ACT 93

S.B. NO. 131

A Bill for an Act Relating to Long-Term Care.

Be It Enacted by the Legislature of the State of Hawaii:

PART I

SECTION 1. Long-term care is an issue of immense importance. Providing adequate care for the aged and disabled is an economic burden for many people. The legislature finds that long-term care insurance policies offer a means of alleviating that load. The legislature believes that the ideal setting to provide long-term care insurance is through the workplace and that the State should encourage the offering of long-term care insurance in order to provide a modicum of financial security. This Act is a recommendation of the Joint Legislative Committee on Long-Term Care, as contained in its report to the 1999 legislature, Miscellaneous Communication No. 9, dated December 1, 1999.

The purpose of this Act is to increase the number of long-term care insurance policies in effect in Hawaii and to conform Hawaii's long-term care insurance statutes to the July 1998 Long-Term Care Insurance Model Act and Model Regulation of the National Association of Insurance Commissioners.

PART II

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

"ARTICLE LONG-TERM CARE INSURANCE
PART I. LONG-TERM CARE INSURANCE MODEL ACT

§431: -101 Purpose. The purpose of this article is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage. (1998 NAIC Act Sec. 1)

§431: -102 Scope. The requirements of this article shall apply to policies delivered or issued for delivery in this State on or after July 1, 2000. This article is not intended to supersede the obligations of entities subject to this article to comply with the substance of other applicable insurance laws insofar as they do not conflict with this article, except that laws and regulations designed and intended to apply to Medicare supplement insurance policies shall not be applied to long-term care insurance. (1998 NAIC Act Sec. 2)

§431: -103 Short title. This article may be known and cited as the "Long-Term Care Insurance Act." (1998 NAIC Act Sec. 3)

§431: -104 Definitions. As used in this article, unless the context requires otherwise, the definitions in this section apply throughout this article.

"Applicant" means:

(1) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and

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

"Certificate" means, for the purposes of this article, any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this State.

"Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this State and issued to:

(1) One or more employers or labor organizations, or a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations; or

(2) Any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if the association:

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

(B) Has been maintained in good faith for purposes other than obtaining insurance; or

(3) An association or a trust or the trustees of a fund established, created, or maintained for the benefit of members of one or more associations. 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 at the outset a minimum of one hundred persons; has been organized and maintained in good faith for purposes other than that of obtaining insurance; has been in active existence for at least one year; and has a constitution and bylaws which provide that:

(A) The association holds regular meetings not less than annually to further purposes of the members;
(B) Except for credit unions, the association collects dues or solicits contributions from members; and
(C) The members have voting privileges and representation on the governing board and committees.

Thirty days after the filing the association will be deemed to satisfy the organizational requirements unless the commissioner makes a finding that the association does not satisfy those organizational requirements; or

(4) A group other than as described in paragraphs (1), (2), and (3), subject to a finding by the commissioner that:
(A) The issuance of the group policy is not contrary to the best interest of the public;
(B) The issuance of the group policy would result in economies of acquisition or administration; and
(C) The benefits are reasonable in relation to the premiums charged.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191.

"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.

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

With regard to life insurance, this term does not include life insurance policies which 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 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.

"NAIC" means the National Association of Insurance Commissioners.

"Policy" means, for the purposes of this article, any policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in this State by an insurer; fraternal benefit society; nonprofit health, hospital, or medical service corporation; prepaid health plan; health maintenance organization; or any similar organization. (1998 NAIC Act Sec. 5 & Reg. Sec. 5)

§431: -105 Extraterritorial jurisdiction; group policies. No group long-term insurance coverage may be offered to a resident of this State under a group policy issued in another state to a group described in paragraph (4) under the definition of "group long-term care insurance" in section 431: -104, unless this

State or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this State has made a determination that these requirements have been met. (1998 NAIC Act Sec. 5)

§431: -106 Rules. The commissioner may adopt rules that include standards for full and fair disclosure setting forth the manner, content, and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, non-duplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definition of terms. (1998 NAIC Act Sec. 6A)

§431: -107 Basic standards. (a)[1] No long-term care insurance policy may:

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

(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 skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care. (1998 NAIC Act Sec. 6B)

§431: -108 Preexisting conditions-group and individual policies. (a) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in paragraph (1) of the definition of ''group long-term care insurance'' in section 431: -104 shall use a definition of ''preexisting condition'' which is more restrictive than the following: ''Preexisting condition'' means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services within six months preceding the effective date of coverage of an insured person.

(b) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in paragraph (1) of the definition of ''group long-term care insurance'' in section 431: -104 may exclude coverage for a loss or confinement which is the result of a preexisting condition unless the loss or confinement begins within six months following the effective date of coverage of an insured person.

(c) The commissioner may extend the limitation periods in subsections (a) and (b) as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(d) The definition of ''preexisting condition'' does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subsection (b) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in subsection (b). (1998 NAIC Act Sec. 6C)

§431: -109 Prior hospitalization; prior institutionalization. (a) No long-term care insurance policy may be delivered or issued for delivery in this State if the policy:

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

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

(3) Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care, or recuperative benefits on a prior institutionalization requirement.

(b) A long-term care insurance policy containing post-confinement, post-acute care, or recuperative benefits shall clearly label, in a separate paragraph of the policy or certificate, entitled "Limitations or Conditions on Eligibility for Benefits," such limitations or conditions including any required number of days of confinement.

(c) A long-term care insurance policy that conditions eligibility of non-institutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty days. (1998 NAIC Act Sec. 6D)

§431: -110 Loss ratio standards; factors; commissioner approval. The commissioner may adopt rules establishing loss ratio standards for long-term care insurance policies; provided that a specific reference to long-term care insurance policies is contained in the rule. (1998 NAIC Act Sec. 6E & Reg. Sec. 17)

§431: -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: -104, the applicant is not satisfied for any reason. (1998 NAIC Act Sec. 6F)

§431: -112 Outline of coverage required. (a) An outline of coverage shall be delivered 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. The commissioner shall prescribe a standard format, including style, arrangement, and overall appearance, and the content of an outline of coverage. In the case of agent solicitations, an agent shall deliver the outline of coverage prior to the presentation of an application or enrollment form. In the case of direct response solicitation, the outline of coverage shall be presented in conjunction with any application or enrollment form. In the case of a policy issued to a group defined in paragraph (1) of the definition of "group long-term care insurance" in section 431: -104, an outline of coverage shall not be required to be delivered; provided that the information described subsection (b) is contained in other materials relating to enrollment. Upon request, these other materials shall be made available to the commissioner.

(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. (1998 NAIC Act Sec. 6G)

§431: -113 Group policy certificate requirements. A certificate issued pursuant to a group long-term care insurance policy which is delivered or issued for delivery in this State shall include:
(1) A description of the principal benefits and coverage provided in the policy;
(2) A statement of the principal exclusions, reductions, and limitations contained in the policy; and
(3) A statement that the group master policy determines governing contractual provisions. (1998 NAIC Act Sec. 6H)

§431: -114 Life insurance policies offering long-term care benefits. (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. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make 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 431: -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 is required to be delivered.

(b) Any time a long-term care benefit funded through a life insurance vehicle by the acceleration of the death benefit is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include:
(1) Any long-term care benefits paid out during the month;
(2) An explanation of any changes in the policy, for example death benefits or cash values, due to long-term care benefits being paid out; and
(3) The amount of long-term care benefits existing or remaining.

(c) Any policy advertised, marketed, or offered as long-term care or nursing home insurance shall comply with this article. (1998 NAIC Act Sec. 6I-K)

§431: -115 Incontestability period-group and individual policies. (a) For a policy or certificate that has been in force for less than six months an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance of coverage.

(b) For a policy or certificate that has been in force at least six months but less than two years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance of coverage and which pertains to the condition for which benefits are sought.

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

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

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

(f) In the event of the death of the insured, this section shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies shall be governed by article 10D of this chapter. In all other situations, this section shall apply to life insurance policies that accelerate benefits for long-term care. (1998 NAIC Act Sec. 7)

§431: -116 Nonforfeiture benefits. (a) Except as provided in subsection (b), a long-term care insurance policy shall not be delivered or issued for delivery in this State unless the policyholder or certificate holder has been offered an option to purchase a policy or certificate that includes a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. If the policyholder or certificate holder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates.

(b) For a group long-term care insurance policy, the offer of a nonforfeiture benefit under subsection (a) shall be made to the group policyholder. However, if the policy is issued as a group long-term care insurance, other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificate holder.

(c) The commissioner shall adopt rules to specify the type of nonforfeiture benefits to be offered as part of long-term care insurance policies or certificates, the standards for nonforfeiture benefits, and the rules for contingent benefit upon lapse, including a determination of the specified period of time during which a contingent benefit upon lapse shall be available and the substantial premium rate increase that triggers a contingent benefit upon lapse as provided in subsection (a). (1998 NAIC Act Sec. 8)

§431: -117 Authority to promulgate regulations. The commissioner may issue reasonable regulations to promote premium adequacy and to protect the policyholder in the event of substantial rate increases, and to establish minimum standards for marketing practices, agent compensation, agent testing, penalties, and reporting practices for long-term care insurance. (1998 NAIC Act Sec. 9)

PART II. LONG-TERM CARE INSURANCE MODEL REGULATION

§431: -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,"[1] 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," 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 "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified. (1998 NAIC Reg. Sec. 5)

§431: -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: -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. (NAIC Reg. Sec. 6A)

§431: -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.

(b) This section is not intended to prohibit exclusions and limitations by type of provider or territorial limitations. (1998 NAIC Reg. Sec. 6B)

§431: -204 Extension of benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy. (1998 NAIC Reg. Sec. 6C)

§431: -205 Continuation or conversion. (a) Group long-term care insurance issued in this State beginning July 1, 2000, shall provide covered individuals with a basis for continuation or conversion of coverage.

(b) For purposes of this section, for ''a basis for continuation of coverage'' means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.

(c) For purposes of this section, ''a basis for conversion of coverage'' means a policy provision that entitles an individual, whose coverage under the group policy would otherwise terminate or has been terminated for any reason including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy or any group policy that it replaced for at least six months immediately prior to termination shall be entitled to the issuance of a converted policy by the insurer under whose group policy the individual is covered, without evidence of insurability.

(d) For purposes of this section, ''converted policy'' means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the commissioner, in making a determination as to substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.

(e) Written application for the converted policy shall be made and the first premium, if any, shall be paid as directed by the insurer no later that thirty-one days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

(f) Unless the group policy from which conversion is made is replaced[1] previous group policy coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced a previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(g) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

(1) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(2) The terminating coverage is replaced not later than thirty-one days after termination by another group coverage effective on the day following the termination of coverage:

(A) Providing benefits or benefits determined by the commissioner to be identical substantially equivalent to or in excess of those provided by the terminating coverage; and

(B) The premium for which is calculated in a manner consistent with the requirements of subsection (f).

(h) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more that one hundred per cent of incurred expenses. The provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

(i) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

(j) Notwithstanding any other provision of this section, an insured individual whose eligibility for group long-term care coverage is based upon the individual's relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage or reciprocal beneficiary relationship.

(k) For purposes of this section ''managed care plan'' is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management, or use of specific provider networks. (1998 NAIC Reg. Sec. 6D)

§431: -206 Discontinuance and replacement. If a group long-term care insurance policy is replaced by another group long-term care insurance policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to person under the new group policy shall not:

(1) Result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

(2) Vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services. (1998 NAIC Reg. Sec. 6E)

§431: -207 Premiums charged-group and individual policies. (a) The premium charged to an insured shall not increase due to either:

(1) Increasing age of the insured at ages beyond sixty-five; or

(2) The duration the insured has been covered under the policy.

(b) The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under section 431: -233,

the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

(c) A reduction of benefits shall not be considered a premium change, but for purpose of calculation required under section 431: -233, the initial annual premium shall be based on reduced benefits. (1998 NAIC Reg. Sec. 6F)

§431: -208 Unintentional lapse. (a) Each insurer offering long-term care insurance, as a protection against unintentional lapse, shall comply with this section.

(b) No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation shall provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address.

(c) In the case of an applicant who elects not to designate an additional person, the waiver shall state:

"Protection Against Unintended Lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

(d) The insurer shall notify the insured of the right to change this written designation, no less often than every two years.

(e) When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the notice requirement contained in subsection (c) need not be met until sixty days after the policyholder or certificate holder is no longer on a payment plan. The application or enrollment form for these policies or certificates shall clearly indicate the payment plan selected by the applicant. (1998 NAIC Reg. Sec. 7A)

§431: -209 Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated in section 431: -208 at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid and notice may not be given until thirty days after a premium is unpaid. Notice shall be deemed to have been given as of five days after the date of mailing. (1998 NAIC Reg. Sec. 7A)

§431: -210 Reinstatement. In addition to the requirements of sections 431: -208 and 431: -209, a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility

criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate. (1998 NAIC Reg. Sec. 7B)

§431: -211 Disclosure; renewability. 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. (1998 NAIC Reg. Sec. 8A)

§431: -212 Disclosure; riders and endorsements. (a) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after the date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured.

(b) After the date of policy issuance, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing by the insured, except if the increased benefits or coverages are required by law.

(c) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider, or endorsement. (1998 NAIC Reg. Sec. 8B)

§431: -213 Disclosure; payment of benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or similar words or phrases shall include a definition of these terms and an explanation of the terms in its accompanying outline of coverage. (1998 NAIC Reg. Sec. 8C)

§431: -214 Disclosure; limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations." (1998 NAIC Reg. Sec. 8D)

§431: -215 Disclosure; other limitations and conditions on eligibility for benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in section 431: -109 shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall be labeled as "Limitations or Conditions on Eligibility of Benefits." (1998 NAIC Reg. Sec. 8E)

§431: -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. (1998 NAIC Reg. Sec. 8F)

§431: -217 Disclosure; benefit triggers. Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this section. If these benefit triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified. (1998 NAIC Reg. 8G)

§431: -218 Prohibition against post-claims underwriting. (a) All applications for long-term care insurance policies or certificates except those that are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(b) If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

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

(d) Except for policies or certificates which are guaranteed issue:

(1) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:
"CAUTION: If your answers on this application are incorrect or untrue, the (company) has the right to deny benefits or rescind your policy.";

(2) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:
"CAUTION: The issuance of this long-term care insurance (policy) (certificate) is based upon your responses to the questions on your application. A copy of your (application) (enrollment form) (is enclosed) (was retained by you when you applied). If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: (insert address).";

(3) Prior to issuance of a long-term care policy or certificate to an applicant age eighty or older, the insurer shall obtain one of the following:
(A) A report of a physical examination;
(B) An assessment of functional capacity;
(C) An attending physician's statement; or
(D) Copies of medical records.

(d)[1] A copy of the completed application or enrollment form, whichever is applicable, shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

(e)[1] 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 NAIC Long-Term Care Insurance Model Regulations. (1998 NAIC Reg. Sec. 9)

§431: -219 Minimum standards for home health and community care benefits. (a) A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits by:

(1) Requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;
(2) Requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community, or institutional setting before home health care services are covered;
(3) Limiting eligible services to services provided by registered nurses or licensed practical nurses;
(4) Requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of the person's licensure or certification;
(5) Excluding coverage for personal care services provided by a home health aide;
(6) Requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;
(7) Requiring that the insured or claimant have an acute condition before home health care services are covered;
(8) Limiting benefits to services provided by Medicare-certified agencies or providers; or
(9) Excluding coverage for adult day care service.

(b) A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

(c) Home health care coverage may be applied to nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate. (1998 NAIC Reg. Sec. 10)

§431: -220 Requirement to offer inflation protection; group and individual policies. (a) No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers shall offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(1) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less that five per cent;
(2) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the

difference between the existing policy benefit and that benefit compounded annually at a rate of at least five per cent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

(3) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(b) Where the policy is issued to a group, the required offer in subsection (a) shall be made to the group policyholder; except if the policy is issued to a group defined in paragraph (4) under the definition of "group long-term care insurance" in section 431: -104 other than to a continuing care retirement community, the offering shall be made to each certificate holder.

(c) The offer in subsection (a)(2) shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

(d) Insurers shall include the following information in or with the outline of coverage:

(1) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty year period.

(2) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(e) Inflation protection benefit increases under a policy which contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy[1]

(f) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(g) Inflation protection in subsection (a)(2) shall be included in a long-term care insurance policy unless the insurer obtains a rejection of inflation protection signed by the policyholder as required in subsection (h).

(h) The rejection shall be considered a part of the application and shall state:

"I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I REJECT INFLATION PROTECTION." (1998 NAIC Reg. Sec. 11)

§431: -221 Requirements for application forms and replacement coverage. (a) Application forms shall include questions designed to elicit information as to whether, as of the date of application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing the questions may be used. With regard to a replacement policy issued to a group defined by paragraph (1) under the definition of "group long-term care insurance" in section 431: -104, the following questions may be modified only to the extent necessary to elicit information about health and long-term care insurance policies other than the group policy being replaced; provided that the certificate holder has been notified of the replacement:

(1) Do you have another long-term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)?

(2) Did you have another long-term care insurance policy or certificate in force during the last twelve months?
(A) If so, with which company?
(B) If that policy lapsed, when did it lapse?
(3) Are you covered by Medicaid?
(4) Do you intend to replace any of your medical or health insurance coverage with this policy (certificate)?

(b) Agents shall list any other health insurance policies they have sold to the applicant, and the agent shall list policies sold that are still in force and list policies sold in the past five years that are no longer in force.

(c) Upon determining that a sale will involve replacement, an insurer; other than an insurer using direct response solicitation methods, or its agent; shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of 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 NAIC Long-Term Care Insurance Model Regulation.

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

(e) Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured, and policy number or address including zip code. Notice shall be made within five working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

(f) Life insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements for life insurance policies. If a life insurance policy that accelerates benefits for long-term care is replaced by another policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements. (1998 NAIC Reg. Sec. 12)

§431: -222 Reporting requirements. (a) Every insurer shall maintain records for each agent of the agent's amount of replacement sales as a per cent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a per cent of the agent's total annual sales.

(b) Every insurer shall report annually by June 30 the ten per cent of its agents with the greatest percentages of lapses and replacements as measured in subsection (a).

(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 agent 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.

(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;

(f) For purposes of this section, ''policy'' means only long-term care insurance and ''report'' means on a statewide basis. (1998 NAIC Reg. Sec. 13)

§431: -223 Discretionary powers of the commissioner. The commissioner may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this part with respect to a specific long-term care insurance policy or certificate upon a written finding that:

(1) The modification or suspension would be in the best interest of the insureds;

(2) The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

(3) One of the following conditions have been met:

(A) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care;

(B) The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of the community; or

(C) The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product. (1998 NAIC Reg. Sec. 15)

§431: -224 Reserve standards; life insurance policies or riders. (a) When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to these policies, the policy reserves for the benefits shall be determined in accordance with section 431:5-307. Claim reserves shall also be established in the case where the policy or rider is in claim status.

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

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

(1) Definition of insured events;

(2) Covered long-term care facilities;

(3) Existence of home convalescence care coverage;

(4) Definition of facilities;

(5) Existence or absence of barriers to eligibility;

(6) Premium waiver provision;

(7) Renewability;

(8) Ability to raise premiums;

(9) Marketing method;

(10) Underwriting procedures;

(11) Claims adjustment procedures;

(12) Waiting period;
(13) Maximum benefit;
(14) Availability of eligible facilities;
(15) Margins in claim costs;
(16) Optional nature of benefit;
(17) Delay in eligibility for benefit;
(18) Inflation protection provisions; and
(19) Guaranteed insurability option.

(d) Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries. (1998 NAIC Reg. Sec. 16A)

§431: -225 Reserve standards; insurance other than life. When long-term care benefits are provided through insurance other than as in section 431: -224, reserves shall be determined by a table certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries and filed with the commissioner. (1998 NAIC Reg. Sec. 16B)

§431: -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: -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. (1998 NAIC Reg. Sec. 17)

§431: -227 Filing requirements. Prior to an insurer or similar organization offering group long-term care insurance to a resident of this State pursuant to section 431: -105, it shall file with the commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this State. (1998 NAIC Reg. Sec. 18)

§431: -228 Filing requirements. (a) Every insurer, health care service plan, or other entity providing long-term care insurance or benefits in this State shall provide a copy of any long-term care insurance advertisement intended for use in this State whether through written, radio, or television medium to the commissioner for review or approval by the commissioner to the extent it may be reviewed under state law. In addition, all advertisements shall be retained by the insurer, health care service plan, or other entity for at least three years from the date the advertisement was first used.

(c)[1] The commissioner may exempt from the requirements of this section any advertising form or material when, in the commissioner's opinion, this requirement may not reasonably be applied. (1998 NAIC Reg. Sec. 19)

§431: -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 agents or other 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;

(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: -202.

(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 agent or insurance company. (1998 NAIC Reg. Sec. 20A & 20B)

§431: -230 Standards of marketing-certain group policies. (a) With respect to the obligations set forth in this section, the primary responsibility of an association as defined in paragraph (2) of the definition of "group long-term care insurance" under section 431: -104, when endorsing or selling long-term care insurance, shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold through the association to ensure that members of the association receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

(b) The insurer shall file the following information with the commissioner:

(1) The policy and certificate;

(2) A corresponding outline of coverage; and

(3) All advertisements requested by the commissioner.

(c) The association shall disclose in any long-term care insurance solicitation:

(1) The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees, and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and

(2) A brief description of the process under which the policies and the insurer issuing the policies were selected.

(d) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

(e) The board of directors of an association endorsing or selling long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

(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 agents; 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.

(g) No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the commissioner the information required in this section.

(h) The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this section.

(i) Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of article 13 of this chapter. (1998 NAIC Reg. Sec. 20C)

§431: -231 Suitability. (a) This section shall not apply to life insurance policies that accelerate benefits for long-term care.

(b) Every insurer, health care service plan, or other entity marketing long-term care insurance (the "issuer") shall:

(1) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

(2) Train its agents in the use of its suitability standards; and

(3) Maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.

(c) To determine whether the applicant meets the standards developed by the issuer, the agent 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 an agent is involved, the agent 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 NAIC Long-Term Care Insurance Model Regulations 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.

(d) A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

(e) The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet in Appendix B of the July 1998 NAIC Long-Term Care Insurance Model Regulations is prohibited.

(f) The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to a particular applicant is appropriate. The agents shall use the suitability standards developed by the issuer in marketing long-term care insurance.

(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 NAIC Model 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 NAIC Long-Term Care Insurance Model Regulations, 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.

(i) The issuer shall report annually to the commissioner the total number of applications received from residents of this State, the number of those who declined to provide information on a personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter. (1998 NAIC Reg. Sec. 21)

§431: -232 Prohibition against preexisting conditions and probationary periods in replacement policies and certificates. If a long-term care insurance policy or certificate replaces another long-term care insurance policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy. (1998 NAIC Reg. Sec. 22)

§431: -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: -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: -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: -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%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%

79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
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: -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: -226 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. (NAIC Act 8 & Reg. Sec. 23)

§431: -234 Standards for benefit triggers. (a) A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

(b) Activities of daily living shall include at least the following as defined in section 431: -201 and the policy: bathing, continence, dressing, eating, toileting, and transferring. Insurers may use activities of daily living to trigger covered benefits in addition to those contained in the preceding sentence as long as they are defined in the policy.

(c) An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate, however the provisions shall not restrict and are not in lieu of the requirements under subsections (a) and (b).

(d) For purposes of this section the determination of a deficiency shall not be more restrictive than:

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

(2) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

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

(f) Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

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

(1) Except as provided in paragraph (2), this section applies to a long-term care policy issued in this State after the[1] June 30, 2000;

(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: -104, which policy was in force on July 1, 2000, this section shall not apply. (1998 NAIC Reg. Sec. 24)

§431: -235 Standards format outline of coverage; group and individual policies. (a)[1] This section implements, interprets, and makes specific, the provisions of section 431: -112 in prescribing a standard format and the content of an outline of coverage, as follows:

(1) The outline of coverage shall be a free-standing 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 of the July 1998 NAIC Long-Term Care Insurance Model Regulation. (1998 NAIC Reg. Sec. 25)

§431: -236 Delivery of shopper's guide; group and individual policies. (a) A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

(b) In the case of agent solicitations, an agent shall deliver the shopper's guide prior to the presentation of an application or enrollment form.

(c) In the case of direct response solicitations, the shopper's guide must be presented in conjunction with application or enrollment form.

(d) Life insurance policies containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under sections 431: -106 to 431: -114. (1998 NAIC Reg. Sec. 26)

PART III. FEDERAL CONFORMITY

§431: -301 Group long-term care insurance policies conformance to HIPAA and Internal Revenue Code. (a) Every group long-term care insurance policy sold after June 30, 2000, may conform to subtitle C of the Health Insurance Portability and Accountability Act of 1996, P.L. No. 104-191, as amended, and to section 7702B of the Internal Revenue Code of 1986, as amended; provided that if it does not conform, then it shall not qualify for federal or state income tax benefits.

(b) A group long-term care insurance policy may provide coverage, at a minimum, for ''qualified long-term care services'', as defined in subtitle C of the

Health Insurance Portability and Accountability Act of 1996, P.L. No. 104-191, as amended, and in section 7702B of the Internal Revenue Code of 1986, as amended.

(c) For the purpose of subsection (b) and for the purpose of describing examples of services typically found in this State, coverage shall be one or more of the following services or any combination of services:

(1) Home health care services, as defined in section 431: -201;
(2) Adult day care, as defined in section 431: -201;
(3) Adult residential care home, as defined in section 321-15.1;
(4) Extended care adult residential care home, as defined in section 323D-2;
(5) Nursing home, as defined in section 457B-2;
(6) Skilled nursing facilities and intermediate care facilities, as referenced in section 321-11(10);
(7) Hospices, as referenced in section 321-11;
(8) Assisted living facility, as defined in section 323D-2;
(9) Personal care, as defined in section 431: -201;
(10) Respite care, as defined in section 333F-1; and
(11) Any other care as provided by rule of the commissioner.

§431: -302 Individual long-term care insurance policy coverages. (a) Every individual long-term care insurance policy sold after June 30, 2000, shall provide coverage for one or more of the types of care enumerated under section 431: -301(c).

(b) An individual long-term care insurance policy sold after June 30, 2000, shall not be required to conform to subtitle C of the Health Insurance Portability and Accountability Act of 1996, P.L. No. 104-191, as amended, and to section 7702B of the Internal Revenue Code of 1986, as amended; provided that if it does not conform, then it shall not qualify for federal or state income tax benefits.

§431: -303 Conflict with HIPAA. If a conflict occurs between a provision of this article and the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended, the provision shall be deemed amended to comply with that federal Act and any related regulations, to the extent that a particular policy is intended to qualify for federal income tax benefits.

§431: -304 Disclosure of qualification for tax benefits. (a) Every policy that is intended to be a qualified long-term care insurance contract as provided in the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended, shall be identified as such by prominently displaying and printing on page one of the policy form and the outline of coverage and in the application the following words: "This contract for long-term care insurance is intended to be a federally qualified long-term care insurance contract and may qualify you for federal and state tax benefits."

(b) Every policy that is not intended to be a qualified long-term care insurance contract as provided in the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended, shall be identified as such by prominently displaying and printing on page one of the policy form and the outline of coverage and in the application the following words: "This contract for long-term care insurance is not intended to be a federally qualified long-term care insurance contract and is not intended to qualify you for federal and state tax benefits."

PART IV. UNIVERSAL AVAILABILITY OF LONG-TERM CARE INSURANCE

§431: -401 Publicizing of policies. For purposes of section 371- , upon request by an employer, labor organization, retiree organization, or other entity specified under the definition of "group long-term care insurance" in section 431: -104, an insurer that is subject to this part shall be allowed, if it chooses, to publicize a long-term care policy and may sell and underwrite that policy.

§431: -402 Purchase of policy and payment of premiums on an individual's behalf. An insurer shall allow a person to purchase an individual or group long-term care insurance policy and pay the premiums for an individual or group long-term care insurance policy that covers the person, the person's spouse, or reciprocal beneficiary, as well as their parents and grandparents, and in-law parents and grandparents. Nothing in this section shall preclude an insurer from underwriting such a policy."

SECTION 3. Chapter 371, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"§371- Employers and entities offering long-term care insurance policies. (a) No later than July 1, 2000, every employer, labor organization, retiree organization, or other entity specified under the definition of "group long-term care insurance" under section 431: -104, may apply the guidelines set out in Title 29, Code of Federal Regulations, section 2510.3-1(j), as amended, if the employer chooses to offer group or group-type long-term care insurance as a benefit to employees in compliance with the federal Employee Retirement Income Security Act of 1974.

(b) Beginning July 1, 2000, every insurer, if it chooses, shall be allowed by every employer, labor organization, retiree organization, or other entity specified under the definition of "group long-term care insurance", if they choose, to publicize one or more long-term care insurance policies that are made available under section 431: -401.

(c) This section shall not be construed to affect the marketing by insurers of individual long-term care insurance policies to an employer, labor organization, retiree organization, or other entity specified under the definition of "group long-term care insurance" under section 431: -104."

SECTION 4. Section 87-23.5, Hawaii Revised Statutes, is amended by amending subsections (a) and (b) to read as follows:

"(a) The board [of trustees] shall determine the benefits of a long-term care benefits plan for employee-beneficiaries, their spouses or reciprocal beneficiaries, as well as their parents and grandparents, and in-law parents and grandparents, and qualified-beneficiaries. The plan shall comply with [the provisions of] article [10A, part V,] _____, of chapter 431[, upon initial plan implementation only].

(b) Notwithstanding any other law to the contrary, [such] the benefits shall be available only to employee-beneficiaries, their spouses or reciprocal beneficiaries, as well as their parents and grandparents, and in-law parents and grandparents, and qualified-beneficiaries who enroll between the ages of twenty and eighty-five. Eligible persons must comply with the plan's age, enrollment, medical underwriting, and contribution requirements."

SECTION 5. Section 431:2-201.5, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) The provisions of the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as it relates to group and individual health insurance[,] and to long-term care insurance to the extent provided in article ___ of chapter 431, shall apply to title 24, except:

(1) Where state law provides greater health benefits or coverage than the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 then the state law shall be applicable;

(2) This section shall not be applicable or affect life insurance, endowment, or annuity contracts, or any supplemental contract thereto, described in section 431:10A-101(4);

(3) The following definitions shall be used when applying the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191:

(A) "Employee" means an employee who works on a full-time basis with a normal workweek of twenty hours or more;

(B) "Group health issuer" means all persons offering benefits under group health plans, but shall not include those persons offering benefits exempted from title I of the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 under section 706(c) of the Employee Retirement Income Security Act of 1974 and sections 2747 and 2791(c) of the Public Health Service Act; and

(C) "Small employer" means an employer who employs between one and no more than fifty employees;

(4) All group health issuers shall offer group health plans to small employers whose employees live, work, or reside in the group health issuer's service areas; provided that the commissioner may exempt a group health issuer if the commissioner determines that the group health issuer does not have the capacity to deliver services adequately to enrollees of additional groups given its obligation to existing employer groups; and

(5) A group health issuer shall be prohibited from imposing any preexisting condition exclusion."

SECTION 6. Section 432:1-102, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) Part III of article 10A, and article ___ of chapter 431 shall apply to nonprofit medical indemnity or hospital service associations. Such associations shall be exempt from the provisions of part I of article 10A; provided that such exemption is in compliance with applicable federal statutes and regulations."

PART III
JOINT LEGISLATIVE COMMITTEE SUNSET

SECTION 7. Act 339, Session Laws of Hawaii 1997, is amended by amending section 4 to read as follows:

"SECTION 4. The joint legislative committee shall submit a report of its findings and recommendations to the legislature by December 1, 1998. The joint legislative committee shall cease to exist on June 30, [1999.] 2000."

PART IV

SECTION 8. Chapter 431:10A, Part V, Hawaii Revised Statutes, is repealed.

PART V
ACTUARIAL STUDY

SECTION 9. The joint legislative committee on long-term care shall contract for a study on the feasibility and advisability of establishing a state-sponsored universal program of long-term care that offers comprehensive, protective coverage to the largest numbers of people through either a mandatory tax-based or voluntary premium funding approach. The study shall include, but not be limited to, alternative models of:

(1) Front-end universal program in which coverage would begin either with:
   (A) The first two years of nursing home care or comparable type care; or
   (B) One and a half years or other length of time, of community or home care covered by the program,

   with a reliance upon private insurance for the remaining years;
(2) Back-end universal program in which coverage would begin on the 366th day of disability and include nursing home care or comparable care, or community or home care, or any combination of these, with the first year to be covered out of pocket or by privately purchased long-term care insurance; or
(3) Comprehensive universal program to provide lifetime full coverage, regardless of private insurance coverage.

The study shall further include an analysis of the provisions of House Bill No. 31, H.D. 1 and H.D. 2, Regular Session of 1993, that proposed the "Hawaii Family Hope Program Act", and make recommendations on legislation for introduction in the 2000 regular session, including figures for the amount of a tax to be imposed and a premium to be collected.

For purposes of this study, the joint legislative committee on long-term care may contract with one or more of the same consultants and advisers, excluding legal consultants, who provided services to the Executive Office on Aging for its reports, "Financing Long Term Care, A Report to the Hawaii State Legislature", dated January, 1991, and "The Long Term Care Advisory Board, Report to the Hawaii State Legislature", dated February, 1992; provided that procurement of services from the same consultants and advisers shall be exempt from any of the provisions of the Hawaii Public Procurement Code, as provided by section 103D-102(b)(6), Hawaii Revised Statutes, on the basis that this study is an update of those reports to design a state-sponsored universal long-term care model that accounts for current statistics and the condition of the State's economy. Inasmuch as the groundwork for this follow-up study has been laid in those previous reports by the same consultants and advisers, the legislature finds that contracting with new consultants and advisers would triple the cost of the study and would be unnecessary duplication of work. The legislature further finds that the same consultants and advisers are qualified to conduct this follow-up study.

SECTION 10. The consultants hired under section 11 of this Act shall submit a report of findings and recommendations to the governor and the legislature not later than November 15, 1999. Based on that report, the joint legislative committee on long-term care shall draft legislation, with the advice of the consultants, for introduction in the regular session of 2000; provided that the services of the consultants for advising in drafting the legislation shall be considered as a part of their services under section 11.

SECTION 11. There is appropriated out of the general revenues of the State of Hawaii, the sum of $100,000, or so much thereof as may be necessary for fiscal year 1999-2000, for the joint legislative committee on long-term care to hire consultants to conduct a study on the feasibility and advisability of establishing a state-sponsored universal program of long-term care that offers comprehensive, protective coverage.

SECTION 12. The sum appropriated by section 11 of this Act shall be expended by the joint legislative committee on long-term care.

SECTION 13. There is appropriated out of the general revenues of the State of Hawaii the following sums, or so much thereof as may be necessary, for fiscal year 1999-2000 for expenses of the joint legislative committee on long-term care to conduct one public briefing each on Oahu, Kauai, and Maui, and two public briefings on Hawaii, on the findings and recommendations of the actuarial study undertaken pursuant to section 11 of this Act.

House of Representatives	$5,000
Senate	$5,000

SECTION 14. The sums appropriated by section 13 shall be expended by the house of representatives and the senate respectively.

PART VI

SECTION 15. In codifying this Act, the revisor of statutes shall insert the number of this Act in section 7 of this Act. The revisor of statutes also shall place a derivation table at the front of the new article added to chapter 431, Hawaii Revised Statutes, by section 2 of this Act, showing the Hawaii Revised Statutes section number and the National Association of Insurance Commissioner (NAIC) Model Act section number or Regulation (Reg) section number. These references in the new article shall be deleted from the text of the Act when codified.

SECTION 16. If any provision of this Act, or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

SECTION 17. Statutory material to be repealed is bracketed. New statutory material is underscored.[2]

SECTION 18. This Act shall take effect on July 1, 2000; provided that sections 7, and 9 to 18 shall take effect on July 1, 1999.

(Approved June 24, 1999.)

Notes

1. So in original.
2. Edited pursuant to HRS §23G-16.5.