SENATE BILL NO. 298

INTRODUCED BY FARRELL, SQUIRES, COHEN

IN THE SENATE

JANUARY 31, 1989	INTRODUCED AND REFERRED TO COMMITTEE ON BUSINESS & INDUSTRY.
	FIRST READING.
FEBRUARY 9, 1989	COMMITTEE RECOMMEND BILL DO PASS AS AMENDED. REPORT ADOPTED.
	STATEMENT OF INTENT ADOPTED.
FEBRUARY 10, 1989	PRINTING REPORT.
FEBRUARY 11, 1989	SECOND READING, DO PASS.
FEBRUARY 13, 1989	ENGROSSING REPORT.
FEBRUARY 14, 1989	THIRD READING, PASSED. AYES, 47; NOES, 0.
	TRANSMITTED TO HOUSE.

IN THE HOUSE

FEBRUARY 14, 1989	INTRODUCED AND REFERRED TO COMMITTEE ON BUSINESS & ECONOMIC DEVELOPMENT.
FEBRUARY 20, 1989	FIRST READING.
MARCH 3, 1989	COMMITTEE RECOMMEND BILL BE CONCURRED IN AS AMENDED. REPORT ADOPTED.
MARCH 6, 1989	SECOND READING, CONCURRED IN.
MARCH 7, 1989	THIRD READING, CONCURRED IN. AYES, 93; NOES, 2.
	RETURNED TO SENATE WITH AMENDMENTS.

IN THE SENATE

MARCH 11, 1989	RECEIVED FROM HOUSE.
	SECOND READING, AMENDMENTS CONCURRED IN.
MARCH 14, 1989	THIRD READING, AMENDMENTS CONCURRED IN.
	SENT TO ENROLLING.
	REPORTED CORRECTLY ENROLLED.

SENATE BILL NO. 298

INTRODUCED BY Farrell Eskridge

A BILL FOR AN ACT ENTITLED: "THE LONG-TERM CARE INSURANCE ACT; ESTABLISHING A PROGRAM TO BE ADMINISTERED BY THE COMMISSIONER OF INSURANCE; GRANTING RULEMAKING AUTHORITY TO CONDUCT THE PROGRAM; AND PROVIDING AN EFFECTIVE DATE."

STATEMENT OF INTENT

A statement of intent is required for this bill because section 14 authorizes the commissioner of insurance of the state of Montana to promulgate rules relating to the disclosure of policy provisions, coverage, marketability, and prohibited practices in the solicitation of long-term care insurance. The legislature intends that the rules which the commissioner adopts to implement this bill be designed principally to protect the insurance-buying public in Montana by requiring insurers who offer long-term care insurance to accurately describe coverages provided by the insurance product and to prohibit certain practices regarding coverage, renewal, and eligibility. The legislature further intends that the commissioner adopt those rules in accordance with 33-1-313, which grants the commissioner general rulemaking authority and which permits the commissioner:

(1) to make only reasonable rules that do not extend, modify, or conflict with any laws of this state or with any reasonable implication of those laws; and

(2) to make or amend those rules only after a hearing of which notice has been given as required by 33-1-703.

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

NEW SECTION. **Section 1.** Short title. [This act] may be cited as the "Long-Term Care Insurance Act".

NEW SECTION. **Section 2.** Purpose. The purpose of [this act] is to:

(1) promote the public interest;

(2) promote the availability of long-term care insurance;

(3) protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices;

(4) establish standards for long-term care insurance;

(5) facilitate public understanding and comparison of long-term care insurance policies; and

(6) facilitate flexibility and innovation in the development of long-term care insurance coverage.

NEW SECTION. **Section 3.** Definitions. As used in [this act], the following definitions apply:

(1) "Applicant" means:

(a) in the case of an individual long-term care

INTRODUCED BILL
SB 298

insurance policy, the person who seeks to contract for the insurance; and

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

(2) "Certificate" means a document issued to a member of the group covered under a group insurance policy that has been delivered or issued for delivery in this state as evidence that the individual named in the certificate is covered under the policy.

(3) "Group long-term care insurance" means a long-term care insurance policy that is delivered or issued for delivery in this state and issued to:

(a) (i) an employer;

(ii) a labor organization;

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

(iv) a trustee of a fund established by an employer or labor organization or a combination thereof for:

(A) employees or former employees or a combination thereof; or

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

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

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

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

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

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

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

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

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

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

(ii) Thirty days after filing, the association is considered as having satisfied the organizational

requirements unless the commissioner finds after hearing that the association does not satisfy the organizational requirements.

(d) a group other than as described in subsections (3)(a) through (3)(c) if the commissioner determines that the:

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

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

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

(4) "Long-term care insurance":

(a) means a policy as defined in subsection (5) that is advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for a covered person, on an expense-incurred, indemnity, prepaid, or other basis, for a necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care service provided in a setting other than an acute care unit of a hospital; and

(b) includes group and individual insurance policies or riders, whether issued by an insurer, fraternal benefit society, health service corporation, prepaid health plan, health maintenance organization, or similar organization.

(5) "Policy" means a policy as defined in 33-15-102, a membership contract as defined in 33-30-101, a health care services agreement as defined in 33-31-102 delivered or issued for delivery in this state by an insurer, fraternal benefit society, health service corporation, prepaid health plan, health maintenance organization, or similar organization.

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

NEW SECTION. **Section 4. Extraterritorial jurisdiction.** A group long-term care insurance policy or certificate may not be delivered or issued for delivery to a resident of Montana under a group policy issued in another state to a group described in [section 3(3)(d)] unless it is approved by:

(1) the commissioner; or

(2) the insurance regulatory official of the state in which the group long-term care insurance policy was delivered or issued for delivery and that state has statutory and regulatory long-term care insurance requirements substantially similar to those adopted in Montana.

NEW SECTION. **Section 5.** **Disclosure and performance standards for long-term care insurance.** (1) The commissioner may by rule adopt standards for full and fair disclosure, setting forth the manner, content, and disclosures required to be made in a long-term care insurance policy, including but not limited to:

(a) terms of renewability;

(b) initial and subsequent conditions of eligibility;

(c) nonduplication of coverage provisions;

(d) coverage of dependents;

(e) preexisting conditions;

(f) termination of insurance;

(g) continuation or conversion;

(h) probationary periods;

(i) limitations;

(j) exceptions;

(k) reductions;

(l) elimination periods;

(m) requirements for replacement;

(n) recurrent conditions; and

(o) definition of terms.

(2) A group long-term care insurance policy must include a provision relating to conversion on termination of eligibility as described in 33-22-508.

(3) A policy must comply with [this act] if it:

(a) is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage; and

(b) offers long-term care insurance benefits for at least 6 months.

NEW SECTION. **Section 6.** **Prohibited practices and policy provisions.** A long-term care insurance policy may not:

(1) be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of an insured or a certificate holder;

(2) contain a provision establishing a new waiting period if 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 only skilled nursing care or provide substantially more coverage for skilled nursing care in a facility than coverage for lower levels of care.

NEW SECTION. **Section 7.** **Preexisting condition definition.** (1) A long-term care insurance policy o

certificate other than a policy or certificate issued to a group as defined in [section 3(3)(a)] may not use a definition of preexisting condition which is more restrictive than the definition in [section 3].

(2) A long-term care insurance policy or certificate may not exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within 6 months following the effective date of coverage of an insured person.

(3) The commissioner may extend the limitation periods in subsections (1) and (2) as to specific age group categories in specific policy forms if extending the limitation periods is in the best interests of the public.

(4) An insurer may use an application form designed to elicit the complete health history of an applicant and on the basis of the answers on that application perform underwriting in accordance with the insurer's established underwriting standards. Unless otherwise provided in the long-term care insurance policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subsection (2) expires. A long-term care insurance policy or certificate may not exclude or use a waiver or rider of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described

preexisting diseases or physical conditions beyond the waiting period described in subsection (2).

NEW SECTION. **Section 8.** **Prior hospitalization or institutionalization.** (1) A long-term care insurance policy may not be delivered or issued for delivery in Montana if the policy conditions eligibility for a benefit:

(a) on a prior hospitalization requirement; or

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

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

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

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

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

NEW SECTION. **Section 9. Loss ratio standards.** The commissioner may by rule establish loss ratio standards for long-term care insurance policies.

NEW SECTION. **Section 10. Right to return policy -- free look.** (1) A person insured under an individual long-term care insurance policy has the right to return the policy within 10 days of its delivery and to have the premium refunded if, after examining the policy, the insured is not satisfied for any reason. An individual long-term care insurance policy must have a notice prominently printed on the first page of the policy or attached to it stating that the insured has the right to return the policy within 10 days of its delivery and to have the premium refunded if, after examining the policy, the insured is not satisfied for any reason.

(2) A person insured under a long-term care insurance policy issued pursuant to a direct response solicitation has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examining the policy, the insured is not satisfied for

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

NEW SECTION. **Section 11. Outline of coverage.** (1) An insurer shall deliver an outline of coverage to a prospective applicant for long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose.

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

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

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

(2) The outline of coverage must include:

(a) a description of the principal benefits and

coverage provided in the policy;

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

(c) a statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premiums. Continuation or conversion provisions of a group policy must be specifically described.

(d) a statement that the outline of coverage is a summary only of the policy issued or applied for, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

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

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

NEW SECTION. **Section 12.** **Required content for certificate.** A certificate issued pursuant to a group long-term care insurance policy that is delivered or issued for delivery in this state must include:

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

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

(3) a statement that the group master policy

determines governing contractual provisions.

NEW SECTION. **Section 13.** **Compliance required.** A policy may not be advertised, marketed, or offered in this state as long-term care insurance or nursing home insurance unless it complies with [this act].

NEW SECTION. **Section 14.** **Rules.** The commissioner may adopt rules necessary to implement [this act].

NEW SECTION. **Section 15.** **Extension of authority.** Any existing authority to make rules on the subject of the provisions of [this act] is extended to the provisions of [this act].

NEW SECTION. **Section 16.** **Codification instruction.** [This act] is intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [this act].

NEW SECTION. **Section 17.** **Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 18.** **Applicability.** [This act] applies 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 may not be applied to long-term care insurance. A policy that is not advertised, marketed, or offered as long-term care insurance or nursing home insurance need not meet the requirements of [this act].

NEW SECTION. **Section 19.** Effective date. [Sections 6, 8, and this section] are effective one year after passage and approval.

-End-

STATE OF MONTANA - FISCAL NOTE
Form BD-15

In compliance with a written request, there is hereby submitted a Fiscal Note for SB298, as introduced.

DESCRIPTION OF PROPOSED LEGISLATION:

The long-term care insurance act; establishing a program to be administered by the commissioner of insurance; granting rulemaking authority to conduct the program; and providing an effective date.

ASSUMPTIONS:

1. Insurance companies are already writing long-term care insurance coverage.
2. No additional FTE required.
3. Only expenditure associated with SB298 would be rule making process.
4. No revenue.

FISCAL IMPACT:

	FY90			FY91		
Expenditures:	Current Law	Proposed Law	Difference	Current Law	Proposed Law	Difference
Operating Expenses	$ -0-	$ -0-	$ -0-	$ -0-	$ 500	$ 500

Funding: Insurance Regulatory Account

Ray Shackleford 2/6/89
RAY SHACKLEFORD, BUDGET DIRECTOR DATE
OFFICE OF BUDGET AND PROGRAM PLANNING

William E. Farrell 2/6/89
WILLIAM E. FARRELL, PRIMARY SPONSOR DATE

Fiscal Note for SB298, as introduced

SB 298

APPROVED BY COMM. ON
BUSINESS & INDUSTRY

SENATE BILL NO. 298

INTRODUCED BY FARRELL, SQUIRES, COHEN

A BILL FOR AN ACT ENTITLED: "THE LONG-TERM CARE INSURANCE ACT; ESTABLISHING A PROGRAM TO BE ADMINISTERED BY THE COMMISSIONER OF INSURANCE; GRANTING RULEMAKING AUTHORITY TO CONDUCT THE PROGRAM; AND PROVIDING AN EFFECTIVE DATE."

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(1) to make only reasonable rules that do not extend, modify, or conflict with any laws of this state or with any reasonable implication of those laws; and

(2) to make or amend those rules only after a hearing of which notice has been given as required by 33-1-703.

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(1) promote the public interest;

(2) promote the availability of long-term care insurance;

(3) protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices;

(4) establish standards for long-term care insurance;

(5) facilitate public understanding and comparison of long-term care insurance policies; and

(6) facilitate flexibility and innovation in the development of long-term care insurance coverage.

NEW SECTION. **Section 3.** Definitions. As used in [this act], the following definitions apply:

(1) "Applicant" means:

(a) in the case of an individual long-term care

SECOND READING

insurance policy, the person who seeks to contract for the insurance; and

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

(2) "Certificate" means a document issued to a member of the group covered under a group insurance policy that has been delivered or issued for delivery in this state as evidence that the individual named in the certificate is covered under the policy.

(3) "Group long-term care insurance" means a long-term care insurance policy that is delivered or issued for delivery in this state and issued to:

(a) (i) an employer;

(ii) a labor organization;

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

(iv) a trustee of a fund established by an employer or labor organization or a combination thereof for:

(A) employees or former employees or a combination thereof; or

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

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

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

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

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

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

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

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

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

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

(ii) Thirty days after filing, the association is considered as having satisfied the organizational

requirements unless the commissioner finds after hearing that the association does not satisfy the organizational requirements.

(d) a group other than as described in subsections (3)(a) through (3)(c) if the commissioner determines that the:

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

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

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

(4) "Long-term care insurance":

(a) means a policy as defined in subsection (5) that is advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for a covered person, on an expense-incurred, indemnity, prepaid, or other basis, for a necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care service provided in a setting other than an acute care unit of a hospital; and

(b) includes group and individual insurance policies or riders, whether issued by an insurer, fraternal benefit society, health service corporation, prepaid health plan, health maintenance organization, or similar organization.

(5) "Policy" means a policy as defined in 33-15-102, a membership contract as defined in 33-30-101, a health care services agreement as defined in 33-31-102 delivered or issued for delivery in this state by an insurer, fraternal benefit society, health service corporation, prepaid health plan, health maintenance organization, or similar organization.

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

NEW SECTION. **Section 4. Extraterritorial jurisdiction.** A group long-term care insurance policy or certificate may not be delivered or issued for delivery to a resident of Montana under a group policy issued in another state to a group described in [section 3(3)(d)] unless it is approved by:

(1) the commissioner; or

(2) the insurance regulatory official of the state in which the group long-term care insurance policy was delivered or issued for delivery and that state has statutory and regulatory long-term care insurance requirements substantially similar to those adopted in Montana.

NEW SECTION. **Section 5. Disclosure and performance standards for long-term care insurance.** (1) The commissioner may by rule adopt standards for full and fair disclosure, setting forth the manner, content, and disclosures required to be made in a long-term care insurance policy, including but not limited to:

(a) terms of renewability;

(b) initial and subsequent conditions of eligibility;

(c) nonduplication of coverage provisions;

(d) coverage of dependents;

(e) preexisting conditions;

(f) termination of insurance;

(g) continuation or conversion;

(h) probationary periods;

(i) limitations;

(j) exceptions;

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(l) elimination periods;

(m) requirements for replacement;

(n) recurrent conditions; and

(o) definition of terms.

(2) A group long-term care insurance policy must include a provision relating to conversion on termination of eligibility as described in 33-22-508.

(3) A policy must comply with [this act] if it:

(a) is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage; and

(b) offers long-term care insurance benefits for at least 6 months.

NEW SECTION. **Section 6. Prohibited practices and policy provisions.** A long-term care insurance policy may not:

(1) be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of an insured or a certificate holder;

(2) contain a provision establishing a new waiting period if 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 only skilled nursing care or provide substantially more coverage for skilled nursing care in a facility than coverage for lower levels of care.

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certificate other than a policy or certificate issued to a group as defined in [section 3(3)(a)] may not use a definition of preexisting condition which is more restrictive than the definition in [section 3].

(2) A long-term care insurance policy or certificate may not exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within 6 months following the effective date of coverage of an insured person.

(3) The commissioner may extend the limitation periods in subsections (1) and (2) as to specific age group categories in specific policy forms if extending the limitation periods is in the best interests of the public.

(4) An insurer may use an application form designed to elicit the complete health history of an applicant and on the basis of the answers on that application perform underwriting in accordance with the insurer's established underwriting standards. Unless otherwise provided in the long-term care insurance policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subsection (2) expires. A long-term care insurance policy or certificate may not exclude or use a waiver or rider of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described

preexisting diseases or physical conditions beyond the waiting period described in subsection (2).

NEW SECTION. **Section 8.** Prior hospitalization or institutionalization. (1) A long-term care insurance policy may not be delivered or issued for delivery in Montana if the policy conditions eligibility for a benefit:

(a) on a prior hospitalization requirement; or

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

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

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

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

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

NEW SECTION. **Section 9.** **Loss ratio standards.** The commissioner may by rule establish loss ratio standards for long-term care insurance policies.

NEW SECTION. **Section 10.** **Right to return policy -- free look.** (1) A person insured under an individual long-term care insurance policy has the right to return the policy within 10 days of its delivery and to have the premium refunded if, after examining the policy, the insured is not satisfied for any reason. An individual long-term care insurance policy must have a notice prominently printed on the first page of the policy or attached to it stating that the insured has the right to return the policy within 10 days of its delivery and to have the premium refunded if, after examining the policy, the insured is not satisfied for any reason.

(2) A person insured under a long-term care insurance policy issued pursuant to a direct response solicitation has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examining the policy, the insured is not satisfied for

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

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

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

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

(2) The outline of coverage must include:

(a) a description of the principal benefits and

coverage provided in the policy;

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

(c) a statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premiums. Continuation or conversion provisions of a group policy must be specifically described.

(d) a statement that the outline of coverage is a summary only of the policy issued or applied for, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

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

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

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

(3) a statement that the group master policy

determines governing contractual provisions.

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NEW SECTION. **Section 14.** Rules. The commissioner may adopt rules necessary to implement [this act].

NEW SECTION. **Section 15.** Extension of authority. Any existing authority to make rules on the subject of the provisions of [this act] is extended to the provisions of [this act].

NEW SECTION. **Section 16.** Codification instruction. [This act] is intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [this act].

NEW SECTION. **Section 17.** Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 18.** Applicability. [This act] applies to policies delivered or issued for delivery in this state on or after ~~the effective date of [this act]~~ OCTOBER 1, 1989. [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 may not be applied to long-term care insurance. A policy that is not advertised, marketed, or offered as long-term care insurance or nursing home insurance need not meet the requirements of [this act].

NEW SECTION. **Section 19.** Effective date. [Sections 6, 8, and this section] are effective one year after passage and approval.

-End-

SENATE BILL NO. 298

INTRODUCED BY FARRELL, SQUIRES, COHEN

A BILL FOR AN ACT ENTITLED: "THE LONG-TERM CARE INSURANCE ACT; ESTABLISHING A PROGRAM TO BE ADMINISTERED BY THE COMMISSIONER OF INSURANCE; GRANTING RULEMAKING AUTHORITY TO CONDUCT THE PROGRAM; AND PROVIDING AN EFFECTIVE DATE."

STATEMENT OF INTENT

A statement of intent is required for this bill because section 14 authorizes the commissioner of insurance of the state of Montana to promulgate rules relating to the disclosure of policy provisions, coverage, marketability, and prohibited practices in the solicitation of long-term care insurance. The legislature intends that the rules which the commissioner adopts to implement this bill be designed principally to protect the insurance-buying public in Montana by requiring insurers who offer long-term care insurance to accurately describe coverages provided by the insurance product and to prohibit certain practices regarding coverage, renewal, and eligibility. The legislature further intends that the commissioner adopt those rules in accordance with 33-1-313, which grants the commissioner general rulemaking authority and which permits the commissioner:

(1) to make only reasonable rules that do not extend, modify, or conflict with any laws of this state or with any reasonable implication of those laws; and

(2) to make or amend those rules only after a hearing of which notice has been given as required by 33-1-703.

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

NEW SECTION. **Section 1.** Short title. [This act] may be cited as the "Long-Term Care Insurance Act".

NEW SECTION. **Section 2.** Purpose. The purpose of [this act] is to:

(1) promote the public interest;

(2) promote the availability of long-term care insurance;

(3) protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices;

(4) establish standards for long-term care insurance;

(5) facilitate public understanding and comparison of long-term care insurance policies; and

(6) facilitate flexibility and innovation in the development of long-term care insurance coverage.

NEW SECTION. **Section 3.** Definitions. As used in [this act], the following definitions apply:

(1) "Applicant" means:

(a) in the case of an individual long-term care

THIRD READING

insurance policy, the person who seeks to contract for the insurance; and

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

(2) "Certificate" means a document issued to a member of the group covered under a group insurance policy that has been delivered or issued for delivery in this state as evidence that the individual named in the certificate is covered under the policy.

(3) "Group long-term care insurance" means a long-term care insurance policy that is delivered or issued for delivery in this state and issued to:

(a) (i) an employer;

(ii) a labor organization;

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

(iv) a trustee of a fund established by an employer or labor organization or a combination thereof for:

(A) employees or former employees or a combination thereof; or

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

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

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

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

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

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

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

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

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

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

(ii) Thirty days after filing, the association is considered as having satisfied the organizational

requirements unless the commissioner finds after hearing that the association does not satisfy the organizational requirements.

(d) a group other than as described in subsections (3)(a) through (3)(c) if the commissioner determines that the:

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

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

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

(4) "Long-term care insurance":

(a) means a policy as defined in subsection (5) that is advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for a covered person, on an expense-incurred, indemnity, prepaid, or other basis, for a necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care service provided in a setting other than an acute care unit of a hospital; and

(b) includes group and individual insurance policies or riders, whether issued by an insurer, fraternal benefit society, health service corporation, prepaid health plan, health maintenance organization, or similar organization.

(5) "Policy" means a policy as defined in 33-15-102, a membership contract as defined in 33-30-101, a health care services agreement as defined in 33-31-102 delivered or issued for delivery in this state by an insurer, fraternal benefit society, health service corporation, prepaid health plan, health maintenance organization, or similar organization.

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

NEW SECTION. **Section 4. Extraterritorial jurisdiction.** A group long-term care insurance policy or certificate may not be delivered or issued for delivery to a resident of Montana under a group policy issued in another state to a group described in [section 3(3)(d)] unless it is approved by:

(1) the commissioner; or

(2) the insurance regulatory official of the state in which the group long-term care insurance policy was delivered or issued for delivery and that state has statutory and regulatory long-term care insurance requirements substantially similar to those adopted in Montana.

NEW SECTION. **Section 5. Disclosure and performance standards for long-term care insurance.** (1) The commissioner may by rule adopt standards for full and fair disclosure, setting forth the manner, content, and disclosures required to be made in a long-term care insurance policy, including but not limited to:

(a) terms of renewability;

(b) initial and subsequent conditions of eligibility;

(c) nonduplication of coverage provisions;

(d) coverage of dependents;

(e) preexisting conditions;

(f) termination of insurance;

(g) continuation or conversion;

(h) probationary periods;

(i) limitations;

(j) exceptions;

(k) reductions;

(l) elimination periods;

(m) requirements for replacement;

(n) recurrent conditions; and

(o) definition of terms.

(2) A group long-term care insurance policy must include a provision relating to conversion on termination of eligibility as described in 33-22-508.

(3) A policy must comply with [this act] if it:

(a) is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage; and

(b) offers long-term care insurance benefits for at least 6 months.

NEW SECTION. **Section 6. Prohibited practices and policy provisions.** A long-term care insurance policy may not:

(1) be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of an insured or a certificate holder;

(2) contain a provision establishing a new waiting period if 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 only skilled nursing care or provide substantially more coverage for skilled nursing care in a facility than coverage for lower levels of care.

NEW SECTION. **Section 7. Preexisting condition -- definition.** (1) A long-term care insurance policy or

certificate other than a policy or certificate issued to a group as defined in [section 3(3)(a)] may not use a definition of preexisting condition which is more restrictive than the definition in [section 3].

(2) A long-term care insurance policy or certificate may not exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within 6 months following the effective date of coverage of an insured person.

(3) The commissioner may extend the limitation periods in subsections (1) and (2) as to specific age group categories in specific policy forms if extending the limitation periods is in the best interests of the public.

(4) An insurer may use an application form designed to elicit the complete health history of an applicant and on the basis of the answers on that application perform underwriting in accordance with the insurer's established underwriting standards. Unless otherwise provided in the long-term care insurance policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subsection (2) expires. A long-term care insurance policy or certificate may not exclude or use a waiver or rider of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described

preexisting diseases or physical conditions beyond the waiting period described in subsection (2).

NEW SECTION. **Section 8.** Prior hospitalization or institutionalization. (1) A long-term care insurance policy may not be delivered or issued for delivery in Montana if the policy conditions eligibility for a benefit:

(a) on a prior hospitalization requirement; or

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

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

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

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

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

NEW SECTION. **Section 9.** Loss ratio standards. The commissioner may by rule establish loss ratio standards for long-term care insurance policies.

NEW SECTION. **Section 10.** Right to return policy -- free look. (1) A person insured under an individual long-term care insurance policy has the right to return the policy within 10 days of its delivery and to have the premium refunded if, after examining the policy, the insured is not satisfied for any reason. An individual long-term care insurance policy must have a notice prominently printed on the first page of the policy or attached to it stating that the insured has the right to return the policy within 10 days of its delivery and to have the premium refunded if, after examining the policy, the insured is not satisfied for any reason.

(2) A person insured under a long-term care insurance policy issued pursuant to a direct response solicitation has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examining the policy, the insured is not satisfied for

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

NEW SECTION. **Section 11.** Outline of coverage. (1) An insurer shall deliver an outline of coverage to a prospective applicant for long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose.

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

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

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

(2) The outline of coverage must include:

(a) a description of the principal benefits and

coverage provided in the policy;

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

(c) a statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premiums. Continuation or conversion provisions of a group policy must be specifically described.

(d) a statement that the outline of coverage is a summary only of the policy issued or applied for, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

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

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

NEW SECTION. **Section 12.** Required content for certificate. A certificate issued pursuant to a group long-term care insurance policy that is delivered or issued for delivery in this state must include:

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

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

(3) a statement that the group master policy

determines governing contractual provisions.

NEW SECTION. **Section 13.** Compliance required. A policy may not be advertised, marketed, or offered in this state as long-term care insurance or nursing home insurance unless it complies with [this act].

NEW SECTION. **Section 14.** Rules. The commissioner may adopt rules necessary to implement [this act].

NEW SECTION. **Section 15.** Extension of authority. Any existing authority to make rules on the subject of the provisions of [this act] is extended to the provisions of [this act].

NEW SECTION. **Section 16.** Codification instruction. [This act] is intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [this act].

NEW SECTION. **Section 17.** Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 18.** Applicability. [This act] applies to policies delivered or issued for delivery in this state on or after ~~the effective date of [this act]~~ OCTOBER 1, 1989. [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 may not be applied to long-term care insurance. A policy that is not advertised, marketed, or offered as long-term care insurance or nursing home insurance need not meet the requirements of [this act].

NEW SECTION. **Section 19.** Effective date. [Sections 6, 8, and this section] are effective one year after passage and approval.

-End-

STANDING COMMITTEE REPORT

Mr. Speaker: We, the committee on Business and Economic Development report that SENATE BILL 298 (blue reference copy), with statement of intent included, be concurred in as amended .

Signed: Robert Pavlovich, Chairman

[REP. SQUIRES CARRY THIS BILL ON THE HOUSE FLOOR]

And, that such amendments read:

1. Page 5, line 13.
Following: "(4)"
Insert: "(a)"

2. Page 5, line 14.
Strike: "(a)"
Insert: "(i)"

3. Page 5, line 22.
Strike: "(b)"
Insert: "(ii)"

4. Page 6, line 1.
Following: page 5
Insert: "(b) Long-term care insurance does not include an insurance policy that is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

(c) An insurance policy that is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage and

that also contains long-term care insurance benefits of a duration of at least 6 months is not required to meet the requirements of [this act] unless the premium allocable to the long-term care insurance benefits contained in the policy is greater than 25% of the total policy premium."

5. Page 6, line 20.
Following: "of"
Strike: "the"
Insert: "a"

6. Page 6, lines 20 through 22.
Following: "state" on line 20
Strike: remainder of line 20 through "and" on line 22

7. Page 6, line 22.
Strike: "state"

8. Page 7, line 24.
Following: "33-22-508"
Insert: "or include a provision for continuation of coverage that maintains coverage under the existing group policy if the coverage would otherwise terminate"

9. Page 7, line 25, through page 8, line 9.
Strike: subsection (3) in its entirety

10. Page 15, line 8.
Following: "act]."
Insert: "A policy that contains long-term care insurance benefits of a duration of at least 6 months must meet the requirements of [this act] if the premium allocable to the long-term care benefits is greater than 25% of the total policy premium."

11. Page 15, line 9.
Strike: "Sections 6,"
Insert: "Section"

12. Page 15, line 10.
Following: "8"
Strike: ","

HOUSE

SENATE BILL NO. 298

INTRODUCED BY FARRELL, SQUIRES, COHEN

A BILL FOR AN ACT ENTITLED: "THE LONG-TERM CARE INSURANCE ACT; ESTABLISHING A PROGRAM TO BE ADMINISTERED BY THE COMMISSIONER OF INSURANCE; GRANTING RULEMAKING AUTHORITY TO CONDUCT THE PROGRAM; AND PROVIDING AN EFFECTIVE DATE."

STATEMENT OF INTENT

A statement of intent is required for this bill because section 14 authorizes the commissioner of insurance of the state of Montana to promulgate rules relating to the disclosure of policy provisions, coverage, marketability, and prohibited practices in the solicitation of long-term care insurance. The legislature intends that the rules which the commissioner adopts to implement this bill be designed principally to protect the insurance-buying public in Montana by requiring insurers who offer long-term care insurance to accurately describe coverages provided by the insurance product and to prohibit certain practices regarding coverage, renewal, and eligibility. The legislature further intends that the commissioner adopt those rules in accordance with 33-1-313, which grants the commissioner general rulemaking authority and which permits the commissioner:

(1) to make only reasonable rules that do not extend, modify, or conflict with any laws of this state or with any reasonable implication of those laws; and

(2) to make or amend those rules only after a hearing of which notice has been given as required by 33-1-703.

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

NEW SECTION. **Section 1.** Short title. [This act] may be cited as the "Long-Term Care Insurance Act".

NEW SECTION. **Section 2.** Purpose. The purpose of [this act] is to:

(1) promote the public interest;

(2) promote the availability of long-term care insurance;

(3) protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices;

(4) establish standards for long-term care insurance;

(5) facilitate public understanding and comparison of long-term care insurance policies; and

(6) facilitate flexibility and innovation in the development of long-term care insurance coverage.

NEW SECTION. **Section 3.** Definitions. As used in [this act], the following definitions apply:

(1) "Applicant" means:

(a) in the case of an individual long-term care

REFERENCE BILL
AS AMENDED

insurance policy, the person who seeks to contract for the insurance; and

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

(2) "Certificate" means a document issued to a member of the group covered under a group insurance policy that has been delivered or issued for delivery in this state as evidence that the individual named in the certificate is covered under the policy.

(3) "Group long-term care insurance" means a long-term care insurance policy that is delivered or issued for delivery in this state and issued to:

(a) (i) an employer;

(ii) a labor organization;

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

(iv) a trustee of a fund established by an employer or labor organization or a combination thereof for:

(A) employees or former employees or a combination thereof; or

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

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

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

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

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

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

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

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

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

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

(ii) Thirty days after filing, the association is considered as having satisfied the organizational

requirements unless the commissioner finds after hearing that the association does not satisfy the organizational requirements.

(d) a group other than as described in subsections (3)(a) through (3)(c) if the commissioner determines that the:

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

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

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

(4) (A) "Long-term care insurance":

~~(a)~~(I) means a policy as defined in subsection (5) that is advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for a covered person, on an expense-incurred, indemnity, prepaid, or other basis, for a necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care service provided in a setting other than an acute care unit of a hospital; and

~~(b)~~(II) includes group and individual insurance policies or riders, whether issued by an insurer, fraternal benefit society, health service corporation, prepaid health

plan, health maintenance organization, or similar organization.

(B) LONG-TERM CARE INSURANCE DOES NOT INCLUDE AN INSURANCE POLICY THAT IS OFFERED PRIMARILY TO PROVIDE BASIC MEDICARE SUPPLEMENT COVERAGE, BASIC HOSPITAL EXPENSE COVERAGE, BASIC MEDICAL-SURGICAL EXPENSE COVERAGE, HOSPITAL CONFINEMENT INDEMNITY COVERAGE, MAJOR MEDICAL EXPENSE COVERAGE, DISABILITY INCOME PROTECTION COVERAGE, ACCIDENT ONLY COVERAGE, SPECIFIED DISEASE OR SPECIFIED ACCIDENT COVERAGE, OR LIMITED BENEFIT HEALTH COVERAGE.

(C) AN INSURANCE POLICY THAT IS OFFERED PRIMARILY TO PROVIDE BASIC MEDICARE SUPPLEMENT COVERAGE, BASIC HOSPITAL EXPENSE COVERAGE, BASIC MEDICAL-SURGICAL EXPENSE COVERAGE, HOSPITAL CONFINEMENT INDEMNITY COVERAGE, MAJOR MEDICAL EXPENSE COVERAGE, DISABILITY INCOME PROTECTION COVERAGE, ACCIDENT ONLY COVERAGE, SPECIFIED DISEASE OR SPECIFIED ACCIDENT COVERAGE, OR LIMITED BENEFIT HEALTH COVERAGE AND THAT ALSO CONTAINS LONG-TERM CARE INSURANCE BENEFITS OF A DURATION OF AT LEAST 6 MONTHS IS NOT REQUIRED TO MEET THE REQUIREMENTS OF [THIS ACT] UNLESS THE PREMIUM ALLOCABLE TO THE LONG-TERM CARE INSURANCE BENEFITS CONTAINED IN THE POLICY IS GREATER THAN 25% OF THE TOTAL POLICY PREMIUM.

(5) "Policy" means a policy as defined in 33-15-102, a membership contract as defined in 33-30-101, a health care services agreement as defined in 33-31-102 delivered or

issued for delivery in this state by an insurer, fraternal benefit society, health service corporation, prepaid health plan, health maintenance organization, or similar organization.

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

NEW SECTION. **Section 4.** **Extraterritorial jurisdiction.** A group long-term care insurance policy or certificate may not be delivered or issued for delivery to a resident of Montana under a group policy issued in another state to a group described in [section 3(3)(d)] unless it is approved by:

(1) the commissioner; or

(2) the insurance regulatory official of ~~the~~ A state ~~in-which-the--group--long-term--care--insurance--policy--was delivered---or--issued--for--delivery--and~~ that state has statutory and regulatory long-term care insurance requirements substantially similar to those adopted in Montana.

NEW SECTION. **Section 5.** **Disclosure and performance standards for long-term care insurance.** (1) The commissioner may by rule adopt standards for full and fair disclosure,

setting forth the manner, content, and disclosures required to be made in a long-term care insurance policy, including but not limited to:

(a) terms of renewability;

(b) initial and subsequent conditions of eligibility;

(c) nonduplication of coverage provisions;

(d) coverage of dependents;

(e) preexisting conditions;

(f) termination of insurance;

(g) continuation or conversion;

(h) probationary periods;

(i) limitations;

(j) exceptions;

(k) reductions;

(l) elimination periods;

(m) requirements for replacement;

(n) recurrent conditions; and

(o) definition of terms.

(2) A group long-term care insurance policy must include a provision relating to conversion on termination of eligibility as described in 33-22-508 OR INCLUDE A PROVISION FOR CONTINUATION OF COVERAGE THAT MAINTAINS COVERAGE UNDER THE EXISTING GROUP POLICY IF THE COVERAGE WOULD OTHERWISE TERMINATE.

~~(3)--A-policy-must-comply-with-[this-act]-if-it:~~

~~(a)--is-offered-primarily--to--provide--basic--medicare supplement--coverage;-basic-hospital-expense-coverage;-basic medical-surgical--expense--coverage;--hospital---confinement indemnity---coverage;---major---medical---expense--coverage; disability--income--protection---coverage;---accident---only coverage;--specified-disease-or-specified-accident-coverage; or-limited-benefit-health-coverage;-and~~

~~(b)--offers-long-term-care-insurance--benefits--for--at least-6-months.~~

NEW SECTION. **Section 6.** **Prohibited practices and policy provisions.** A long-term care insurance policy may not:

(1) be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of an insured or a certificate holder;

(2) contain a provision establishing a new waiting period if 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 only skilled nursing care or provide substantially more coverage for skilled nursing care in a facility than coverage for lower levels of care.

NEW SECTION. **Section 7.** **Preexisting condition -- definition.** (1) A long-term care insurance policy or

certificate other than a policy or certificate issued to a group as defined in [section 3(3)(a)] may not use a definition of preexisting condition which is more restrictive than the definition in [section 3].

(2) A long-term care insurance policy or certificate may not exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within 6 months following the effective date of coverage of an insured person.

(3) The commissioner may extend the limitation periods in subsections (1) and (2) as to specific age group categories in specific policy forms if extending the limitation periods is in the best interests of the public.

(4) An insurer may use an application form designed to elicit the complete health history of an applicant and on the basis of the answers on that application perform underwriting in accordance with the insurer's established underwriting standards. Unless otherwise provided in the long-term care insurance policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subsection (2) expires. A long-term care insurance policy or certificate may not exclude or use a waiver or rider of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described

preexisting diseases or physical conditions beyond the waiting period described in subsection (2).

NEW SECTION. **Section 8.** Prior hospitalization or institutionalization. (1) A long-term care insurance policy may not be delivered or issued for delivery in Montana if the policy conditions eligibility for a benefit:

(a) on a prior hospitalization requirement; or

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

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

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

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

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

NEW SECTION. **Section 9.** Loss ratio standards. The commissioner may by rule establish loss ratio standards for long-term care insurance policies.

NEW SECTION. **Section 10.** Right to return policy -- free look. (1) A person insured under an individual long-term care insurance policy has the right to return the policy within 10 days of its delivery and to have the premium refunded if, after examining the policy, the insured is not satisfied for any reason. An individual long-term care insurance policy must have a notice prominently printed on the first page of the policy or attached to it stating that the insured has the right to return the policy within 10 days of its delivery and to have the premium refunded if, after examining the policy, the insured is not satisfied for any reason.

(2) A person insured under a long-term care insurance policy issued pursuant to a direct response solicitation has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examining the policy, the insured is not satisfied for

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

NEW SECTION. **Section 11.** Outline of coverage. (1) An insurer shall deliver an outline of coverage to a prospective applicant for long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose.

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

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

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

(2) The outline of coverage must include:

(a) a description of the principal benefits and

coverage provided in the policy;

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

(c) a statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premiums. Continuation or conversion provisions of a group policy must be specifically described.

(d) a statement that the outline of coverage is a summary only of the policy issued or applied for, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

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

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

NEW SECTION. **Section 12.** Required content for certificate. A certificate issued pursuant to a group long-term care insurance policy that is delivered or issued for delivery in this state must include:

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

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

(3) a statement that the group master policy

determines governing contractual provisions.

NEW SECTION. **Section 13.** Compliance required. A policy may not be advertised, marketed, or offered in this state as long-term care insurance or nursing home insurance unless it complies with [this act].

NEW SECTION. **Section 14.** Rules. The commissioner may adopt rules necessary to implement [this act].

NEW SECTION. **Section 15.** Extension of authority. Any existing authority to make rules on the subject of the provisions of [this act] is extended to the provisions of [this act].

NEW SECTION. **Section 16.** Codification instruction. [This act] is intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [this act].

NEW SECTION. **Section 17.** Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 18.** Applicability. [This act] applies to policies delivered or issued for delivery in this state on or after ~~the effective date of [this act]~~ OCTOBER 1, 1989. [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 may not be applied to long-term care insurance. A policy that is not advertised, marketed, or offered as long-term care insurance or nursing home insurance need not meet the requirements of [this act]. A POLICY THAT CONTAINS LONG-TERM CARE INSURANCE BENEFITS OF A DURATION OF AT LEAST 6 MONTHS MUST MEET THE REQUIREMENTS OF [THIS ACT] IF THE PREMIUM ALLOCABLE TO THE LONG-TERM CARE BENEFITS IS GREATER THAN 25% OF THE TOTAL POLICY PREMIUM.

NEW SECTION. **Section 19.** Effective date. [~~Sections 6,~~ SECTION ~~8,~~ and this section] are effective one year after passage and approval.

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