REQUEST FOR MODEL LAW DEVELOPMENT

This form is intended to gather information to support the development of a new model law or amendment to an existing model law. Prior to development of a new or amended model law, approval of the respective Parent Committee and the NAIC's Executive Committee is required. The NAIC's Executive Committee will consider whether the request fits the criteria for model law development. Please complete all questions and provide as much detail as necessary to help in this determination.

Please check whether this is: X New Model Law or ☐ Amendment to Existing Model

1. **Name of group to be responsible for drafting the model:**

   Short Duration Long-Term Care Policies (B) Subgroup

2. **NAIC staff support contact information:**

   David Torian
   Health Policy Advisor & Counsel
   202-471-3979
   dtorian@naic.org

3. **Please provide a description and proposed title of the new model law. If an existing law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.**

   Title: Short Duration Long-Term Care Policies Model. This new Subgroup will create a separate model addressing long-term care (LTC) products of short duration that are excluded from the LTC model.

4. **Does the model law meet the Model Law Criteria? X Yes or ☐ No (Check one)**

   (If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).

   a. **Does the subject of the model law necessitate a national standard and require uniformity amongst all states? X Yes or ☐ No (Check one)**

      If yes, please explain why

      The Senior Issues (B) Task Force established the Short Term Health Policies Providing Long-Term Care Benefits (B) Subgroup to address the appropriate means of addressing these unique policies. The Short Term Health Policies Providing Long-Term Care Benefits (B) Subgroup noted that these long-term care (LTC) policies of short duration (of less than one year) are excluded from the LTC Model but do not quite fall in the Accident and Sickness Model. The Subgroup surveyed the states serving on the Senior Issues (B) Task Force. Upon review and discussion of the responses to the Subgroup's survey and laws enacted in other states addressing this product; concerns with leaving this product in the Accident and Sickness Model include protections under the LTC model not present in the Accident and Sickness Model, including but not limited to, no third party premium notice; guaranteed renewability/non-cancellable; nonforfeiture benefits; elimination periods; and inflation protection. Therefore, the Subgroup recommends the Senior Issues Task Force establish a subgroup to create a separate model addressing LTC products of short duration that are excluded from the LTC model.

   b. **Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law?**

      X Yes or ☐ No (Check one)

5. **What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?**

   X 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

   High Likelihood Low Likelihood

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Explanation, if necessary:

6. **What is the likelihood that a minimum two-thirds majority of NAIC members would ultimately vote to adopt the proposed model law?**

☐ **1** **X 2** ☐ **3** ☐ **4** ☐ **5** **(Check one)**

High Likelihood **Low Likelihood**

Explanation, if necessary:

7. **What is the likelihood that state legislature will adopt the model law in a uniform manner within three years of adoption by the NAIC?**

☐ **1** **X 2** ☐ **3** ☐ **4** ☐ **5** **(Check one)**

High Likelihood **Low Likelihood**

Explanation, if necessary:

8. **Is this model law referenced in the Accreditation Standards? If so, does the standard require the model law to be adopted in a substantially similar manner?**

No

9. **Is this model law in response to or impacted by federal laws or regulations? If yes, please explain.**

No

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LIMITED LONG-TERM CARE INSURANCE MODEL ACT

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Section 1. Purpose

The purpose of this Act is to promote the public interest, to promote the availability of limited long-term care insurance policies, to protect applicants for limited long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to establish standards for limited long-term care insurance, to facilitate public understanding and comparison of limited long-term care insurance policies, and to facilitate flexibility and innovation in the development of limited long-term care insurance coverage.

Drafting Note: The purpose clause evidences legislative intent to protect the public while recognizing the need to permit flexibility and innovation with respect to limited long-term care insurance coverage.

Section 2. Scope

The requirements of this Act shall apply to policies delivered or issued for delivery in this state on or after the effective date of this Act. This Act is not intended to supersede the obligations of entities subject to this Act to comply with the substance of other applicable insurance laws insofar as they do not conflict with this Act, except that laws and regulations designed and intended to apply to Medicare supplement insurance policies shall not be applied to limited long-term care insurance.

Drafting Note: This section makes clear that entities subject to the Act must continue to comply with other applicable insurance legislation not in conflict with this Act.

Section 3. Short Title

This Act may be known and cited as the "Limited Long-Term Care Insurance Act."

Section 4. Definitions

Unless the context requires otherwise, the definitions in this section apply throughout this Act.

A. "Applicant" means:

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

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

B. “Certificate” means, for the purposes of this Act, any certificate issued under a group limited long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

C. “Commissioner” means the Insurance Commissioner of this state.

D. “Limited long-term care insurance” means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for less than twelve (12) 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 also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Limited long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Limited long-term care insurance shall not include any insurance policy that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. Notwithstanding any other provision of this Act, any product advertised, marketed or offered as limited long-term care insurance shall be subject to the provisions of this Act.

Drafting Note: Where the word “Commissioner” appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted.

E. “Group limited long-term care insurance” means a limited long-term care insurance policy that is delivered or issued for delivery in this state and issued to:

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

(2) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if 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 associations, or the insurer of the association or associations, shall file evidence with the commissioner that the association or associations have, at the outset, a minimum of 100 persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws that provide that:

(a) The association or associations hold regular meetings not less than annually to further purposes of the members;

(b) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(c) The members have voting privileges and representation on the governing board and committees.

Thirty (30) days after the filing, the association or associations will be deemed to satisfy the organizational requirements, unless the Commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

(4) A group other than as described in Subsections E(1), E(2) and E(3), subject to a finding by the Commissioner that:

(a) The issuance of the group policy is not contrary to the best interest of the public;

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

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

F. "Policy" means, for the purposes of this Act, any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this state by an insurer; fraternal benefit society; nonprofit health, hospital, or medical service corporation; prepaid health plan; health maintenance organization or any similar organization.

Drafting Note: This Act is intended to apply to the specified group and individual policies, contracts, and certificates whether issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization. In order to include such organizations, each state should identify them in accordance with its statutory terminology or by specific statutory citation. Depending upon state law, insurance department jurisdiction and other factors, separate legislation may be required. In any event, the legislation should provide that the particular terminology used by these plans and organizations may be substituted for, or added to, the corresponding terms used in this Act. The term "regulations" should be replaced by the terms "rules and regulations" or "rules" as may be appropriate under state law.

The definition of "limited long-term care insurance" under this Act is designed to allow maximum flexibility in benefit scope, intensity and level, while assuring that the purchaser's reasonable expectations for a limited long-term care insurance policy are met. The Act is intended to permit limited long-term care insurance policies to cover diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, or any combination thereof, and not to mandate coverage for each of these types of services. The language in the definition concerning "other than an acute care unit of a hospital" is intended to allow payment of benefits when a portion of a hospital has been designated for, and duly licensed or certified as a long-term care provider or swing bed.

G. "Waiting Period" means, for the purposes of this Act, the time an insured must wait before some or all of their coverage comes into effect. "Elimination Period" means, for purposes of this Act, the length of time between meeting the eligibility for benefit payment and receiving benefit payments from an insurer.

Section 5. Extraterritorial Jurisdiction—Group Limited Long-Term Care Insurance

No group limited long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in Section 4E(4), unless this state or another state having statutory and regulatory limited long-term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met.

Drafting Note: By limiting extraterritorial jurisdiction to "discretionary groups," it is not the drafters' intention that jurisdiction over other health policies should be limited in this manner.

Drafting Note: States should consider deletion of this section if they already have statutes or rules governing extraterritorial jurisdition that would automatically encompass limited long-term care policies.

Section 6. Disclosure and Performance Standards for Limited Long-Term Care Insurance

A. No limited long-term care insurance policy may:

(1) Be cancelled, non-renewed or otherwise terminated on the grounds of the age, gender 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 in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(3) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

B. Preexisting condition.

(1) No limited long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4E(1) shall use a definition of "preexisting condition" that 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 (6) months preceding the effective date of coverage of an insured person.

(2) No limited long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4E(1) may exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within six (6) months following the effective date of coverage of an insured person.

(3) The Commissioner may extend the limitation periods set forth in Sections 6C(1) and (2) as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(4) 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 Section 6C(2) expires. No limited 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 Section 6C(2).

C. Prior hospitalization/institutionalization.

(1) No limited long-term care insurance policy may be delivered or issued for delivery in this state if the policy:

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

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

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

(2) A limited long-term care insurance policy or rider shall not condition eligibility for non-institutional benefits on the prior or continuing receipt of skilled care services.

D. The Commissioner may adopt regulations establishing loss ratio standards for limited long-term care insurance policies provided that a specific reference to limited long-term care insurance policies is contained in the regulation.

E. Right of Return

(1) Limited long-term care insurance applicants shall have the right to return the policy, certificate or rider to the company or an agent/insurance producer of the company within thirty (30) days of its receipt and to have the premium refunded if, after examination of the policy, certificate or rider, the applicant is not satisfied for any reason.

(2) Limited long-term care insurance policies, certificates and riders shall have a notice prominently printed on the first page or attached thereto including specific instructions to accomplish a return. This requirement shall not apply to certificates issued pursuant to a policy issued to a group defined in Section 4E(1) of this Act. The following free look statement or language substantially similar shall be included:

"You have 30 days from the day you receive this policy, certificate or rider to review it and return it to the company if you decide not to keep it. You do not have to tell the company why you are returning it. If you decide not to keep it, simply return it to the company at its administrative office. Or you may return it to the agent/insurance producer that you bought it from. You must return it within 30 days of the day you first received it. The company will refund the full amount of any premium paid within 30 days after it receives the returned policy, certificate or rider. The premium refund will be sent directly to the person who paid it. The policy, certificate or rider will be void as if it had never been issued."

F. Outline of Coverage

(1) An outline of coverage shall be delivered to a prospective applicant for limited long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose.

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

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

(c) In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form.

(d) In the case of a policy issued to a group defined in Section 4E(1) of this Act, an outline of coverage shall not be required to be delivered, provided that the information described in Section 6F(2)(a) through (h) is contained in other materials relating to enrollment. Upon request, these other materials shall be made available to the Commissioner.

Drafting Note: States may wish to review specific filing requirements as they pertain to the outline of coverage and these other materials.

(2) The outline of coverage shall include:

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

(b) A description of the eligibility triggers for benefits and how those triggers are met;

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

(d) 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;

(e) 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;

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

(g) A brief description of the relationship of cost of care and benefits; and

(h) A statement that discloses to the policyholder or certficateholder that the policy is not long-term care insurance.

G. A certificate issued pursuant to a group limited long-term care insurance policy that 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.

H. If an application for a limited long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than thirty (30) days after the date of approval.

I. If a claim under a limited long-term care insurance contract is denied, the issuer shall, within sixty (60) days of the date of a written request by the policyholder or certificateholder, or a representative thereof:

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

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

J. Any policy, certificate or rider advertised, marketed or offered as limited long-term care insurance, as defined in Section 4A of this Act, shall comply with the provisions of this Act.

K. Any disclosure, statement, or written information and explanations required in this Act, whether in print or electronic form, will accommodate the communication needs of individuals with disabilities and persons with limited English proficiency as required by law.

Section 7. Incontestability Period

A. For a policy or certificate that has been in force for less than six (6) months, an insurer may rescind a limited long-term care insurance policy or certificate or deny an otherwise valid limited long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.

B. For a policy or certificate that has been in force for at least six (6) months but less than two (2) years, an insurer may rescind a limited long-term care insurance policy or certificate or deny an otherwise valid limited long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.

C. After a policy or certificate has been in force for two (2) years, it is not contestable upon the grounds of misrepresentation alone; such 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. (1) A limited long-term care insurance policy or certificate may be field issued if the compensation to the field issuer is not based on the number of policies or certificates issued.

(2) For purposes of this section, “field issued” means a policy or certificate issued by a producer or a third-party administrator pursuant to the underwriting authority granted to the producer or third party administrator by an insurer and using the insurer’s underwriting guidelines.

E. If an insurer has paid benefits under the limited long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

Section 8. Nonforfeiture Benefits

A. A limited long-term care insurance policy may offer the option of purchasing a policy or certificate including a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. In the event the policyholder or certificateholder does not purchase 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. When a group limited long-term care insurance policy is issued, any offer of a nonforfeiture benefit shall be made to the group policyholder. However, if the policy is issued as group limited long-term care insurance as defined in Section 4E(4), other than to a continuing care retirement community or other similar entity, any offering shall be made to each proposed certificateholder.

C. The Commissioner shall promulgate regulations specifying the type or types of nonforfeiture benefits to be offered as part of limited long-term care insurance policies and certificates, the standards for nonforfeiture benefits, and the rules regarding contingent benefit upon lapse, including a determination of the specified period of time during which a contingent benefit upon lapse will be available and the substantial premium rate increase that triggers a contingent benefit upon lapse as described in Subsection A.

Section 9. Producer Training Requirements [OPTIONAL]

Drafting Note: If a state believes that there is evidence that the limited long-term care insurance market is experiencing deficiencies in producer or agent training or abusive marketing practices, the state may wish to consider adopting the optional producer training requirements below.

A. (1) An individual may not sell, solicit or negotiate limited long-term care insurance unless the individual is licensed as an insurance producer for accident and health or sickness or [include other lines of authority as applicable] and has completed a one-time training course. The training shall meet the requirements set forth in Subsection B.

(2) An individual already licensed and selling, soliciting or negotiating limited long-term care insurance on the effective date of this Act may not continue to sell, solicit or negotiate short-term care insurance unless the individual has completed a one-time training course as set forth in Subsection B, within one year from [insert effective date of this legislation].

(3) In addition to the one-time training course required in Paragraphs (1) and (2) above, an individual who sells, solicits or negotiates limited long-term care insurance shall complete ongoing training as set forth in Subsection B.

(4) The training requirements of Subsection B may be approved as continuing education courses under [insert reference to applicable state law or regulation].

B. (1) The training required by Subsection A shall be no less than:

(a) An additional one (1) hour of one-time training for an individual who has completed the required training for long-term care insurance.

(b) Completion of four (4) hours of one-time training for an individual who does not sell long-term care insurance.

(c) And ongoing training of four (4) hours every 24 months for an individual thatdoes not sell long-term care insurance, or an additional one (1) hour every 24 months for an individual who has completed the ongoing training requirement for long term care.

(2) The training required under Paragraph (1) shall consist of topics related to similarities and differences between long-term care and limited long-term care insurance, and topics related to long-term care services and providers. Training materials shall include:

(a) State and federal regulations and requirements and the relationship between qualified state long-term care insurance Partnership programs and other public and private coverage of long-term care services, including Medicaid;

(b) Alternatives to the purchase of private limited long-term care insurance;

(c) The effect of inflation on benefits and the importance of inflation protection; and

(d) Consumer suitability standards and guidelines.

(3) The training required by this section shall not include training that is insurer or company product specific or that includes any sales or marketing information, materials, or training, other than those required by state or federal law.

C. (1) Insurers subject to this Act shall obtain verification that a producer receives training required by Subsection A before a producer is permitted to sell, solicit or negotiate the insurer's limited long-term care insurance products, maintain records subject to the state's record retention requirements, and make that verification available to the Commissioner upon request.

(2) Insurers subject to this Act shall maintain records that verify its producers have completed the training required for short-term care policies and that they demonstrate an understanding of the policies and their relationship to public and private long-term care. These records shall be maintained in accordance with the state's record retention requirements and shall be made available to the Commissioner upon request.

D. The satisfaction of these training requirements in any state shall be deemed to satisfy the training requirements in this state.

Section 10. Authority to Promulgate Regulations

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 limited 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.

The Commissioner may adopt regulations regarding standards for full and fair disclosure that set forth the manner, content and required disclosures. Such disclosures may include, but are not limited to, the sale of limited long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, non-duplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions and definitions of terms.

Drafting Note: This subsection permits the adoption of regulations establishing disclosure standards, renewability and eligibility terms and conditions, and other performance requirements for long-term care insurance. Regulations under this subsection should recognize the developing and unique nature of long-term care insurance and the distinction between group and individual long-term care insurance policies.

Section 11. Administrative Procedures

Regulations adopted pursuant to this Act shall be in accordance with the provisions of [cite section of state insurance code relating to the adoption and promulgation of rules and regulations or cite the state's administrative procedures act, if applicable].

Section 12. Severability

If any provision of this Act or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 13. Penalties

In addition to any other penalties provided by the laws of this state, any insurer and any producer found to have violated any requirement of this state relating to the regulation of limited long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

Drafting Note: The intention of this section is to authorize separate fines for both the insurer and the producer in the amounts suggested above.

Section 14. Effective Date

This Act shall be effective [insert date].

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PROJECT HISTORY

LIMITED LONG-TERM CARE INSURANCE MODEL ACT

1. Description of the Project, Issues Addressed, etc.

Changes were made to the *Long-Term Care Insurance Model Act* (#640) pursuant to the charge of the Short Duration Long-Term Care Policies (B) Subgroup.

2. Name of Group Responsible for Drafting the Model and States Participating

Short Duration Long-Term Care Policies (B) Subgroup of the Senior Issues (B) Task Force:

Connecticut, Chair	Kentucky	Oklahoma
California, Vice Chair	Missouri	Pennsylvania
Florida	Nebraska	Texas
Indiana	New Hampshire	Utah
Kansas	New Mexico	Wisconsin

3. Project Authorized by What Charge and Date First Given to the Group

The Senior Issues (B) Task Force first appointed the Short-Term Health Policies Providing Long-Term Care Benefits (B) Subgroup at the 2016 Summer National Meeting to determine whether short-term health policies providing long-term care (LTC) benefits should be moved under the purview of LTC insurance. The Subgroup determined that a new model act and new model regulation should be adopted. The Short-Term Health Policies Providing Long-Term Care Benefits (B) Subgroup was disbanded at the 2016 Fall National Meeting.

The Task Force appointed the Short Duration Long-Term Care Policies (B) Subgroup at the 2016 Fall National Meeting to address LTC products of short duration that are excluded from Model #640 and the *Long-Term Care Insurance Model Regulation* (#641), but do not quite fit under the *Accident and Sickness Insurance Minimum Standards Model Act* (#170) and the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171).

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated

The Short Duration Long-Term Care Policies (B) Subgroup made changes to various parts of Model #640. Interested parties, including industry and consumer groups, were able to comment on each draft. The Subgroup considered and accepted several comments made to the draft, including comments from industry and consumer groups. Interested parties that commented on the drafts included: America's Health Insurance Plans (AHIP); Aetna; and California Health Advocates (CHA).

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Short Duration Long-Term Care Policies (B) Subgroup met 14 times via open conference calls (March 7, 2018; Feb. 14, 2018; Jan. 24, 2018; Dec. 13, 2017, Nov. 15, 2017; Oct. 25, 2017; Oct. 4, 2017; Sept. 13, 2017; Aug. 16, 2017; July 12, 2017; June 21, 2017; May 31, 2017; May 10, 2017; and March 29, 2017). The Subgroup adopted the revisions to Model #640 on March 7, 2018.

The Senior Issues (B) Task Force held an exposure period from March 24, 2018, to May 4, 2018. A draft was circulated to interested parties, including industry and consumer groups, and was posted to the NAIC website. The Task Force considered each comment that was received. The Task Force adopted the revisions to Model #640 on June 7, 2018.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

None.

7. Any Other Important Information (e.g., amending an accreditation standard)

None.