S.B. NO. 1410

JAN 22 2007

A BILL FOR AN ACT

RELATING TO INSURANCE.

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

SECTION 1. The purpose of this Act is to conform current statutes to the recommendations of the National Association of Insurance Commissioners to bring Hawaii's insurance laws into conformity with the federal law and national standards as follows:

(1) Part I authorizes the insurance commissioner to adopt rules to implement model standards that are being developed by the National Association of Insurance Commissioners to implement the directives of the federal Military Services Personnel Financial Services Protection Act (Public Law No. 109-290), which was signed into law in 2006 to protect members of the United States armed forces from unscrupulous practices regarding sales of insurance, financial, and investment products. The Military Services Personnel Financial Services Protection Act requires the states to implement its directives by September 29, 2007;

(2) Part II focuses on long-term care by promoting the availability of long-term care insurance, protecting applicants for long-term care insurance from unfair or deceptive sales or enrollment practices, updating standards for long-term care insurance, and facilitating flexibility and innovation in the development of long-term care insurance coverage; and

(3) Part III enables the sharing of information by the insurance commissioner with the insurance regulatory agencies of foreign countries, including the sharing of confidential information, to facilitate the regulation of the insurance industry.

PART I.

SECTION 2. Chapter 431, Hawaii Revised Statutes, is amended by adding to article 2 a new section to be appropriately designated and to read as follows:

"**§431:2-A Sales to members of the armed forces.** The commissioner may make rules regarding the sales of insurance products to members of the armed forces of the United States including, but not limited to:

(1) Limiting sales authority to persons licensed by the insurance division;

(2) Creating standards for products specifically designed for members of the armed forces, regardless of the sales location; and

(3) Determining the extent to which life insurance products marketed to members of the armed forces comply with otherwise applicable provisions of state law."

PART II.

SECTION 3. Chapter 431, Hawaii Revised Statutes, is amended by adding to part I of article 10H two new sections to be appropriately designated and to read as follows:

"**§431:10H-AAA Denial of claims; compliance requirements.** (a) If a claim under a long-term care insurance contract is denied, the issuer shall, within sixty days of the date of a written request by the policyholder or certificate holder, or a representative thereof:

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

(2) Make available all information directly related to the denial.

(b) Any policy or rider advertised, marketed, or offered as long-term care or nursing home insurance shall comply with the provisions of this article.

§431:10H-BBB Delivery of the contract or certificate of insurance. If an application for a long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than thirty days after the date of approval."

SECTION 4. Chapter 431, Hawaii Revised Statutes, is amended by adding to part II of article 10H seven new sections to be appropriately designated and to read as follows:

"**§431:10H-CCC Electronic enrollment for group policies.** (a) In the case of a group defined in paragraph (1) of the definition of "group long-term care insurance" in section 431:10H-104, any requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:

(1) The signature is obtained by electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

(2) The electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention, and prompt retrieval of records; and

(3) The electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and privileged information is maintained.

(b) The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

§431:10H-DDD Required disclosure of rating practices to consumers. (a) This section shall apply as follows:

(1) Except as provided in paragraph (2), this section applies to any long-term care policy or certificate issued in this State on or after January 1, 2008; and

(2) For policies or certificates issued on or after July 1, 2007, under a group long-term care insurance policy as defined in paragraph (1) of the definition of "group long-term care insurance" in section 431:10H-104, which policy was in force on July 1, 2007, the provisions of this section shall apply on the policy anniversary following July 1, 2007.

(b) Other than for policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subsection to the applicant at the time of application or enrollment; unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this subsection to the applicant no later than at the time of delivery of the policy or certificate as follows:

(1) A statement that the policy may be subject to rate increases in the future;

(2) An explanation of potential future premium rate revisions and the policyholder's or certificate holder's option in the event of a premium rate revision;

(3) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(4) A general explanation for applying premium rate or rate schedule adjustments that shall include:

(A) A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date or next billing date); and

(B) The right to a revised premium rate or rate schedule as provided in paragraph (3) if the premium rate or rate schedule is changed;

(5) With respect to disclosure of premium rate increases:

(A) Information regarding each premium rate increase on this policy form or similar policy forms over the past ten years for this State or any other state that, at a minimum, identifies:

(i) The policy forms for which premium rates have been increased;

(ii) The calendar years when the policy form was available for purchase; and

(iii) The amount or per cent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics;

(B) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases;

(C) An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition;

(D) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of July 1, 2007, or the end of a twenty-four-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with subparagraph (A); and

(E) If the acquiring insurer in subparagraph (D) files for a subsequent rate increase, even within the twenty-four-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in subparagraph (D), the acquiring insurer shall make all disclosures required by paragraph (5), including disclosure of the earlier rate increase referenced in subparagraph (D).

(c) An applicant shall sign an acknowledgment at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under subsection (b)(1) through (5). If due to the method of application the applicant cannot sign an acknowledgment at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

(d) An insurer shall use the forms in Appendices B and F of the April 2002 NAIC Model Long-Term Care Insurance Model Regulation to comply with the requirements of subsections (b) and (c).

(e) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, if applicable, at least forty-five days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by subsection (b) when the rate increase is implemented.

§431:10H-EEE Initial filing requirements. (a) This section applies to any long-term care policy issued in this State on or after January 1, 2008.

(b) An insurer shall provide the information listed in this subsection to the commissioner thirty days prior to making a long-term care insurance form available for sale as follows:

(1) A copy of the disclosure documents required in section 431:10H-221; and

(2) An actuarial certification consisting of at least the following:

(A) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(B) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(C) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(D) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

(i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(ii) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(iii) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and

(iv) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover

expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur; provided that an aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship; provided further that if the gross premiums for certain age groups are inconsistent with this requirement, the commissioner may request a demonstration under subsection (c) based on a standard age distribution;

and

(E) With respect to premium rate schedules:

(i) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(ii) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

(c) The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both. In the event the commissioner asks for additional information under this provision, the period in subsection (b) does not include the period during which the insurer is preparing the requested information.

§431:10H-FFF Licensing. A producer is not authorized to sell, solicit, or negotiate with respect to long-term care insurance except as authorized by article 9A.

§431:10H-GGG Premium rate schedule increases. (a) This section shall apply as follows:

(1) Except as provided in paragraph (2), this section applies to any long-term care policy or certificate issued in this State on or after January 1, 2008; and

(2) For certificates issued on or after July 1, 2007, under a group long-term care insurance policy, as defined in paragraph (1) of the definition of "group long-term care insurance" in section 431:10H-104, which policy was in force on July 1, 2007, the provisions of this section shall apply on the policy anniversary following July 1, 2007.

(b) An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least thirty days prior to the notice to the policyholders and shall include:

(1) Information required by section 431:10H-221;

(2) A certification by a qualified actuary that:

(A) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated; and

(B) The premium rate filing is in compliance with the provisions of this section;

(3) An actuarial memorandum justifying the rate schedule change request that includes:

(A) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale; provided that:

(i) Annual values for the five years preceding and the three years following the valuation date shall be provided separately;

(ii) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(iii) The projections shall demonstrate compliance with subsection (c); and

(iv) For exceptional increases, the projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase. In the event the commissioner determines, as provided in paragraph (4) of

the definition of "exceptional increase" in section 431:10H-104, that offsets may exist, the insurer shall use appropriate net projected experience;

(B) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger a contingent benefit upon lapse;

(C) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

(D) A statement that policy design, underwriting, and claims adjudication practices have been taken into consideration; and

(E) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need file composite rates reflecting projections of new certificates;

(4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules

except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

(5) Sufficient information for the review of the premium rate schedule increase by the commissioner.

(c) All premium rate schedule increases shall be determined in accordance with the following requirements:

(1) Exceptional increases shall provide that seventy per cent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(2) Premium rate schedule increases shall be calculated so that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(A) The accumulated value of the initial earned premium times fifty-eight per cent;

(B) Eighty-five per cent of the accumulated value of prior premium rate schedule increases on an earned basis;

(C) The present value of future projected initial earned premiums times fifty-eight per cent; and

(D) Eighty-five per cent of the present value of future projected premiums not in subparagraph (C) on an earned basis;

(3) In the event that a policy form has both exceptional and other increases, the values in paragraph (2)(B) and (D) shall also include seventy per cent for exceptional rate increase amounts; and

(4) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves, as applicable, as specified in sections 431:5-303 and 431:5-307. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

(d) For each rate increase that is implemented, the insurer shall file for review by the commissioner updated projections, as provided in subsection (b)(3)(A), annually for the next three years, and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group

insurance policies that meet the conditions in subsection (k), the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

(e) If any premium rate in the revised premium rate schedule is greater than two hundred per cent of the comparable rate in the initial premium schedule, lifetime projections, as provided in subsection (b)(3)(A), shall be filed for review by the commissioner every five years following the end of the required period in subsection (d). For group insurance policies that meet the conditions in subsection (k), the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

(f) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection (c), the commissioner may require the insurer to implement any of the following:

(1) Premium rate schedule adjustments; or

(2) Other measures to reduce the difference between the projected and actual experience.

In determining whether the actual experience adequately matches the projected experience, consideration should be given to subsection (b)(3)(E), if applicable.

(g) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(1) A plan, subject to the commissioner's approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in subsection (h); and

(2) The original anticipated lifetime loss ratio and the premium rate schedule increase that would have been calculated according to subsection (c), had the greater of the original anticipated lifetime loss ratio or fifty-eight per cent been used in the calculations described in subsection (c)(2)(A) and (C).

(h) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve months following each increase to determine if significant adverse lapsing has occurred or is anticipated:

(1) The rate increase is not the first rate increase requested for the specific policy form or forms;

(2) The rate increase is not an exceptional increase; and

(3) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

In the event significant adverse lapsing has occurred, is anticipated in the filing, or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in force insureds, subject to the rate increase, the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates;

provided that the offer shall be subject to the approval of the commissioner, be based on actuarially sound principles but not on attained age, and provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of the maximum rate increase determined based on the combined experience or the maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten per cent.

(i) If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of subsection (h), prohibit the insurer from either of the following:

(1) Filing and marketing comparable coverage for a period of up to five years; or

(2) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

(j) Subsections (a) through (i) shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in section 431:10H-104, if the policy complies with all of the following provisions:

(1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) The portion of the policy that provides insurance benefits, other than long-term care coverage, meets the nonforfeiture requirements as applicable in any of the following:

(A) Section 431:10D-104; and

(B) Section 431:10D-107;

(3) The policy meets the disclosure requirements of sections 431:10H-113 and 431:10H-114;

(4) The portion of the policy that provides insurance benefits, other than long-term care coverage, meets the requirements as applicable in the following:

(A) Policy illustrations as required by part IV of article 10D; and

(B) Disclosure requirements, as applicable, in article 431:10D; and

(5) An actuarial memorandum is filed with the insurance division that includes:

(A) A description of the basis on which the long-term care rates were determined;

(B) A description of the basis for the reserves;

(C) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(D) A description and a table of each actuarial assumption used. For expenses, an insurer shall include per cent of premium dollars per policy and dollars per unit of benefits, if any;

(E) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(F) The estimated average annual premium per policy and the average issue age;

(G) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when that underwriting occurs; and

(H) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

(k) Subsections (f) and (h) shall not apply to group insurance policies as defined in paragraph (1) of the definition of "group long-term care insurance" in section 431:10H-104 where:

(1) The policies insure two hundred fifty or more persons and the policyholder has five thousand or more eligible employees of a single employer; or

(2) The policyholder, and not the certificate holders, pays a material portion of the premium, which shall not be less than twenty per cent of the total premium for the group in the calendar year prior to the year a rate increase is filed.

(1) "Exceptional increase" for purposes of this section shall be as defined in section 431:10H-104.

§431:10H-HHH Additional standards for benefit triggers for qualified long-term care insurance contracts. (a) For purposes of this section the following definitions apply:

"Chronically ill individual" has the meaning prescribed for this term by section 7702B(c)(2)(A) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

(1) Being unable to perform (without substantial assistance from another individual) at least two activities of daily living for a period of at least ninety days due to a loss of functional capacity;

(2) Having a level of disability similar (as determined under regulations prescribed by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services) to the level of disability described in paragraph (1); or

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

"Chronically ill individual" shall not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner has certified that the individual meets these requirements.

"Licensed health care practitioner" means a physician, as defined in section 1861(r)(1) of the Social Security Act, and any registered professional nurse, licensed social worker, or other individual who meets requirements prescribed by the Secretary of the Treasury.

"Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from

threats to health and safety due to severe cognitive impairment).

"Qualified long-term care services" means services that meet the requirements of section 7702B(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(b) A qualified long term care insurance contract shall pay only for qualified long term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

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

(d) Certifications regarding activities of daily living and cognitive impairment required pursuant to subsection (c) shall be performed by a licensed health care practitioner.

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

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

§431:10H-III Penalties. In addition to any other penalties provided by the laws of this State, any insurer or producer found to have violated any requirement of this State relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater."

SECTION 5. Section 431:10H-104, Hawaii Revised Statutes, is amended by adding three new definitions to read as follows:

""Exceptional increase" means only those increases filed by an insurer that are extraordinary and for which the commissioner determines the need for the premium rate increase is justified:

(1) Due to:

(A) Changes in laws or rules applicable to long-term care coverage in this State; or

(B) Increased and unexpected utilization that affects the majority of insurers of similar products;

(2) Except as provided in section 431:10H-232, exceptional increases are subject to the same requirements as other premium rate schedule increases;

(3) The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase; and

(4) The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

"Incidental", as used in section 431:10H-GGG(j), means that the value of the long-term care benefits provided is less than ten per cent of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

"Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means an individual or group insurance contract that meets the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as amended, as follows:

(1) The only insurance protection provided under the contract is coverage of qualified long-term care services. A contract shall not fail to satisfy the requirements of this paragraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

(2) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under title XVIII of the Social Security Act, as amended, or would be so reimbursable but for the application of a deductible

or coinsurance amount. The requirements of this paragraph do not apply to expenses that are reimbursable under title XVIII of the Social Security Act only as a secondary payor. A contract shall not fail to satisfy the requirements of this paragraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

(3) The contract is guaranteed renewable, within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended;

(4) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in paragraph (5);

(5) All refunds of premiums and all policyholder dividends or similar amounts under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract; and

(6) The contract meets the consumer protection provisions set forth in section 7702B(g) of the Internal Revenue Code of 1986, as amended.

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

SECTION 6. Section 431:10H-104, Hawaii Revised Statutes, is amended by amending the definition of "long-term care insurance" to read as follows:

""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. The term includes group and individual annuities and life insurance policies or riders that provide directly or that supplement long-term care

insurance. The term also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or loss of functional capacity. The term shall also include qualified long-term care insurance contracts. Long-term care insurance may be issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations, or any similar organization to the extent they are otherwise authorized to issue life or health insurance.

Long-term care insurance shall not include any insurance policy [~~which~~] that is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

With regard to life insurance, this term does not include life insurance policies [~~which~~] that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement,

and [~~which~~] that provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

Notwithstanding any other provision contained herein, any product advertised, marketed, or offered as long-term care insurance shall be subject to this article."

SECTION 7. Section 431:10H-111, Hawaii Revised Statutes, is amended to read as follows:

"[~~+~~] **§431:10H-111** [~~+~~] **Right to return; free look provision.** Long-term care insurance applicants shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in paragraph (1) of the definition of "group long-term

care insurance" in section 431:10H-104, the applicant is not satisfied for any reason. This section shall also apply to a denial of an application for a long-term care contract. Any refund shall be made within thirty days of the return or denial."

SECTION 8. Section 431:10H-112, Hawaii Revised Statutes, is amended by amending subsection (b) to read as follows:

"(b) The outline of coverage shall include:

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

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

(3) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;

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

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

(6) A brief description of the relationship of costs of care and benefits[~~.~~]; and

(7) A statement that discloses to the policyholder or certificate holder whether the policy is intended to be a federally tax-qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended."

SECTION 9. Section 431:10H-114, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy that provides long-term care benefits within the policy[~~.~~] or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of the request shall make delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the policy summary shall also include:

(1) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

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

(3) Any exclusions, reductions, and limitations on benefits of long-term care;

(4) A statement that any long-term care inflation protection option required by section 431:10H-220 is not available under this policy;

(5) If applicable to the policy type, the summary shall also include a disclosure of the effects of exercising other rights under the policy, a disclosure of guarantees related to long-term care costs of insurance charges, and current and projected maximum lifetime benefits; and

(6) The provisions of the policy summary listed above may be incorporated into a basic illustration required to be delivered or into the life insurance policy summary [~~which~~] that is required to be delivered."

SECTION 10. Section 431:10H-201, Hawaii Revised Statutes, is amended to read as follows:

"[~~[~~]**§431:10H-201**[~~]~~] **Policy definitions.** (a) No long-term care insurance policy delivered or issued for delivery in this State shall use the terms set forth in this section, unless the terms are defined in the policy and the definitions satisfy the following requirements:

"Activities of daily living" means at least bathing, continence, dressing, eating, toileting, and transferring.

"Acute condition" means that the individual is medically unstable. This individual requires frequent monitoring by medical professionals such as physicians and registered nurses, in order to maintain the individual's health status.

"Adult day care" means a program for six or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

"Bathing" means washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.

"Cognitive impairment" means a deficiency in a person's short- or long-term memory, orientation as to person, place, and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

"Continence" means the ability to maintain control of bowel and bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

"Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

"Eating" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

"Hands-on assistance" means physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living.

"Home health care services" means medical and nonmedical services, provided to ill, disabled, or infirm persons in their residences. These services may include homemaker services, assistance with activities of daily living, and respite care services.

"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.

"Mental or nervous disorder" means neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder, and shall not be defined beyond these terms.

"Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

"Skilled nursing care", [~~"intermediate care",~~] "personal care", "home care", "specialized care", "assisted living 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.

"Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

"Transferring" means moving into or out of a bed, chair, or wheelchair.

(b) All providers of services, including but not limited to a "skilled nursing facility", "extended care facility", [~~"intermediate care facility",~~] "convalescent nursing home", "personal care facility", [~~and~~] "assisted living facility", "home care agency", and "specialized care providers", shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration, or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed [~~or~~], certified[~~,~~], or registered; provided that when the definition so requires, it shall also state what requirements a provider shall meet in lieu of licensure, certification, or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified, or registered, or when the state licenses, certifies, or registers the provider of services under another name."

SECTION 11. Section 431:10H-202, Hawaii Revised Statutes, is amended to read as follows:

"[~~[~~]**§431:10H-202**[~~]~~] **Renewability.** (a) 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 431:10H-211. A policy issued to an individual shall not contain renewal provisions other than guaranteed renewable or noncancellable.

(b) 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.

(c) The term "noncancellable" means 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.

(d) The term "level premium" may only be used when the insurer does not have the right to change the premium.

(e) In addition to the other requirements of this section, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of section

7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended."

SECTION 12. Section 431:10H-203, Hawaii Revised Statutes, is amended to read as follows:

"[~~§~~]**§431:10H-203**[~~]~~] **Limitations and exclusions.** (a) A policy may not be delivered or issued for delivery in this State as long-term care insurance if the 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); [~~or~~]

(5) Treatment provided in a government facility (unless 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 insurance 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) Expenses for services or items available or paid under another long-term care insurance or health insurance policy; or

(7) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.

(b) This section is not intended to prohibit exclusions and limitations by type of provider [~~or territorial limitations~~]. However, no long-term care issuer may deny a claim because services are provided in a state other than the state of policy issue under the following conditions:

(1) When the state other than the state of policy issue does not have the provider licensing, certification, or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification, registration; or

(2) When the state other than the state of policy issue licenses, certifies, or registers the provider under another name.

For purposes of this paragraph, "state of policy issue" means the state in which the individual policy or certificate was originally issued.

(c) This section is not intended to prohibit territorial limitations."

SECTION 13. Section 431:10H-211, Hawaii Revised Statutes, is amended to read as follows:

"[~~§~~] §431:10H-211 [~~§~~] **Disclosure; renewability.** (a) Individual long-term care insurance policies shall contain a renewability provision. The 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 that do not contain a nonrenewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

(b) A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change."

SECTION 14. Section 431:10H-216, Hawaii Revised Statutes, is amended to read as follows:

"[~~§~~] §431:10H-216 [~~§~~] **Disclosure of tax consequences.** With regard to life insurance policies that provide for an accelerated benefit for long-term care, a disclosure is required at the time of application for the policy and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance

should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy and any other related documents. This section shall not apply to qualified long-term care insurance contracts."

SECTION 15. Section 431:10H-218, Hawaii Revised Statutes, is amended by amending subsection (f) to read as follows:

"(f) 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 that the insured voluntarily effectuated. Every insurer shall annually furnish this information to the insurance commissioner in the format prescribed by the National Association of Insurance Commissioners in Appendix A to the [~~July 1998~~] April 2002 NAIC Long-Term Care Insurance Model Regulation."

SECTION 16. Section 431:10H-221, Hawaii Revised Statutes, is amended by amending subsections (c) and (d) to read as follows:

"(c) Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its producer, shall furnish the applicant, prior to issuance or delivery of the individual

long-term care insurance policy, a notice regarding replacement of accident and health or sickness or long-term care coverage. One copy of the 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 same manner as shown in [~~Section 12(C) of the July 1998~~] section 14C of the April 2002 NAIC Long-Term Care Insurance Model Regulation.

(d) Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and health or sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the same manner as shown in [~~Section 12(D) of the July 1998~~] section 14D of the April 2002 NAIC Long-Term Care Insurance Model Regulation."

SECTION 17. Section 431:10H-222, Hawaii Revised Statutes, is amended to read as follows:

"**§431:10H-222 Reporting requirements.** (a) Every insurer shall maintain records for each producer of the producer's amount of replacement sales as a per cent of the producer's total annual sales and the amount of lapses of long-term care

insurance policies sold by the producer as a per cent of the producer's total annual sales.

(b) Every insurer shall report annually by June 30 the ten per cent of its producers with the greatest percentages of lapses and replacements as measured in subsection (a). The form shall be in the format contained in Appendix G to the April 2002 NAIC Long-Term Care Insurance Model Regulation.

(c) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely producer activities regarding the sale of long-term care insurance.

(d) Every insurer shall report annually by June 30 the number of lapsed policies as a per cent of its total annual sales and as a per cent of its total number of policies in force as of the end of the preceding calendar year. The form shall be in the format contained in Appendix G to the April 2002 NAIC Long-Term Care Insurance Model Regulation.

(e) Every insurer shall report annually by June 30 the number of replacement policies sold as a per cent of its total annual sales and as a per cent of its total number of policies in force as of the end of the preceding calendar year. The form

shall be in the format contained in Appendix G to the April 2002 NAIC Long-Term Care Insurance Model Regulation.

(f) For [~~purposes of this section, "policy" means only long-term care insurance and "report" means on a statewide basis.~~] qualified long-term care insurance contracts, every insurer shall report annually by June 30, the number of claims denied for each class of business, expressed as a percentage of claims denied. The form shall be in the format contained in Appendix E to the April 2002 NAIC Long-Term Care Insurance Model Regulation.

(g) Reports required under this section shall be filed with the commissioner.

(h) For purposes of this section:

"Claim" means a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met. Claims shall be subject to the definition of "denied".

"Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

"Policy" means only long-term care insurance.

"Report" means on a statewide basis."

SECTION 18. Section 431:10H-226, Hawaii Revised Statutes, is amended to read as follows:

"[~~§~~]**§431:10H-226**[~~]~~] **Loss ratio.** (a) Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums; provided that the expected loss ratio is at least sixty per cent, calculated in a manner that 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:

(1) Statistical credibility of incurred claims experience and earned premiums;

(2) The period for which rates are computed to provide coverage;

(3) Experienced and projected trends;

(4) Concentration of experience within early policy duration;

(5) Expected claim fluctuation;

(6) Experience refunds, adjustments, or dividends;

(7) Renewability features;

(8) All appropriate expense factors;

(9) Interest;

(10) Experimental nature of the coverage;

(11) Policy reserves;

(12) Mix of business by risk classification, if applicable; and

(13) Product features such as long elimination periods, high deductibles, and high maximum limits.

(b) For purposes of this section, the commissioner shall consult with a qualified long-term care actuary.

(c) Subsection (a) shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

(1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements for life insurance;

(3) The policy meets the disclosure requirements of section 431:10H-114 as applicable;

(4) Any policy illustration that meets the applicable requirements for policy illustration;

(5) An actuarial memorandum is filed with the insurance division that includes:

(A) A description of the basis on which the long-term care rates were determined;

(B) A description of the basis for the reserves;

(C) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(D) A description and a table of each actuarial assumption used. For expenses, an insurer shall include per cent of premium dollars per policy and dollars per unit of benefits, if any;

(E) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(F) The estimated average annual premium per policy and the average issue age;

(G) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used, and if used, the statement shall include a description of the type or types of underwriting used such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(H) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

(d) This section shall apply to all long-term care insurance policies or certificates except those covered under sections 431:10H-EEE and 431:10H-GGG."

SECTION 19. Section 431:10H-229, Hawaii Revised Statutes, is amended to read as follows:

"**§431:10H-229 Standards for marketing.** (a) Every insurer, health care service plan, or other entity marketing long-term care insurance coverage in this State, directly or through producers, shall:

(1) Establish marketing procedures to assure that any comparison of policies by its producers will be fair and accurate;

(2) Establish marketing procedures to assure excessive insurance is not sold or issued;

(3) Display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and policy the following:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.";

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance currently has long-term care insurance and the types and amounts of any such insurance[~~.~~], except that in the case of qualified long-term care insurance contracts, an inquiry into

whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required;

(5) Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with subsection (a);

(6) If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the commissioner, the insurer, at solicitation, shall provide written notice to the prospective policyholder or certificate holder of a state senior insurance counseling program including the name, address, and telephone number of the program; [~~and~~]

(7) For long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to section 431:10H-202[~~.~~];

(8) Provide copies of the disclosure forms required in section 431:10H-DDD(c) to the applicant; and

(9) Provide an explanation of contingent benefit upon lapse provided for in section 431:10H-233(f).

(b) In addition to the acts or practices prohibited in article 13 of this chapter, all of the following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.

(4) Misrepresentation. Falsifying a material fact in selling or offering to sell a long-term care insurance policy."

SECTION 20. Section 431:10H-230, Hawaii Revised Statutes, is amended by amending subsection (f) to read as follows:

"(f) The association shall also:

(1) At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including benefits, features, and rates, and update the examination thereafter in the event of material change;

(2) Actively monitor the marketing efforts of the insurer and its producers; and

(3) Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

This subsection shall not apply to qualified long-term care insurance contracts."

SECTION 21. Section 431:10H-231, Hawaii Revised Statutes, is amended by amending subsection (c) to read as follows:

"(c) To determine whether the applicant meets the standards developed by the issuer, the producer and issuer shall develop procedures that take the following into consideration:

(1) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(2) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

(3) The values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

The issuer, and where a producer is involved, the producer shall make reasonable efforts to obtain the information set out above. The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet". The personal worksheet used by the issuer shall contain, at a minimum, information in the format contained in Appendix B of the [~~July 1998~~] April 2002 NAIC Long-Term Care Insurance Model Regulation, in not less than twelve-point type. The issuer may request the applicant to provide additional

information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the commissioner."

SECTION 22. Section 431:10H-231, Hawaii Revised Statutes, is amended by amending subsection (e) to read as follows:

"(e) The sale or dissemination outside the company or agency by the issuer or producer of information obtained through the personal worksheet in Appendix B of the [~~July 1998~~] April 2002 NAIC Long-Term Care Insurance Model Regulation is prohibited."

SECTION 23. Section 431:10H-231, Hawaii Revised Statutes, is amended by amending subsections (g) and (h) to read as follows:

"(g) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix C to the [~~July 1998~~] December 2006 NAIC Long-Term Care Insurance Model Regulation, in not less than twelve-point type.

(h) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject

the application. In the alternative, the issuer shall send the applicant a letter similar to the [~~July 1998~~] April 2002 NAIC Long-Term Care Insurance Model Regulation, Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternate method of verification shall be made part of the applicant's file."

SECTION 24. Section 431:10H-233, Hawaii Revised Statutes, is amended to read as follows:

"[~~:~~] **§431:10H-233** [~~:~~] **Nonforfeiture benefit requirement.** (a) This section does not apply to life insurance policies containing accelerated long-term care benefits.

(b) To comply with the requirement to offer a nonforfeiture benefit pursuant to section 431:10H-116, the following shall be met:

(1) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers, and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the

offer shall be the benefit described in subsection (h); and

(2) The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

(c) If the offer required to be made under section 431:10H-116 is rejected, the insurer shall provide the contingent benefit upon lapse described in this section.

(d) After rejection of the offer required under section 431:10H-116, for individual and group policies without nonforfeiture benefits issued after June 30, 2000, the insurer shall provide a contingent benefit upon lapse.

(e) If a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(f) The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in the table below based on the

insured's issue age, and the policy or certificate lapses within one hundred twenty days of the due date of the premium so increased. Unless otherwise required, policyholders and certificate holders shall be notified at least thirty days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Per Cent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%

1	67	46%
2	68	44%
3	69	42%
4	70	40%
5	71	38%
6	72	36%
7	73	34%
8	74	32%
9	75	30%
10	76	28%
11	77	26%
12	78	24%
13	79	22%
14	80	20%
15	81	19%
16	82	18%
17	83	17%
18	84	16%
19	85	15%
20	86	14%
21	87	13%
22	88	12%

89		11%
90 and over		10%

(g) On or before the effective date of a substantial premium increase as defined in subsection (f), the insurer shall:

(1) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(2) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection (h). This option may be elected at any time during the one-hundred-twenty-day period referenced in subsection (f); and

(3) Notify the policyholder and certificate holder that a default or lapse at any time during the one-hundred-twenty-day period under subsection (f) shall be deemed to be the election offer to convert in paragraph (2).

(h) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in this subsection, as follows:

(1) For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one per cent per year prior to age fifty, and at least three per cent per year beyond age fifty;

(2) For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) shall be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as provided in paragraph (3);

(3) The standard nonforfeiture credit shall be equal to one hundred per cent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard forfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty times the daily nursing home benefit at the time of

lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subsection (i);

(4) The nonforfeiture benefit and contingent benefit upon lapse shall begin not later than the end of the third year following the policy or certificate issue date. Notwithstanding the preceding sentence, except for a policy or certificate with a contingent benefit upon lapse or a policy or certificate with attained age rating, the nonforfeiture benefit shall begin the earlier of:

(A) The end of the tenth year following the policy or certificate issue date; or

(B) The end of the second year following the date the policy or certificate is no longer subject to attained age rating; and

(5) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(i) All benefits paid by the insurer while the policy or certificate is in premium paying status and in paid up status

shall not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.

(j) There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

(k) The requirements set forth in this section shall become effective July 1, 2000, and shall apply as follows:

(1) This section shall apply to any long-term care policy issued in this State after June 30, 2000; and

(2) For certificates issued after June 30, 2000, under a group long-term care insurance policy as defined in paragraph (1) under the definition of "group long-term care insurance" in section 431:10H-104, which policy was in force on July 1, 2000, this section shall not apply.

(l) Premiums charged for a policy or certificate containing nonforfeiture benefits or contingent benefit on lapse shall be subject to the loss ratio requirements of section 431:10H-226 or section 431:10H-GGG, whichever is applicable, treating the policy as a whole.

(m) To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection (f), a replacing

insurer that purchases or assumes a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

(n) A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

(1) The nonforfeiture provision shall be appropriately captioned;

(2) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the commissioner for the same contract form; and

(3) The nonforfeiture provision shall provide at least one of the following:

(A) Reduced paid-up insurance;

(B) Extended term insurance;

(C) Shortened benefit period; or

(D) Other similar offerings approved by the commissioner."

SECTION 25. Section 431:10H-235, Hawaii Revised Statutes, is amended to read as follows:

"[~~[~~] **§431:10H-235** [~~]~~] **Standard format outline of coverage; group and individual policies.** This section implements, interprets, and makes specific, the provisions of section 431:10H-112 in prescribing a standard format and the content of an outline of coverage, as follows:

(1) The outline of coverage shall be a freestanding document, using no smaller than ten-point type;

(2) The outline of coverage shall contain no material of an advertising nature;

(3) Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring;

(4) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated; and

(5) The format for outline of coverage shall be substantially similar to the Outline of Coverage in [~~Section 25~~] section 29 of the [~~July 1998~~] April 2002 NAIC Long-Term Care Insurance Model Regulation."

PART III.

SECTION 26. Section 431:2-209, Hawaii Revised Statutes, is amended by amending subsection (e) to read as follows:

"(e) The following records and reports on file with the commissioner shall be confidential and protected from discovery, production, and disclosure for so long as the commissioner deems prudent:

(1) Complaints and investigation reports;

(2) Working papers of examinations, complaints, and investigation reports;

(3) Proprietary information, including trade secrets, commercial information, and business plans, which, if disclosed may result in competitive harm to the person providing the information;

(4) Any documents or information received from the National Association of Insurance Commissioners, the federal government, insurance regulatory agencies of foreign countries, or insurance departments of other states,

territories, and commonwealths that are confidential in other jurisdictions. The commissioner [~~shall be authorized to~~] may share information, including otherwise confidential information, with the National Association of Insurance Commissioners, the federal government, insurance regulatory agencies of foreign countries, or insurance departments of other states, territories, and commonwealths so long as the statutes or regulations of the other jurisdictions permit them to maintain the same level of confidentiality as required under Hawaii law."

SECTION 27. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 28. This Act shall take effect on July 1, 2007.

INTRODUCED BY: _____

BY REQUEST

S.B. 1410

JUSTIFICATION SHEET

DEPARTMENT: Commerce and Consumer Affairs

TITLE: A BILL RELATING TO INSURANCE.

PURPOSE: To update and conform current statutes to recommendations of the National Association of Insurance Commissioners (NAIC) with respect to: (1) the authority required to implement rules to carry out the directives of the federal Military Personnel Financial Services Protection Act; (2) long-term care insurance; and (3) the sharing of information with the insurance regulatory agencies of foreign countries.

MEANS: Add a new section to article 2, chapter 431, Hawaii Revised Statutes (HRS); add nine new sections to part I of article 10H, chapter 431, HRS, and amend sections 431:2-209(e), 431:10H-104, 431:10H-111, 431:10H-112(b), 431:10H-114(a), 431:10H-201, 431:10H-202, 431:10H-203, 431:10H-211, 431:10H-216, 431:10H-218(f); 431:10H-221(c) and (d), 431:10H-222, 431:10H-226, 431:10H-229, 431:10H-230(f), 431:10H-231(c), (e), (g), and (h), 431:10H-233, and 431:10H-235, HRS.

JUSTIFICATION: The Department of Commerce and Consumer Affairs is continuing its efforts to modernize Hawaii's insurance laws, ease insurers' filing requirements, and bring Hawaii's insurance laws into conformity with the federal law and national standards.

Thus, Part I of the bill provides the Insurance Commissioner with the requisite authority to adopt rules to implement upcoming NAIC model standards

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that carry out the objectives of the federal Military Personnel Financial Services Protection Act, Public Law No. 109-290, which protect members of the United States armed forces from unscrupulous practices regarding sales of insurance, financial, and investment products.

Part II of the bill updates and conforms current long-term care statutes to the changes and revisions in the most currently adopted NAIC Model Laws, Regulations, and Guidelines, thus promoting the availability of long-term care insurance policies, protecting applicants of long-term care insurance from unfair or deceptive sales or enrollment practices, updating standards for long-term care insurance, and facilitating flexibility and innovation in the development of long-term care insurance coverage.

Finally, Part III of the bill incorporates the NAIC recommendation that all states allow for the sharing of information regarding domestic companies with the regulatory officials of foreign countries.

More specifically:

1. Part I of this bill authorizes the Insurance Commissioner to develop and adopt rules to implement model standards that are being developed by the NAIC to implement the directives of the Military Personnel Financial Services Protection Act, which was recently signed into law in 2006. In preparing for implementation of the upcoming NAIC model standards, the legal staff of the Insurance Division, with the assistance of the Department of the Attorney

General, determined that existing state law may not be specific enough to authorize the adoption of the necessary rules. Part I of this bill corrects the deficiency by adding a new section to article 2, chapter 431, HRS, specifically authorizing the Insurance Commissioner to make rules regarding the sale of insurance products to members of the United States armed forces. At minimum, these rules will: (A) limit sales authority to persons licensed by the Insurance Division; (B) allow the establishment of standards for insurance products designed for members of the United States armed forces; and (C) determine the extent to which life insurance products marketed to members of the armed forces comply with otherwise applicable provisions of state law. Passage of Part I of the bill during the 2007 Regular Session is necessary to authorize the Insurance Commissioner to meet the September 29, 2007, implementation deadline set by the federal Act.

2. Part II of this bill incorporates into Hawaii law several new consumer protection provisions that have been developed by the NAIC for its long-term care model regulation. These provisions were developed to prevent the problem of consumers buying long-term care insurance in their 60s (when it is affordable), only to find in their 70s and 80s (the time period when they need the coverage) that they cannot keep up with premiums because rate increases have made the coverage too expensive. Thus, these provisions focus on

stabilizing premium rates, ensuring proper product pricing that will keep premiums level, and ensuring that consumers receive necessary documents and disclosures in a timely manner.

This part of the measure adds nine new sections to article 10H of chapter 431, HRS, which, among other things: requires an insurer to respond in writing if a claim for benefits is denied; requires an insurer to deliver a contract or certificate to a policyholder thirty days after the date of approval; allows for the electronic enrollment for group policies; requires insurers to disclose certain rating practices to consumers; updates insurer filing requirements with the Insurance Division; requires that persons selling long-term care insurance be properly licensed as producers; requires insurers to provide at least thirty days notice to consumers of pending premium increases; defines "chronically ill individual", "licensed health care practitioner", "maintenance or personal care services", "qualified long-term care insurance contract", "federally tax-qualified long-term care insurance contract", "exceptional increase", "incidental", and "qualified long-term care services"; and establishes penalties for insurers and producers that violate long-term care regulations.

This part also amends current statutes by, among other things: defining "claim", "denied",

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"policy", and "report"; amending the term "long-term care insurance"; requiring that refunds be made within thirty days of a policy's return or denial; requiring that a policy outline include a statement as to whether the policy is intended to be a federally tax-qualified long-term care insurance contract; clarifying how "specialized care" and "assisted living care" should be defined; requiring a qualified long-term care insurance contract to be guaranteed to be renewable; allowing for the exclusion of certain payments under the long-term care policy if the expenses are already covered under another insurance policy or are reimbursable; clarifying what expenses are reimbursable for qualified long-term care insurance contracts; prohibiting claim denial because services are provided in a state other than the state of policy issue and specifying the conditions applicable thereto; requiring the insurer to disclose to policyholders that, when applicable, premium rates may change; clarifying that qualified long-term care insurance contracts do not have to comply with the disclosure requirements which apply to life insurance policies that provide for accelerated benefits; exempting long-term care insurance policies from complying with loss ratio requirements if they already comply with initial filing requirements and premium rate schedule increases; requiring that insurers report annually by June 30 of each year the number of claims denied for each class of

business, expressed by a percentage of claims, for qualified long-term care insurance contracts; clarifying that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required; requiring that copies of the disclosure forms and explanations of contingent benefits be provided to applicants; prohibiting the misrepresentation by a licensee of a policy's material facts in the selling or the offering to sell a long-term care insurance policy; requiring qualified long-term care insurance contracts that are level premium contracts offering nonforfeiture benefits follow specific guidelines; and making other technical changes; and

3. Part III of the bill incorporates the recommendation of the NAIC Financial Regulation Standards and Accreditation Program that all states allow for the sharing of information regarding domestic companies with the regulatory officials of foreign countries. This will promote the protection of the public by enabling the exchange of information, including confidential information, which is needed for effective and efficient regulation of the insurance industry.

   This part accomplishes the foregoing by amending section 431:2-209, HRS, to add the regulatory agencies of foreign countries to the list of entities

with which the Insurance Commissioner may share information, including confidential information, regarding domestic companies. The bill allows this sharing of confidential information only if the recipients of the information are required, under the laws of their respective jurisdictions, to maintain the information's confidentiality.

Impact on the public: Part I of the bill should have a positive impact on the members of the United States armed forces and their families as it will facilitate the implementation of the objectives of the federal Military Personnel Financial Services Protection Act. Part II should have a positive impact on the public by promoting the availability of long-term care insurance policies, protecting applicants for long-term care insurance from unfair and deceptive sales and enrollment practices, updating standards for long-term care insurance, and facilitating flexibility and innovation in the development of long-term care coverage. Part III should have a positive impact on the public by promoting information exchange between different jurisdictions worldwide, while maintaining the confidentiality of the information.

Impact on the department and other agencies: The Department of Commerce and Consumer Affairs will be able to better protect and serve the members of the United States armed forces and their families, as well as the public in general.

GENERAL FUND: None.

OTHER FUNDS: None.

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PPBS PROGRAM DESIGNATION: CCA-106.

OTHER AFFECTED AGENCIES: None.

EFFECTIVE DATE: July 1, 2007.