph if
11 the director determines that the issuance of the group policy is
12 not contrary to the best interest of the public, would result in
13 economies of acquisition or administration, and the benefits are
14 reasonable in relation to the premiums charged;

15 (4) "long-term care disability insurance" means an indi-
16 vidual or group insurance policy, including group and individual life
17 insurance or annuities, a subscriber's contract, fraternal benefit
18 society certificate, or rider advertised, marketed, offered, or de-
19 signed to provide coverage for not less than 12 consecutive months for
20 each covered person on an expense incurred, indemnity, prepaid, or
21 other basis, for one or more necessary or medically necessary diagnos-
22 tic, preventive, therapeutic, rehabilitative, maintenance, or personal
23 care services that are provided in a setting other than an acute care
24 unit of a hospital, and includes a policy or rider that provides for
25 payment of benefits based on cognitive impairment or loss of func-
26 tional capacity; "long-term care disability insurance" does not in-
27 clude an insurance policy, subscriber's contract, or fraternal benefit
28 society certificate that is offered primarily to provide basic Medi-
29 care supplement coverage, basic hospital expense coverage, basic

1 medical-surgical expense coverage, hospital confinement indemnity
2 coverage, major medical expense coverage, disability income and relat-
3 ed asset protection coverage, catastrophic coverage, comprehensive
4 coverage, accident only coverage, specified disease or specified
5 accident coverage, or limited benefit health coverage;

6 (5) "policy" means a contract, subscriber agreement, rider,
7 or endorsement delivered or issued for delivery in this state by an
8 insurer, fraternal benefit society, nonprofit health, hospital or
9 medical service corporation, prepaid health plan, or health mainte-
10 nance organization.

11 * Sec. 3. AS 21.84.590 is amended to read:

12 Sec. 21.84.590. OTHER PROVISIONS APPLICABLE. In addition to the
13 provisions contained in this chapter, the following provisions of this
14 title apply to fraternal benefit societies to the extent applicable
15 and not in conflict with the express provisions of this chapter and
16 the reasonable implications of this chapter:

- 17 (1) AS 21.03
18 (2) AS 21.06
19 (3) AS 21.09.050 and 21.09.100
20 (4) AS 21.33
21 (5) AS 21.36
22 (6) AS 21.42.290 and 21.42.355
23 (7) AS 21.53
24 (8) AS 21.69.370 and 21.69.640
25 (9) [(8)] AS 21.78
26 (10) [(9)] AS 21.89.060.

27 * Sec. 4. AS 21.87.340 is amended to read:

28 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the
29 provisions contained or referred to previously in this chapter, the

1 following chapters and provisions of this title also apply with re-
2 spect to service corporations to the extent applicable and not in
3 conflict with the express provisions of this chapter and the reason-
4 able implications of the express provisions, and for the purposes of
5 the application the corporations shall be considered to be mutual
6 "insurers":

- 7 (1) AS 21.03
8 (2) AS 21.06
9 (3) AS 21.09, except AS 21.09.090
10 (4) AS 21.18.010
11 (5) AS 21.18.030
12 (6) AS 21.18.040
13 (7) AS 21.18.120
14 (8) AS 21.21.321
15 (9) AS 21.36
16 (10) AS 21.53
17 (11) AS 21.69.400
18 (12) [(11)] AS 21.69.520
19 (13) [(12)] AS 21.69.600, 21.69.620, and 21.69.630
20 (14) [(13)] AS 21.78
21 (15) [(14)] AS 21.90
22 (16) [(15)] AS 21.42.345 - 21.42.365
23 (17) [(16)] AS 21.89.040
24 (18) [(17)] AS 21.89.060.

25 * Sec. 5. This Act takes effect July 1, 1990.
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28
29

Draft: December 5, 1989

Adds Prohibition Against Post-Claims Underwriting, pp. 8-10

Adds Standards for Home Health Care Benefits, p. 2, 10

Adds Requirement to Offer Inflation Protection, p. 11

LONG-TERM CARE INSURANCE MODEL REGULATION

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Section 1. Purpose

The purpose of this regulation is to implement [cite section of law which sets forth the NAIC Long-Term Care Insurance Model Act], to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance.

Section 2. Authority

This regulation is issued pursuant to the authority vested in the Commissioner under [cite sections of law enacting the NAIC Long-Term Care Insurance Model Act and establishing the Commissioner's authority to issue regulations].

Section 3. Applicability and Scope

Except as otherwise specifically provided, this regulation applies to all long-term care insurance policies delivered or issued for delivery in this state on or after the effective date hereof, by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations.

Drafting Note: This regulation, like the NAIC Long-Term Care Insurance Model Act, is intended to apply to policies, contracts, subscriber agreements, riders and endorsements whether issued by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations. In order to include such organizations, regulations should identify them in accordance with statutory terminology or by specific statutory citation. Depending upon state law and regulation, insurance department jurisdiction, and other factors, separate regulations may be required. In any event, the regulation should provide that the particular terminology used by these plans, organizations and arrangements (e.g., contract, policy, certificate, subscriber, member) may be substituted for, or added to, the corresponding terms used in this regulation.

Section 4. Definitions

For the purpose of this regulation, the terms "long-term care insurance," "group long-term care insurance," "commissioner," "applicant," "policy" and "certificate" shall have the meanings set forth in Section 4 of the NAIC Long-Term Care Insurance Model Act.

Drafting Note: Where the word "Commissioner" appears in this regulation, the appropriate designation for the chief insurance supervisory official of the state should be substituted. To the extent that the model act is not adopted, the full definition of the above terms contained in that model act should be incorporated into this section.

Section 5. Policy Definitions

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

- A. "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain their health status.
- B. "Home health care services" means medical and nonmedical services provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.
- A: C. "Medicare" shall be defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

- B: D. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.
- G: E. "Skilled nursing care," "intermediate care," "personal care," "home care," and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.
- D: F. All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal care facility," and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

Drafting Note: State laws relating to nursing and other facilities and agencies are not uniform. Accordingly, specific reference to or incorporation of the individual state law may be required in structuring each definition.

Comment: This section is intended to specify required definitional elements of several terms commonly found in long-term care insurance policies, while allowing some flexibility in the definitions themselves.

Section 6. Policy Practices and Provisions

- A. Renewability. The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 7 of this regulation.
- (1) No such policy issued to an individual shall contain renewal provisions less favorable to the insured than "guaranteed renewable." However, the Commissioner may authorize nonrenewal on a statewide basis, on terms and conditions deemed necessary by the Commissioner, to best protect the interests of the insureds, if the insurer demonstrates:
- (a) That renewal will jeopardize the insurer's solvency; or
 - (b) That:
 - (i) The actual paid claims and expenses have substantially exceeded the premium and investment income associated with the policies; and
 - (ii) The policies will continue to experience substantial and unexpected losses over their lifetime; and
 - (iii) The projected loss experience of the policies cannot

be significantly improved or mitigated through reasonable rate adjustments or other reasonable methods; and

(iv) The insurer has made repeated and good faith attempts to stabilize loss experience of the policies, including the timely filing for rate adjustments.

(2) The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(3) The term "noncancellable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

B. Limitations and Exclusions. No policy may be delivered or issued for delivery in this state as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

(1) Preexisting conditions or diseases;

(2) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;

(3) Alcoholism and drug addiction;

(4) Illness, treatment or medical condition arising out of:

(a) War or act of war (whether declared or undeclared);

(b) Participation in a felony, riot or insurrection;

(c) Service in the armed forces or units auxiliary thereto;

(d) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or

(e) Aviation (this exclusion applies only to non-fare-paying passengers).

(5) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid),

any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.

- (6) This Subsection B is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

Drafting Note: Paragraph (6) is intended to permit (a) exclusions and limitations for payment for services provided outside the United States and (b) legitimate variations in benefit levels to reflect differences in provider rates.

C. Extension of Benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

D. Continuation or Conversion.

- (1) Group long-term care insurance issued in this state on or after the effective date of this section shall provide covered individuals with a basis for continuation or conversion of coverage.
- (2) For the purposes of this section, "a basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies which restrict provision of benefits and services to, or contain incentives to use certain providers and/or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The Commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.
- (3) For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured

class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

- (4) For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers and/or facilities, the Commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.
- (5) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.
- (6) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.
- (7) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:
 - (a) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or
 - (b) The terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage:
 - (1) Providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to

or in excess of those provided by the terminating coverage; and

- (ii) The premium for which is calculated in a manner consistent with the requirements of Paragraph (6) of this section.
- (8) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.
- (9) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.
- (10) Notwithstanding any other provision of this section, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.
- (11) For the purposes of this section: a "Managed-Care Plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

Section 7. Required Disclosure Provisions

- A. Renewability. Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. This provision shall not apply to policies which do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

Drafting Note: The last sentence of this subsection is intended to apply to long-term care policies which are part of or combined with life insurance

policies, since life insurance policies generally do not contain renewability provisions.

- B. Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.
- C. Payment of Benefits. A long-term care insurance policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.
- D. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."
- E. Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in [insert citation to state law corresponding to Section 6D(2) of the Long-Term Care Insurance Model Act] shall set forth a description of such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

Section 8. Prohibition Against Post-Claims Underwriting

- A. All applications for long-term care insurance policies or certificates except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.
- B. (1) If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

- (2) If the medications listed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

C. Except for policies or certificates which are guaranteed issue:

- (1) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy.

- (2) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

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

- (3) Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the insurer shall obtain one of the following:

- (a) A report of a physical examination;
- (b) An assessment of functional capacity;
- (c) An attending physician's statement; or
- (d) Copies of medical records.

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

E. Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated and shall annually furnish

this information to the Insurance Commissioner in the format prescribed by the National Association of Insurance Commissioners.

Section 9. Minimum Standards for Home Health Care Benefits in Long-Term Care Insurance Policies

A. A long-term care insurance policy or certificate may not, if it provides benefits for home health care services, limit or exclude benefits:

- (1) By requiring that the insured/claimant would need skilled care in a skilled nursing facility if home health care services were not provided;
- (2) By requiring that the insured/claimant first or simultaneously receive nursing and/or therapeutic services in a home or community setting before home health care services are covered;
- (3) By limiting eligible services to services provided by registered nurses or licensed practical nurses;
- (4) By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification.
- (5) By requiring that the insured/claimant have an acute condition before home health care services are covered;
- (6) By limiting benefits to services provided by Medicare-certified agencies or providers.

B. Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

Drafting Note: Subsection B permits the home health care benefits to be counted toward the maximum length of long-term care coverage under the policy. The subsection is not intended to restrict home health care to a period of time which would make the benefit illusory. It is suggested that fewer than 40 visits amount to an illusory home health care benefit.

Section 10. Requirement to Offer Inflation Protection

A. No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care

services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

- (1) Increases benefit levels annually, [in a manner so that the increases are compounded annually];
- (2) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined; or
- (3) Covers a specified percentage of actual or reasonable charges.

B. Where the policy is issued to a group, the required offer in Subsection A above shall be made to the group policyholder; except, if the policy is issued to a group defined in [Section 4E(4) of the act] other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

C. The offer in Subsection A above shall not be required of:

- (1) Life insurance policies or riders containing accelerated long-term care benefits, nor
- (2) Expense incurred long-term care insurance policies.

D. Insurers shall include the following information in or with the outline of coverage:

- (1) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period.
- (2) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75, and 85 for benefit increases.

An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

Drafting Note: It is intended that meaningful inflation protection be provided. It is suggested that a minimum of five percent (5%) (compounded) annual cost increase be used as a base for determining future costs and premiums. Meaningful benefit minimums or durations could include providing increases to attained age, or for a period such as at least 20 years, or for

some multiple of the policy's maximum benefit, or throughout the period of coverage.

Section 8: 11. Requirements for Replacement

- A. Question Concerning Replacement. Individual and direct response solicited long-term care insurance application forms shall include a question designed to elicit information as to whether the proposed insurance policy is intended to replace any other accident and sickness or long-term care insurance policy presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.
- B. Solicitations Other than Direct Response. Upon determining that a sale will involve replacement, an insurer; other than an insurer using direct response solicitation methods, or its agent; shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

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

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides ten (10) ~~thirty~~ (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your

medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

- C. Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

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

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

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all

questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

Section 9: 12. Discretionary Powers of Commissioner

The Commissioner may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this regulation with respect to a specific long-term care insurance policy or certificate upon a written finding that:

- A. The modification or suspension would be in the best interest of the insureds; and
- B. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and
- C. (1) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or
(2) The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or
(3) The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

Drafting Note: This provision is intended to provide the Commissioner with limited discretion and flexibility to accommodate specific and innovative long-term care insurance products which are shown to be in the public's best interest. This provision is intended to be used sparingly for this purpose.

Section 10: 13. Reserve Standards

- A. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for such benefits shall be determined in accordance with [cite the standard valuation law for life insurance, which contains a section referring to "special benefits" for which tables must be approved by the commissioner]. Claim reserves must

also be established in the case when such policy or rider is in claim status.

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

In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

- (1) Definition of insured events;
- (2) Covered long-term care facilities;
- (3) Existence of home convalescence care coverage;
- (4) Definition of facilities;
- (5) Existence or absence of barriers to eligibility;
- (6) Premium waiver provision;
- (7) Renewability;
- (8) Ability to raise premiums;
- (9) Marketing method;
- (10) Underwriting procedures;
- (11) Claims adjustment procedures;
- (12) Waiting period;
- (13) Maximum benefit;
- (14) Availability of eligible facilities;
- (15) Margins in claim costs;
- (16) Optional nature of benefit;

- (17) Delay in eligibility for benefit;
- (18) Inflation protection provisions; and
- (19) Guaranteed insurability option.

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

- B. When long-term care benefits are provided other than as in Subsection A above, reserves shall be determined in accordance with [cite law referring to minimum health insurance reserves, the NAIC version of which requires reserves "using a table established for reserve purposes by a qualified actuary and acceptable to the commissioner"].

Section 11: 14. Loss Ratio

Benefits under individual long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

- A. Statistical credibility of incurred claims experience and earned premiums;
- B. The period for which rates are computed to provide coverage;
- C. Experienced and projected trends;
- D. Concentration of experience within early policy duration;
- E. Expected claim fluctuation;
- F. Experience refunds, adjustments or dividends;
- G. Renewability features;
- H. All appropriate expense factors;
- I. Interest;
- J. Experimental nature of the coverage;
- K. Policy reserves;
- L. Mix of business by risk classification; and
- M. Product features such as long elimination periods, high deductibles and high maximum limits.

Drafting Note: The enumeration of the thirteen items includes factors traditionally not allowed in calculating rates. Because of the desire to foster development of the long-term care product, the drafters' intention is that the consideration of these factors will provide sufficient latitude to achieve the sixty percent loss ratio.

Section 12: 15. Filing Requirement

Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state pursuant to Section 5 of the Long-Term Care Insurance Model Act, it shall file with the Commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

Section 13: 16. Standard Format Outline of Coverage

This section of the regulation implements, interprets and makes specific, the provisions of [Section 6G of the Long-Term Care Insurance Model Act] [cite provision of law requiring the Commissioner to prescribe the format and content of an outline of coverage] in prescribing a standard format and the content of an outline of coverage.

- A. The outline of coverage shall be a free-standing document, using no smaller than ten point type.
- B. The outline of coverage shall contain no material of an advertising nature.
- C. Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.
- D. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.
- E. Format for outline of coverage:

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

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

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

1. This policy is [an individual policy of insurance]([a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).
2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!
3. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.
 - (a) [Provide a brief description of the right to return--"free look" provision of the policy.]
 - (b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]
4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.
 - (a) [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.
 - (b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.
5. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or

personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

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

6. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Non-institutional benefits, by skill level.]

[Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.]

7. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities/provider;

(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions/exceptions;

(e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in (6) above.]

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

8. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

- (a) That the benefit level will not increase over time;
 - (b) Any automatic benefit adjustment provisions;
 - (c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;
 - (d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;
 - (e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]
9. TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.
- [(a) Describe the policy renewability provisions;
 - (b) For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;
 - (c) Describe waiver of premium provisions or state that there are not such provisions;
 - (d) State whether or not the company has a right to change premium, and if such a right exists, describe clearly and concisely each circumstance under which premium may change.]
10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.
- [State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]
11. PREMIUM.
- [(a) State the total annual premium for the policy;
 - (b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]
12. ADDITIONAL FEATURES.
- [(a) Indicate if medical underwriting is used;
 - (b) Describe other important features.]

Draft: Dec. 5, 1989

Eliminates Prior Stays on Home Health Care Benefit, pp. 6-7

LONG-TERM CARE INSURANCE MODEL ACT
PROPOSED AMENDMENTS

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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.

Comment: 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.

Comment: 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.

Note: See Section 6I.

Comment: 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.

- A. "Long-term care insurance" means any insurance policy 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 or 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 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 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 protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.
- 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 which 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 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
 - (3) An association or a trust or the trustee(s) 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 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 by-laws 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 will be deemed to satisfy such 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; non-profit 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, 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.

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.

Comment: 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