4296S.03C

SENATE COMMITTEE SUBSTITUTE

FOR

HOUSE BILL NO. 1701

AN ACT

To repeal sections 376.671, 376.951, 376.952, 376.955 and 376.957, RSMo, and to enact in lieu thereof nine new sections relating to long-term care insurance.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF MISSOURI, AS FOLLOWS:

Section A. Sections 376.671, 376.951, 376.952, 376.955 and 376.957, RSMo, are repealed and nine new sections enacted in lieu thereof, to be known as sections 376.671, 376.951, 376.952, 376.955, 376.957, 376.1121, 376.1124, 376.1127 and 376.1130, to read as follows:

376.671. 1. This section shall not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as now or hereafter amended, premium deposit fund, variable annuity, investment annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity, nor to any contract which shall be delivered outside this state through an agent or other representative of the company issuing the contract.

2. In the case of contracts issued on or after the operative date of this section as defined in subsection 11, no contract of annuity, except as stated in subsection 1, shall be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the director are at least as favorable to the contractholder, upon cessation of payment of considerations under the contract:

(1) That upon cessation of payment of considerations under a contract, the company will grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in subsections 4, 5, 6, 7, and 9;

(2) If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the company will pay in lieu of any paid-up annuity benefit a cash surrender benefit of such amount as is specified in subsections 4, 5, 7, and 9. The company shall reserve the right to defer the payment of such cash surrender benefit for a period of six months after demand therefor with surrender of the contract;

(3) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of such benefits;

(4) A statement that any paid-up annuity, cash surrender or death benefits that may be available under the contract are not

less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract or any prior withdrawals from or partial surrenders of the contract.

Notwithstanding the requirements of this section, any deferred annuity contract may provide that if no considerations have been received under a contract for a period of two full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from considerations paid prior to such period would be less than twenty dollars monthly, the company may at its option terminate such contract by payment in cash of the then present value of such portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by such payment shall be relieved of any further obligation under such contract.

3. The minimum values as specified in subsections 4, 5, 6, 7, and 9 of any paid-up annuity, cash surrender or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this section.

(1) With respect to contracts providing for flexible considerations, the minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payment shall be equal to an accumulation up to such time at a rate of interest of three percent per annum of percentages of the net considerations (as hereinafter defined) paid prior to such time, decreased by

the sum of

(a) Any prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest of three percent per annum; and

(b) The amount of any indebtedness to the company on the contract, including interest due and accrued and increased by any existing additional amounts credited by the company to the contract. The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount not less than zero and shall be equal to the corresponding gross considerations credited to the contract during that contract year less an annual contract charge of thirty dollars and less a collection charge of one dollar and twenty-five cents per consideration credited to the contract during that contract year. The percentages of net considerations shall be sixty-five percent of the net consideration for the first contract year and eighty-seven and one-half percent of the net considerations for the second and later contract years. Notwithstanding the provisions of the preceding sentence, the percentage shall be sixty-five percent of the portion of the total net consideration for any renewal contract year which exceeds by not more than two times the sum of those portions of the net considerations in all prior contract years for which the percentage was sixty-five percent;

(2) With respect to contracts providing for fixed scheduled considerations, minimum nonforfeiture amounts shall be calculated on the assumption that considerations are paid annually in advance and shall be defined as for contracts with flexible

considerations which are paid annually with two exceptions:

(a) The portion of the net consideration for the first contract year to be accumulated shall be the sum of sixty-five percent of the net consideration for the first contract year plus twenty-two and one-half percent of the excess of the net consideration for the first contract year over the lesser of the net considerations for the second and third contract years;

(b) The annual contract charge shall be the lesser of thirty dollars or ten percent of the gross annual consideration;

(3) With respect to contracts providing for a single consideration, minimum nonforfeiture amounts shall be defined as for contracts with flexible considerations except that the percentage of net consideration used to determine the minimum nonforfeiture amount shall be equal to ninety percent, and the net consideration shall be the gross consideration less a contract charge of seventy-five dollars;

(4) Notwithstanding any other provision of this subsection, for any contract issued on or after July 1, 2002 and before July 1, 2004, the interest rate at which net considerations, prior withdrawals and partial surrenders shall be accumulated, for the purpose of determining minimum nonforfeiture amounts, shall be one and one-half percent per annum.

4. Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Such present value shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits

guaranteed in the contract.

5. For contracts which provide cash surrender benefits, such cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit which would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than one percent higher than the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

6. For contracts which do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the

interest rate specified in the contract for accumulating the net considerations to determine such maturity value, and increased by any existing additional amounts credited by the company to the contract. For contracts which do not provide any death benefits prior to the commencement of any annuity payments, such present values shall be calculated on the basis of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

7. For the purpose of determining the benefits calculated under subsections 5 and 6, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity date, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

8. Any contract which does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

9. Any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment

of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

10. For any contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of subsections 4, 5, 6, 7, and 9, additional benefits payable in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, or as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this section. The inclusion of such additional benefits shall not be required in any paid-up benefits, unless such additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.

11. After September 28, 1979, any company may file with the director a written notice of its election to comply with the provisions of this section after a specified date before September 28, 1981. After the filing of such notice, then upon

such specified date, which shall be the operative date of this section for such company, this section shall become operative with respect to annuity contracts thereafter issued by such company. If a company makes no such election, the operative date of this section for such company shall be September 28, 1981.

376.951. 1. Sections 376.951 to 376.958 and sections 376.1121 to 376.1133 may be known and cited as the "Long-term Care Insurance Act".

2. As used in sections 376.951 to 376.958 and sections 376.1121 to 376.1133, unless the context requires otherwise, the following terms mean:

(1) "Applicant":

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

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

(2) "Certificate", any certificate or evidence of coverage issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state;

(3) "Director", the director of the department of insurance of this state;

(4) "Group long-term care insurance", a long-term care insurance policy which is delivered or issued for delivery in this state and issued to:

(a) 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 organization; or

(b) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such 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

(c) An association or a trust or the trustee of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the director that the association or associations have at the outset a minimum of one hundred 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 which 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 days after such filing the association or associations shall be deemed to satisfy

such organizational requirements, unless the director makes a finding that the association or associations do not satisfy those organizational requirements;

(d) A group other than as described in paragraph (a), (b) or (c) of subdivision (4) of this subsection, subject to a finding by the director 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;

(5) "Long-term care insurance", any insurance policy[, contract, certificate, evidence of coverage] 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 of personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Long-term care insurance also includes qualified long-term care insurance contracts. Long-term care insurance may be issued by insurers; fraternal benefit societies; health services

corporations; prepaid health plans; [and] health maintenance organizations, or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which 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, long-term care insurance does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision of sections 376.951 to 376.958 and sections 376.1121 to 376.1133 to the contrary, any product advertised, marketed, or offered as long-term care insurance shall be subject to the provisions of sections 376.951 to 376.958 and sections 376.1121 to 376.1133;

(6) "Policy", any policy, [contract, certificate, evidence of coverage,] subscriber agreement, rider or endorsement delivered or issued for delivery in this state by an insurer; fraternal benefit society; health services corporation; prepaid health plan or health maintenance organization, or any similar

organization;

(7) "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract", the portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract that satisfies the requirements of Section 7702B(b) and (e) of the Internal Revenue Code of 1986, as amended. Qualified long-term care insurance contract also includes an individual or group insurance contract that meets the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as amended, as follows:

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

(b) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act, as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this paragraph do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payor. A contract shall not fail to satisfy the requirements of this paragraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

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

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

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

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

376.952. 1. The provisions of sections 376.951 to 376.958 and sections 376.1121 to 376.1133 shall apply to policies delivered or issued for delivery in this state on or after August 28, **[**1990**]** 2002. Sections 376.951 to 376.958 and sections 376.1121 to 376.1133 are not intended to supersede the obligations of entities subject to the provisions of sections 376.951 to 376.958 and sections 376.1122 to 376.1133 to comply with the substance of other applicable insurance laws insofar as they do not conflict with the provisions of sections 376.951 to 376.958 and sections 376.1122 to 376.1133, except that laws and regulations designed and intended to apply to medicare supplement insurance policies shall not be applied to long-term care

insurance.

2. The purposes of the provisions of sections 376.951 to 376.958 and sections 376.1122 to 376.1133 are 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.

3. Any policy or rider advertised, marketed or offered as long-term care or nursing home insurance shall comply with the provisions of sections 376.951 to 376.958 and sections 376.1122 to 376.1133.

376.955. 1. The director may adopt regulations 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, nonduplication 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. Regulations adopted pursuant to sections 376.951 to 376.958 and sections 376.1122 to 376.1133 shall be in accordance with the provisions of chapter 536, RSMo.

2. 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; or

(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 for lower levels of care.

3. No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in paragraph (a) of subdivision (4) of subsection 2 of section 376.951:

(1) 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;

(2) May exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six months following the effective date of coverage of an insured person.

4. The director may extend the limitation periods set forth in subdivisions (1) and (2) of subsection 3 of this section as to

specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

5. The definition of preexisting condition provided in subsection 3 of this section 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 subdivision (2) of subsection 3 of this section 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 subdivision (2) of subsection 3 of this section.

6. No long-term care insurance policy may be delivered or issued for delivery in this state if such policy:

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

(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 **[**on a prior institutionalization requirement, except in the case of**]** <u>other than</u> waiver of premium, post-confinement, post-acute care or

recuperative benefits on a prior institutionalization requirement.

7. 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.

8. A long-term care insurance policy or rider which conditions eligibility of noninstitutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty days.

9. No long-term care insurance policy or rider which provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related conditions within a period of less than thirty days after discharge from the institution.

10. The director may adopt regulations 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 regulation.

11. 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 (a) of subdivision (4) of subsection 2 of section 376.951, the applicant is not satisfied for any reason. This subsection shall also apply to denials of applications and any refund must be made within thirty days of the return or denial.

376.957. 1. An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose. The director 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 **[**applicant**]** application or enrollment form. In the case of direct response solicitations, 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 section 376.951, an outline of coverage shall not be required to be delivered; provided that the information described in subdivisions (1) to (6) of subsection 2 of this section is contained in other materials relating to enrollment. Upon request, such other materials shall be made available to the director.

2. 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 the 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 cost of care and benefits; and

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

3. A certificate issued pursuant to a group long-term care insurance policy which policy 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.

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

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

(4) A statement that any long-term care inflation protection option that may be required by the laws of this state is not available under the policy; and

(5) If applicable to the policy type, the summary shall also include:

(a) A disclosure of the effects of exercising other rights under the policy;

(b) A disclosure of guarantees related to long-term care costs of insurance charges [or notice that such guarantees are included in the policy or rider; and];

(c) Current and projected maximum lifetime benefits; and

(d) The provisions of the policy summary listed in paragraphs (a) to (c) of this subdivision may be incorporated into a basic illustration required to be delivered in accordance with sections 375.1509, RSMo, or into the life insurance policy summary required to be delivered in accordance with section 376.706.

376.1121. If a claim under a long-term care insurance contract is denied, the issuer shall, within sixty days of the date of a written request by the policyholder or certificate holder, or a representative thereof:

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

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

376.1124. 1. For a policy or certificate that has been in force 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 for coverage.

2. For a policy or certificate that has been in force for 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 conditions for which benefits are sought.

3. After a policy or certificate has been in force for two years, such policy or certificate 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.

4. No long-term care insurance policy or certificate shall 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 third-party administrator pursuant to the underwriting authority granted to the agent or third-party administrator by an insurer.

5. If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments shall not be recovered by the insurer if such policy or certificate is rescinded.

6. 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 the contestability provisions otherwise applicable in the policy to life insurance benefits. In all other situations, this section shall apply to life insurance policies that accelerate benefits for long-term care.

376.1127. 1. Except as provided in subsection 2 of this

section, 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 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. If a policyholder or certificate holder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that will be available for a specified period of time following a substantial increase in premium rates.

2. When a group long-term care insurance policy is issued, the offer required in subsection 1 of this section shall be made to the group policyholder; except that, if the policy is issued as group long-term care insurance, as defined in section 376.951, other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificate holder.

3. The director shall promulgate rules specifying the type or types of nonforfeiture benefits to be offered as part of 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 1 of this section.

376.1130. 1. The director shall promulgate reasonable rules to promote premium adequacy and to provide alternatives for

the policyholder in the event of substantial rate increases, and to establish minimum standards for marketing practices, agent testing, penalties, and reporting practices for long-term care insurance.

2. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in sections 376.1121 to 376.1133 shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2002, shall be invalid and void.