

Draft: 6/15/09
Revisions to Model 640

Adopted by the Health Insurance and Managed Care (B) Committee

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LONG-TERM CARE INSURANCE MODEL ACT

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Section 10. Authority to Promulgate Regulations

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The commissioner shall 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 producer education, marketing practices, producer compensation, producer testing, [independent review of benefit determinations](#), penalties and reporting practices for long-term care insurance.

Drafting Note: Each state should examine its statutory authority to promulgate regulations and revise this section accordingly so that sufficient rulemaking authority is present and that unnecessary duplication of unfair practice provisions does not occur.

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Draft: 6-15-09
Revisions to Model 641

Adopted by the Health Insurance and Managed Care (B) Committee

LONG-TERM CARE INSURANCE MODEL REGULATION

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Section 4. Definitions

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For the purpose of this regulation, the terms “long-term care insurance,” “qualified long-term care insurance,” “group long-term care insurance,” “commissioner,” “applicant,” “policy” and “certificate” shall have the meanings set forth in section 4 of the NAIC Long-Term Care Insurance Model Act. In addition, the following definitions apply.

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

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A. “Benefit trigger”, for the purposes of independent review, means a contractual provision in the insured’s policy of long-term care insurance conditioning the payment of benefits on a determination of the insured’s ability to perform activities of daily living and on cognitive impairment. For purposes of a tax-qualified long-term care insurance contract, as defined in section 7702B of the Internal Revenue Code of 1986, as amended, “benefit trigger” shall include a determination by a licensed health care practitioner that an insured is a chronically ill individual.

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Drafting Note: This definition is not intended to be a required definitional element of a long-term care insurance policy, but rather intended to clarify the scope and intent of section 31. The requirement for a description of the benefit trigger in the policy or certificate is currently found in section 8.

B. (1) “Exceptional increase” means only those increases filed by an insurer as exceptional for which the commissioner determines the need for the premium rate increase is justified:

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- (a) Due to changes in laws or regulations applicable to long-term care coverage in this state; or
- (b) Due to increased and unexpected utilization that affects the majority of insurers of similar products.

(2) Except as provided in section 20, exceptional increases are subject to the same requirements as other premium rate schedule increases.

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

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

Drafting Note: The commissioner may wish to review the request with other commissioners.

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C. “Incidental,” as used in section 20J, means that the value of the long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

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Drafting Note: The phrase “value of the benefits” is used in defining “incidental” to make the definition more generally applicable. In simple cases where the base policy and the long-term care benefits have separately identifiable premiums, the premiums can be directly compared. In other cases, annual cost of insurance charges might be available for comparison. Some cases may involve comparison of present value of benefits.

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D. “Independent review organization” means an organization that conducts independent reviews of long-term care benefit trigger decisions.

E. “Licensed health care professional” means an individual qualified by education and experience in an appropriate field, to determine, by record review, an insured’s actual functional or cognitive impairment.

Drafting Note: For purposes of section 31, it may be appropriate for certain licensed health care professionals, such as physical therapists, occupational therapists, neurologists, physical medicine specialists, and rehabilitation medicine specialists, to review a benefit trigger determination. However, some of these health care professionals may not meet the definition of a licensed health care practitioner under section 7702B(c)(4) of the Internal Revenue Code. For tax-qualified long-term care insurance contracts, only a licensed health care professional who meets the definition of a licensed health care practitioner may certify that an individual is a chronically ill individual.

F. “Qualified actuary” means a member in good standing of the American Academy of Actuaries.

G. “Similar policy forms” means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in [insert reference to section 4E(1) of the NAIC Long-Term Care Model Act] are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

Section 31. Appealing An Insurer’s Determination That The Benefit Trigger Is Not Met.

Drafting Note: Consistent with the NAIC model law procedures revised and adopted by the NAIC in September 2008, these revisions to the Long Term Care Insurance Model Regulation provide minimum regulatory standards for independent review of benefit trigger determinations. The regulatory provisions and procedures set forth in this section are the minimum national standard for benefit trigger independent review. Nothing in this regulation would, nor is it the intent of these revisions to prohibit a state that supported these model revisions from enacting regulations that go beyond this minimum standard to provide for a larger role and greater involvement for insurance departments in the independent review process. In determining the use of these minimum standards for any federal legislation or regulations pertaining to long-term care insurance, policymakers should view these as minimum standards and not prohibit states from enacting standards that go beyond these minimums.

A. For purposes of this section, “authorized representative” is authorized to act as the covered person’s personal representative within the meaning of 45 CFR 164.502(g) promulgated by the Secretary under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act and means the following:

- (1) A person to whom a covered person has given express written consent to represent the covered person in an external review;
- (2) A person authorized by law to provide substituted consent for a covered person; or
- (3) A family member of the covered person or the covered person’s treating health care professional only when the covered person is unable to provide consent.

B. If an insurer determines that the benefit trigger of a long-term care insurance policy has not been met, it shall provide a clear, written notice to the insured and the insured’s authorized representative, if applicable, of all of the following:

- (1) The reason that the insurer determined that the insured’s benefit trigger has not been met;

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- (2) The insured's right to internal appeal in accordance with subsection C, and the right to submit new or additional information relating to the benefit trigger denial with the appeal request; and
- (3) The insured's right, after exhaustion of the insurer's internal appeal process, to have the benefit trigger determination reviewed under the independent review process in accordance with subsection D.

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C. Internal Appeal. The insured or the insured's authorized representative may appeal the insurer's adverse benefit trigger determination by sending a written request to the insurer, along with any additional supporting information, within 120 calendar days after the insured and the insured's authorized representative, if applicable, receives the insurer's benefit determination notice. The internal appeal shall be considered by an individual or group of individuals designated by the insurer, provided that the individual or individuals making the internal appeal decision may not be the same individual or individuals who made the initial benefit determination. The internal appeal shall be completed and written notice of the internal appeal decision shall be sent to the insured and the insured's authorized representative, if applicable, within thirty (30) calendar days of the insurer's receipt of all necessary information upon which a final determination can be made.

- (1) If the insurer's original determination is upheld upon internal appeal, the notice of the internal appeal decision shall describe any additional internal appeal rights offered by the insurer. Nothing herein shall require the insurer to offer any internal appeal rights other than those described in this subsection.
- (2) If the insurer's original determination is upheld after the internal appeal process has been exhausted, and new or additional information has not been provided to the insurer, the insurer shall provide a written description of the insured's right to request an independent review of the benefit determination as described in subsection D to the insured and the insured's authorized representative, if applicable.

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- (3) As part of the written description of the insured's right to request an independent review, an insurer shall include the following, or substantially equivalent, language: "We have determined that the benefit eligibility criteria ("benefit trigger") of your [policy] [certificate] has not been met. You may have the right to an independent review of our decision conducted by long-term care professionals who are not associated with us. Please send a written request for independent review to us at [address]. You must inform us, in writing, of your election to have this decision reviewed within 120 days of receipt of this letter. Listed below are the names and contact information of the independent review organizations approved or certified by your state insurance commissioner's office to conduct long-term care insurance benefit eligibility reviews. If you wish to request an independent review, please choose one of the listed organizations and include its name with your request for independent review. If you elect independent review, but do not choose an independent review organization with your request, we will choose one of the independent review organizations for you and refer the request for independent review to it."

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Drafting Note: States that do not maintain a list of qualified independent review organizations to review long-term care benefit trigger decisions should modify the language in paragraph (3) accordingly.

- (4) If the insurer does not believe the benefit trigger decision is eligible for independent review, the insurer shall inform the insured and the insured's authorized representative, if applicable, and the commissioner in writing and include in the notice the reasons for its determination of independent review ineligibility.
- (5) The appeal process described in subsection C is not deemed to be a 'new service or provider' as referenced in section 26, Availability of New Services or Providers, and therefore does not trigger the notice requirements of that section.

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D. Independent Review of Benefit Trigger Determination.

(1) Request. The insured or the insured's authorized representative may request an independent review of the insurer's benefit trigger determination after the internal appeal process outlined in subsection C has been exhausted. A written request for independent review may be made by the insured or the insured's authorized representative to the insurer within 120 calendar days after the insurer's written notice of the final internal appeal decision is received by the insured and the insured's authorized representative, if applicable.

(2) Cost. The cost of the independent review shall be borne by the insurer.

(3) Independent Review Process.

(a) Within five (5) business days of receiving a written request for independent review, the insurer shall refer the request to the independent review organization that the insured or the insured's authorized representative has chosen from the list of certified or approved organizations the insurer has provided to the insured. If the insured or the insured's authorized representative does not choose an approved independent review organization to perform the review, the insurer shall choose an independent review organization approved or certified by the state. The insurer shall vary its selection of authorized independent review organizations on a rotating basis.

(b) The insurer shall refer the request for independent review of a benefit trigger determination to an independent review organization, subject to the following:

(i) The independent review organization shall be on a list of certified or approved independent review organizations that satisfy the requirements of a qualified long-term care insurance independent review organization contained in this section.

(ii) The independent review organization shall not have any conflicts of interest with the insured, the insured's authorized representative, if applicable, or the insurer; and

(iii) Such review shall be limited to the information or documentation provided to and considered by the insurer in making its determination, including any information or documentation considered as part of the internal appeal process.

(c) If the insured or the insured's authorized representative has new or additional information not previously provided to the insurer, whether submitted to the insurer or the independent review organization, such information shall first be considered in the internal review process, as set forth in subsection C.

(i) While this information is being reviewed by the insurer, the independent review organization shall suspend its review and the time period for review is suspended until the insurer completes its review.

(ii) The insurer shall complete its review of the information and provide written notice of the results of the review to the insured and the insured's authorized representative, if applicable, and the independent review organization within five (5) business days of the insurer's receipt of such new or additional information.

(iii) If the insurer maintains its denial after such review, the independent review organization shall continue its review, and render its decision within the time period specified in subparagraph (i) below. If the insurer overturns its decision following its review, the independent review request shall be considered withdrawn.

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- ~~(d) The insurer shall acknowledge in writing to the insured and the insured's authorized representative, if applicable, and the commissioner that the request for independent review has been received, accepted and forwarded to an independent review organization for review. Such notice will include the name and address of the independent review organization.~~
- ~~(e) Within five (5) business days of receipt of the request for independent review, the independent review organization assigned pursuant to this paragraph shall notify the insured and the insured's authorized representative, if applicable, the insurer and the commissioner that it has accepted the independent review request and identify the type of licensed health care professional assigned to the review. The assigned independent review organization shall include in the notice a statement that the insured or the insured's authorized representative may submit in writing to the independent review organization within seven (7) days following the date of receipt of the notice additional information and supporting documentation that the independent review organization should consider when conducting its review.~~
- ~~(f) The independent review organization shall review all of the information and documents received pursuant to subparagraph (e) that has been provided to the independent review organization. The independent review organization shall provide copies of any documentation or information provided by the insured or the insured's authorized representative to the insurer for its review, if it is not part of the information or documentation submitted by the insurer to the independent review organization. The insurer shall review the information and provide its analysis of the new information in accordance with subparagraph (h).~~
- ~~(g) The insured or the insured's authorized representative may submit, at any time, new or additional information not previously provided to the insurer but pertinent to the benefit trigger denial. The insurer shall consider such information and affirm or overturn its benefit trigger determination. If the insurer affirms its benefit trigger determination, the insurer shall promptly provide such new or additional information to the independent review organization for its review, along with the insurer's analysis of such information.~~
- ~~(h) If the insurer overturns its benefit trigger determination:~~
- ~~(i) The insurer shall provide notice to the independent review organization and the insured and the insured's authorized representative, if applicable, and the commissioner of its decision; and~~
- ~~(ii) The independent review process shall immediately cease.~~
- ~~(i) The independent review organization shall provide the insured and the insured's authorized representative, if applicable, the insurer and the commissioner written notice of its decision, within 30 calendar days from receipt of the referral referenced in paragraph (3)(b). If the independent review organization overturns the insurer's decision, it shall:~~
- ~~(i) Establish the precise date within the specific period of time under review that the benefit trigger was deemed to have been met;~~
- ~~(ii) Specify the specific period of time under review for which the insurer declined eligibility, but during which the independent review organization deemed the benefit trigger to have been met; and~~
- ~~(iii) For tax-qualified long-term care insurance contracts, provide a certification (made only by a licensed health care practitioner as defined in section~~

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7702B(c)(4) of the Internal Revenue Code) that the insured is a chronically ill individual.

(j) The decision of the independent review organization with respect to whether the insured met the benefit trigger will be final and binding on the insurer.

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(k) The independent review organization's determination shall be used solely to establish liability for benefit trigger decisions, and is intended to be admissible in any proceeding only to the extent it establishes the eligibility of benefits payable.

(l) Nothing in this section shall restrict the insured's right to submit a new request for benefit trigger determination after the independent review decision, should the independent review organization uphold the insurer's decision.

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(m) The insurance department shall utilize the criteria set forth in Appendix H, Guidelines for Long-Term Care Independent Review Entities, in certifying or approving entities to review long-term care insurance benefit trigger decisions.

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Drafting Note: States that do not maintain a list of qualified independent review organizations to review long-term care benefit trigger decisions or have another mechanism for certifying or approving independent review organizations, should replace the language in subparagraph (m) with the following:

The insurance department shall accept another state's certification of an independent review organization, provided such state requires the independent review organization to meet substantially similar qualifications as those contained in Appendix H.

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(n) The commissioner shall maintain and periodically update a list of approved independent review organizations.

E. Certification of Long-Term Care Insurance Independent Review Organizations. The commissioner shall certify or approve a qualified long-term care insurance independent review organization, provided the independent review organization demonstrates to the satisfaction of the commissioner that it is unbiased and meets the following qualifications:

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(1) Have on staff, or contract with, a qualified and licensed health care professional in an appropriate field for determining an insured's functional or cognitive impairment (e.g. physical therapy, occupational therapy, neurology, physical medicine and rehabilitation) to conduct the review.

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(2) Neither it nor any of its licensed health care professionals may, in any manner, be related to or affiliated with an entity that previously provided medical care to the insured.

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(3) Utilize a licensed health care professional who is not an employee of the insurer or related in any manner to the insured.

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(4) Neither it nor its licensed health care professional who conducts the reviews may receive compensation of any type that is dependent on the outcome of the review.

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(5) Be state approved or certified to conduct such reviews if the state requires such approvals or certifications.

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(6) Provide a description of the fees to be charged by it for independent reviews of a long-term care insurance benefit trigger decision. Such fees shall be reasonable and customary for the type of long-term care insurance benefit trigger decision under review.

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(7) Provide the name of the medical director or health care professional responsible for the supervision and oversight of the independent review procedure.

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(8) Have on staff or contract with a licensed health care practitioner, as defined by section 7702B(c)(4) of the Internal Revenue Code of 1986, as amended, who is qualified to certify that an individual is chronically ill for purposes of a qualified long-term care insurance contract.

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F. Maintenance of Records and Reporting Obligations by Independent Review Organizations. Each certified independent review organization shall comply with the following:

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(1) Maintain written documentation establishing the date it receives a request for independent review, the date each review is conducted, the resolution, the date such resolution was communicated to the insurer and the insured, the name and professional status of the reviewer conducting such review in an easily accessible and retrievable format for the year in which it received the information, plus two (2) calendar years. (2) Be able to document measures taken to appropriately safeguard the confidentiality of such records and prevent unauthorized use and disclosures in accordance with applicable federal and state law.

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(3) Report annually to the commissioner, by June 1, in the aggregate and for each long-term care insurer all of the following:

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(a) The total number of requests received for independent review of long-term care benefit trigger decisions;

(b) The total number of reviews conducted and the resolution of such reviews (i.e., the number of reviews which upheld or overturned the long-term care insurer's determination that the benefit trigger was not met);

(c) The number of reviews withdrawn prior to review;

(d) The percentage of reviews conducted within the prescribed timeframe set forth in subsection C(3)(i); and

(e) Such other information the commissioner may require.

(4) Report immediately to the commissioner any change in its status which would cause it to cease meeting any of the qualifications required of an independent review organization performing independent reviews of long-term care benefit trigger decisions.

Drafting Note: States may wish to consider the mechanism to be used for oversight of independent review entities' activities as they relate to the review of long-term care insurance benefit trigger decisions. Specifically, states will need to consider whether the oversight mechanism should be statutory, regulatory or contractually based (i.e., in the state's contract with the independent review organization) to specify such details as the term of any state approval or certification of an independent review organization, privacy protections afforded protected health information, commitment to review benefit trigger decisions within the prescribed regulatory timeframe, notice requirements to the state should the independent review entity cease to meet the qualifications required of an independent review organization for long-term care insurance benefit trigger decisions, and to establish a reporting mechanism by which independent review organization report to the commissioner on the number of requests received for independent review of long-term care benefit trigger decisions in the aggregate and from each long-term care insurer, and the resolution of such review (e.g., uphold insurer benefit trigger denial, overturn insurer benefit trigger denial).

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G. Additional Rights. Nothing contained in this section shall limit the ability of an insurer to assert any rights an insurer may have under the policy related to:

(1) An insured's misrepresentation;

(2) Changes in the insured's benefit eligibility; and

(3) Terms, conditions, and exclusions of the policy, other than failure to meet the benefit trigger.

- H. Applicability. The requirements of this Regulation apply to a benefit trigger request made on or after [insert number of months after adoption of the regulation] under a long-term care insurance policy.
- I. Conflict with Other Laws. The provisions of this section supersede any other external review requirements found in [insert reference to state external review law].

Section 32. Prompt Payment of Clean Claims

- A. For purposes of this section:
 - (1) "Claim" means a request for payment of benefits under an in-force policy, regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.
 - (2) "Clean claim" means a claim that has no defect or impropriety, including any lack of required substantiating documentation, such as satisfactory evidence of expenses incurred, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.
- B. Within thirty (30) business days after receipt of a claim for benefits under a long-term care insurance policy or certificate, an insurer shall pay such claim if it is a clean claim, or send a written notice acknowledging the date of receipt of the claim and one of the following:
 - (1) The insurer is declining to pay all or part of the claim and the specific reason(s) for denial; or
 - (2) That additional information is necessary to determine if all or any part of the claim is payable and the specific additional information that is necessary.
- C. Within thirty (30) business days after receipt of all the requested additional information, an insurer shall pay a claim for benefits under a long-term care insurance policy or certificate if it is a clean claim, or send a written notice that the insurer is declining to pay all or part of the claim, and the specific reason or reasons for denial.
- D. If an insurer fails to comply with subsection B or C, such insurer shall pay interest at the rate of 1% per month on the amount of the claim that should have been paid but that remains unpaid forty-five (45) business days after the receipt of the claim with respect to subsection B or all requested additional information with respect to subsection C. The interest payable pursuant to this subsection shall be included in any late reimbursement without requiring the person who filed the original claim to make any additional claim for such interest.
- E. The provisions of section 32 shall not apply where the insurer has a reasonable basis supported by specific information that such claim was fraudulently submitted.
- F. Any violation of this regulation by an insurer if committed flagrantly and in conscious disregard of the provisions of this regulation or with such frequency as to constitute a general business practice shall be considered a violation of the [insert reference to state law equivalent to the NAIC Unfair Trade Practices Model Act].
- G. The provisions of section 32 supersedes any other claim payment requirement found in [insert reference to state prompt payment law].

**** Appendix H.

Guidelines for Long-Term Care Independent Review Entities

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In order for an organization to qualify as an independent review organization for long-term care insurance benefit trigger decisions, it shall comply with all of the following:

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a. The independent review organization shall ensure that all health care professionals on its staff and with whom it contracts to provide benefit trigger determination reviews hold a current unrestricted license or certification to practice a health care profession in the United States.

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b. The independent review organization shall ensure that any health care professional on its staff and with whom it contracts to provide benefit trigger determination reviews who is a physician holds a current certification by a recognized American medical specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

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c. The independent review organization shall ensure that any health care professional on its staff and with whom it contracts to provide benefit trigger determination reviews who is not a physician holds a current certification in the specialty in which that person is licensed, by a recognized American specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

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d. The independent review organization shall ensure that all health care professionals on its staff and with whom it contracts to provide benefit trigger determination reviews have no history of disciplinary actions or sanctions including, but not limited to, the loss of staff privileges or any participation restriction taken or pending by any hospital or state or federal government regulatory agency.

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e. The independent review organization shall ensure that neither it, nor any of its employees, agents, or licensed health care professionals utilized for benefit trigger determination reviews receives compensation of any type that is dependent on the outcome of the review.

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f. The independent review organization shall ensure that neither it, nor any of its employees, agents, or licensed health care professionals it utilizes for benefit trigger determination reviews are, in any manner related to, employed by or affiliated with the insurer, insured or with a person who previously provided medical care or long term care services to the insured.

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g. The independent review organization shall provide a description of the qualifications of the reviewers retained to conduct independent review of long-term care insurance benefit trigger decisions, including the reviewer's current and past employment history, practice affiliations and a description of past experience with decisions relating to long-term care, functional capacity, dependency in activities of daily living, or in assessing cognitive impairment. Specifically, with regard to reviews of tax qualified long-term care insurance contracts, it must demonstrate the ability to assess the severity of cognitive impairment requiring substantial supervision to protect the individual from harm, or with assessing deficits in the ability to perform without substantial assistance from another person at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity.

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h. The independent review organization shall provide a description of the procedures employed to ensure that reviewers conducting independent reviews are appropriately licensed, registered or certified; trained in the principles, procedures and standards of the independent review organization; and knowledgeable about the functional or cognitive impairments associated with the diagnosis and disease staging processes, including expected duration of such impairment, which is the subject of the independent review.

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i. The independent review organization shall provide the number of reviewers retained by the independent review organization and a description of the areas of expertise available from such reviewers and the types of cases such reviewers are qualified to review (e.g., assessment of cognitive impairment or inability to perform activities of daily living due to a loss of functional capacity).

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j. The independent review organization shall provide a description of the policies and procedures employed to protect confidentiality of protected health information, in accordance with federal and state law.

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k. The independent review organization shall provide a description of its quality assurance program.

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l. The independent review organization shall provide the names of all corporations and organizations owned or controlled by the independent review organization or which own or control the organization, and the nature and

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extent of any such ownership or control. The independent review organization shall ensure that neither it, nor any of its employees, agents, or licensed health care professionals utilized are not a subsidiary of, or owned or controlled by, an insurer or by a trade association of insurers of which the insured is a member.

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m. The independent review organization shall provide the names and resumes of all directors, officers and executives of the independent review organization.

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