Life and Health Insurance

Massachusetts

State Law Supplement

Financial Education

KAPLAN UNIVERSITY
SCHOOL OF PROFESSIONAL AND CONTINUING EDUCATION

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Effective November 1, 2013

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MASSACHUSETTS LIFE AND HEALTH INSURANCE LAW
SUPPLEMENT, EFFECTIVE NOVEMBER 1, 2013

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Published in April 2014 by Kaplan Financial Education.

Printed in the United States of America.

ISBN: 978-1-4754-2496-6 / 1-4754-2496-5

PPN: 3200-5091

INTRODUCTION

This supplement focuses on statutes regarding Massachusetts insurance law. Key aspects of each statute are discussed to help the student pass the state law portion of the licensing examination. In order to understand the content of this supplement, the student should first study the national insurance License Exam Manual. Thorough preparation for the exam requires the complete study of both the national License Exam Manual and the supplement.

I. MASSACHUSETTS INSURANCE REGULATIONS

A. LICENSING PROCESS [175:162 G-X]

1. Types of licenses

a. Producers [175:162H, L, M] Before approving an individual's application for a producer license, the Commissioner must find that the individual:

- is at least 18 years of age;
- has not committed any act that is a ground for denial, suspension, or revocation of a license;
- when required by the Commissioner, has completed a prelicensing course of study for the line(s) of authority for which he has applied;
- has paid the fees prescribed; and
- has successfully passed the examinations for the lines of authority for which the person has applied.

A resident applying for an insurance producer license must pass a written examination unless exempt. The examination will test the knowledge of the individual concerning the lines of authority for which application is made, the duties and responsibilities of an insurance producer, and the insurance laws and regulations of the commonwealth. An applicant who fails to appear for a scheduled examination or who fails to pass an examination must reapply and submit all required fees and forms before being rescheduled for another examination.

1.) An insurance producer may receive qualification for a license in one or more of the following lines of authority:

- Life insurance coverage on human lives including benefits of endowment and annuities and may include benefits in the event of death or dismemberment by accident and benefits for disability income
- Accident and health or sickness insurance coverage for sickness, bodily injury, or accidental death and may include benefits for disability income (this license is also needed for any long-term care sales, whether a rider or stand alone policy)
- Property insurance coverage for the direct or consequential loss or damage to property of every kind
- Casualty insurance coverage against legal liability, including that for death, injury, disability, or damage to real or personal property

- Variable life and variable annuity products insurance coverage
- Personal lines property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes
- Limited line credit insurance
- Any other line of insurance permitted under state law

b. Business entity producers [175:162L] A business entity acting as an insurance producer is required to obtain an insurance producer license. Application must be made using the uniform business entity application. Before approving the application, the Commissioner must find that:

- the business entity has paid the fees prescribed; and
- the business entity has designated a licensed producer responsible for the business entity's compliance with the insurance laws, rules, and regulations of the commonwealth.

1.) The Commissioner may require any documents reasonably necessary to verify the information contained in an application.

c. Nonresident producers [175:162N, U] A nonresident person shall receive a nonresident producer license if:

- the person is currently licensed as a resident and in good standing in his home state;
- the person has submitted the proper request for licensure and has paid the fees;
- the person has submitted or transmitted to the Commissioner the application for licensure that the person submitted to his home state or a completed uniform application; and
- the person's home state awards nonresident producer licenses to residents of the commonwealth on the same basis.

1.) A nonresident producer who moves from one state to another or a resident producer who moves from the commonwealth to another state shall file a change of address and provide certification from the new resident state within 30 days of the change of legal residence. No fee or license application is required.

d. Temporary [175:162Q] The Commissioner may issue a temporary insurance producer license for a period not to exceed 180 days without requiring an examination if necessary for the servicing of an insurance business in the following cases:

- To the surviving spouse or court-appointed personal representative of a licensed insurance producer who dies or becomes mentally or physically disabled to allow adequate time for the sale of the insurance business owned by the producer, for the recovery or return of the producer to the business, or to provide for the training and licensing of new personnel to operate the producer's business

- To a member or employee of a business entity licensed as an insurance producer, upon the death or disability of an individual designated in the business entity application or the license
- To the designee of a licensed insurance producer entering active service in the armed forces of the United States
- In any other circumstance where the Commissioner deems that the public interest will best be served by the issuance of this license

1.) The Commissioner may require a temporary licensee to have a suitable sponsor who is a licensed producer or insurer and who assumes responsibility for the temporary licensee's activities. The Commissioner may revoke a temporary license if the interests of insureds or the public are endangered. A temporary license may not continue after the owner or the personal representative disposes of the business.

e. Special brokers [175:168] The Commissioner may issue a license to act as a **special insurance broker** to negotiate, continue, or renew contracts of insurance (except accident and health, workers' compensation, compulsory motor vehicle liability, and life insurance) on property or interests in this commonwealth in **foreign** (out-of-state) companies not authorized to transact business in Massachusetts.

1.) When a special broker places coverage with an unauthorized insurer, he must, in every case, execute within 20 days an affidavit stating that the full amount of insurance required to protect the property or interest is not procurable, after a diligent effort has been made to do so, from among companies admitted to transact insurance in the commonwealth against the hazard or hazards involved, and that the amount of insurance procured in non-authorized foreign companies is only the excess over the amount that may be procured from admitted companies.

2.) A special broker who neglects to make and file the affidavit and statements required, willfully makes a false affidavit or statement, or negotiates, continues, or renews any contracts of insurance after the revocation or during the suspension of his license will forfeit his license if not previously revoked and be punished by a fine of between $100 and $500, by imprisonment for not more than one year, or both.

3.) Special brokers must keep a separate account of the business done under the special broker license, showing the exact amount of insurance placed under the license, the gross premiums for the coverage, the companies in which the coverage is placed, the date and term of the policies, and all policies that are cancelled. Each January, special brokers must pay to the commonwealth an amount equal to 4% of the gross premiums, minus any return premiums for cancelled coverage, on insurance issued under the license during the previous year.

4.) Any insurance policy procured under this section shall contain the following disclosure notice to the policyholder: This policy is insured by a company which is not admitted to transact insurance in the commonwealth, is not supervised by the Commissioner of insurance and, in the event of an insolvency of such company, a loss shall not be paid by the Massachusetts Insurers Insolvency Fund.

f. Advisers [175:177A, B] An **insurance adviser** is considered an individual who has passed an examination, is appropriately licensed (licenses renew every three years), and for a fee offers to examine any policy of insurance for the purpose of giving advice, counsel, recommendation, or information in respect to the terms, conditions, benefits, coverage, or premium of any policy or contract, or in respect to the expediency or advisability of altering, changing, exchanging, converting, replacing, surrendering, continuing, renewing, or rejecting any such policy or contract, or of accepting or procuring any policy or contract from any company.

1.) An adviser may not be an officer or a regular salaried employee of any company and acting for the company, or be an insurance producer acting for any company.

2.) A duly authorized attorney-at-law or a certified public accountant acting within the course or scope of his profession or business may provide insurance advice without being licensed as an adviser.

3.) Someone who uses the title *insurance adviser, insurance specialist, insurance counselor, insurance analyst, policyholders' adviser, policyholders' counselor*, or any other similar title in an advertisement, business card, etc., must be licensed as an adviser.

4.) The Commissioner may require that an applicant take a written examination that would indicate the appointee's ability to perform his duties satisfactorily.

5.) The application for an advisor's license must state the name, age, residence, and occupation of the applicant at the time of the application and his residence, occupation, and all business affiliations for the preceding 10 years. The application must also contain a statement as to the trustworthiness and competency of the applicant, signed by at least three reputable citizens of this commonwealth.

6.) Whoever acts as an insurance adviser without a license or during a suspension of his license will be punished by a fine of not less than $50 nor more than $500 or by imprisonment for not more than six months, or both.

7.) An adviser license may be issued to a partnership (if each partner is considered qualified to be an adviser) or a corporation (if a majority of the officers are considered qualified to be an adviser).

8.) An adviser's license must be renewed every three years.

g. Public insurance adjusters [175:172] To be licensed as a **public adjuster** in Massachusetts, an applicant must:

- be at least 21 years of age;
- be a resident of Massachusetts or a reciprocal state;
- have two years' experience performing services in connection with the adjustment of property losses;
- satisfy the Commissioner of his competence and trustworthiness;
- file a written application, including
  - — two photos taken within 60 days of the application, and
  - — a certified criminal background check;
- pay the licensing fee; and
- successfully complete the licensing exam.

1.) A public adjuster license expires after three years, unless sooner revoked or suspended.

2.) Upon payment of the renewal fee, the license may be renewed for any succeeding three-year period without requiring an additional written examination.

3.) A person renewing a public insurance adjuster's license must have a total of 15 hours of continuing education instruction.

4.) Individuals, partnerships, and corporations may be licensed as public adjusters in Massachusetts.

5.) Anyone acting without an adjuster license or during a suspension of his license, or in violation of this section, shall be punished by a fine of not more than $10,000 or by imprisonment for not more than six months.

h. Reinsurance intermediaries [175:177M–W] A **reinsurance intermediary broker** is defined as any person other than an officer or employee of the ceding insurer, firm, association, or corporation who solicits, negotiates, or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of the insurer.

1.) A reinsurance intermediary broker must also be licensed as a producer (either resident or nonresident) in Massachusetts. The Commissioner may require bonding and maintenance of errors and omissions in an amount acceptable to the Commissioner.

2.) A reinsurance intermediary broker shall represent or perform services for an insurer only pursuant to a written contract that specifies the responsibilities of each party. At least 30 days before the reinsurer assumes or cedes business through the reinsurance intermediary manager, a true copy of the approved contract shall be filed with the Commissioner.

3.) For at least 10 years after expiration of each contract of reinsurance negotiated by or through the reinsurance intermediary broker, the reinsurance intermediary broker will keep a complete record for each transaction.

4.) The insurer must obtain a copy of the current annual statement of financial condition or documents providing similar information for each reinsurance intermediary broker with which it transacts business.

5.) Within 30 days of termination of a contract with a reinsurance intermediary manager, the reinsurer must provide written notification of the termination to the Commissioner that includes a statement of all reasons for the termination.

6.) Each violation is subject to a penalty in an amount up to $10,000; in addition, the Commissioner will require the reinsurance intermediary to make restitution to the insurer, reinsurer, rehabilitator, or liquidator of the insurer or reinsurer for the net losses incurred by the insurer or reinsurer attributable to the violation.

7.) A reinsurance intermediary's license must be renewed every three years.

i. Life Settlement Act [175:212-223E] The Life Settlement Act applies to life settlement contracts entered into on or after June 1, 2013, and subsumes the previous Viatical Settlement Act. A person licensed to act as a viatical settlement broker or provider is now deemed to be qualified for licensure as a life settlement broker or life settlement provider, respectively.

Viatical and life settlements involve third-party sales of existing life insurance policies. With the assistance of a settlement broker (who represents the current owner) a policy owner sells a life insurance policy for cash, giving up all rights—also known as an absolute assignment. The settlement provider becomes the new policyowner and beneficiary and is responsible for any premium payments that come due. Upon the insured's death, the settlement provider recoups its investment and would owe tax on net profits.

Viatical settlements generally do not result in taxable income to the original owner because of the requirement that the insured be considered "terminally ill." With a life settlement, the insured is not ill but no longer needs the death benefit for his family or business. The seller in a life settlement may owe income and capital gains tax after the transaction. In both settlements, the settlement provider will usually owe tax on any gain.

1.) A life settlement broker represents only the owner and owes her a fiduciary duty regardless of how the broker is compensated. The identity of the insured is to be protected.

2.) No person may act as a life settlement provider or broker with an owner who is a resident of the commonwealth without first obtaining a license.

a.) Licenses can be renewed on their anniversary date by payment of a renewal fee.

b.) Biennially, a person licensed as a life settlement broker must complete 15 hours of training related to the business of life settlements in order to renew the license. (A life insurance producer who is operating as a life settlement broker is not subject to this same requirement.)

c.) Resident or nonresident life producers licensed for at least one year meet the licensing requirements provided that, not later than 30 days from the first day of operation, the producer notifies the Commissioner, on the prescribed form and with the fee, that the producer is acting as a life settlement broker.

d.) Licensed attorneys, certified public accountants, or financial planners may be exempt from life settlement broker license requirements as long as compensation is not paid, either directly or indirectly, by the life settlement provider.

3.) Upon filing for initial licensure, the Commissioner will examine each applicant and may issue a license if the Commissioner finds that the applicant:

a.) has provided a detailed plan of operation, if applying as a life settlement provider;

b.) is competent, trustworthy, and intends to transact its business in good faith;

c.) has a good business reputation and has the experience, training, and education to be qualified in the business for which the license is applied;

d.) if a legal entity, provides a certificate of good standing from the state of its domicile; and

e.) if a life settlement provider, has provided an antifraud plan to the Commissioner.

4.) A license issued to a legal entity shall authorize all members, officers, and designated employees to act as licensees under the license provided those persons are identified in the initial application. Any new or revised information about officers, 10% or more stockholders, partners, directors, members, or designated employees should be submitted within 30 days to update the Commissioner.

5.) The Commissioner can suspend, revoke, or deny licenses of those in the life settlement business if the licensee or any officer, partner, member, or key management personnel has violated any life settlement sections. Before taking any such action, the Commissioner will conduct a hearing.

6.) Settlement providers must file annual reports on or before March 1. A provider that willfully fails to file or to reply within 30 days after receipt of a written inquiry by the Commissioner shall, in addition to any other penalties prescribed by law, be subject to a penalty of up to $250 per day of delay, not to exceed $25,000 in the aggregate, for each such failure.

The annual statement shall:

- specify the total number, aggregate face amount, and life settlement proceeds of policies settled during the immediately preceding calendar year, together with a breakdown of the information by policy issue year for each carrier;
- include the names of the insurance companies whose policies have been settled; and
- include only those transactions where the owner is a resident of the commonwealth.

7.) When reasonably necessary to protect the interests of the public, the Commissioner may examine the business and affairs of any licensee or applicant for a license. The expenses incurred in conducting an examination shall be paid by the licensee or applicant.

8.) Records should be maintained by the life settlement provider for three years after the death of the insured and be available to the Commissioner for inspection during reasonable business hours.

j. Licensing requirement exceptions [175:162J] A license as an insurance producer is not required of:

- an officer, director, or employee of an insurer or of an insurance producer if the person does not receive any commission on policies written or sold to insure risks in the commonwealth, and
  - — the person's activities are executive, administrative, managerial, or clerical and are only indirectly related to the sale, solicitation, or negotiation of insurance,
  - — the person's function relates to underwriting, loss control, inspection, or the processing, adjusting, or settling of claims, or
  - — the person is acting as a special agent or agency supervisor assisting insurance producers and the person's activities are limited to providing technical advice and assistance to producers and do not include the sale, solicitation, or negotiation of insurance;
- a person who services group insurance plans or who performs administrative services related to mass marketed insurance, if the person receives no commission for the services;
- a person engaged in the administration of employee benefits that are funded by insurance contracts, as long as the person is not compensated, directly or indirectly, by the company issuing the contracts;
- employees of insurers who are engaged in the inspection, rating, or classification of risks, or in the supervision of the training of insurance producers, and who are not individually engaged in the sale, solicitation, or negotiation of insurance;

- a person whose activities are limited to advertising insurance through printed publications or other forms of electronic mass media whose distribution is not limited to residents of the commonwealth if the person does not sell, solicit, or negotiate insurance on risks in the commonwealth;
- a nonresident who sells, solicits, or negotiates insurance for commercial property and casualty risks to an insured with risks located in more than one state, if the person is licensed as an insurance producer in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state;
- a salaried full-time employee who advises the person's employer about the employer's insurance interests if the employee does not sell or solicit insurance or receive a commission; or
- a person who is licensed to sell credit life, credit disability, or guaranteed automobile protection insurance in connection with the sale or lease of a motor vehicle.

k. Prelicensing education or examination requirements [175:162O] An individual who applies for an insurance producer license in the commonwealth who was previously licensed for the same lines of authority in another state is not required to complete any prelicensing education or examination. This exemption is available only if the person is currently licensed in that state or if the application is received within 90 days of the cancellation of the applicant's previous license and if, at the time of cancellation, the applicant was in good standing in that state.

B. MAINTENANCE AND DURATION

1. Reinstatement and renewal [175:162M(b–d); 177B, 177O] An insurance producer license remains in effect unless revoked or suspended as long as the fee prescribed is paid and the continuing education requirements for resident individual producers are met by the due date.

a. An individual insurance producer who allows his license to lapse may, within 12 months from the due date of the renewal fee, reinstate the same license without the necessity of passing a written examination, but a penalty in the amount of double the unpaid renewal fee shall be required for any renewal fee received after the due date.

b. A licensed insurance producer who is unable to comply with license renewal procedures due to military service or some other extenuating circumstance may request a waiver of those procedures. The producer may also request a waiver of any examination requirement or any other fine or sanction imposed for failure to comply with renewal procedures.

c. A special broker's license expires one year from its date of issuance, unless suspended or revoked earlier. The Commissioner may renew the license for succeeding one-year periods, provided the required fee is paid.

d. Insurance adviser and reinsurance intermediary licenses expire three years from the date of issue, unless revoked or suspended earlier. The Commissioner may renew a license for additional three-year periods, provided the required fee is paid.

2. **Address change [175:162M(f)]** Licensees must inform the Commissioner by any means acceptable to the Commissioner of a change of address within 30 days of the change.

3. **Reporting of actions [175:162V]**

   a. A producer must report to the Commissioner any administrative action taken against the producer in another jurisdiction or by another governmental agency in the commonwealth within 30 days of the final disposition of the matter. This report must include a copy of the order, consent to order, or other relevant legal documents.

   b. Within 30 days of the initial pretrial hearing date, a producer must report to the Commissioner any criminal prosecution of the producer taken in any jurisdiction. The report must include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents.

4. **Assumed names [175:162P]** An insurance producer doing business under any name other than the producer's legal name is required to notify the Commissioner prior to using the assumed name.

5. **Continuing education [175:177E; Reg. 211 CMR 50.00]** The provisions of this section apply to resident and nonresident persons licensed to engage in the sale of life insurance, annuity contracts, variable annuity contracts and variable life insurance, sickness, accident, and health insurance, and all lines of property and casualty insurance.

   a. Resident and nonresident licensed persons must satisfactorily complete courses or programs of instruction in the minimum number of classroom hours as follows.

      1.) Any person holding one or more such licenses must, during the first 36-month period following the date of original issue of the licenses, satisfactorily complete courses or programs of instruction or attend seminars equivalent to a minimum of 60 hours of instruction.

      2.) After their first 36-month period of licensure, producers must satisfactorily complete courses or programs of instruction or attend seminars equivalent to 45 classroom hours of instruction for each subsequent 36-month renewal period.

      3.) Excess classroom hours accumulated during any one 36-month period may be carried forward to the next 36-month period.

b. The courses or programs of instruction successfully completed that have been deemed to meet the continuing educational requirements and the number of classroom hours for which they are equivalent are:

- any part of the Life Underwriting Training Council (LUTC) life course curriculum, 50 hours; health course, 25 hours;
- any part of The American College Chartered Life Underwriter® (CLU®) diploma curriculum, 30 hours;
- any part of the Insurance Institute of America's program in general insurance, 25 hours;
- any part of the American Institute for Property and Liability Underwriters Charter Property Casualty Underwriter (CPCU®) professional designation program, 30 hours;
- any part of the Certified Insurance Counselor (CIC) program, 25 hours;
- any insurance course approved by the Commissioner taught by an accredited college or university per credit hour granted, 15 hours;
- any course or program of instruction or seminar developed or sponsored by an authorized insurer, recognized producers association, insurance trade association, or any independent program of instruction shall, subject to the approval of the Commissioner, qualify for the same number of classroom hours assigned by the Commissioner;
- any correspondence course approved by the Commissioner shall qualify for the same number of classroom hours; and
- any part of the Accredited Associate in Insurance (AAII), 25 hours.

c. A person teaching any course of instruction described or lecturing at any seminar approved qualifies for the same number of classroom hours as would be granted to a person taking and successfully completing the course, seminar, or program.

d. For good cause shown, the Commissioner may grant an extension of time during which the requirements of this section may be satisfied by any licensed person.

e. Every person subject to this section must furnish in a form satisfactory to the Commissioner written certification of the courses, programs, or seminars of instruction taken and successfully completed.

f. Any person failing to meet these requirements and who has not been granted an extension of time within which to comply or who has submitted to the Commissioner a false or fraudulent certificate of compliance will, after a hearing, be subjected to the suspension of all licenses issued for any and all kind or kinds of insurance until the person has complied with all of the requirements of the continuing education regulation.

g. The continuing education requirement does not apply to:

- persons holding resident licenses for which an examination is not required;

- nonresident producers who hold an equivalent license or licenses in their home state and have satisfied their home state's continuing education requirements, if the home state recognizes continuing education requirements on the same basis; and
- any limited or restricted license.

h. A continuing education course review committee is composed of a representative of the Division of Insurance who serves as chairman, two representatives from the Independent Insurance Agents of Massachusetts, two representatives of the Massachusetts Association of Life Underwriters, and two representatives of the Professional Insurance Agents of New England.

C. DISCIPLINARY ACTIONS

1. Cease and desist orders [176D:7] If the Commissioner determines after a hearing that a person has engaged in an unfair or deceptive act or practice, the Commissioner will order the person to **cease and desist** from engaging in that activity. The Commissioner may also suspend or, in the case of repeated violations, revoke the person's license. In addition, whoever commits such an act or practice will be fined up to $1,000 for each violation.

a. The Commissioner may order an insurer or its agent to make restitution to a claimant who has suffered actual economic damage as a result of an unfair or deceptive trade practice.

b. In an action to recover on an insurance policy, a court may award additional punitive damages of up to 25% of the claim if the court finds that the party seeking to recover has been damaged by an unfair or deceptive trade practice.

c. Any person who violates a cease and desist order of the Commissioner is subject to a maximum penalty of $10,000 and suspension or revocation of the person's license.

2. Hearings [175:162R; 176D:6] Notices of hearings of the revocation or suspension of any license will be deemed sufficient when sent postpaid by registered mail to the last business or residence address of the licensee appearing on the records of the Commissioner.

a. Whenever the Commissioner has reason to believe that any person has engaged or is engaging in any unfair method of competition or any unfair or deceptive act or practice and that a proceeding by him would be in the interest of the public, he may issue and serve a statement of the charges and a notice of a hearing to be held at a time and place fixed in the notice, which may not be less than 21 days after the date of the service.

b. At the time and place fixed for the hearing, the person will have an opportunity to be heard and to show cause why an order should not be made by the Commissioner requiring the person to cease and desist from the acts, methods, or practices detailed.

3. **Probation, suspension, revocation, refusal to issue or renew [175:162R; 177B; 176D:7, 10; 30A:13]** The Commissioner, after giving proper notice, may place on probation, suspend, revoke, or refuse to issue or renew an insurance producer's license. A cease and desist order may be issued and the Commissioner may levy a variety of civil penalties for any one or more of the following causes:
   - Providing incorrect, misleading, incomplete, or materially untrue information in the license application
   - Violating any insurance laws or any regulation, subpoena, or order of the Commissioner or of another state's Insurance Commissioner
   - Obtaining or attempting to obtain a license through misrepresentation or fraud
   - Improperly withholding, misappropriating, or converting any monies or properties received in the course of doing insurance business
   - Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance
   - Having been convicted of a felony
   - Having admitted or been found to have committed any insurance unfair trade practice or fraud
   - Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness, or financial irresponsibility in the conduct of business in the commonwealth or elsewhere
   - Having an insurance producer license or its equivalent denied, suspended, or revoked in any other state, province, district, or territory
   - Forging another's name to an application for insurance or to any document related to an insurance transaction
   - Improperly using notes or any other reference material to complete an examination for an insurance license
   - Knowingly accepting insurance business from an individual who is not licensed
   - Failing to comply with an administrative or court order imposing a child support obligation
   - Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax

4. **Penalties and fines [175:162R(b–e), 170, 174, 175, 176, 177, 194; 176D:7, 10]** The Commissioner may issue a cease and desist order to protect the public. Notice of such may be published. Anyone violating a cease and desist may owe restitution and a penalty of $10,000.

   In the event that the action by the Commissioner is to nonrenew or deny an application for a license, the Commissioner must notify the applicant or licensee and advise, in writing, the reason for the denial or nonrenewal of the applicant's or licensee's license. The applicant or licensee may make written demand upon the Commissioner within 30 days for a hearing before the Commissioner to determine the reasonableness of the Commissioner's action.

   a. The license of a business entity may be suspended, revoked, or refused if the Commissioner finds, after hearing, that an individual licensee's violation was known or should have been known by one or more of the partners, officers, or

managers acting on behalf of the partnership or corporation and the violation was not reported to the Commissioner, nor was corrective action taken.

b. In addition to or in lieu of any applicable denial, suspension, or revocation of a license, a person may, after hearing, be subject to a civil fine.

c. The Commissioner retains the authority to enforce the provisions of and impose any penalty or remedy authorized even if the person's license or registration has been surrendered or has lapsed by operation of law.

d. An insurance agent or broker who knowingly procures by fraudulent representations payment or the obligation for the payment of any premium on any policy of insurance or any annuity or pure endowment contract will be punished by a fine of not less than $100 nor more than $1,000 or by imprisonment for not more than one year.

e. Any person who violates a provision of the insurance code for which no penalty is specified will be punished by a maximum fine of up to $500.

f. Producers who fail to forward the premiums they have collected on behalf of a company are guilty of larceny.

g. Whoever commits a deceptive act or practice will be punished by a fine of not more than $1,000 for each act or practice. The Commissioner may also order that restitution be made by an insurer or its producer to any claimant who has suffered economic damage as a result of a violation.

h. In any action to recover on an insurance policy, a court may award punitive damages, in addition to the amount of the claim, not to exceed 25% of the claim if the court finds that the party seeking to recover has been damaged by a violation.

i. Any person who defaults on an educational loan will be denied a professional license in Massachusetts. The license applicant may request a review of the alleged loan default, during which time a provisional license may be granted.

j. Every officer or director specified in the license of a corporation is personally liable for any violation, although the act of violation is done on behalf of the corporation. The corporation is liable for any such violation; the responsibility for it cannot be placed on any individual officer or director.

k. The Commissioner may examine a corporation's books and affairs as he deems necessary. Corporations and their officers and directors are subject to the same penalties as individuals are for failing to cooperate with an examination.

l. Amendments to a licensed corporation's articles of incorporation must be forwarded to the Commissioner within 30 days, and if the corporation is dissolved, the Commissioner must be notified immediately.

m. Unlicensed persons who advertise themselves as being in the insurance business or producers who advertise a line of insurance for which they are not licensed are subject to a fine of between $10 and $100. Paying an unlicensed producer results in a fine from $50 to $500.

D. STATE REGULATIONS

1. Commissioner's general duties and powers [175:3A; 175:4; 176D:5]

The Commissioner administers and enforces the provisions of the insurance laws and regulations. If, upon complaint, examination, or other evidence exhibited to him, he is of the opinion that any law has been violated, he will report the facts to the attorney general or to the proper district attorney, who will prosecute the offender.

a. Before granting licenses or **certificates of authority** to a company to issue insurance, annuity, or pure endowment contracts, the Commissioner must be satisfied, by examination and evidence as the Commissioner may require, that the company is duly qualified under the laws of the commonwealth to transact business. The Commissioner will require every domestic company to keep its books, records, accounts, and vouchers in a manner that the Commissioner or any authorized representatives may readily verify its annual statements and ascertain whether the company has complied with the law.

b. At least once every five years and whenever the Commissioner determines it to be prudent, the Commissioner will, personally or by any deputy or examiner, visit each domestic company and any foreign company applying for admission or already admitted to do business in the commonwealth, and thoroughly inspect and examine its affairs and ascertain its financial condition, its ability to fulfill its obligations, whether it has complied with the law, and any other facts relating to its business methods and management, and the equity of its dealings with its policyholders.

c. The Commissioner will also conduct an examination upon the request of five or more stockholders, creditors, policyholders, or financially interested persons who make an affidavit of their belief, with specifications of the reasons therefore, that the company is in an unsound condition.

d. The charge for each examination will be determined annually by the Commissioner of administration and paid by each company within 30 days after notice of the charge.

e. The Commissioner has the power to examine and investigate the affairs of every person engaged in the business of insurance in this commonwealth in order to determine whether the person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or prohibited practice.

E. COMPANY REGULATION

1. **Certificate of authority [175:4, 32, 151]** Prior to granting a certificate of authority to an insurer to issue policies, the Commissioner, through an extensive examination, must determine that the company is qualified under the laws of the commonwealth to transact business. Before granting a certificate of authority to a domestic company, the Commissioner requires an affidavit to be filed with the Division of Insurance that is signed by the officers of the company and states the amount of expenses incurred in the organization and that the company has no outstanding liabilities except organization expenses and, in the case of a stock company or a mutual company with a guaranty capital, its liabilities to stockholders for the amount paid in for shares of stock.

   a. No domestic company may make or issue any insurance or annuity or pure endowment contracts until it has obtained from the Commissioner a certificate stating that the company has complied with the conditions set forth in this section and all other provisions of law, and authorizing it to make or issue these policies or contracts.

   b. **Foreign companies** A foreign company that seeks authorization to do business in Massachusetts must:
      - deposit with the Commissioner a certified copy of its charter or deed of settlement and a statement of its financial condition and business;
      - satisfy the Commissioner that it is legally organized under the laws of its state or government to do the business it proposes to transact and meet certain financial requirements;
      - file with the Commissioner a power of attorney authorizing the Commissioner to receive legal process in any legal proceeding against it; and
      - obtain from the Commissioner a license specifying the kinds of business it is authorized to transact.

         1.) The license expires on June 30 of each year but may be renewed by the Commissioner upon written application of the company.

2. **Solvency [175:6; 180A-L; 175J]**

   a. **Administrative supervision of insurers** An insurer may be subject to administrative supervision by the Commissioner, without a prior hearing, if the Commissioner determines that:
      - the insurer's condition renders the continuance of its business hazardous to its policyholders or the general public;
      - the insurer gives its consent; or
      - the insurer's business is being conducted fraudulently.

         1.) An insurer may also be subject to administrative supervision by the Commissioner if, after a hearing, the Commissioner determines that the insurer has exceeded its powers or that the insurer has engaged in a deliberate pattern or practice of failing to comply with certain laws and regulations.

2.) If the Commissioner determines that the insurer's business is hazardous to the public or that the insurer's financial condition is unsound, the Commissioner may issue notice to the insurer of the reason for this determination and the requirements the insurer must meet to be removed from administrative supervision.

3.) The Commissioner may employ staff personnel, outside counsel, and other consultants as necessary to properly conduct the administrative supervision. All reasonable costs of using outside counsel, consultants, and staff personnel are the responsibility of the insurer under administrative supervision.

4.) An insurer has 60 days to correct the conditions that caused it to be placed under administrative supervision. If, after notice and hearing, it is determined that these conditions still exist at the end of the supervision period, the Commissioner may extend the period. If it is determined that none of the conditions giving rise to the supervision exist, the Commissioner will release the insurer from supervision.

b. Delinquency proceedings If the Commissioner finds that a domestic insurer is in unsound financial condition or that is has committed certain violations of the insurance laws, the Commissioner may apply for an injunction restraining it in whole or in part from further proceeding with its business and for the appointment of a receiver. The court may issue a temporary injunction and appoint the Commissioner as temporary receiver. After a full hearing, the court may make the injunction permanent and appoint the Commissioner permanent receiver to take possession of all the property and effects of the company, settle its affairs, and distribute its assets.

c. Rehabilitation, conservation, and liquidation of insurers The Commissioner may institute a rehabilitation proceeding against a domestic company by applying to the supreme judicial court to be appointed as a receiver to rehabilitate the company and conserve its assets. The court may issue a temporary injunction restraining the company from further proceeding with its business by appointing the receiver and authorizing him to take possession of the company and conduct its business for the purpose of rehabilitating it.

1.) Written notice of the appointment of a receiver must be given to all of the company's policyholders within 20 days after the appointment.

2.) If necessary, the Commissioner will be appointed as an ancillary receiver in delinquency proceedings for an insurer that is not domiciled in Massachusetts. The Commissioner will be authorized to conserve the insurers' assets within Massachusetts.

3.) If the Commissioner determines that a domestic company is insolvent and should be liquidated, he will apply to the court for a decree authorizing him to liquidate the company. The court, after notice to all known creditors and stockholders of the company and a full hearing, may order its liquidation and appoint the Commissioner as its permanent receiver.

4.) Within 120 days of a final determination of insolvency, the receiver must apply to the supreme judicial court for approval of a proposal to disburse the company's assets to the Massachusetts Insurers Insolvency Fund, the Massachusetts Life and Health Insurance Guaranty Association, and any similar organization in another state. The court may approve or disapprove the proposal in whole or in part.

3. Rates

a. Premium rates for insurance [175:113B; 175A; 175E] The Commissioner regulates premium rates for insurance policies to ensure that they are not excessive, inadequate, or unfairly discriminatory.

1.) When setting rates, consideration must be given to:

- past and prospective loss experience within and outside Massachusetts;
- catastrophe hazards, if any;
- a reasonable margin for underwriting profit and contingencies;
- investment income on unearned premium and loss reserves;
- dividends, savings, or unabsorbed premium deposits; and
- past and prospective expenses both countrywide and those specially applicable to Massachusetts.

2.) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks that reflect differences in probable losses or expenses.

3.) Willful violation of this chapter is punishable by a fine of up to $500.

b. Filing of rate information [175A:6] Insurers must file with the Commissioner every manual of classifications, rules, and rates; every rating plan; and every modification of any of these items at least 15 days before their proposed effective date. The Commissioner may delay the effective date for up to 30 additional days if the delay is needed to properly examine the filing and any supporting information or to permit a hearing. If a filing is made for medical malpractice insurance, the Commissioner may further delay the effective date of the filing for up to 90 additional days.

1.) No insurer may make or issue a contract or policy except in accordance with filings made as provided by this section.

c. Rates for legal service and small group health insurance plans [176H:6; 176J:3] For every health benefit plan issued or renewed to eligible individuals and eligible small groups, carriers will develop a group base premium rate that is the same for both eligible individuals and small groups. In developing these merged market group base premium rates, carriers:

- should consider all enrollees in those health plans (other than grandfathered health plans) to be members of a merged individual and small group risk pool;

- when calculating the premium to be charged to each eligible individual or small group, will develop a base premium and use only those rate adjustment factors identified by law. Rate adjustment factors may be developed and filed annually with the United States Department of Health and Human Services for the following reasons:
  - — standard age rate adjustment factor (applied based on the covered person's age when the coverage period begins),
  - — area rate adjustments for not more than seven distinct regions of the state,
  - — whether the health benefit plan covers an individual or family. For purposes of this section, the total premium for family coverage must be determined by summing the premiums for each individual family member. With respect to family members under the age of 21, the premiums for not more than the three oldest covered children must be taken into account in determining the total family premium, and
  - — a standard tobacco use factor; and
- may offer any rate basis types but the rate types used must be offered to every eligible individual or eligible small group for all coverage issued or renewed. However, if an eligible small group does not meet a carrier's minimum or participation contribution requirements, the carrier may separately rate each employee as an eligible individual;
- must make any coverage offered available to every eligible individual and eligible small group; and
- having a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents who are enrolled in health benefit plans sold, issued, delivered, made effective, or renewed in the previous calendar year shall be required annually to file a plan with the Connector (The Commonwealth Health Insurance Connector Authority-state health exchange) for its consideration, which meets the requirements for the Connector seal of approval; provided, however, that the plan shall be filed not later than October 1.

The Commissioner may conduct an examination with respect to the derivation of group base premium rates in order to identify whether any expenses inappropriately increase the cost in relation to the risks of the merged individual and small group health insurance market.

d. Rates for guaranteed issue health plans [176M:4] Premiums charged to individuals for guaranteed issue health plans, whether at issue or renewal, must be based on a base premium rate, which may then be multiplied by an age rate adjustment, an area rate adjustment, and a benefit level rate adjustment to arrive at the final premium.

4. Policy forms [175:2B, 192] No policy form of insurance may be delivered or issued for delivery to more than 50 policyholders in the commonwealth until a copy of the policy form has been on file for 30 days with the Commissioner, unless approved before the expiration of the 30 days (after the 30 days, a policy form may be used unless it is rejected by the Commissioner). No policy may be delivered or issued for delivery if the Commissioner notifies the company in writing within the 30 days that in his opinion the form does not comply with the provisions of this section, specifying

the reasons for his opinion. Policy forms may not be delivered or issued for delivery unless:

- the text achieves a minimum Flesch scale readability score of 50;
- it is printed, except for tables, in not less than 10-point type;
- the style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text of the policy and any endorsements or riders;
- it contains a table of contents or an alphabetical subject index;
- the width of margins and ink-to-paper contrast do not unreasonably interfere with the readability of the form; and
- the organization of the content of the policy and the summary of the policy are conducive to understandability of the form.

These provisions also apply to all riders, endorsements, and applications.

5. **Examination of books and records [175:4]** The Commissioner requires every domestic company to keep its books, records, accounts, and vouchers in such manner that the Commissioner or any authorized representatives may readily verify its annual statements and ascertain whether the company has complied with the law. Every insurer will be examined at least once every five years, or at the request of five or more stockholders, creditors, policyholders, or other persons with a financial interest in the company. The company must pay the expenses of the examination within 30 days of notification. A report of each examination will be issued 60 days after the examination is completed.

6. **Producer appointments [175:162S]** An insurance producer may not act as an agent of an insurer unless the insurance producer becomes an appointed agent of that insurer. An insurance producer who is not acting as an agent of an insurer is not required to become appointed.

   a. To appoint a producer as its agent, the appointing insurer must file, in a format approved by the Commissioner, a notice of appointment within 15 days from the date the agency contract is executed or the first insurance application is submitted. An insurer may also elect to appoint a producer to all or some insurers within the insurer's holding company system or group by filing a single appointment request.

   b. Upon receipt of the notice of appointment, the Commissioner must verify within a reasonable time not to exceed 30 days that the insurance producer is eligible for appointment. If the insurance producer is determined to be ineligible for appointment, the Commissioner shall notify the insurer within five days of its determination.

   c. An insurer must pay an appointment fee in the amount prescribed for each insurance producer appointed by the insurer.

7. **Termination of producer appointment [175:162T]** An insurer that terminates the appointment, employment, contract, or other insurance business relationship with a producer must notify the Commissioner within 30 days following the effec-

tive date of the termination whether or not the reason for termination is one of the reasons indicated as grounds for probation, suspension, revocation, or refusal to issue or renew, or the insurer has knowledge the producer was found by a court, government body, or self-regulatory organization authorized by law to have engaged in any of the activities that are grounds for license suspension, revocation, or nonrenewal under Massachusetts law.

a. Within 15 days after making the required notification, the insurer must mail a copy of the notification to the producer at his last known address. If the producer is terminated for cause or because he or she has committed an act that is grounds for license suspension, revocation, or nonrenewal, the insurer must provide a copy of the notification to the producer at his last known address by certified mail, return receipt requested, postage prepaid, or by overnight delivery using a nationally recognized carrier.

b. Within 30 days after the producer has received the original or additional notification, the producer may file written comments concerning the substance of the notification with the Commissioner.

c. In the absence of actual malice, neither insurers, producers, nor the Commissioner is subject to any civil liability in connection with information reported under this section.

F. PRODUCER REGULATION

1. **Impersonation (fraudulently misrepresenting oneself as being licensed) [175:175]** Whoever, not licensed as an insurance producer or as an adjuster of fire losses, represents or holds himself out to the public as being a producer or adjuster, or as being engaged in the insurance business, by means of advertisements, cards, circulars, letterheads, signs, or other methods, or whoever, being duly licensed, advertises or carries on such business in any other name than that stated in his license, will be punished by a fine of not less than $10 nor more than $100.

2. **Larceny [175:176]** An insurance producer who acts in negotiating or renewing a policy of insurance or annuity contract issued by a company lawfully doing business in the commonwealth and who receives any money as a premium from the insured will be deemed to hold the premium in trust for the company. If he fails to pay the money to the company after written demand is made, less his commission and any deductions to which, by the written consent of the company, he may be entitled, such failure will be prima facie evidence that he has used or applied the premium for a purpose other than paying it over to the company, and upon conviction will be guilty of larceny.

3. **Unlicensed persons compensation [175:177]**

a. Insurers and licensed producers may not pay or offer to pay compensation or anything of value to a person who is not licensed as an insurance producer. An intentional violation is punishable by a fine of $50 to $500.

b. This does not prohibit a licensed producer from paying referral fees to unlicensed employees for referring customers to the producer in connection with the purchase of insurance.

4. Unfair or deceptive insurance practices

a. Misrepresentation [175:181, 186; 176D:3(1), (11)] No company, officer, insurance producer, or insurance adviser may make any written or oral misrepresentation or misleading representation about the terms, benefits, or privileges of any insurance policy, or make any written or oral incomplete or misleading comparison of any policy or contract or of any of its terms, benefits, or privileges with any other policy or any of its terms (this is known as **twisting**), benefits, or privileges, in order to induce a person to lapse, forfeit, or surrender the policy issued to him or to alter or convert it into or exchange it for any other policy or contract. Whoever violates any provision of this section will be punished by a fine of not more than $1,000 or by imprisonment for not more than six months.

1.) No oral or written misrepresentation or warranty made in the negotiation of an insurance policy by the insured will be deemed material or defeat or void the policy or prevent its attaching unless the misrepresentation or warranty is made with actual intent to deceive or unless the matter increased the risk of loss.

2.) Misrepresentations, false advertising of insurance policies, and unfair or deceptive acts or practices No insurer or producer may make, issue, circulate, or cause to be made, issued, or circulated any estimate, illustration, circular, statement, or advertisement that:

- misrepresents the benefits, advantages, conditions, or terms of any insurance policy;
- misrepresents the dividends or shares of the surplus to be received or previously paid on any insurance policy;
- misleads or misrepresents the financial condition of any person or the legal reserve system upon which any life insurer operates;
- uses any name or title of any insurance policy or class of insurance policies misrepresenting their true nature;
- misrepresents for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy;
- misrepresents for the purpose of effecting a pledge, assignment of, or loan against any insurance policy; or
- misrepresents any insurance policy as being shares of stock.

3.) Misrepresentation in insurance applications No one may make false or fraudulent statements or representations on an application for an insurance policy for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, producer, or individual.

b. False advertising [175:181; 176D:3(1), (2)] **False advertising** is defined as disseminating a statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading. The rules and regulations concerning advertising of insurance policies assure that the advertising is truthful and not misleading. The regulations adhere to the following principles:

1.) Words, phrases, or illustrations may not be used to mislead or deceive as to the extent of any policy benefit, loss covered, or premium. An advertisement must be complete and clear so as to avoid deception.

2.) When an advertisement refers to any dollar amount, period of time for which any benefit is paid, cost of policy, or specific policy benefit or the loss for which such benefit is payable, it must also disclose any exceptions, reductions, and limitations affecting the basic provisions of the policy.

3.) An advertisement that refers to the right to renew, cancel, or terminate a policy; that refers to a policy benefit; or that states or illustrates time or age in connection with the eligibility of applicants or the right to continue a policy must disclose the provisions relating to the right to renew, cancel, and terminate the policy. The advertisement also must disclose any modification of benefits, losses covered, or premiums because of age or for other reasons, in such a manner as not to minimize or obscure the qualifying conditions.

4.) All information required to be disclosed must be set out conspicuously and in close conjunction with the statements to which such information relates or under appropriate and prominent captions so that the information will not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the advertisements so as to be confusing or misleading.

5.) Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised, and be accurately reproduced. The insurer, in using a testimonial, is responsible for all the statements contained in the advertisement.

6.) An advertisement referring to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to an insurer or policy may not be used unless it accurately reflects all of the relevant facts. Such an advertisement may not imply that such statistics are derived from the policy advertised unless that is the fact.

7.) When a choice of benefits is referred to, an advertisement must disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits.

8.) When an advertisement refers to various benefits that may be contained in two or more policies, other than group master policies, the advertise-

ment must disclose that such benefits are provided only through a combination of policies.

9.) An advertisement must not make unfair or incomplete comparisons of policies or benefits or falsely disparage competitors, their policies, services, or business methods.

10.) The identity of the insurer must be made clear in all of its advertisements. An advertisement may not use a trade name, service mark, slogan, symbol, or other device that has the capacity to mislead or deceive as to the true identity of the insurer.

11.) An advertisement of a particular policy may not state or imply that prospective policyholders become group or quasi-group members and, as such, enjoy special rates or underwriting privileges, unless that is the fact.

c. Defamation of insurer [175D:3(3)] **Defamation** is defined as making, publishing, disseminating, or circulating, directly or indirectly, aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature that is false, or maliciously critical of or derogatory to the financial condition of any person, and that is calculated to injure such person.

d. Boycott, coercion, and intimidation [176D:3(4), 3A] **Boycott, coercion, and intimidation** are defined as entering into any agreement to commit, or by concerted action committing, an act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

1.) The following are unfair methods of competition and unfair or deceptive acts or practices in the business of insurance by entities organized as insurance companies, nonprofit health service corporations, medical service corporations, HMOs, or PPOs:

- Refusing to enter into a contract with a health care facility on the basis of the facility's religious affiliation
- Seeking to set the price to be paid to any health care facility by reference to the lowest price paid that provider under contract with any other nonprofit hospital service corporation, medical service corporation, insurance company, health maintenance organization, or preferred provider arrangement
- Refusing to contract or affiliate with a health care facility solely because the facility does not provide a specific service or range of services
- Refusing to enter into a contract with a health care facility solely on the basis of the facility's governmental affiliation

e. False financial statements [176D:3(5)] **False financial statements** are defined by law as:

- knowingly causing or filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating, or delivering to any person, or placing before the public any false material statement of fact as to the financial condition of a person; or
- knowingly making any false entry of a material fact in any book, report, or statement of any person or knowingly omitting to make a true entry of any material fact pertaining to the business of such person in any book, report, or statement of such person.

f. Failure to maintain complaint record [176D:3(10)] Failure to maintain **complaint handling procedures** is defined as failure of any person to maintain a complete record of all of the complaints received since the date of its last examination. The record must indicate in form and detail as the Commissioner may prescribe the total number of complaints; their classification by line of insurance; and the nature, disposition, and time of processing of each complaint. For purposes of this subsection, **complaint** means any written communication primarily expressing a grievance. Producers and adjusters must maintain any written communications received by them that express a grievance for a period of two years from receipt, with a record of their disposition, that must be available for examination by the Commissioner at any time.

g. Unfair discrimination [176D:3(7)] **Unfair discrimination** is defined as:

- making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for life insurance or life annuity or in the dividends or other benefits paid, or in any other of the terms and conditions of a contract; or
- making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any accident or health insurance policy or in the benefits paid or in any of the terms or conditions of the contract.

h. Unfair claims settlement practices [176D:3(9)] An unfair claim settlement practice consists of any of the following acts or omissions:

- Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue
- Failing to acknowledge and act reasonably and promptly upon communications with respect to claims arising under insurance policies
- Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance contracts
- Refusing to pay claims without conducting a reasonable investigation based upon all available information
- Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed
- Failing to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear

- Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by insureds
- Attempting to settle a claim for less than the amount to which a reasonable person would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application
- Attempting to settle claims on the basis of an application that was altered without notice, knowledge, or consent of the insured
- Making claim payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage for which payments are being made
- Making known to insureds or claimants a policy of appealing arbitration awards made in favor of insureds or claimants, for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration
- Delaying the investigation or payment of claims by requiring that an insured or claimant, or the physician of either, submit a preliminary claim report and then requiring the subsequent submission of former proof of loss forms, both of which contain substantially the same information
- Failing to settle claims promptly, where liability has become reasonably clear under one portion of the insurance policy, to influence settlements under other portions of the insurance policy coverage
- Failing to promptly provide a reasonable explanation of the basis in the insurance policy with relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement

i. Rebating (splitting commissions with insureds) [175:182–184; 176D:3(8)] No company, officer, or insurance producer may pay or allow, in connection with placing or negotiating any insurance policy or its renewal, any valuable consideration or inducement not specified in the policy or contract, or any special favor or advantage in dividends or other benefits, or may give, sell, or purchase anything of value not specified in the policy.

No person may receive or accept from any company, officer, agent, insurance broker, or other person any rebate of premium paid or payable, special favor or advantage in the dividends or other benefits, or valuable consideration or inducement not specified in the policy or contract.

1.) The following practices are not considered rebating:

- For life insurance policies or annuities, paying bonuses to policyholders or otherwise abating their premiums out of surplus accumulated from nonparticipating insurance, as long as any bonuses or abatements are fair and equitable to policyholders and for the best interests of the company and its policyholders
- For life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously made premium payments directly to an office of the insurer in an amount that fairly represents the saving in collection expenses
- Readjusting the premium rate of a group insurance policy based on the loss or expense experienced under the policy during the policy year

j. Insurance fraud regulation [175:170, 181; 176D.3] A person commits an offense if he, knowingly and with the intent to defraud, does any of the following:

- Files or causes to be filed with the state or local government agency a document that contains false, incomplete, or misleading information concerning any fact or thing material to the agency's determination in approving an insurance rate filing, transaction, or other insurance action that is filed in response to an agency's request
- Presents or causes to be presented to any insurer or self-insured any statement forming a part of a claim that contains any false, incomplete, or misleading information concerning any fact or thing material to the claim
- Assists, abets, solicits, or conspires with another to prepare any statement that is intended to be presented to any insurer or self-insured in connection with a claim that contains false, incomplete, or misleading information concerning any fact material to the claim, including information that documents or supports an amount in excess of the actual loss
- Knowingly benefits from the proceeds derived from a violation of this section due to the assistance, conspiracy, or urging of any person
- Is the owner, administrator, or employee of any health care facility who knowingly allows the use of the facility by any person to further a scheme or conspiracy to violate any of the provisions of this section
- Borrows or uses another person's financial responsibility or other insurance identification card or permits his identification card to be used by another person knowingly and with intent to present a fraudulent claim to an insurer.

A hearing will be held within 21 days of notice. Any person found by court to have violated any provision of this section is subject to civil penalties. Punitive damages up to 25% of the claim may be ordered as well.

5. Insurance information and privacy protection [175I]

a. Scope of provisions [175I:1] These rules apply to any insurance institution, insurance representative, or insurance-support organization that collects, receives, or maintains information in connection with an insurance transaction involving life, health, and disability insurance that pertains to a resident of Massachusetts, or that engages in an insurance transaction involving life, health, and disability insurance with an applicant, individual, or policyholder who is a resident of Massachusetts.

b. Definitions [175I:2]

1.) Adverse underwriting decision Any of the following actions in connection with insurance that is individually underwritten are considered adverse underwriting decisions:

- Declination or termination of coverage
- Failure of an insurance representative to apply for coverage with a specific insurance institution represented by the insurance representative as requested by an applicant

- For life, health, or disability coverage, an offer to insure at higher than standard rates

The following actions are not considered adverse underwriting decisions:

- Termination of an individual policy form on a class or statewide basis
- Declination of coverage solely because the coverage is not available on a class or statewide basis
- Rescission of a policy

2.) Consumer report A written, oral, or other communication of information bearing on a person's creditworthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living that is used in connection with an insurance transaction.

3.) Investigative consumer report A consumer report in which information about a person's character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with the person's neighbors, friends, associates, acquaintances, or others who may be able to provide this information. The report may not contain any information designed to determine the sexual orientation of any person or contain information relating to counseling for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC).

4.) Pretext interview A **pretext interview** is an interview by a person who attempts to obtain information about a person and who:

- pretends to be someone he is not;
- pretends to represent a person he does not represent;
- misrepresents the true purpose of the interview; or
- refuses to identify himself upon request.

c. Pretext interviews [175I:3] An insurance institution, insurance representative, or insurance-support organization generally may not use pretext interviews to obtain information in connection with an insurance transaction. Pretext interviews may be used for purposes of investigating a claim when there is a reasonable basis for suspecting criminal activity, fraud, or material misrepresentation in connection with the claim.

d. Notice of insurance information practices [175I:4] An insurance institution or representative must provide a notice of information practices to all applicants or policyholders in connection with insurance transactions.

1.) For applications for insurance, notice must be provided no later than at the time the application is made. For policy renewals, notice must be provided no later than the policy renewal date. Notice is not required when personal information is collected only from the policyholder or from public records or if notice has been given within the previous 24 months.

2.) For policy reinstatements or changes in benefits, notice must be provided no later than the time the request for reinstatement or change is received by the insurance institution. Notice is not required if personal information is collected only from the policyholder or from public records.

3.) The notice must be written and contain the following information:

- Whether personal information may be collected from persons other than the individual
- The types of personal information that may be collected and the source and investigative technique that may be used to collect this information
- The types of disclosure permitted by these rules and the circumstances under which disclosure may be made without prior authorization (only required for circumstances that occur frequently enough to be considered a general business practice)
- Description of the rights regarding individual access to recorded personal information, correction of recorded personal information and reasons for adverse underwriting decisions, and the manner in which these rights may be exercised
- That information obtained from a report prepared by an insurance-support organization may be retained by that organization and disclosed to other persons

4.) Instead of the prescribed notice, the insurance institution or representative may provide an abbreviated notice informing the applicant or policyholder that the more detailed notice will be furnished upon request.

e. Information disclosure authorization forms [175I:6] Forms that authorize the disclosure of personal or privileged information about an individual to an insurance institution, insurance representative, or insurance-support organization must:

- be written in plain language and dated;
- specify who is authorized to disclose information, the nature of the information to be disclosed, and the purpose for which information is collected;
- identify the insurance institution or insurance representative to whom the individual is authorizing information to be disclosed; and
- advise the individual that he is entitled to receive a copy of the authorization form.

1.) An authorization form must also specify the length of time the authorization is valid, which may be no longer than:

- 30 months for authorizations to collect information in connection with an insurance application, policy reinstatement, or change in benefits;
- the term of the policy for authorizations to collect information in connection with claims for health insurance benefits; or
- the duration of the claim for authorizations to collect information in connection with claims that are not related to health insurance benefits.

f. Investigative consumer reports—rights of individuals [175I:7] No insurance institution, insurance representative, or insurance support organization may prepare or request an investigative consumer report about an individual in connection with an insurance transaction unless the individual is informed that he may ask to be interviewed in connection with the preparation of the report and that he is entitled to receive a copy of the report.

1.) An investigative consumer report may not contain any information designed to determine a person's sexual orientation or information relating to counseling for AIDS or ARC.

g. Individual access to recorded personal information [175I:8] An insurance institution, insurance representative, or insurance-support organization must make any personal information collected or maintained in connection with an insurance transaction in its possession or control available to the individual.

1.) If an individual submits a written request for access to recorded personal information that is reasonably described by the individual and reasonably locatable and retrievable, the insurance institution, representative, or insurance-support organization must do one of the following within 30 business days from the date the request is received:

- Provide the individual with a copy of the recorded personal information or inform the individual of the nature and substance of the information in writing
- Allow the individual to see and copy the information or obtain a copy of the information by mail
- Disclose the identity, if recorded, of any person to whom the information has been disclosed within the two years prior to the request. If the identity is not recorded, the names of insurance institutions, insurance representatives, insurance-support organizations, or other persons to whom the information is normally disclosed must be given.
- Provide the individual with a summary of the procedures by which he may request correction, amendment, or deletion of recorded personal information

h. Correction of recorded personal information [175I:9] An individual has a right to have any factual error, misrepresentation, or misleading entry in his recorded personal information corrected.

1.) If the individual submits a written request for information to be corrected, the insurance institution, representative, or insurance-support organization has 30 days to either make the correction or reinvestigate the disputed information and notify the individual of:

- its refusal to make the correction and the reason for the refusal; and
- the individual's right to file a statement and request review by the Commissioner.

2.) If the individual disagrees with a refusal to correct recorded personal information, he may file a statement with the insurance institution, insurance

representative, or insurance-support organization that explains what he believes is the correct information and why he disagrees with the refusal to correct the information. This statement must be included whenever the individual's personal information is disclosed.

i. Reasons for adverse underwriting decisions [175I:10] In the event of an adverse underwriting decision, the insurance institution or insurance representative responsible for the decision must either provide the specific reason for the decision in writing to the affected individual or advise the individual that this information will be provided if requested in writing within 90 days. (If an adverse underwriting decision results solely from an oral request, any explanation of the reasons may be given orally.)

1.) If the individual makes a written request for this information, the following information must be provided within 21 business days:

- Specific reason for the decision
- Specific items of personal and privileged information that support the decision
- Name and address of the source that supplied the information

j. Basis for adverse underwriting decisions [175I:12] An adverse underwriting decision may not be based on:

- a previous adverse underwriting decision;
- the fact that the individual has previously obtained insurance coverage through a residual market mechanism;
- personal information received from an insurance-support organization whose primary source of information is insurance institutions; or
- sexual orientation.

k. Limitations on disclosure of recorded personal information [175I:13] An insurance institution, representative, or insurance-support organization may disclose personal or privileged information about an individual collected or received in connection with an insurance transaction only if the individual authorizes the disclosure in writing and the disclosure falls into one of the categories specifically authorized by law. Some examples of authorized disclosures include those that are:

- reasonably necessary to determine an individual's eligibility for an insurance benefit or to detect or prevent criminal activity, fraud, or material misrepresentation in connection with an insurance transaction;
- made to a medical-care institution or medical professional for the purpose of verifying insurance coverage or benefits;
- made to an insurance regulatory authority;
- made in response to law enforcement, or a valid administrative or judicial order, including a search warrant or subpoena;
- made to a person whose only use of the information will be in connection with the marketing of a product or service;

- made to a group policyholder for the purpose of reporting claims experience or conducting an audit of the insurance institution's or insurance representative's operations or services; or
- made to a governmental authority for the purpose of determining the individual's eligibility for public health benefits.

l. Enforcement by Commissioner [175I:14-18] If the Commissioner finds after a hearing that a violation of these rules has occurred, the Commissioner will issue a cease and desist order. If the violation was intentional, the Commissioner may also impose a fine of up to $1,000 for each violation. The maximum fine is $10,000 for an insurance representative and $50,000 for an insurance institution or insurance support organization.

1.) Violating a cease and desist order is punishable by one or more of the following:

- A fine of up to $10,000 for each violation
- A fine of up to $50,000 if the violation has occurred with such frequency as to constitute a general business practice
- License suspension or revocation

m. Remedies available to individuals [175I:20] Any person whose rights are violated under this chapter may apply to a court of competent jurisdiction for appropriate equitable relief.

1.) An insurance institution, representative, or insurance-support organization that illegally discloses information is liable for special and compensatory damages sustained by the individual whose information was disclosed. The court may also award the cost of the action and reasonable attorney's fees to the prevailing party.

2.) An action under this section must be brought within two years from the date the alleged violation is or should have been discovered.

n. Obtaining information under false pretenses [175I:22] Any person who knowingly and willfully obtains information about an individual from an insurance institution, insurance representative, or insurance-support organization under false pretenses will be fined up to $10,000, imprisoned for up to one year, or both.

6. Life and Health Insurance Guaranty Association law [175:146B] To provide protection for policyowners, insureds, beneficiaries, annuitants, payees, and assignees against the financial impairment of an insurer, the Life and Health Insurance Guaranty Association was created. Any insurer admitted to do business in this state must be a member. Member companies are assessed to provide funds. The yearly total of all assessments upon a member may not exceed 2% of the insurer's average premiums received during the three preceding calendar years. The association is governed by a board consisting of between five and nine directors. The association's obligations may not exceed $300,000 in death benefits or $100,000 in cash values, annuity values,

or health benefits. The limit is $300,000 for all types of benefits for any one person combined. No company or producer may advertise, as an inducement for an individual to purchase insurance, the fact that the company is a member of the association.

G. FEDERAL REGULATION

1. **Fair Credit Reporting Act [15 USC 1681–1681d]** According to federal regulations regarding life insurance transactions, each insurer and its producers are obligated to satisfy the terms of the federal Fair Credit Reporting Act with regard to information obtained concerning the applicant from a third party.

   a. The Fair Credit Reporting Act states that when an applicant is denied coverage because of information obtained from a third-party source, the applicant will be informed of the source.

   b. The insurer is also obligated to allow an applicant to refute any adverse information.

   c. Insurance companies may use consumer reports, or investigative consumer reports, to compile additional information regarding the applicant.

   d. If the applicant feels that the information compiled by the consumer inspection service is inaccurate, he may send a brief statement to the reporting agency with the correct information.

   e. A notice to the applicant must be issued to all applicants for life insurance coverage. This notice informs the life insurance applicant that a credit report will be obtained concerning his past history and any other life insurance he has previously applied for. The producer must leave this notice with the applicant along with the receipt.

2. **Fraud and false statements [18 USC 1033, 1034]** Specifically, the Violent Crime Control Law Enforcement Act provides that a person convicted of a felony involving breach of trust, dishonesty, or insurance crimes as defined in 18 USC 1033 is prohibited from engaging in insurance activities unless written consent is granted by the Commissioner of Insurance. Any individual who has been convicted of a felony who desires a license to engage in insurance transactions may seek an exemption from the federal prohibition of engaging in insurance activities by filing an application for licensure with the Commissioner of Insurance.

   a. Section 1033 is captioned "Crimes by and Affecting Persons Engaged in the Business of Insurance Whose Activities Affect Interstate Commerce." The section describes certain activities as crimes if they are carried out by individuals engaged in the business of insurance and whose activities affect interstate commerce. Prohibited activities include:

   - knowingly, with the intent to deceive, making any false material statement or report or willfully and materially overvaluing any land, property, or security in connection with any financial reports or documents presented to any insurance regulatory official or agency for the purpose of influencing the actions of that official or agency;

- willfully embezzling, abstracting, or misappropriating any of the monies, funds, premiums, credits, or other property of any person engaged in the business of insurance;
- knowingly making any false entry of material fact in any book, report, or statement of the person engaged in the business of insurance with the intent to deceive any person about the financial condition or solvency of such business;
- by threats of force or by any threatening letter or communication corruptly influencing, obstructing, or impeding the proper administration of the law under which any proceeding is pending before any insurance regulatory official or agency; and
- willfully engaging in the business of insurance whose activities affect interstate commerce if the individual has been convicted of a criminal felony involving dishonesty or a breach of trust or has been convicted of an offense under Section 1033.

1.) Punishments for engaging in the prohibited activities specified range from a maximum of 1–15 years of imprisonment plus fines established under Title 18. Under certain provisions, penalties may be more severe if the activity jeopardized the safety and soundness of an insurer and was a significant cause of an insurer being placed into conservation, rehabilitation, or liquidation.

b. Section 1034 is captioned "Civil Penalties and Injunctions for Violations of Section 1033." The section allows the US attorney general to bring civil actions against a person who engages in conduct constituting an offense under Section 1033. If found to have committed the offense, the person is subject to a civil penalty of not more than $50,000 for each violation or the amount of compensation the person received or offered for the prohibited conduct, whichever is greater.

1.) If the offense contributed to the decision of a court issuing an order directing the conservation, rehabilitation, or liquidation of an insurer, the penalty is remitted to the appropriate regulatory official for the benefit of the troubled insurer's estate.

2.) Imposition of a civil penalty under Section 1034 does not preclude any other criminal or civil statutory, common law, or administrative remedy available by law to the United States or any other person.

3.) The section also permits the attorney general to seek an order (injunction) prohibiting persons from engaging in any illegal conduct.

II. MASSACHUSETTS LAW AND REGULATIONS PERTINENT TO LIFE INSURANCE ONLY

A. LIFE SETTLEMENT ACT [175:212, 213E] Viatical and life settlements involve third party sales of existing life insurance policies. With the assistance of a settlement broker (who represents the current owner) a policyowner sells a life insurance policy for cash, giving up all rights—also known as an absolute assignment. The settlement provider becomes the new policyowner and beneficiary and is responsible for any premium payments that come due. Upon the insured's death, the settlement provider recoups its investment and would owe tax on net profits.

1. Definitions

a. Life settlement broker A person who, on behalf of an owner and for a fee, commission, or other consideration, offers or attempts to negotiate a life settlement contract between an owner and a life settlement provider.

b. Owner The owner of a life insurance policy or a certificate holder under a group policy who enters or seeks to enter into a life settlement contract.

c. Premium finance loan A loan made for the purpose of making premium payments on a life insurance policy with the loan secured by an interest in the life insurance policy.

d. Terminal illness For viatical settlements, a licensed health care professional must certify that the insured has a condition expected to result in death in 24 months or less.

e. Life settlement provider This is the person or party who enters into a life settlement contract with the policyowner. Provider does not include:

- a bank, savings bank, savings and loan association, or credit union;
- a licensed lending institution, creditor, or secured party in a premium finance loan agreement using the policy as collateral for a loan;
- accelerated death benefits;
- a financing entity;
- purchaser; or
- an accredited investor or institutional buyer who purchases a life settlement policy from a life settlement provider.

f. Life settlement contract This is a written agreement entered into between a life settlement provider and an owner, establishing terms and compensation in return for the owner's assignment, sale, or bequest of some or all the death benefit for compensation today. The minimum value for a life settlement contract is greater than the cash surrender value or accelerated death benefit available at the time.

1.) A "life settlement contract" does not include:

- a policy loan by a life insurance company pursuant to the terms of the policy or accelerated death provisions contained in the policy, whether issued with the original policy or as a rider;
- a collateral assignment of a life insurance policy by an owner;
- key person insurance or business succession arrangements; or
- an agreement where all parties
  - — are closely related to the insured by blood or law,
  - — have a lawful substantial economic interest in the continued life, health and bodily safety of the person insured, or
  - — are trusts established primarily for the benefit of the parties.

g. Stranger-originated life insurance (STOLI) An illegal arrangement to initiate the issue of a life insurance policy for the benefit of a third-party investor who, at the time of policy origination, has no insurable interest in the life of the insured. In these arrangements, there is generally an understanding that the owner will later transfer ownership or policy benefits to the third party. Stranger-originated life transactions include trusts that are created to give the appearance of insurable interest and that are used to initiate policies for investors. Not only does this violate insurable interest laws but also the prohibition against wagering on life.

2. Fraudulent Life Settlement Act [175:223A] No one may commit a fraudulent life settlement. No one may knowingly, and with an intent to defraud, act with the purpose of depriving another of property or for pecuniary gain. This includes, but is not limited to, the following:

- Concealing or providing false material information during solicitation, the application, underwriting, servicing, or claims process of life settlement contracts and life insurance
- Concealing or providing false information about life settlement activity and financials to the Commissioner
- Making statements or advertising that would cause an owner to reasonably believe that the insurance is free for any period of time
- Engaging in stranger-originated life insurance

3. Disclosure to customers [175:220] The owner in a life settlement legally sells all of his rights to the provider. The owner's family and business beneficiaries will be changed and cut out. It is vital that practical and financial consequences of this transaction are communicated to and analyzed by the owner before consenting.

a. Provider disclosures to the owner Not later than the date of application, the provider shall provide to the owner, in a separate document signed by the owner, the following information:

- That possible alternatives to life settlement contracts exist including, but not limited to, accelerated benefits offered by the issuer of the life insurance policy

- That a life settlement broker exclusively represents the owner and not the insurer, the life settlement provider, or any other person, and that the broker owes a fiduciary duty to the owner, including a duty to act according to the owner's instructions and in the best interest of the owner
- That some or all of the proceeds of a life settlement contract may be taxable and that assistance should be sought from a professional tax advisor
- That the proceeds from a life settlement contract may be subject to the claims of creditors
- That receipt of proceeds from a life settlement contract may adversely affect the recipients' eligibility for public assistance or other government benefits and that advice should be obtained from the appropriate agencies
- That the owner has a right to rescind or terminate a life settlement contract not more than 15 days after the date it is executed by all parties
- That the owner has received the disclosures required, Buyer's Guides, and fraud warning statements
- Affiliations between the provider, insurer, and broker and amount of any compensation paid to the life settlement broker(s)
- The statement: ALL MEDICAL, FINANCIAL OR PERSONAL INFORMATION SOLICITED OR OBTAINED BY A LIFE SETTLEMENT PROVIDER OR LIFE SETTLEMENT BROKER ABOUT AN INSURED, INCLUDING THE INSURED'S IDENTITY OR THE IDENTITY OF THE INSURED'S FAMILY MEMBERS, A SPOUSE, OR A SIGNIFICANT OTHER, MAY BE DISCLOSED AS NECESSARY TO EFFECT THE LIFE SETTLEMENT CONTRACT BETWEEN THE OWNER AND THE LIFE SETTLEMENT PROVIDER. IF YOU ARE ASKED TO PROVIDE THIS INFORMATION, YOU WILL BE ASKED TO CONSENT TO THE DISCLOSURE. THE INFORMATION MAY BE PROVIDED TO SOMEONE WHO BUYS THE POLICY OR PROVIDES FUNDS FOR THE PURCHASE. YOU MAY BE ASKED TO RENEW YOUR PERMISSION TO SHARE INFORMATION EVERY TWO YEARS.
- The date by which the funds will be available to the owner and the transmitter of the funds
- Proceeds will be sent to the owner within three business days after the life settlement provider has received the insurer's acknowledgement that ownership of the policy has been transferred and the beneficiary has been designated in accordance with the terms of the life settlement contract
- That the insured may be contacted by either the life settlement provider, broker, or its authorized representative for the purpose of determining the insured's health status or to verify the insured's address, provided, however, that this contact is limited to once every three months if the insured has a life expectancy of more than one year and not more than once per month if the insured has a life expectancy of one year or less
- Names and contact information of all parties, including the independent third-party escrow agent

b. Broker disclosures to the owner and life settlement provider A broker must provide the following disclosures no later than the date the settlement contract is signed by all parties. Disclosures should be conspicuously displayed either in the contract or in a separate document signed by the owner and provide the following information:

- The name, business address, and telephone number of the broker
- A complete, accurate description of all offers, counter offers, acceptances, and rejections relating to the proposed life settlement contract
- Any affiliations or contractual arrangements between the life settlement broker and any person making an offer
- The name of each life settlement broker involved who receives compensation and the amount
- A complete reconciliation of the gross offer or bid by the life settlement provider to the net amount of proceeds to be received by the owner
- That a failure to provide the disclosures or rights described shall be deemed an unfair trade practice

4. Provider requirements [175:222]

a. If the insured has a terminal or chronic illness or condition, and the owner is engaging in a life settlement, the provider must first obtain:

- if the owner is the insured, a written statement from a licensed attending physician that the owner is of sound mind; and
- a document in which the insured consents to the release of the insured's medical records to life settlement parties and, if the policy was issued less than two years from the date of application for a life settlement contract, to the insurance company that issued the policy.
  - All medical information is to be treated with confidentiality.

b. Within 20 days after an owner executes the life settlement contract, the life settlement provider shall give written notice to the original insurer that the policy has become subject to a life settlement contract.

c. Prior to or at the time of execution of the life settlement contract, the life settlement provider shall obtain a witnessed document in which the owner:

- consents to the life settlement contract;
- represents that the owner has a full and complete understanding of the life settlement contract and benefits of the policy;
- acknowledges that the owner is entering into the settlement contract freely and voluntarily; and
- for viatical settlements, acknowledges that the insured has a terminal or chronic illness or condition that was diagnosed after the policy was issued.

d. A life settlement contract shall provide that the owner may rescind the life settlement contract not more than 15 days after the date it was executed by all parties. Failure to give written notice of the right of rescission shall toll the right of rescission until 30 days after the written notice of the right of rescission has been given.

B. REGULATION OF VARIABLE PRODUCTS [SEC, FINRA AND MA REG. 95.03] More detail on variable products follows. Insurers issuing variable life insurance policies must establish one or more **separate accounts** to fund these policies. Assets must be maintained in each separate account that are at least equal in value to the valuation reserves for the variable portion of the policies or the benefit base for those policies, whichever is greater. The separate account must have sufficient net investment income and readily marketable assets to meet anticipated withdrawals under policies funded by the accounts.

1. **Valuation** The assets in a separate account must be valued at least once per month or as often as variable benefits are determined.

2. **Employees handling separate account assets** No insurer may knowingly contract with or employ any person in any material connection with the handling of separate account assets without the prior written approval of the Commissioner if that person has, within the last 10 years:
   - been convicted of any felony or a misdemeanor arising out of embezzlement, fraudulent conversion, or misappropriation of funds or securities;
   - been found by any state regulatory authority to have violated any provisions of any state insurance law involving fraud, deceit, or knowing misrepresentation; or
   - been found by federal or state regulatory authorities to have violated any provision of federal or state securities laws involving fraud, deceit, or knowing misrepresentation.

3. **Bonds** All persons with access to the cash, securities, or other assets of the separate account must be bonded for at least $100,000.

C. SOLICITATION AND SALES PRESENTATIONS [211 CMR 31.07] The following general rules apply to all sales presentations.

1. Each insurer must maintain at its home or principal office a complete file containing one copy of each form authorized for use in Massachusetts. This file must contain one copy of each authorized form for a period of three years following the date of its last authorized use.

2. A producer must inform the prospective purchaser, prior to commencing a life insurance sales presentation, that he is acting as a life insurance producer and inform the prospective purchaser of the full name of the insurance company that he is representing to the buyer. In sales situations in which a producer (such as direct sales) is not involved, the insurer must identify its full name.

3. Terms such as *financial planner*, *investment advisor*, *financial consultant*, or *financial counseling* may not be used in such a way as to imply that the insurance producer is generally engaged in an advisory business in which compensation is unrelated to sales unless that is actually the case.

4. Any reference to policy dividends must include a statement that dividends are not guaranteed.

5. The annual premium for a basic policy or rider, for which the company reserves the right to change the premium, must be the maximum annual premium.

D. ADVERTISING (176D:3) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

1. Misrepresentations and false advertising of insurance policies: making, issuing, or causing to be made, issued or circulated, any estimate, illustration, circular or statement which:

a. misrepresents the benefits, advantages, conditions, or terms of any insurance policy;

b. misrepresents the dividends or shares of surplus to be received on any insurance policy;

c. makes any false or misleading statements as to dividends, share, or surplus previously paid on any insurance policy;

d. misleads or misrepresents the financial condition of any person or the legal reserve system upon which any life insurer operates;

e. uses any name or title of any insurance policy or class of insurance policies misrepresenting their true nature;

f. misrepresents for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy;

g. misrepresents for the purpose of effecting a pledge, assignment, or loan against any insurance policy; or

h. misrepresents any insurance policy as being shares of stock.

E. POLICY SUMMARY [Reg. 31.04, 05] Insurers must provide a policy summary to prospective purchasers of policies that are not marketed with an **illustration,** which is a computer generated spreadsheet of policy premiums and value projections. The policy summary must consist of a separate document, be dated, and must show guarantees only.

1. The policy summary must be provided before the insurer accepts the applicant's initial premium. If the policy being applied for contains a **free-look period** of at least 10 days, however, the policy summary may be delivered with or before delivery of the policy.

2. Information that must be in the policy summary includes:

- the name and address of the insurance producer or, if no insurance producer is involved, a statement of the procedure for receiving responses to questions about the policy summary;
- the full name and office address of the insurer;
- the generic name of the basic policy and each rider; information about the premiums, death benefits, and cash values of the policy at certain prescribed intervals; and
- the effective interest rate on policy loans.

F. BUYER'S GUIDE [Reg. 31.05 (1)(A)] The insurer must provide a Buyer's Guide to all prospective purchasers before accepting the applicant's initial premium or premium deposit. If the policy being applied for contains a free-look period of at least 10 days, however, the Buyer's Guide may be delivered with or before delivery of the policy.

G. LIFE INSURANCE POLICY COST COMPARISON METHODS [Reg. 31.04, 31.05] Cost indexes use one or more of these factors to provide a convenient way to compare relative costs of similar policies.

1. **Life insurance surrender cost index** This index is useful if the buyer considers the level of the cash values to be of primary importance. It helps compare costs if at some future point in time, such as 10 or 20 years, the insured were to "surrender" the policy and take its cash value.

2. **Life insurance net payment cost index** This index is useful if the main concern is benefits that are to be paid at death and if the level of cash values is of secondary importance. It helps the applicant compare costs at some future point in time, such as 10 or 20 years, if they continue paying premiums on the policy and do not take its cash value.

3. The most important thing when using cost indices is that a policy with a small index number is generally a better buy than a comparable policy with a larger index number. The following rules are also important:

   a. Cost comparisons should only be made between similar plans of life insurance. Similar plans are those that provide essentially the same basic benefits and require premium payments for approximately the same period of time.

   b. Compare index numbers only for the kind of policy, for the insured's age, and for the amount an insured intends to buy. Since no one company offers the lowest cost for all types of insurance at all ages and for all amounts of insurance, it is important that the buyer get the indices for the actual policy, age, and amount which he intends to buy.

   c. Small differences in index numbers could be offset by other policy features or differences in the quality of service the insured may expect from the company or its producer. Therefore, when an insured finds small differences in cost indices, his choice should be based on something other than cost.

   d. The policyowner should be sure he can afford the premiums and that he understands the policy's cash values, any dividends, and death benefits. A buyer should also make a judgment on how well the life insurance company or producer will provide service in the future.

   e. Life insurance cost indices apply to new policies and should not be used to determine whether an insured should drop a policy already owned in favor of a new one.

H. REPLACEMENT [Reg. 34.01–34.09] The purpose of Massachusetts law regarding replacement sales is to regulate the acts and practices of insurers with respect to new life insurance or annuities replacing existing life insurance or annuities. These laws protect the interest of the insurance buying public by establishing minimum standards of conduct to be observed when replacements occur. Replacement regulations reduce the opportunity for misrepresentation and incomplete comparisons, and producers transacting business more for their own gain than the consumer's.

1. Definition of replacement Any transaction where a new life insurance or annuity contract is to be purchased and it is known or should be known to the producer that any previously existing life insurance has been or is to be:

- lapsed or surrendered;
- converted into paid-up insurance;
- continued as extended term insurance, or under another form of nonforfeiture benefit;
- converted otherwise so as to effect a reduction either in the amount of the existing life insurance or annuity or in the period of time the existing life insurance or annuity will continue in force; or
- reissued with a reduction in an amount such that substantial cash values are released.

a. Exemptions Certain exemptions are present with respect to replacements. Replacement regulations generally do not apply:

- when an application for new life insurance is made to the same insurer (when the replacing insurer and the existing company are the same);
- to group life insurance or group annuities; or
- to credit life, annuities, or life insurance issued in connection with pension or profit-sharing plans.

b. Replacement disclosure notice When a replacement occurs, the producer is required to provide the insured with a disclosure notice, in a form approved by the Commissioner, for each policy. This notice must be signed by the producer and policyholder, and its purpose is to provide the policyholder with pertinent information regarding replacements.

1.) The notice contains a statement encouraging the applicant to request from the existing and replacing insurers policy yield index figures for 5, 10, and 20 years. The yield index is a percentage that represents an estimate of the interest rate the insurer projects will be earned on the savings portion of the cash value policy (the policy with the higher yield index will generally be considered the better buy).

c. Duties of producers Life insurance producers have specific responsibilities when a replacement is present. Each producer must:

- obtain with or as part of each application a statement signed by the applicant as to whether the new insurance will replace existing life insurance or an annuity;

- submit to the insurer in connection with each application for life insurance or annuity a statement as to whether, to the best of the producer's knowledge, replacement is involved in the transaction;
- where a replacement is involved, present to the applicant, not later than at the time of taking the application, a replacement disclosure notice, signed by the producer and the applicant; and
- submit with the application to the insurer a copy of the proposal or sales material used, the completed replacement disclosure notice, and the name of each insurer (and policy numbers, if any) that issued any insurance being replaced; the applicant must also acknowledge receipt of the completed replacement disclosure notice (a copy of the proposal or sales material must also be left with the applicant).

d. Duties of insurers All companies have specific duties when replacement occurs.

1.) They must require with or as part of each application a list prepared by the producer representing, to the best of the producer's knowledge, all of the existing life insurance policies and/or annuities proposed to be replaced.

2.) They must obtain a copy of any proposal or sales material used, the completed replacement disclosure notice, and the names of each insurer whose insurance is being replaced.

3.) Within seven working days, they must send each existing insurer a written communication advising of the replacement together with the policy information included on the replacement disclosure notice, and a copy of the policy summary.

4.) The replacing insurer must provide a 20-day free-look provision in the policy issued during which the insured may obtain a full refund if the policy is returned within 20 days from the date of delivery.

5.) The company must maintain copies of the policy summary, ledger statements, and the completed replacement disclosure notice in its home office for at least three years.

e. Conservation This is the attempt by an existing insurer or its producer to dissuade a policyowner from replacing life insurance or an annuity with another policy. Conservation efforts do not include late payment reminders, late payment offers, or reinstatement offers. The existing insurer must, within 20 days from its receipt of notification from the replacing insurer, provide a policy summary for the existing life insurance to the insured.

f. *Miscellaneous* Notice of replacements are also required of direct response insurers—companies that do not use producers. It markets its product through the mail, advertisements, television, radio, and so on. Any violation of replacement regulations will be deemed to be an unfair trade practice.

g. Violations A violation of the replacement rules occurs if an agent, broker, or insurer recommends the replacement or conservation of an existing policy by using a substantially inaccurate or incomplete presentation or comparison of an existing contract's premiums and benefits or dividends and values, if any. Any comparison of a participating policy that does not include projected dividends based upon the most recent dividend scale applicable is considered to be a violation, except when the agent or company has made written request for that dividend information from the company that issued the participating policy and the information is not received within seven working days of the request.

1.) A pattern of action by a policy owner who purchases replacing policies from the same agent or broker, after indicating on applications that replacement is not involved, is evidence the agent or broker knew that replacement was intended and intended to violate these rules.

2.) A replacement that does not comply with the rules is considered to be an unfair method of competition and an unfair or deceptive practice in the business of insurance.

I. USE AND DISCLOSURE OF INSURANCE INFORMATION [Reg. 31.05]

Insurers must provide all prospective purchasers of life insurance with a buyer's guide before accepting the applicant's initial premium or premium deposit. In addition, where the insurer has identified the policy form as one that will not be marketed with an illustration, the producer must also provide a policy summary before accepting consideration. If the policy contains a free-look period of at least 10 days, the Buyer's Guide and policy summary may be delivered with, or prior to delivery of, the policy.

1. The purpose of this preliminary statement of policy cost and the buyer's guide is to provide information that will help the applicant decide how much life insurance he should buy, improve his ability to select the most appropriate plan of insurance for his needs, improve his understanding of the basic features of the policy that has been purchased or that is under consideration, and improve his ability to evaluate the relative costs of similar plans of insurance.

J. BACKDATING [175:130] Life insurance policies and endowment contracts may not be issued to take effect on a date more than six months prior to the date of the original written application if doing so would allow the applicant to be rated at a younger age. Annuity and pure endowment contracts may not be issued to take effect at an age higher than the age of the applicant at his nearest birthday at the time of the original written application.

K. INDIVIDUAL UNDERWRITING PRACTICES

1. Investigative consumer (inspection) report [175I:7]

a. An insurer may not request an investigative consumer report in connection with an insurance application, policy renewal, or policy reinstatement unless it informs the individual that he or she:

- may request to be interviewed in connection with the preparation of the investigative consumer report; and
- is entitled to a copy of the report.

b. An investigative consumer report may not contain any information designed to determine the sexual orientation of the applicant, proposed insured, policyholder, beneficiary or other person, or information about such persons relating to counseling for AIDS or AIDS-related complex.

2. Medical examinations and lab tests including HIV [Reg. 36.03] Regulations regarding the use of AIDS-related information for life and health insurance and informed consent have the following meanings:

a. AIDS-related information This is any information concerning an individual's diagnosis or treatment for AIDS or ARC, including HIV-related test information and other information relating to HIV. It includes AIDS-related test information reported to the MIB (Medical Information Bureau) or any other insurance support organization under any code. It does not include information not identifiable to any individual or information in the public domain.

b. AIDS-related test This is a test for exposure to HIV or any virus or agent believed to cause AIDS, including an HIV-related test, or any test intended to identify the presence or potential presence of the AIDS virus.

c. HIV-related test This is a test for exposure to HIV, including a test for the antibody or antigen to HIV, including ELISA and Western blot assays.

3. Discrimination prohibited [175:120] Life insurers and their agents may not unfairly discriminate between insureds of the same class and equal expectation of life in the rates charged for policies, the dividends or other benefits payable under those policies, or in any terms and conditions of the policy.

4. Discrimination based on genetic test or genetic information prohibited [175:120A–E]

a. Insurers, agents, and brokers authorized to issue life insurance policies on Massachusetts residents may not unfairly discriminate on the basis of the results of genetic tests or the provision of genetic information, nor may there be discrimination based on information that a proposed insured has been a victim of abuse. For purposes of this section, **unfair discrimination** means cancellation, refusing to issue or renew, charging increased rates, restricting the length of coverage, or practicing discrimination in any way unless the action is taken on the basis of reliable information relating to the insured's mortality or morbidity that is based on sound actuarial principles or actual or reasonably anticipated claim experience. For example, this rules out discrimination based solely on mental retardation or blindness.

b. Insurers, agents, and brokers authorized to issue life insurance policies on Massachusetts residents may not require an applicant to undergo a genetic test as a condition of the issuance or renewal of a policy. If the applicant chooses to submit genetic information, the insurer may use that information to set the terms of a policy if it is reliable information relating to the insured's mortality or morbidity that is based on sound actuarial principles or actual or reasonably anticipated experience.

L. POLICY PROVISIONS

1. **Assignability [175:134C]** Subject to the policy's terms relating to assignment of incidents of ownership, insureds under a group life insurance policy may assign any or all incidents of ownership granted under the policy, including, but not limited to, the right to designate a beneficiary, have an individual policy issued to the insured, and to pay premiums.

2. **Entire contract [175:132(3)]** Life insurance policies and annuities must contain an entire contract provision stating that the policy and the application constitute the entire contract between the parties. No statement made by the insured or on his behalf can be used in defense to a claim under the policy unless it is contained in a written application, and a copy of the application is endorsed or attached to the policy when issued.

3. **Right to examine: free-look period [175:187H; Reg. 34.06(1)(d)]** Individual life insurance policies with face amounts less than $25,000 must give the policyowner the option of cancelling the policy within 10 days of its delivery if he is not satisfied with the policy for any reason. Once the policy is returned, the policyowner must be given a full refund of any premiums paid, and the policy will be considered voided.

   a. In the event of a replacement, the insurer must provide in its policy or in a separate written notice (which is delivered with the policy) that the applicant has a right to an unconditional refund of all premiums paid, which right may be exercised within a period of 20 days from the date of policy delivery.

4. **Grace period [175:132(1)]** Life insurance policies must contain a 30-day grace period for the payment of any premium (after the first). The insurer may, at its option, charge up to 6% interest per annum for the number of days elapsing before the payment of the premium, during which period of grace the policy will continue in full force. If the insured dies during the grace period before any overdue premium is paid, the overdue premium plus interest may be subtracted from the policy settlement.

5. **Reinstatement [175:132(11)]** Individual life insurance policies must include a reinstatement provision stating that a policy can be reinstated at any time within three years from the date of premium default if the following are submitted to the insurer:
   - evidence of insurability;
   - repayment of any outstanding policy loan indebtedness; and
   - payment of all overdue premiums, plus any interest.

   This provision does not apply if the cash surrender value has been exhausted or the extension period has expired.

6. **Incontestability [175:132(2)]** Life insurance policies must contain an incontestability provision stating that the policy's validity cannot be contested (except for nonpayment of premiums or violating the policy's conditions relating to military or naval service in time of war) after two years from its issue date.

7. **Misstatement of age [175:132(4), (12)]** Life insurance policies must include a misstatement of age provision stating that if the insured's age was misstated on the application, any amount payable under the policy will be determined according to how much coverage the premium paid would have purchased for the correct age.

8. **Interest on insurance proceeds [175:119A, 119C]**

   a. The proceeds payable under an individual life insurance policy that is in force on the date of the insured's death must include the payment of interest at the rate for proceeds left on deposit with the insurer beginning 30 days after the death of the insured, and are not payable until the insurer receives proof of the insured's death. If the insurer does not pay interest on proceeds left on deposit with the insurer, the rate of interest will be 6%. If the beneficiary brings an action to enforce these payments and prevails, the court will award the amount of interest permitted by law for contract violations in lieu of any interest payment contained in this section.

   b. If the proceeds of an annuity or life insurance policy are retained by the insurer at maturity or otherwise, or if they are being paid out under a settlement option, no person entitled to any part of the proceeds or interest can commute, anticipate, encumber, alienate or assign the proceeds or interest, if such permission is expressly withheld by the terms of the contract or policy. That is, a beneficiary is protected against the claims of creditors.

9. **Accidental death benefits; waiver of premium [175:24; 144(7)(i)]** Life insurance companies may include accidental death benefit riders in their life, group life, or endowment contracts. They also may incorporate provisions for the waiver of premiums if the insured becomes totally and permanently disabled. These provisions must define the special benefits to be granted, the cost to the insured, and what constitutes total and permanent disability. The cost for the additional benefits must be stated separately in the policy or contract.

M. GROUP LIFE INSURANCE CONVERSION RIGHTS [175:134(4); 134A]

1. An individual whose coverage under a group employee life policy terminates because of termination of employment, termination of membership in the class eligible for coverage, or termination of coverage of the class of insured persons to which he belongs, is eligible to continue coverage under the policy for 31 days.

2. When this period expires, he is also entitled to be issued an individual policy without providing evidence of insurability if he applies for the policy and pays the required attained age premium within this 31-day period.

3. The amount of coverage to which the person is entitled is generally limited to the amount of coverage that ceases because of the termination. When coverage terminates because of the individual's termination of membership in the class eligible for coverage

or termination of coverage on the class to which the person belongs, however, individual coverage may be limited to the lesser of:

- the amount of coverage previously provided to the individual under the group plan, less any amount of life insurance for which he is become eligible within 31 days after the termination; or
- $2,000.

4. An individual insured under a group life policy who is entitled to convert to another type of life insurance within a certain time period after a qualifying event occurs must be notified of this privilege and the length of the time period within 15 days after that event occurs.

5. If notice is given within 15–90 days after the qualifying event, the time allowed to exercise the conversion privilege must be extended for 15 days after notice is provided. If notice is not given within 90 days, the time allowed to exercise the conversion privilege will expire after 90 days.

N. VARIABLE LIFE [211 CMR 95.00] Variable life insurance means any individual policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account(s) established and maintained by the insurer (discussed previously). The policyowner allocates premiums to the stock and bond markets, so she assumes risk rather than the insurer. Variable policy sales require additional producer licensing through the Securities Exchange Commission (SEC; FINRA licensing) and products must be sold with a prospectus.

- **Scheduled Premium Policy** means any variable life insurance policy under which both the amount and timing of premium payments are fixed by the insurer.
- **Flexible Premium Policy** means any variable life other than a scheduled premium policy.

1. Variable life insurers and their products must be approved and state their standards of suitability, which will be binding on the insurer, its producers, and any others involved in the promotion, sale, marketing, and advertising of the insurer's variable life insurance products. These standards should, at a minimum, specify that:
   - no recommendation may be made to an applicant to purchase a variable life insurance policy, and that no variable life insurance policy shall be issued, in the absence of reasonable grounds to believe that the policy is suitable for such applicant;
   - this suitability determination must be based on reasonable inquiry of the applicant concerning the applicant's insurance and investment objectives, financial situation, and needs, as well as any other information known to the insurer or to the insurance producer making the recommendation; and
   - no recommendation shall be made to an applicant to purchase a variable life insurance policy until the applicant has been provided with an accurate and comprehensive explanation of the product.

2. No material change in the investment policy of a separate account shall be made unless the insurer has given the Commissioner at least 60 days advance written notice.

3. Every variable life insurance policy delivered or issued for delivery in this state shall be subject to the following.

a. The mortality and expense risks must be borne by the insurer. The mortality and expense charges are subject to the maximums stated in the contract.

b. For scheduled premium policies, a minimum death benefit will be provided in an amount at least equal to the initial face amount of the policy so long as premiums are duly paid.

c. The policy benefits shall reflect the investment experience of one or more separate accounts established and maintained by the insurer.

d. Each variable life insurance policy must be credited with the full amount of the net investment return applied to the benefit base.

e. Any changes in variable death benefits of each variable life insurance policy shall be determined at least annually.

f. The cash value and cash surrender value of each variable life insurance policy will be determined at least monthly.

g. For scheduled premium policies, a provision for a grace period of not less than 31 days.

h. For flexible premium policies, a grace period of at least 61 days.

i. A provision for policy loans after the policy has been in force for three years which is not less favorable to the policyholder than the following:

- the loan value available shall be at least equal to 75% of the policy's cash surrender value; and
- the amount borrowed shall bear interest at a rate not to exceed the rate permitted by state insurance law.

4. The application for a variable life insurance policy shall contain:

- a prominent statement that the death benefit may be variable or fixed under specified conditions;
- a prominent statement that cash values may increase or decrease, even to the extent of being reduced to zero, in accordance with the experience of the separate account (subject to any specified minimum guarantees);
- for an application for a variable endowment policy, a prominent statement that the amount of the endowment payable at maturity is not guaranteed but is dependent upon the then cash surrender value and may in fact be reduced to zero (subject to any specified minimum guarantees);
- for flexible premium policies that do not have a guaranteed death benefit until the maturity date of the policy, a prominent statement explaining that the applicant could lose his entire investment depending on the performance of the fund, and that as a result there could be no death benefit absent additional payments made to keep the policy in force;

- questions designed to elicit sufficient information to enable the insurer or agent to determine the suitability of variable life insurance for the applicant;
- illustrations of benefits including death benefits and cash surrender values should not use projections of past investment experience into the future or attempt predictions of future investment experience but may use hypothetical assumed rates of return to illustrate possible levels of benefits if it is made clear that such assumed rates are hypothetical only, and are not predictions of actual future performance, and as long as one of the hypothetical assumed rates is 0% and assumes maximum guaranteed mortality and expense charges (at least one set of illustrations provided to the applicant must disclose all charges that would be levied against the contract, with a clear explanation of the nature and amount or those charges; the Commissioner may disapprove any illustration he or she deems to be misleading, inadequate, or incorrect);
- any other application provisions required for use in connection with general account life insurance policies.

5. Each variable life insurance policyholder must receive the following reports:

a. Within 60 days after each anniversary of the policy, a report of the cash surrender value, cash value, death benefit, any partial withdrawal, partial surrender or policy loan, any interest charge, and any optional payments allowed pursuant to 211 CMR 95.08 under the policy, computed as of the policy anniversary date; provided, however, that such statement may be furnished within 30 days after a specified date in each policy year so long as the information contained is computed as of a date of not more than 60 days prior to the mailing of such notice.

1.) For flexible premium policies, the report must contain a reconciliation of the changes since the previous report in cash value and cash surrender value, if different, because of payments made, withdrawals, investment experience, insurance charges and any other charges made against the cash value.

2.) Reports for flexible premium policies must also show the projected cash value and cash surrender value, as of one year from the end of the period covered by the report assuming that:

- planned periodic premiums, if any, are paid as scheduled;
- guaranteed costs of insurance are deducted; and
- the net return is equal to the guaranteed rate or, in the absence of a guaranteed rate, is not greater than zero. If the projected value is less than zero, a warning message must be included that states that the policy may be in danger of terminating without value in the next 12 months unless additional premium is paid.

b. Annually, a report including:

- a summary of the financial statement of each separate account;
- the net investment return of the separate account for the last year and a comparison with the investment rate during prior years, up to a total of not less than five years when available;

- a list of investments held by the separate account as of a date not earlier than the end of the last year;
- all annual charges levied against the separate account during the previous year; and
- a statement of any change, since the last report, in the investment objectives of the separate account.

O. EQUITY INDEXED PRODUCTS [BUL. 98-17] The purpose of this bulletin is to provide guidelines to assist insurers with filing individual indexed products.

1. Requirements for applications and policies The policy application for an individual indexed product must include a prominent acknowledgment that the applicant understands that he is applying for an indexed life or annuity product. This statement must also disclose that while the values of the policy may be affected by an external index, the policy does not directly participate in any stock or equity investments. It must include a statement of understanding that any values shown, other than guaranteed minimum values, are not guarantees, promises, or warranties. This disclosure statement must be printed in at least 10-point type and appear immediately before the signature line.

a. All policies must comply with the following requirements.

1.) They must contain a prominent notice on the cover page that describes the contract's involvement with an external index and states that while policy values may be affected by an external index, the policy does not directly participate in any stock or equity investments.

2.) They must define the death benefit provided by the policy and how the death of the policyholder affects the cash value and excess interest accumulation in the policy.

3.) They must disclose all available indexed periods, the date of expiration of the elected period, and what happens when an indexed period expires.

4.) If a policy is to be linked to an index for some specified period less than the time to the maturity date of the policy, the expiration date of that period and any minimum guaranteed rates applied thereafter must be specified.

5.) They must define the formula used to determine indexed credits and indexed value.

6.) They must provide for and describe the use of a substitute index in the event that the named index is discontinued.

7.) If premiums may be allocated to different accounts applicable to different portions of the policy value, the policy must describe the allocation of interest credits.

8.) They must disclose the minimum guaranteed rates that apply until the maturity date of the policy.

9.) They must define the policy's value upon surrender during an indexed term, at the end of the term, or at any time prior to maturity.

10.) They must disclose the guaranteed **participation rate** at issue and during the first indexed period. If the participation rate may be redetermined at any time during an indexed period or at the end of an indexed period, the policy must clearly disclose the minimum participation rate for all periods and the factors that would lead to a change in any participation rate.

11.) If the policy contains a **cap or floor** for the indexed benefits, the policy must clearly disclose any guaranteed cap or floor at issue and during the first indexed period. If the cap or floor may be redetermined during an indexed period or at the end of the guaranteed period, the policy must clearly describe the minimum cap or floor relative to the indexed benefits.

12.) They must disclose that in the event of insolvency of the issuing insurer, policyholders must look to the guaranty fund system in their state of residence.

b. Forms may not:

- use investment terms (e.g., *investment performance, investment returns, maximizing returns, Wall Street*) except with extreme care and with appropriate caveats;
- describe the indexing feature or formula as a means of participation in the stock market, the equity markets, or the S&P 500 or other index;
- provide a partial or complete list of the stocks or companies that constitute the index; or
- stress similarities to variable products, mutual funds, or other investment vehicles.

2. Advertising materials Filings must include all advertising materials, including any illustrations used in marketing the contract. These materials are subject to appropriate review. Language in marketing materials must be balanced and must disclose:

- that the policy does not directly participate in any stock or equity investments;
- that failure to maintain the policy to maturity may result in no participation in the equity index;
- the participation rate and its relation to the index, including an invitation to contract, the excess interest formula, any caps or floors on excess interest, surrender and other charges, and the guaranteed minimum rate of interest payable; and
- the death benefit provided by the policy and how the death of the policyholder affects cash value and excess interest accumulation in the policy.

P. NONFORFEITURE REQUIREMENTS FOR ANNUITIES [175:144A½] Annuity contracts issued in Massachusetts must contain a nonforfeiture provision that takes effect if the owner stops making payments or surrenders the contract.

1. A nonforfeiture provision must provide that if the owner stops paying into the contract, the company will grant a paid-up annuity.

2. If an annuity provides for a lump-sum settlement at maturity or any other time, the nonforfeiture provision may provide that if the contract is surrendered at or before the beginning of annuity payments, the company will pay a cash surrender benefit in lieu of a paid-up annuity benefit. The company may reserve the right to defer the payment of the cash surrender benefit for up to six months.

3. A deferred annuity contract may provide that if the owner has not paid into the contract for two full years and the paid-up annuity benefit would be less than $20 per month, the company may terminate the contract by paying the present value of the paid-up annuity benefit in cash.

Q. NONFORFEITURE REQUIREMENTS FOR LIFE INSURANCE [175:144; 175:144(7)(I), (IV)]

1. All policies must include a nonforfeiture provision, stating that in the event of any default in premium payment, the insured may elect in writing, within 60 days to:
   - surrender the policy and receive its cash surrender value (provided premiums have been paid for at least three years), or
   - take a specified paid-up nonforfeiture benefit on a plan stipulated in the policy or an actuarially equivalent alternative.

2. These additional benefits are not required to be granted in connection with any nonforfeiture benefits.
   - Accidental death or total and permanent disability benefit provisions included in a life insurance policy,
   - Term insurance on a child's life provided in a policy on the life of the child's parent, which expires before the child reaches age 26, if uniform in amount after age one, and has not become paid-up by reason of the parent's death

R. ACCELERATED BENEFIT PRODUCTS [Reg. 55.01-.07, 55.100, 110]

This refers to a provision or rider that reduces the otherwise payable death benefit in the event the insured becomes totally and permanently disabled. Death benefit is accelerated and released while the insured is still alive.

1. **Applicability [Reg. 55.02]** This regulation applies since 2005 to all life insurance with accelerated benefit provisions issued in Massachusetts and to annuity contracts with waivers of surrender charges.

2. **Definitions [Reg. 55.04]**

   a. **Chronic illness** A condition that, as certified by a licensed health care practitioner, has resulted in an individual:

- being unable to perform at least two **activities of daily living**, including eating, toileting, transferring, bathing, dressing, and continence, without substantial assistance from another individual for at least 90 days due to a loss of functional capacity;
- having a level of disability similar to the level of disability described in the previous paragraph; or
- requiring substantial supervision to protect from threats to health and safety due to severe cognitive impairment.

b. Qualified long-term care services Necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services that are required by a chronically ill individual and are provided under a plan of care prescribed by a licensed health care practitioner.

c. Special benefits Special benefits are benefits including, but not limited to:

- acceleration of the death benefit in life insurance policies;
- payments made over and above the accelerated benefit for expenses incurred for qualified long-term care services in policies providing benefits for chronic illness only; and
- waiver of the surrender charge for early withdrawal of annuity proceeds in annuity contracts.

d. Terminal illness A condition that a physician certifies will reasonably be expected to result in dramatically limited life span as specified in the contract, such as 24 months or less.

e. Total and permanent disability Any of the following conditions are considered total and permanent disability as specified in the policy:

- Terminal illness
- Chronic illness
- Medical condition that the insured's physician certifies has required or will require extraordinary medical intervention, without which the insured would have died or will die (examples include AIDS, major organ transplants, and end-stage kidney disease)

3. Minimum standards [Reg. 55.05]

a. Policies and annuities with accelerated benefit provisions may not contain any preexisting condition exclusions or contain an incontestability clause that has a different duration or effective date than the one contained in any total and permanent disability provision of the underlying contract.

b. A carrier may require that reasonable additional evidence be provided that the insured is totally and permanently disabled. **Reasonable additional evidence** means:

- additional certification at the carrier's expense by a physician or licensed health care practitioner;

- a finding by the Social Security Administration that the insured is entitled to disability benefits;
- a finding of eligibility for total and permanent disability by an Industrial Accident Board or similar agency under a workers' compensation system;
- a disability determination enabling an insured to make an early withdrawal from an individual retirement account (IRA) or similar instrument without penalty from the IRS; or
- any other evidence approved by the Commissioner.

c. The accelerated benefit provision for qualifying events due to accidental injury must begin on the effective date of the policy. For qualifying events that are not due to accidental injury, the provision must start no more than 30 days after the effective date of the policy unless the insured has chosen an elimination period or deductible amount for policies providing accelerated benefits for conditions for chronic illness only.

d. The policy or annuity contract must specify all possible payment options. A policyholder is not required to specify the option to exercise until the time of a qualifying event, except when the individual qualifies for benefits only because of chronic illness, or when the policy provides benefits only for chronic illness.

e. The carrier must give the policyholder the option to receive the full amount of the accelerated benefit or early withdrawal of the annuity proceeds as a lump sum, in addition to any other methods of payment offered. This does not apply when the individual qualifies for benefits because of chronic illness only, or in cases when the policy provides benefits for chronic illness only. In no event may the benefit be made available as an annuity contingent upon the life of the insured.

f. A carrier offering policies providing benefits for conditions of chronic illness only may also provide special benefits over and above the accelerated benefits or waiver of surrender charges to be payable for expenses incurred for qualified long-term care services.

g. No carrier may restrict the use of accelerated benefits or the early withdrawal of the annuity proceeds in any way, or attempt to recoup all or any portion of benefits paid out under an accelerated benefit product, except in contestable cases of material misrepresentation, fraud, or criminal misconduct.

h. In cases that the individual qualifies for benefits because of chronic illness only, the benefit amount will be payable only for expenses incurred for qualified long-term care services.

i. If a policyholder elects to accelerate the full amount of the death benefit, future premium payments on the underlying life insurance policy will be waived without requiring a waiver of premium rider. If a policyholder accelerates any amount less than the full amount of the death benefit, carriers are not required to waive future premium payments unless the policy already contains a waiver of premium provision that applies.

j. The carrier may require a separate premium for an accelerated benefit product or for a provision allowing for the waiver of surrender charges for early withdrawals on annuity proceeds.

k. When an accelerated benefit is payable or there is a waiver of surrender charge for an early withdrawal of annuity proceeds, there may be no more than a pro rata reduction in the cash value based on the percentage of the death benefit accelerated to produce the accelerated benefit payment or the early withdrawal in relation to the annuity proceeds. Alternatively, the payment of accelerated benefits or waiver of surrender charge for an early withdrawal of annuity proceeds, and any reasonable administrative expense charges, any future premiums, and any accrued interest, may be considered a lien against the death benefit or annuity proceeds of the underlying policy or rider, and the access to the cash value may be restricted to any excess of the cash value over the sum of any other outstanding loans and the lien. Future access to additional policy loans may be limited to any excess of the cash value over the sum of the lien and any other outstanding policy loans.

l. If and when an accelerated benefit payment or early withdrawal of annuity proceeds with a waiver of surrender charge causes a pro rata reduction in the cash value of the underlying policy or annuity, the policyholder may elect to have the payment applied first toward repaying all or a portion of any outstanding policy loan.

m. For accelerated benefit products and annuities requiring no additional premium payments, the death benefit may not be reduced by more than the amount of the accelerated benefits paid, or the annuity may not be reduced by more than the amount of the early withdrawal for which surrender charges were waived.

n. If any death benefit or annuity balance remains after payment of accelerated benefits or the early withdrawal of annuity proceeds for which surrender charges were waived, the accidental death benefit provision, if any, in the underlying policy will not be affected by the payment of any accelerated benefits or early withdrawal of annuity proceeds. If no death benefit or annuity balance remains, the accidental death benefit provision, if any, in the underlying policy will have no effect.

4. Disclosure statements [Reg. 55.06(1); 55.100, 110]

a. All carriers offering either accelerated benefit products or waiver of surrender charges for early withdrawals of annuity proceeds must give the applicant a disclosure statement specifying the potential tax and policy consequences of receiving accelerated benefits, the circumstances in which those benefits will be payable, and the amount of premium, if any, attributable to the accelerated benefits provision.

1.) The disclosure statement must be a separate document printed in at least 12-point type, and it may not contain any advertising material. The statement must be provided either when the application is made or when the

policy is delivered, and must be signed by the policyowner and the writing agent, broker, or company representative.

b. Another disclosure statement must be provided when application for accelerated benefits or early withdrawal is made. The statement must include disclosures similar to those required in the initial disclosure statements, plus an illustration of the effect of receiving the accelerated benefits on the policy cash value or annuity proceeds. All terms used must be clearly explained so that the policyholder understands the effect of accelerating death benefits or making an early withdrawal on annuity proceeds.

5. Other requirements [Reg. 55.06(2)] It is considered an unfair and deceptive practice if a carrier fails to meet the following requirements:

- All terms used in the policy must be fully explained so that the policyholder or certificateholder understands his relationship to the benefits provided.
- No misleading policy names may be used.
- The term *accelerated benefit* must be included in the description, and the term *long-term care insurance* may not be used in describing or marketing accelerated benefit products.
- Limitations or exclusions must be highlighted on the first page of the policy, or there must be a highlighted cross-reference on the first page to the limitations or exclusions section of the policy.
- If a policy is convertible, there must be a notice on the first page identifying that the policy is convertible.
- If not issued on an individual basis, policies providing conversion privileges must specify the benefits to be provided or must state that the converted coverage will be on the policy form then being issued by the company for this purpose.
- When age is to be used as a determining factor for reducing the benefits made available in the policy as originally issued, this fact must be prominently set forth in the policy.
- If the policy is issued on a basis other than that applied for, a disclosure statement properly describing the policy must accompany the policy when it is delivered, and it must contain the following statement, in no less than 14-point type, immediately above the company name: "NOTICE: Read this disclosure statement carefully. The coverage you originally applied for has not been issued. This policy is therefore not identical to the coverage you requested—it differs in the following respects: [list]."
- Riders or endorsements that provide a benefit for which a specific premium is charged must show the premium on the application, rider, or elsewhere in the policy. Any rider that reduces benefits requires a signed acceptance by the policyholder unless this coverage is provided under a master policy owned by an employer or trade union.
- Before adding an accelerated benefit product to an existing life insurance policy or paying any accelerated benefit, the carrier must notify any assignee or irrevocable beneficiary in writing of any present or future effect on the rights of such third parties under the life insurance policy, and may require a signed acknowledgment of concurrence before paying accelerated benefits.

- The carrier must prominently note the following on the face of the policy or rider:

  Accelerated benefit payments from this policy may qualify for special tax status if, according to federal definitions, the insured qualifies as terminally ill, or qualifies as chronically ill and uses the accelerated benefit to pay for costs incurred for qualified long-term care services during the chronic illness. However, if the accelerated benefit is based on "medical conditions" and not terminal or chronic illness as defined in the federal tax code, the benefits may be taxable. We recommend that you contact a tax advisor when making tax-related decisions about electing to receive and use benefits from an accelerated benefit product.

6. Additional disclosure required at time of claim [Reg. 55.06(3), (4)] The carrier must include the notice regarding special tax status described in the previous section on the face of the claim settlement for accelerated benefits. The carrier must also provide illustrations of the impact of payment of accelerated benefits on the policy.

a. If the accelerated benefit is paid in periodic payments instead of a lump sum and the policy's underlying contract values change with each payment, the carrier must send the policyholder a statement containing the underlying contract values each time an accelerated benefit payment is made.

S. POLICY LOANS [175.142] When a life insurance policyowner has paid premiums for three years, he may apply for a policy loan. The maximum interest rate on the loan is 8% per year or an adjustable rate. This maximum rate must be determined at least once every 12 months, but not more often than once every three months.

T. LONG-TERM CARE RIDERS [Reg. 65] The purpose of long-term care regulation is to protect purchasers from deceptive sales practices and to establish standards for this type of insurance. Massachusetts requires that insurers and their producers be properly licensed (and trained) in both life and health insurance when addressing long-term care. Here we will focus on the sale of riders. Later, the book will thoroughly cover more specific provisions and procedures governing the sale of standalone long-term care policies. A long-term care rider provides reimbursement for personal and skilled care received before death. These funds may be in addition to the life insurance death benefit or reduce the life insurance payout. Receipts for long-term care are reimbursable up to a daily benefit or rider maximum if care is delivered by non-family members or recognized service agencies, which include both nursing homes and home health care.

1. Definition Federally qualified long-term care triggers by either:

- needing substantial assistance with two or more (of six) activities of daily living: bathing, dressing, transferring, toileting, continence, or eating; and/or
- needing substantial supervision because of a cognitive impairment (confirmed by standardized testing by a medical professional).

2. Disclosure requirements [Reg. 65.09, 100, 101] Individual and group long-term care insurance policies must adequately disclose all policy provisions and comply with the specific disclosure requirements discussed in this section.

a. The first page of the policy or rider must contain the following disclosures.

1.) If the rider does not provide coverage for care in a nursing home, a notation of that fact must be attached in at least 18-point type or in some other manner that distinguishes it from the other print appearing in the policy.

2.) There must be a statement that the policy may not cover all the costs associated with long-term care incurred by the buyer during the period of coverage and that the buyer is advised to review carefully all policy and rider limitations.

3.) A section in boldface type highlighted on the first page of the rider must either list all preexisting condition exclusions or limitations or refer the individual to the section in the policy that lists all preexisting condition exclusions or limitations.

4.) A renewability notice must clearly identify whether the rider is noncancelable or guaranteed renewable and whether it is being issued on other than an individual basis. Policies providing conversion privileges must specify the benefits to be provided or must state that the converted coverage will be on the policy form then being issued by the carrier for this purpose.

5.) A statement indicating whether the rider is intended to be a federally qualified long-term care insurance contract and whether the policy is intended to satisfy the coverage requirements for certain asset and liability exemptions under the Massachusetts MassHealth (Medicaid) program.

b. Policy language All terms used in the policy must be fully explained so that the insured understands their relationship to the benefits covered. No misleading policy or rider names may be used. The policy, riders, and all amendments, as well as the application, outline of coverage, and other required disclosure materials must be presented in at least 12-point type and must satisfy the readability standards of Massachusetts law.

1.) Riders or endorsements that provide a benefit for which a specific premium is charged must show the premium on the application, rider, or elsewhere in the policy. Any rider that reduces benefits requires a signed acceptance by the policyholder.

c. Separate disclosure forms

1.) Your Options for Financing Long-Term Care: [Reg. 65.09(3)(a)] A Massachusetts Guide A long-term care insurance policy or rider may not be delivered or issued for delivery in Massachusetts unless the potential insured receives *Your Options for Financing Long-Term Care: A Massachusetts Guide*, including any inserts, as prescribed by the Commissioner, regarding changes to state or federal

laws, no later than the first face-to-face contact between the potential insured and the agent, or in cases of direct response sales, at the time that the application or enrollment form is sent to the potential insured.

2.) **Policy illustration [Reg. 65.09(3)(b)]** A long-term care insurance policy or rider may not be delivered or issued for delivery in Massachusetts unless the applicant receives a policy illustration in a form prescribed by the regulations. The carrier or its agents must deliver the illustration(s) no later than the time of each policy proposal or quote. In the case of direct response sales, the carrier must deliver the form at the time that the application or enrollment form is sent to the potential insured.

3.) **Outline of coverage [Reg. 65.09(3)(c); 65.101]** A long-term care insurance policy or rider may not be delivered or issued for delivery in Massachusetts unless the applicant receives an outline of coverage substantially similar to the one provided in the regulations. The carrier or its agent must deliver the outline of coverage prior to the presentation of the application or enrollment form. In the case of direct response sales, the carrier must deliver the outline of coverage at the time that the application or enrollment form is sent to the potential insured. The carrier must also make an outline of coverage available at any time at the potential insured's request. The outline of coverage must be a document separate from the policy.

d. Special disclosure forms

1.) **Other than requested** If the policy is issued on a basis other than applied for, a disclosure statement properly describing the actual policy terms must accompany the policy and rider when it is delivered. The statement must list the ways in which the coverage as issued differs from that requested.

2.) **Required disclosure regarding changes to MassHealth (Medicaid) eligibility and recovery exemptions** If the carrier issued a policy or rider that met the standards for asset protection under MassHealth and those standards are later changed, the carrier must notify all insureds whose policies will no longer satisfy the standards and offer them on a guaranteed issue basis the opportunity to purchase needed benefits to meet the MassHealth (Medicaid) policy criteria. The rates for any change in benefits must be based on the insured's rate characteristics at the time of policy change.

3. The term *long-term care insurance* includes group and individual policies or riders whether issued by insurers, fraternal benefit societies, nonprofit health, hospital and medical service corporations, prepaid health plans, HMOs, or any similar organization.

4. Limitations and exclusions [Reg. 65.05(3)] Preexisting condition limitations must be identified on the front of the policy and the outline of coverage. No long-term

care policy may include a preexisting condition provision of more than six months. The only permissible exclusions include:

- war or act of war;
- participation in a felony, riot, or insurrection;
- service in the armed forces;
- attempted suicide or intentionally self-inflicted injury;
- aviation (applies only to non-fare paying passengers);
- services for alcohol or drug detoxification;
- services for which benefits are payable under government programs such as Medicare, workers' compensation, or any motor vehicle no-fault law;
- services provided by members of the insured's immediate family; and
- services for which no amount is normally charged in the absence of insurance.

a. An individual policy may not exclude otherwise eligible persons from policy benefits due to the presence or history of mental or nervous conditions, Alzheimer's disease, alcoholism, or other chemical dependency.

b. An individual policy may not exclude otherwise eligible policy benefits because those benefits are also payable by a non-Medicare government agency or because the covered services are being received in a governmental facility.

5. Standards for agent training and marketing [Reg. 65.08] Requirements for producer training and marketing are as follows.

a. Each carrier must provide appropriate training to producers about its long-term care insurance products, maintain records regarding producers who have satisfactorily completed such training, and file with the Commissioner lists identifying those producers who have completed the carrier's long-term care insurance training program.

b. All long-term care insurance marketing and advertising must conform to the applicable code provisions. In addition, carriers must establish auditable internal marketing procedures, methods for assuring compliance by producers, and prohibitions against twisting, high-pressure tactics, and cold-lead advertising.

c. All producers marketing a carrier's long-term care insurance must clearly identify which plans being offered are individual products and which are group products. When marketing group products, the producer must clearly identify the name of the group policyholder and any conditions that the eligible person must satisfy to join and remain a member of the group.

d. All producers marketing a carrier's long-term care insurance must disclose to potential applicants the name of the carrier that the producer represents in the sale. The carrier's name must be disclosed on any and all printed sales or materials provided, distributed, or shown to potential applicants and/or during presentations made to potential applicants in association with a sale, whether part of a presentation or not.

e. All producers marketing a carrier's long-term care insurance policy must disclose the fact that the producer receives compensation in connection with the sale or replacement of all long-term care insurance.

f. All producers marketing a carrier's long-term care insurance may not misrepresent their expertise, qualifications, or training to potential clients and may not comment on the legal or tax implications of purchasing long-term care insurance to the extent that they lack the training, qualification, or license to provide such advice.

g. A carrier whose producer fails to comply with any of these provisions will be deemed to have committed an unfair and deceptive act in the business of insurance.

6. Benefit triggers [Reg. 65.05(1)]

a. Individual long-term care policies that are not intended to be federally qualified may not include benefit eligibility standards that are more stringent than a requirement that the insured be unable to perform at least two activities of daily living (ADLs) due to a loss of functional capacity or severe cognitive impairment.

b. Individual policies that are intended to be federally qualified must meet the standards provided in the federal Internal Revenue Code and related federal regulations.

7. Right to return [Reg. 65.101(5)] Long-term care insurance policies must provide a free-look period of at least 10 days from the date of policy delivery.

U. VARIABLE ANNUITIES [175:144A 1/2; 175:132F, G, H]

1. The term **pension contract** means life policies and annuity contracts, group or individual, and any supplementary agreements issued in connection with a pension, profit-sharing, or retirement plan. It includes any contracts assigned wholly or in part to any separate account and agreements reinsuring pension contracts.

2. Separate account assets are not chargeable with liabilities arising out of any other business the life company may conduct. Separate accounts must be valued at their market value at the date of valuation. The limitations on investing the general account assets of life insurance companies are not applicable to separate accounts. However, if separate accounts assets exceed $1 million, no more than 10% of those assets may be invested in any one entity, other than an open-end, diversified investment company (mutual fund).

3. In determining the qualification of a company requesting authority to issue or deliver variable contracts within this commonwealth, the Commissioner shall consider, among other things:

- the history and financial condition of the company;

- the character, responsibility and general fitness of the officers and directors of the company; and
- in the case of a company other than a domestic company, whether the regulation provided by its domiciliary jurisdiction provides a degree of protection to policyholders and the public which is substantially equal to that provided by this state.

4. Before a variable contract may be sold in Massachusetts, a copy of the contract form, any certificate for group contracts, and the application must have been on file with the Commissioner for at least 30 days, unless the Commissioner approves the contract before the 30 days expires.

III. MASSACHUSETTS LAW AND REGULATIONS PERTINENT TO ACCIDENT AND HEALTH INSURANCE ONLY

A. REQUIREMENTS FOR DISABILITY INCOME INSURANCE [Reg. 42.05(1)(g)]

1. Disability income insurance provides weekly or monthly benefits to replace income that is lost due to disability resulting from accident and/or sickness. It also includes business expense insurance and business buy-out insurance policies that condition receipt of benefits upon the disability of the insured. To promote clarity and readability, **total disability** must be defined to make clear the time, if any, for which an insured must be disabled, whether by being unable to engage in his own occupation or in other occupations for which he is qualified by education, training, and experience. Definitions should avoid hard-to-understand expressions like inability to perform "each and every" or "any and every" duty of an insured's occupation.

2. To promote clarity and readability, **partial disability**, if included, must be defined in relation to the insured's inability to perform some or all of the "major," "important," or "essential" duties of employment or occupation. If a policy covers both total and partial disability, the partial disability benefit will be considered to be in compliance if it is not contingent upon prior payments for total disability benefits.

3. The policy must clearly explain all limitations and elimination (waiting) periods, including elimination periods affecting different levels of benefits. In addition, no benefits can be reduced in coordination with any increased benefits the insured may receive from the Social Security system after the effective date of the benefit period.

B. MINIMUM DISCLOSURE STANDARDS FOR ACCIDENT AND SICKNESS INSURANCE [175:110E]

The Commissioner at any time may alter, amend, or make interpretations, to establish minimum standards for full and fair disclosure, for the form and content of policies of accident and sickness insurance which provide medical, surgical, or hospital expense benefits, whether on an indemnity, reimbursement, service, or prepaid basis.

These disclosure rules and regulations may apply to all, any portion, or reasonable classifications of these policies or contracts, and will be made to bring about:

- reasonable standardization and simplification of coverages to facilitate their understanding and comparison;

- elimination of provisions that may be misleading or unreasonably confusing in connection either with the purchase of this insurance or with the settlement of claims;
- elimination of deceptive practices in connection with the sale of insurance;
- elimination of provisions that may be contrary to the health care needs of the public; and
- elimination of coverages that are so limited in scope as to be of no substantial economic value to the holders.

C. ADVERTISEMENTS OF ACCIDENT AND SICKNESS INSURANCE [175:110E; Reg. 40.00] The Commissioner must make, and may at any time alter or amend, reasonable rules and regulations, and interpretations concerning advertising of accident and sickness insurance policies to assure that advertising is truthful and not misleading. These regulations must contain, but not be limited to, the following principles.

1. Words, phrases, or illustrations may not be used in a manner that misleads or has the capacity and tendency to deceive as to the extent of any policy benefit payable, loss covered, or premium payable. An advertisement must be sufficiently complete and clear as to avoid deception.

2. When an advertisement refers to any dollar amount, period of time for which any benefit is payable, cost of a policy, or specific policy benefit for the loss for which the benefit is payable, it must also disclose those exceptions, reductions, and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity and tendency to mislead or deceive.

3. An advertisement that refers to the right to renew, cancel, or terminate a policy, refers to a policy benefit, or states or illustrates time or age in connection with the eligibility of applicants or the right to continue a policy must disclose the provisions relating to the above in such a manner not to minimize or render obscure the qualifying conditions.

4. Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised, and be accurately reproduced. The insurer, in using a testimonial, makes as its own those statements.

5. An advertisement relating to the dollar amount of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy may not be used unless it accurately reflects all of the relevant facts. An advertisement may not imply that statistics are derived from the policy advertised unless they are factual.

6. An advertisement may not directly or indirectly make unfair or incomplete comparisons of policies or benefits or otherwise falsely disparage competitors, their policies, services, or business methods.

7. The identity of the insurer must be made clear in all of its advertisements. An advertisement may not use a trade name, service mark, slogan, symbol, or other device that has the capacity and tendency to mislead or deceive as to the true identity of the insurer. The trade name or any other name may be used, but only if the actual name of the insurer is disclosed.

8. An advertisement may not state or imply that an insurer or policy has been approved or endorsed by government, an individual, group of individuals, society, association, or other organizations, unless this is the fact.

9. Policies of a limited nature, such as a cancer-only policy, must have this fact prominently displayed on the policy so as not to confuse any member of the public considering its purchase. These policies are deemed to be **limited policies**.

10. Advertisements include any sales aids, including audio visuals, prepared sales talks, or other printed material used by a licensee; television or radio ads; newspaper circulars; or newsletter information. In addition, if an insured needs a medical exam in order to receive coverage, this fact must be disclosed in the advertisement.

11. An insurer must keep copies of all advertisements for at least four years or until the next regular examination of the insurer, whichever is longer.

    The Commissioner may order any insurer or producer violating advertising regulations to cease and desist from this advertising and to put all policyholders or applicants on notice of the violation in such a manner as he deems appropriate. In the case of repeated violations, the Commissioner may suspend or revoke the licenses of any of these persons and impose reasonable conditions for reinstatement.

D. ADVERTISING OF GUARANTY ASSOCIATION [175:146B(19)] No person, including an insurer, agent, or affiliate of an insurer, may make, publish, disseminate, circulate, or place before the public any advertisement, announcement, or statement that uses the existence of the Massachusetts Life and Health Insurance Guaranty Association for the purposes of sales, solicitation, or inducement to purchase any form of life and health insurance. This is so as not to mislead the buyer that a refund is guaranteed in all circumstances. Refer to the specific limits in a previous section of this book.

E. REQUIREMENTS FOR DISCLOSURE AND OUTLINE OF COVERAGE [Reg. 42.09]

1. No misleading policy names may be used and no policy may be marketed or advertised as a group policy unless it qualifies as one. A carrier's policy name may not misrepresent the extent of benefits actually provided, nor may a name be used that conflicts with the prescribed category name or that is similar to the prescribed name of a different category.

2. If age is used as a determining factor for reducing the benefits made available in the policy as originally issued, this fact must be prominently set forth in the policy.

3. All insurance policies must contain a renewability provision on the first page.

4. If the policy is issued on a basis other than as applied for, a disclosure statement properly describing the policy must accompany the policy when it is delivered, and it must contain the following statement, in no less than 12-point type, immediately above the company name: "Notice: Read this disclosure statement carefully. The coverage you originally applied for has not been issued. This policy is therefore not identical to the coverage you requested—it differs in the following respects: [list]."

5. Any policy summary for a policy that is not a Medicare supplement policy delivered to a person eligible for Medicare must include a prominent statement or sticker on the first page that the policy IS NOT A MEDICARE SUPPLEMENT INSURANCE POLICY. This statement is not required for policies that do not cover hospital, medical, or surgical expenses.

6. Policies providing conversion privileges must specify the benefits to be provided or must state that the converted coverage will be on the policy form then being issued by the company for this purpose.

7. Riders or endorsements used to reduce or eliminate coverage at the date of policy issue are not effective without the policyholder's signed acceptance. Riders or endorsements that provide a benefit for which a specific premium is charged must show the premium on the application, rider, or elsewhere in the policy. When the Medical Information Bureau (MIB) is used by the carrier, the policy application, or another appropriate notice must indicate the possible use of this service as it relates to medical information concerning the insured.

8. No individual health insurance policy may be delivered or issued for delivery in Massachusetts unless the disclosure form is delivered with the policy or provided at the time application is made. If the policy is issued on a changed basis, a revised summary must be affixed to the policy.

   a. Disclosure forms must include the following information as applicable:
      - Name of the carrier, policy type, and policy number
      - Description of benefits
      - Deductibles, coinsurance, and benefit maximums
      - Whether the policy is renewable until eligibility for Medicare
      - Whether there are age limitations
      - Whether the policy is subject to increases in premiums
      - Preexisting condition limitations and waiting periods
      - Whether mental illness is covered and the extent of benefits
      - Whether pregnancy is covered
      - Free-look provisions and the procedure for returning the policy for a refund
      - A statement that the disclosure form is a summary of the policy and that it is important to read the policy carefully
      - Exclusions, limitations, and reductions
      - A statement that the insured can contact his agent or the Massachusetts Division of Insurance with complaints

F. DISCLOSURE OF MENTAL OR NERVOUS CONDITION [175:108E] An insurer may not disclose any information it may have acquired from or about any insured or covered family member pertaining to benefits provided for outpatient diagnosis or treatment of mental or nervous conditions without the express written consent of the insured or family member. The consent required for this disclosure may not have different terms and conditions than the consent required for disclosure of information for other medical conditions.

1. This rule does not prohibit an insurer from:

- disclosing aggregate patient data if the data contains no information personally identifying any insured or family member of the insured;
- disclosing patient utilization data to a law enforcement authority, state board of registration, or court if there is reason to believe a patient or provider has committed fraud; or
- using or disclosing patient information for coordination of benefits, subrogation, peer review, or utilization review.

G. CONSIDERATIONS IN REPLACING HEALTH INSURANCE

1. Unfair discrimination; waiting periods [176J:4; 176N:2]

a. Health plans may not exclude an eligible insured on the basis of the person's age, occupation, actual or expected health condition, claims experience, duration of coverage, or medical condition.

b. Effective 2014, a carrier cannot impose a preexisting condition exclusion or waiting period of any duration on a medical health plan.

1.) Insurers must enroll eligible individuals, as defined in the Health Insurance Portability and Accountability Act of 1996, into a health plan if the individual requests coverage within 63 days of termination of any prior creditable coverage. A carrier must also enroll eligible individuals, as permitted under the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148, and any rules, regulations, and guidances applicable, as amended from time to time.

2.) Insurers will allow eligible individuals to renew coverage if that coverage is available to other eligible individuals. Coverage becomes effective in accordance with the PPACA and any other rules or regulations applicable, subject to reasonable verification of eligibility, and is effective through December 31 of that same year. Carriers will notify eligible individuals that:

- coverage shall be in effect only through December 31 of the year of enrollment;
- if any such eligible individual is in a health plan with a plan-year deductible or out-of-pocket maximum, an explanation of how that deductible or out-of-pocket maximum and premiums will be impacted for the period between the plan effective date and December 31 of the enrollment year; and
- the next open enrollment period during which eligible individuals will have the opportunity to enroll in a health plan that will begin on January 1 of the following calendar year.

3.) For those not meeting the requirements of the above paragraph, their open enrollment period (including for their dependents) will be from

October 15 to December 7, inclusive, unless otherwise designated by the Commissioner. Coverage will begin on January 1 of the following year.

c. Health benefit plans offered only through a public exchange that do not include pediatric dental may deny an eligible individual or small business of any size enrollment unless they enroll through the Connector (The Commonwealth Health Insurance Connector Authority-state health exchange). If enrolled through the Connector, a carrier may not deny anyone eligible.

d. Every health benefit plan is renewable by law unless the individual or small business:

- has not paid the required premiums;
- has committed fraud, misrepresented whether or not a person is an eligible individual or eligible employee, or misrepresented information necessary to determine the size of a group, the participation of a group, or the premium rate for a group;
- failed to comply in a material manner with health benefit plan provisions;
- fails, at the time of renewal, to satisfy the definition of an eligible individual or eligible small business; or
- in the case of a group, is not actively engaged in business.

e. Health plans may not exclude late enrollees from coverage for more than 12 months from the date of the application for coverage.

2. Massachusetts individual mandate for minimum creditable coverage (RL Title XVI M.G.L.C. 111M 956 CMR 5.00) This regulation establishes the criteria for the lowest threshold health benefit plan that an individual must purchase in order to satisfy the legal requirement that a resident of Massachusetts have health coverage that constitutes minimum creditable coverage to avoid paying a penalty to the Department of Revenue. Massachusetts minimum coverage includes health benefits defined as essential in the Patient Protection and Affordable Care Act. Minimum creditable coverage is designed to provide individuals (and dependents) access to a broad range of health care services, including preventive health care, without incurring severe financial losses as a result of serious illness or injury.

3. Requirements for replacement [175:110(N)(3)(a); Reg. 42.08, 42.11]

a. Application forms for individual accident and health insurance must contain a question to elicit whether the insurance to be issued is to replace any other accident and sickness insurance currently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

b. Upon determining that a sale will involve replacement, the agent or carrier must furnish the applicant with a prescribed notice at the time of taking the application or before the policy is issued. A copy of the notice must be retained by both the applicant and the carrier. The notice must inform the applicant that:

- health conditions the applicant presently has may not be covered under the new policy; this could result in a claim for benefits being denied that may have been payable under the present policy;

- even though some of the applicant's present health conditions may be covered under the new policy, these conditions may be subject to waiting periods under the new policy before coverage is effective;
- questions in the application for the new policy must be answered truthfully and completely; otherwise, the validity of the policy and the payment of any benefits may be voided; and
- it may be to the applicant's advantage to secure the advice of the applicant's present carrier or its agent regarding the proposed replacement.

c. Any carrier providing replacement coverage for group hospital, medical, or surgical benefits within 60 days from the date of discontinuance of a prior policy must immediately cover all enrollees who were validly covered under the previous coverage at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active employment or hospital confinement or pregnancy.

H. OTHER PROVISIONS

1. Required provisions [175:108(3)(a)]

a. Grace period Health insurance policies must contain a grace period of not less than seven days for weekly premium policies, 10 days for monthly premium policies, and 31 for all other policies for paying each premium other than the first, during which period the policy will continue in force. In policies in which the insurer reserves the right to refuse renewal, the grace period provision will not apply if the insurer has given the insured notice of nonrenewal at least 30 days prior to the premium due date.

b. Physical examinations The insurer, at its own expense, has the right and opportunity to examine the insured when and as often as it may reasonably require during the pendency of a claim.

c. Right to examine: free-look period Health insurance policies must include a free-look period of at least 10 days.

d. Entire contract The health insurance policy, including the endorsements and any attachments, constitutes the entire contract of insurance. Changes to the policy are valid only when approved by an executive officer of the insurer and the approval is endorsed or attached to the contract. No agent has authority to change the policy or to waive any of its provisions.

e. Time limit on certain defenses After two years from the policy's issue date, the insurer cannot use any misstatements, except fraudulent misstatements, made by the applicant in the application to void the policy or to deny a claim for loss or disability.

f. Reinstatement All individual health insurance policies must include a reinstatement provision stating that the policy can be reinstated at any time after premium default if the insurer or an agent accepts the delinquent premium payment(s). If the insurer requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated when the insurer approves the application, or if it takes no action on the application for 45 days, the policy is reinstated automatically. However, the reinstated policy will only cover losses resulting from accidental injury sustained after the date of reinstatement, or from sickness that occurs at least 10 days after the reinstatement date.

g. Notice of claim The policyowner must give written notice of claim to the insurer within 20 days after a covered loss or as soon thereafter as is reasonably possible. If the loss involves disability income payments that are payable for two or more years, the disabled claimant must submit proof of loss every six months.

h. Claim forms The insurer must provide claim forms to the insured within 15 days after receiving a notice of claim. If the insurer fails to do so within this time period, the claimant may submit written proof covering the occurrence, the character and the extent of the loss for which claim is made.

i. Proof of loss After a loss occurs, the insured has 90 days in which to submit proof of loss. The claim will not be invalidated if it is not reasonably possible for the insured to give proof within the 90-day time period and such proof is submitted within one year from the time proof is otherwise required.

j. Time of payment of claims This provision provides for immediate payment of the claim (unless periodic payments are to be made) after the insurer receives notification and written proof of loss. Periodic payments must not be paid less frequently than monthly.

k. Payment of claims This provision specifies that indemnity for loss of life will be payable to the designated beneficiary. If no beneficiary has been named, death proceeds are to be paid to the deceased insured's estate. Claims other than death benefits are to be paid to the insured.

l. Legal actions The insured cannot take legal action against the insurer in a claim dispute until after 60 days from the time the insured submits proof of loss. Legal action against an insurer must be taken within three years after written proof of loss is required to be furnished.

m. Change of beneficiary Unless the policyholder makes an irrevocable designation of beneficiary, she may change the beneficiary designation at any time. The owner/insured also may surrender or assign the policy without obtaining the beneficiary's consent, provided the owner reserves the right to change the beneficiary.

2. Optional provisions [175:108(3)(b)]

a. Change of occupation This provision sets forth the changes that may be made to premium rates or benefits payable if the insured changes occupations. If the insured changes to a more hazardous occupation, the insurer can reduce the maximum benefit payable under the policy. If the insured changes to a less hazardous occupation, the insurer may reduce the premium rate charged and return any excess pro rata unearned premium.

b. Misstatement of age The misstatement of age provision allows the insurer to adjust the benefit payable if the age of the insured has been misstated. Benefit amounts payable in such cases will be what the premium paid would have purchased at the correct age.

c. Other insurance in this insurer Under this provision, the total amount of coverage to be underwritten by a company on one person is restricted to a specified maximum amount, regardless of the number of policies issued.

d. Insurance with other insurer If there is valid coverage with other insurers, benefits payable on an expense-incurred basis will be prorated in cases where the insurer accepted the risk without being notified of other existing coverage for the same risk.

e. Insurance with other insurers This provision calls for the prorating of benefits that are payable on any basis other than expenses incurred. It also calls for a return of premiums that exceed the amount needed to pay for the company's portion of prorated benefits.

f. Unpaid premium If there is an unpaid premium at the time a claim becomes payable, the amount of the premium may be deducted from the sum payable to the insured or beneficiary.

g. Conformity with state statutes If any policy is in conflict with state statutes of the state in which the insured resides, the policy is automatically amended to conform to the minimum statutory requirements.

h. Illegal occupation The insurer is not liable for any loss attributed to the insured's commission of or attempt to commit a felony or participation in any illegal occupation.

I. PREFERRED PROVIDER ARRANGEMENTS

1. Definitions [Reg. 51.03]

a. Organization An entity authorized by the Commissioner to bear risk, including companies licensed or otherwise authorized to write accident and health insurance. This includes fraternal benefit societies, nonprofit hospitals, medical, dental, and optometric service corporations, or health maintenance organizations.

b. Preferred provider A health care provider, group, or network of health care providers, who have contracted with an organization to provide specified covered services in the context of a preferred provider arrangement.

c. Preferred provider arrangement (PPA) A contract between or on behalf of an organization and a preferred provider.

J. GROUP HEALTH INSURANCE

1. Eligible groups [175:110] General and blanket group health insurance policies may be issued to the following groups:

- Employers
- Municipal corporations
- Police and fire departments, including volunteer fire departments
- Colleges, schools, and other learning institutions
- Organizations for health, recreational, or military instruction or treatment
- Automobile clubs, underwriters corps, salvage bureaus, or similar organizations
- Trade unions and other associations of wage workers
- Multiple employer trusts
- Association and labor groups
- Creditor groups

2. Continuation of coverage under COBRA and Massachusetts-specific rules [175:110D] Group health insurance policies must contain a provision that allows an individual who leaves the group to continue coverage under the policy for 31 days unless he becomes eligible for similar insurance within this time period.

3. Continuation of coverage after death or layoff [175:110G] When a member of a group insurance plan becomes ineligible for continued participation in the plan because of involuntary layoff or death, coverage will continue for the insured, his spouse, and dependents for 39 weeks or until the insured, spouse, and dependents become eligible for benefits under another group plan, whichever occurs first. The continuation period may not exceed the period that the insured was covered under the plan. An insured who is involuntarily laid off or the surviving spouse and dependents of a deceased insured may elect to continue participation in the plan by giving at least 30 days written notice to the employer or policyholder and paying the required premium.

a. Plant closing When a member of a group health insurance plan becomes ineligible for continued participation because his employment is terminated because of a plant closing, the coverage originally provided for the member and his dependents must continue for 90 days or until the member and his dependents become eligible for benefits under another group plan, whichever comes first.

1.) The terminated employee is responsible for paying any part of the premium normally paid by the terminated employee as originally provided in the plan throughout the 90-day period.

2.) A collective bargaining agreement that requires an employer to pay for the continuation of insurance for employees whose employment is terminated by a plant closing supersedes these requirements if the agreement provides for at least three months or 90 days' continuation of coverage.

4. Continuation of coverage after separation or divorce [175:110I] In the case of divorce or separation, the spouse of an individual insured under a group health policy or HMO contract may continue to be covered under the plan without paying additional premium unless the divorce or separation decree specifies otherwise. Eligibility continues as long as the insured participates in the plan until either party remarries or until the time provided in the decree, whichever is earlier.

a. If the group plan member remarries, the former spouse may be eligible to continue receiving the same benefits available to the plan member if this right is specified in the divorce or separation agreement. Coverage may be provided by adding a rider to the family plan or issuing an individual plan, and may require additional premium payment.

5. Dependent child age limit and disabled adult children [175:110(P), 175:108(2)(a)(3); 176A:8BB, 176B:4BB; 176B:6(c); 176A:8(d); 176G:4T] A blanket or general policy of insurance (except policies or certificates that provide stand-alone dental services or coverage to Medicare or other governmental programs) that is delivered, issued, or renewed in the commonwealth must provide, as benefits to all group members having a place of employment in the commonwealth, coverage to dependent persons under 26 years of age.

a. Any subscription certificate under an individual or group nonprofit hospital service agreement, except certificates that provide stand-alone dental services, supplemental coverage to Medicare or other governmental programs, that is delivered, issued, or renewed in the commonwealth, will provide, as benefits to all individuals or to all group members having a principal place of employment within the commonwealth, coverage to eligible dependents under 26 years of age.

Plans must insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be considered the policyholder, two or more eligible members of that family, including the policyholder, spouse, dependent children and other dependent persons, children during pendency of adoption procedures, children under 26 years of age, and children who are mentally or physically incapable of earning their own living, if due proof of the incapacity is received by the insurer within 31 days of the date upon which the coverage would otherwise be terminated.

b. Any child mentally or physically incapable of earning his own living who is eligible for services by membership of his parent under a family contract is eligible as a member of that family contract as long as he continues to be mentally or physically incapable of earning his own living, without any limitation as to age.

K. MEDICARE SUPPLEMENT [Regs. 71.10, 71.01] The purpose of this regulation is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies that some seniors buy to plug coinsurance and deductible gaps in Medicare Parts A and B. Additional purposes are to facilitate public understanding and comparison of these policies, eliminate provisions contained in these policies that may be misleading or confusing, and provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare by reason of age.

1. Applicability and scope This regulation applies to all individual or group Medicare supplement policies and subscriber contracts delivered or issued for delivery in this state. Sometimes Medicare supplement insurance is referred to as MediGap.

2. A Medicare supplement policy must provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically (notice of benefit changes) to coincide with any changes in the applicable Medicare deductible amount, coinsurance, and co-payment percentage factors. Premiums may be modified to correspond with these changes.

3. No Medicare supplement may provide the same benefits (duplicate) provided by Parts A or B of Medicare.

4. Required disclosure provisions and benefit standards [Regs. 40.15; 71.08, 71.13, 71.15, 71.17, 71.18, 71.98; Appendix F 176K:3(b)]

a. Medicare supplement policies must have a 30-day free-look provision listed prominently on the first page of the policy.

b. Insurers issuing Medicare supplement policies in this state must provide a policy summary and outline of coverage to all applicants at the time of application.

c. All Medicare supplement policy advertisements must be submitted at least 15 days before use to the Insurance Commissioner for approval.

d. A producer must make a reasonable effort to determine the appropriateness of the recommended purchase or replacement of a Medicare supplement policy. Any sale of Medicare supplement coverage that will provide an individual with more than one Medicare supplement policy is prohibited. An insurer may not issue a Medicare Supplement Insurance Policy to an individual enrolled in Medicare Part C (Medicare Advantage) unless the effective date of coverage is after the termination date of Part C.

e. First-year commissions may not exceed 200% of the compensation paid for selling or servicing the policy in the second year; renewal commissions must be the same as those paid in the second year and must be provided for at least five renewal years. If a replacement is involved, replacement commissions must not be greater than the renewal commissions paid by the replacing insurer unless the benefits of the new policy are substantially and clearly greater than the replaced policy.

f. No insurer may issue a policy with a waiting period or preexisting limitation or exclusion.

g. All policies must be guaranteed renewable.

h. Insurers must make available a Medicare Supplement Core insurance policy.

5. Requirements for replacement [Reg. 71.13]

a. Application forms must include certain prescribed questions and statements to determine whether the applicant has other Medicare supplement, Medicare Advantage, Medicaid coverage, or other health insurance policies in force or whether a Medicare supplement policy is intended to replace any other health policy presently in force.

1.) Agents must list any other health insurance policies they have sold to the applicant, including policies that are still in force and policies sold in the past five years that are no longer in force.

b. Upon determining that a sale will involve replacement, an insurer or its producer must furnish the applicant with a notice regarding replacement before issuance or delivery of the Medicare supplement policy. One copy of the notice signed by the applicant and the producer must be provided to the applicant, and an additional signed copy must be retained by the issuer.

1.) A direct-response issuer must deliver the notice regarding replacement to the applicant at the time the policy is issued.

6. Standards for marketing [Reg. 71.16] Every insurer marketing Medicare supplement insurance in Massachusetts, directly or through its producers, must establish marketing procedures to:

- ensure that any comparison of policies by its producers will be fair and accurate;
- ensure excessive insurance is not sold or issued;
- ensure that insureds are informed that the policy they are purchasing does not cover all of the costs associated with medical care incurred by the insureds by displaying prominently by type, stamp, or other appropriate means, on the first page of the policy the following: "Notice to Buyer: This policy may not cover all of your medical expenses";
- inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance;
- ensure that applicants and insureds are clearly informed of the basic nature and provisions of their Medicare supplement insurance policy; and
- ensure that insureds are clearly informed as to the benefits provided by Medicare.

a. Every insurer or producer marketing Medicare supplement insurance in Massachusetts is prohibited from cold-lead advertising, twisting, and high-pressure tactics.

1.) **Cold-lead advertising** means using any method of marketing that fails to disclose conspicuously that a purpose of the marketing is solicitation of insurance and that contact will be made by an insurance producer or issuer.

2.) **High-pressure tactics** means any method of marketing that tends to induce the purchase of insurance through force, fright, threat, or undue pressure to purchase or recommend the purchase of insurance.

3.) **Twisting** means knowingly making a misleading representation or fraudulent comparison of insurance policies or carriers to induce a person to lapse, forfeit, surrender, terminate, borrow on, or convert any insurance policy or to take out a policy with another carrier.

7. Open enrollment [176K:3; Reg. 71.10]

a. Carriers may not deny or condition the issuance of Medicare supplement or Medicare Select insurance or discriminate in the pricing of coverage to any eligible person on the basis of age, health status, claims experience, receipt of health care, or medical condition. Carriers may not require genetic tests or information as a condition of the issuance or renewal of a policy. Waiting periods or preexisting condition limitations and exclusions are prohibited.

b. Carriers must make all Medicare supplement policies they issue available to individuals who apply for a Medicare supplement policy prior to or during the six month period beginning with the first day of the first month in which the individual is both 65 years of age or older and enrolled for benefits under Medicare Part B. In other words, no one may be denied during this time.

c. The required annual open enrollment period for eligible individuals runs from February 1–March 31. During this period, carriers must make all Medicare supplement policies they issue available to applicants. Coverage is effective June 1 of that year or no later than when Medicare coverage is first effective, whichever is earlier.

d. Carriers may hold additional optional open enrollment periods at other times of the year if these periods run for at least 60 consecutive days. Carriers may also elect to maintain continuous open enrollment but if the carrier chooses to discontinue continuous open enrollment, it must notify the Commissioner at least 60 days prior to the ending date.

8. Reporting multiple policies [Reg. 71.19] On or before March 1 of each year, issuers must file a report with the Insurance Division identifying every Massachusetts resident for whom they have more than one Medicare supplement policy in force. The report must include the policy number and the date the policy was issued.

9. Renewability [Reg. 71.07] Medicare supplement policies must include a renewability provision. Policies may not contain renewal provisions less favorable to the insured than **guaranteed renewable**. Policies can only be canceled for nonpayment of premium or material misrepresentation. Insureds receiving coverage through group contracts are protected as well, should they leave the group or the group terminate the plan.

a. The policy must provide that benefits and premiums under the policy may be suspended at the request of the policyholder for up to 24 months if the policyholder becomes eligible for Medicaid. The policyholder must notify the issuer within 90 days after he becomes eligible. If the policyholder loses entitlement to medical assistance, the policy must be automatically reinstated as of the date of termination of entitlement. The policyholder must notify the issuer within 90 days after termination and pay the required premium.

b. Similar procedures exist for a senior to suspend Medicare Supplement coverage if again covered under a group health plan.

c. The reinstated coverage may not require any waiting period for preexisting conditions and must be substantially equivalent to the coverage that was in effect before the date coverage was suspended. Classification of premiums must be at least as favorable to the policyholder as the premium classifications that would have applied if coverage had not been suspended.

10. Required disclosures for Medicare-eligible applicants [Reg. 40.15; 71.13]

a. Insurers that offer health insurance policies that provide hospital or medical expense coverage must provide all applicants who are eligible for Medicare by reason of age a *Guide to Health Insurance for People with Medicare*. The guide must also include an attachment concerning Massachusetts Medicare supplement insurance. The guide must be provided at the time of application, and the insurer must obtain acknowledgment of receipt of the guide. Direct response carriers must deliver the guide upon request, but no later than at the time the policy is delivered.

b. Any health, long-term care, disability income, or other policy issued to persons eligible for Medicare (other than a Medicare supplement policy) must notify insureds that the policy is not a Medicare supplement policy. The notice must be printed or attached to the first page of the outline of coverage or the policy.

c. Applications provided to persons eligible for Medicare must disclose the extent to which the policy duplicates Medicare.

11. Standardized plans [Regs. 71.08, 71.90-71.92 (Appendices A-C)] There are three standardized Medicare supplement policies available in Massachusetts: the core policy, Supplement 1, and Supplement 2. No other Medicare supplement policies are available. All three must provide the benefits established by law and may not provide any additional benefits except as otherwise permitted by law.

L. COORDINATION OF BENEFITS [Regs. 38.01-.08] This type of provision helps to avoid claim payment delays and any duplication of benefits when two or more policies are owned by (or cover) an individual. The initial contract owned or protecting the covered person is generally viewed as the primary policy. All subsequent or supplementary accident and health contracts owned or covering the insured are considered to be secondary or excess coverage. The primary contract will pay its benefits first, and the secondary policies will follow.

1. Rules for coordination of benefits [Reg. 38.05] The primary plan must pay its benefits as if secondary plans did not exist. A plan that does not include a coordination of benefits provision may not take the benefits of another plan into account when it determines its benefits. There is one exception—a contract holder's coverage that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage is excess to any other parts of the plan provided to the contract holder. Any plan containing a coordination of benefits (COB) provision must provide information to those covered about its COB provision and the rules used to determine primary and secondary coverage and calculate allowable expense.

a. A plan may take the benefits of another plan into account only when it is secondary to that other plan.

b. The benefits of the plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) are determined before those of the plan that covers the person as a dependent.

c. If two or more plans cover a dependent child whose parents are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the parent for a shorter period.

d. Unless there is a court decree to the contrary, if two or more plans cover a dependent child whose parents are divorced or separated, the order of payment is:

- first, the plan of the parent with custody of the child;
- second, the plan of the spouse of the parent with the custody of the child; and
- third, the plan of the parent not having custody of the child.

e. The benefits of a plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

f. If none of the above rules determines the order of benefits, the benefits of the plan that covered a person longer are determined before those of the plan that covered a person for the shorter term.

M. SMALL GROUP HEALTH PLANS The information presented here is based on Massachusetts insurance regulations specifically addressing small group plans.

1. Definition of a small group [176J:1] A **small group** means a business or organization that employs, on at least 50% of its working days, one and up to 50 employees, including owners and self-employed persons.

a. Definition of eligible employee [Reg. 66.04] An eligible employee is one who:

- works on a full-time basis with a normal workweek of at least 30 hours, including an owner, a sole proprietor, or a partner of a partnership; and
- is hired to work for a period of at least five months.

b. Participation requirement [Reg. 66.04] For groups of five or fewer eligible persons, a carrier may require a participation rate of 100%. For groups of six or more eligible persons, a carrier may require a participation rate of up to 75%.

2. Availability of coverage [Reg. 66.05] Small group carriers are required to make available to every eligible small business every health insurance plan it currently makes available to any eligible small business and at the same price.

a. A carrier may deny a group of five or fewer enrollment in a health benefit plan unless the group enrolls through an intermediary or The Commonwealth Health Insurance Connector Authority (the Connector).

b. Carriers are not required to issue a health benefit plan for an eligible small business if the carrier can demonstrate that:

- the business has made at least three or more late premium payments in a 12-month period;
- the business has committed fraud or misrepresentation;
- the business has noncompliance with plan provisions;
- the business has been covered by three or more plans during the four preceding years;
- the small business fails to comply with the carrier's reasonable requests; or
- acceptance of the group will financially impair the carrier.

c. Due to 2012 changes in state and federal laws, carriers transitioned from continuous open enrollment for eligible employees to a limited open enrollment. The new open enrollment takes place each year between July 1 and August 15 for both the individual and small group markets (called the "Merged Market").

This open enrollment period does not apply to people enrolling in employer-sponsored health insurance or seeking coverage in government plans like Medicare or Medicaid.

Some people may meet special conditions (qualifying events) to buy outside of the open enrollment period. For example, a person may qualify if he used some of his COBRA benefits but canceled them within the past 30 days.

3. **Renewability of coverage [Reg. 66.06]** Every plan must be renewable with respect to all eligible persons and eligible dependents, except for reasons that permit a carrier to deny issuance of a plan as listed above; a carrier must provide at least 60 days' advance notice of its intent not to renew.

4. **Preexisting conditions and waiting periods [176J:5; Reg. 66.07]**

   a. Carriers may not exclude any eligible individual, employee, or dependent from a health benefit plan on the basis of age, occupation, actual or expected health condition, claims experience, duration of coverage, or medical condition.

   b. Carriers may not modify the coverage of an eligible individual, employee, or dependent through riders or endorsements or otherwise restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan, except as permitted by law.

   c. Health benefit plans may not include preexisting condition provisions that exclude coverage beyond six months after the date of enrollment, issued to eligible persons aged 19 and over, including eligible individuals, employees, or dependents. Pregnancy may not be a preexisting condition.

   d. Health benefit plans may not include waiting periods that exclude coverage for more than four months following the date of enrollment. No waiting period may be imposed if an eligible individual, employee, or dependent lacked creditable coverage for 18 months or more immediately before the date of enrollment.

   e. When an eligible individual or eligible small group changes from one health benefit plan to another, the carrier may impose a new waiting period of up to four months on any services that are covered under the new plan but were not covered under the old plan.

   f. In determining whether a preexisting condition provision or waiting period applies to an eligible individual, employee, or dependent, health benefit plans must credit the time the person was covered under prior creditable coverage if the prior creditable coverage was continuous to a date no more than 63 days before the request for new coverage, exclusive of any applicable waiting period under the new coverage.

   g. If a health benefit plan includes a waiting period, emergency services must be covered during the waiting period.

   h. A carrier may impose either a preexisting condition limitation or a waiting period but not both.

5. **Rates [Reg. 66.08]** The group base premium rates charged to an eligible small business and eligible individuals within any group purchasing cooperative may not exceed two times the group base premium rate that could be charged to the eligible

small business with the lowest group base premium rate for that rate basis type within that class of business and geographic area.

a. Rates may not be based on health status, duration of coverage, or actual or expected claims experience.

6. Continuation of coverage [176J:9] Subject to certain limitations, every carrier must offer continuation coverage under a health benefit plan to any qualified beneficiary who would lose coverage under the plan as the result of a qualifying event and who makes a written election for continued coverage within the election period. A qualifying event includes:

- death of the eligible employee;
- termination of employment other than by reason of the employee's gross misconduct or reduction of hours of the eligible employee's employment;
- divorce or legal separation of the eligible employee;
- eligible employee becomes eligible for Medicare;
- dependent child loses his eligibility under the plan; or
- a proceeding under federal bankruptcy law with respect to the employer from whose employment the eligible employee retired.

a. The continuation period must extend for at least 18 months if the prior coverage is lost because of termination of employment. In most other cases, the continuation period must extend for at least 36 months.

1.) The continuation period will terminate earlier than 18 or 36 months if the qualified beneficiary becomes covered under another health plan or becomes eligible for Medicare.

b. The carrier may require the beneficiary to pay a premium for the continuation coverage. The premium may not exceed 102% of the premium charged for other beneficiaries who have not had a qualifying event.

c. The carrier may not require evidence of insurability as a condition for issuing continuation coverage.

d. If a qualified beneficiary's continuation period expires, the carrier must offer the beneficiary the option of enrolling in a conversion nongroup plan. The offer must be made during the 180-day period before the continuation period expires.

e. The period for electing continuation coverage extends for 60 days following the loss of coverage under the previous plan.

f. These rules do not apply to health plans that cover only one eligible employee or more than 19 eligible employees.

N. MEDICAL EXAMINATIONS AND LAB TESTS [Reg. 36.05]

1. Before an insurer may conduct an AIDS-related test, the individual to be tested must give prior written informed consent to the insurer, laboratories and blood testing centers, or agents involved in the testing. The consent must indicate that the individual understands that the test is being performed, the nature of the test, the persons or entities that may have access to the test results, the purpose for which the test results may be used, and any reasonably foreseeable risks and benefits resulting from the test.

2. An authorization to conduct an AIDS-related test may be valid for no longer than 90 days after the date on which the informed consent form is signed.

3. The tested individual must be notified of positive test results no later than 45 days after the individual's blood sample is taken. The individual must have the option to receive the information from a physician he designates on the form or directly from the insurer. The individual may change his election by so informing the insurer in writing.

O. REQUIRED COVERAGES The following coverages must be included with each health insurance plan issued in the state of Massachusetts.

1. Newborn and adopted children; disabled adult children [175:47C; 175:108(2)(a)(3); 176A:8B; 176A:8(d); 176B:6(c); 176B:4C; 176G:4] All individual and group health insurance policies providing coverage on an expense-incurred basis or those issued by an indemnity corporation that provides coverage for a family member of the insured or subscriber must also provide that the health insurance benefits applicable for children are payable with respect to a newly born or newly adopted child of the insured or subscriber from the moment of birth or the filing of a petition to adopt. Coverage also extends to adult children who are physically or mentally handicapped dependents.

a. The coverage for children will also consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

b. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newborn or adopted child and payment of the required premium or fees must be furnished to the insurer or indemnity corporation.

c. Preventative care services are provided from birth through the attainment of age six; early intervention services will be provided from birth through the child's third birthday.

d. Coverage also may extend to the policyholder's spouse, dependent children and other dependent persons, children during pendency of adoption procedures, and children under age 26.

1.) Coverage may include children age 26 or older who are mentally or physically incapable of earning their own living, if the insurer receives proof of incapacity within 31 days of the date when coverage would otherwise be terminated.

P. MASSACHUSETTS CHILD HEALTH INSURANCE PROGRAM (CHIP) [118E.9A, 16C] The program provides medical assistance or medical benefits to infants, children, and adolescents to age 18 whose financial eligibility does not exceed 300% of the federal poverty level. This CHIP plan is now part of the MassHealth plan.

Q. PROHIBITED USE OF GENETIC INFORMATION [175:108H, 108I] No insurer may cancel, refuse to issue or renew, or in any way make or permit any distinction or discrimination in the amount of payment of premiums or rates charged, the length of coverage, or any other of the terms and conditions of any individual policy of long-term care, disability, accident, or sickness insurance based on genetic information. **Unfair discrimination** means cancellation, refusing to issue or renew, charging any increased rate, restricting any length of coverage, or in any way practicing discrimination against persons unless such action is taken pursuant to reliable information relating to the insured's mortality or morbidity, based on sound actuarial principles or actual or reasonably anticipated claim experience.

1. An application form may ask whether the applicant has taken a genetic test, but the applicant is not required to answer such a question. An application requesting this information must contain language informing the applicant that he is not required to answer any questions in connection with genetic testing and that failure to do so may result in an increased rate or denial of coverage.

a. If the applicant chooses to submit genetic information, the insurer can use that information to set the terms of a policy as long as the information is reliably related to the insured's mortality or morbidity, based on sound actuarial principles, or actual or reasonably anticipated experience.

R. NONDISCRIMINATION [175:108C; 176A:3A, 176A:8E; 176B:4E, 176B:5A; 176G:19] Health insurers cannot discriminate against anyone because that person has been:

- exposed to, or suspected of exposure to, the potential hazards of diethylstilbestrol (DES); or
- been a victim of abuse (domestic, child, or otherwise).

This kind of discrimination is considered an unfair method of competition or an unfair or deceptive act or practice.

S. OVERVIEW OF THE STATE'S SPONSORED HEALTH INSURANCE PLANS The state sponsored three major health insurance plans for residents—MassHealth, Commonwealth Care, and Commonwealth Choice. With the roll out of the Patient Protection and Care Act, residents of Massachusetts either maintain their eligibility through MassHealth or essentially obtain health coverage through the Connector after January 2014.

T. MASSHEALTH HEALTH CARE PLAN [118E:9A] MassHealth is a public comprehensive health insurance program for eligible low and middle income state residents. It is the name used for the Medicaid program and the Child Health Insurance Program (CHIP) combined into one program. Medical benefits include managed care programs provided to beneficiaries pursuant to the terms and conditions established by the division and the PPACA, and including but not limited to medical insurance purchased for plan beneficiaries.

1. MassHealth may provide a program or programs of medical benefits to one or more of the beneficiary categories described in the following clauses:

- Children and adults who, in the absence of a demonstration project, would be otherwise eligible for medical assistance pursuant to section nine and who fall within the definition of traditional beneficiaries, including those individuals who received medical assistance
- Infants to age one and pregnant women whose financial eligibility as determined by the division does not exceed 200% of the federal poverty level, and children and adolescents aged one to 18 years, inclusive, whose financial eligibility as determined by the division falls between 133% and 300% of the federal poverty level and who would otherwise not qualify for Medicaid within the definition of traditional beneficiaries
- Adults 21 to 64, inclusive, whose financial eligibility as determined by the division does not exceed 133% of the federal poverty level and who otherwise would not qualify for Medicaid within the definition of traditional beneficiaries; provided, however, that these adults meet other eligibility criteria that the division and the secretary may establish, including, but not limited to, the presence of dependent children in the household
- Persons who are disabled, blind, or chronically ill and eligible for benefits
- Persons receiving, or eligible to receive, unemployment insurance benefits who meet the eligibility requirements established under MassHealth
- Persons who would be eligible for financial or medical assistance under the foregoing clauses, but for income or resources, except where the terms and conditions of the demonstration project provide for more restrictive or less restrictive eligibility criteria, including the payment of premiums as a condition of eligibility
- Persons who have tested positive for the human immunodeficiency virus whose financial eligibility as determined by the division does not exceed 200% of the federal poverty level

2. The division may establish premium and copayment amounts for plan beneficiaries of MassHealth. These premiums and copayments may be established on a sliding scale commensurate with beneficiary income levels. The division may waive premiums and copayments upon a finding of substantial financial or medical hardship.

3. Residency requirements [Reg. 130 CMR 503.002] To be eligible for MassHealth, an applicant or member must be 21 or older and live in Massachusetts with the intent to remain permanently or for an indefinite period but is not required

to maintain a permanent residence or fixed address. Examples of applicants or members who do not meet the residency requirement for MassHealth are:

- inmates of penal institutions; and
- individuals who came to Massachusetts for the purpose of receiving medical care in a setting other than a nursing facility and who maintain a residence outside of Massachusetts.

4. Exclusions [Reg. 130 CMR 503.007] MassHealth is the payor of last resort and generally pays for health care and related services only when no other source of payment is available. All applicants and members must obtain and maintain any available group health insurance or after 2014, obtain insurance through the Connector. Failure to do so may result in loss of eligibility for all individuals within the family group unless the applicant or member is:

- receiving MassHealth Standard or MassHealth CommonHealth; and
- under age 21 or pregnant.

a. MassHealth does not pay for health care and related services that are available:

- through the member's health insurance, if any; or
- at no cost to the member, including services that are available through a local, state, or federal agency, or any entity legally obligated to provide those services.

5. Coinsurance [Reg. 130 CMR 520.037, 038] The required co-payments for MassHealth members include:

- $1 for each prescription and refill for each generic drug and over-the-counter drug covered by MassHealth that are mainly used to treat diabetes, hypertension, and high cholesterol;
- $3.65 for each prescription and refill for all other drugs covered by MassHealth; and
- $3 for an acute inpatient hospital stay.

a. Excluded individuals Individuals who are not required to pay co-payments under MassHealth include:

- members under age 21;
- members who are pregnant or in the postpartum period that extends through the last day of the second calendar month following the month in which their pregnancy ends (for example, if the woman gave birth May 15, she is exempt from the co-payment requirement until August 1);
- members who are inpatients in nursing facilities, chronic disease or rehabilitation hospitals, or intermediate-care facilities for the mentally retarded or are admitted to hospitals from such facilities; and
- members receiving hospice services.

1.) Members who have accumulated co-payment charges totaling the calendar-year maximum of $250 on pharmacy services do not have to pay further co-payments on pharmacy services during the calendar year.

2.) Members who have accumulated co-payment charges totaling the calendar-year maximum of $36 on nonpharmacy services do not have to pay further co-payments on nonpharmacy services during the calendar year.

3.) Members who have other comprehensive medical insurance, including Medicare, do not have to pay co-payments on nonpharmacy services.

4.) Members who are inpatients in a hospital do not have to pay a separate co-payment for pharmacy services provided as part of the hospital stay.

b. Excluded services Services that are not subject to co-payment requirements under MassHealth include:

- family-planning services and contraceptive supplies;
- nonpharmacy behavioral health services;
- provider-preventable services; and
- emergency services.

U. LONG-TERM CARE [Reg. 65] The purpose of long-term care regulation is to protect purchasers of coverage from deceptive sales practices and to establish standards for this type of insurance.

1. Disclosure requirements [Reg. 65.09; 65:100; 65:101] Individual and group long-term care insurance policies must adequately disclose all policy provisions and comply with the specific disclosure requirements discussed in this section.

a. The first page of the policy must contain the following disclosures.

1.) If the policy does not provide coverage for care in a nursing home, a notation of that fact must be attached in at least 18-point type or in some other manner that distinguishes it from the other print appearing in the policy.

2.) There must be a statement that the policy may not cover all the costs associated with long-term care incurred by the buyer during the period of coverage and that the buyer is advised to review carefully all policy limitations.

3.) A section in boldface type highlighted on the first page of the policy must either list all preexisting condition exclusions or limitations or refer the individual to the section in the policy that lists all preexisting condition exclusions or limitations.

4.) A renewability notice must clearly identify whether the policy is noncancelable or guaranteed renewable and whether it is being issued on other than an individual basis. Policies providing conversion privileges must specify the benefits to be provided or must state that the converted coverage will be on the policy form then being issued by the carrier for this purpose.

5.) A statement indicating whether the policy is intended to be a **federally qualified** long-term care insurance contract and whether the policy is intended to satisfy the coverage requirements for certain asset and liability exemptions under the Massachusetts MassHealth (Medicaid) program.

b. Policy language All terms used in the policy must be fully explained so that the insured understands the relationship to the benefits covered. No misleading policy names may be used. The policy, riders, and all amendments, as well as the application, outline of coverage, and other required disclosure materials must be presented in at least 12-point type and must satisfy the readability standards of Massachusetts law.

1.) Riders or endorsements that provide a benefit for which a specific premium is charged must show the premium on the application, rider, or elsewhere in the policy. Any rider that reduces benefits requires a signed acceptance by the policyholder.

c. Separate disclosure forms

1.) Your Options for Financing Long-Term Care: [Reg 65.09(3)(a)] A Massachusetts Guide A long-term care insurance policy may not be delivered or issued for delivery in Massachusetts unless the potential insured receives *Your Options for Financing Long-Term Care: A Massachusetts Guide*, including any inserts, as prescribed by the Commissioner, regarding changes to state or federal laws, no later than the first face-to-face contact between the potential insured and the agent, or in cases of direct response sales, at the time that the application or enrollment form is sent to the potential insured.

2.) Policy illustration [Reg 65.09(3)(b)] A long-term care insurance policy may not be delivered or issued for delivery in Massachusetts unless the applicant receives a policy illustration in a form prescribed by the regulations. The carrier or its agents must deliver the policy illustration no later than the time of each policy proposal or quote. In the case of direct response sales, the carrier must deliver the form at the time that the application or enrollment form is sent to the potential insured.

3.) Outline of coverage [Reg 65.09(3)(c), 101] A long-term care insurance policy may not be delivered or issued for delivery in Massachusetts unless the applicant receives an outline of coverage substantially similar to the one provided in the regulations. The carrier or its agent must deliver the outline of coverage prior to the presentation of the application or enrollment form. In the case of direct response sales, the carrier must deliver the outline of coverage at the time that the application or enrollment form is sent to the potential insured. The carrier must also make an outline of coverage available at any time at the potential insured's request. The outline of coverage must be a document separate from the policy.

d. Special disclosure forms

1.) Other than requested If the policy is issued on a basis other than that applied for, a disclosure statement properly describing the actual policy terms must accompany the policy when it is delivered. The statement must list the ways in which the coverage as issued differs from that requested.

2.) Required disclosure regarding changes to MassHealth (Medicaid) eligibility and recovery exemptions If the carrier issued a policy that met the standards for asset protection under MassHealth and those standards are later changed, the carrier must notify all insureds whose policies will no longer satisfy the standards and offer them on a guaranteed issue basis the opportunity to purchase needed benefits to meet the MassHealth (Medicaid) policy criteria. The rates for any change in benefits must be based on the insured's rate characteristics at the time of policy change.

2. Inflation adjustment benefit [Reg. 65.06(1)] Insurers must offer some form of inflation adjustment at the time of application; the option to purchase the inflation protection must be offered without additional underwriting. The insurer must require the applicant to specifically reject this benefit on the application if the applicant chooses not to include the benefit in the individual policy.

3. The term *long-term care insurance* includes group and individual policies or riders whether issued by insurers, fraternal benefit societies, nonprofit health, hospital and medical service corporations, prepaid health plans, HMOs, or any similar organization.

4. Prohibition on post claims underwriting [Reg. 65.11] Post-claims underwriting is prohibited: an insurer must determine an applicant's acceptability as an insured before a policy is issued.

5. Limitations and exclusions [Reg. 65.05(3)] Preexisting condition limitations must be identified on the front of the policy and the outline of coverage. No long-term care policy may include a preexisting condition provision of more than six months. The only permissible exclusions include:

- war or act of war;
- participation in a felony, riot, or insurrection;
- service in the armed forces;
- attempted suicide or intentionally self-inflicted injury;
- aviation (applies only to non-fare paying passengers);
- services for alcohol or drug detoxification;
- services for which benefits are payable under government programs such as Medicare, workers' compensation, or any motor vehicle no-fault law;
- services provided by members of the insured's immediate family; and
- services for which no amount is normally charged in the absence of insurance.

a. An individual policy may not exclude otherwise eligible persons from policy benefits due to the presence or history of mental or nervous conditions, Alzheimer's disease, alcoholism, or other chemical dependency.

b. An individual policy may not exclude otherwise eligible policy benefits because those benefits are also payable by a non-Medicare government agency or because the covered services are being received in a governmental facility.

6. Standards for agent training and marketing [Reg. 65.08] Requirements for producer training and marketing are as follows.

a. Each carrier must provide appropriate training to producers about its long-term care insurance products, maintain records regarding producers who have satisfactorily completed such training, and file with the Commissioner lists identifying those producers who have completed the carrier's long-term care insurance training program.

b. All long-term care insurance marketing and advertising must conform to the applicable code provisions. In addition, carriers must establish auditable internal marketing procedures, methods for assuring compliance by producers, and prohibitions against twisting, high-pressure tactics, and cold-lead advertising.

c. All producers marketing a carrier's long-term care insurance must clearly identify which plans being offered are individual products and which are group products. When marketing group products, the producer must clearly identify the name of the group policyholder and any conditions that the eligible person must satisfy to join and remain a member of the group.

d. All producers marketing a carrier's long-term care insurance must disclose to potential applicants the name of the carrier that the producer represents in the sale. The carrier's name must be disclosed on any and all printed sales materials provided, distributed, or shown to potential applicants and/or during presentations made to potential applicants in association with a sale, whether part of a presentation or not.

e. All producers marketing a carrier's long-term care insurance policy must disclose the fact that the producer receives compensation in connection with the sale or replacement of long-term care insurance.

f. All producers marketing a carrier's long-term care insurance may not misrepresent their expertise, qualifications, or training to potential clients and may not comment on the legal or tax implications of purchasing long-term care insurance to the extent that they lack the training, qualification, or license to provide such advice.

g. A carrier whose producer fails to comply with any of these provisions will be deemed to have committed an unfair and deceptive act in the business of insurance.

7. **Nonforfeiture benefit offer [Reg. 65.06(2)]** A carrier must make available, at the time of application, an option to purchase a nonforfeiture benefit. The applicant must be informed regarding the cost of this benefit. The carrier must require the applicant to specifically reject this benefit on the application if he chooses not to include it in the individual policy.

8. **Home health care [Reg. 65.05(2)(c); 65.06(3)]** Carriers must offer all applicants for long-term care insurance at least one policy covering home health care.

   a. An individual policy that provides benefits for home health care services may not limit or exclude benefits by:
   - requiring that the insured would need care in a skilled nursing facility if home health care were not provided;
   - requiring that the insured first or simultaneously received nursing or therapeutic services, or both, in a hospital or institutional setting before home health care services are covered;
   - limiting eligible services to services provided by registered nurses or licensed practical nurses;
   - requiring that the provisions of home health care services be at a level of certification or licensure greater than that required by the eligible services;
   - requiring that the insured have an acute condition before home health care services are covered; or
   - limiting benefits to services provided by Medicare-certified agencies or providers.

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

   c. Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

9. ***MassHealth exemption [Reg. 515.014]*** A long-term care policy must meet certain minimum coverage requirements to entitle the insured to the MassHealth exemptions. These rules exempt the insured's former home and certain other assets from the rules that normally allow the commonwealth to recover nursing home and other long-term care expenses from the estates of people who received commonwealth assistance during their lives.

   a. To qualify for the MassHealth exemptions, an individual must be covered under a long-term care policy that meets the individual policy minimum standards and all of the following requirements.

      1.) The policy must cover nursing and custodial care in a nursing facility licensed by the Department of Public Health.

2.) The policy must have available benefits of at least $125 per coverage day in a nursing facility, except where the actual expense incurred is less, regardless of whether accrued benefits are measured in terms of days or dollar amount.

3.) The policy must have benefits available sufficient to cover at least 730 days in a nursing facility.

4.) The policy may not have an elimination period longer than 365 days in a nursing facility. The application of more than one elimination period is not allowed unless the insured has received no benefits for at least 180 consecutive days. In lieu of an elimination period, the policy may have a deductible of no more than $54,750.

10. Benefit triggers [Reg. 65.05(1)]

a. Individual long-term care policies that are not intended to be federally qualified may not include benefit eligibility standards that are more stringent than a requirement that the insured be unable to perform at least two activities of daily living (ADLs) due to a loss of functional capacity or a severe cognitive impairment.

b. Individual policies that are intended to be federally qualified must meet the standards provided in the federal Internal Revenue Code and related federal regulations.

11. Protection against unintentional lapse [Reg. 65.10]

a. Notice of nonpayment of premiums before lapse or termination No individual or group long-term care insurance policy may be issued until the carrier has received from the applicant either a written designation of at least one additional person who is to receive notice of lapse or termination for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The carrier must notify the insured of the right to change this written designation at least once every two years.

b. Lapse or termination for nonpayment of premium A long-term care insurance policy may not lapse or be terminated for nonpayment of premium unless the carrier, at least 30 days before the effective date of the lapse or termination, gives notice to the insured and any persons designated by the insured for purposes of receiving notice of lapse or termination. Notice must be given by first class US mail, postage prepaid, no sooner than 30 days after a premium is due and unpaid. Notice is considered to be given as of 10 days after the date of mailing.

c. Reinstatement All long-term care insurance policies must include a provision for reinstatement of coverage in the event of lapse, if the carrier is provided proof that the insured was cognitively impaired or had a loss of functional capacity before expiration of the policy's grace period. Reinstatement must be available to the insured if requested within five months after termination and must allow for the collection of any past-due premium.

12. Disclosures regarding suitability standards [Reg. 65.09(4)(b)] If an insurer uses a worksheet or other marketing material to examine a potential applicant's financial situation, or uses any other marketing material that provides guidance as to whether the applicant is suitable for long-term care insurance and subsequently notifies the applicant that the insurer finds the applicant to be suitable for long-term care insurance, the insurer must provide a disclosure notice that:

- states the insurer has determined that the applicant meets its internal standards of suitability, but there are other considerations that might influence the applicant's decision about whether this product is appropriate;
- lists the standards the insurer uses to determine suitability for its long-term care insurance policies; and
- advises the applicant not to rely on this statement alone in making the purchase and to contact a financial advisor for additional information.

13. Right to return [Reg. 65.101(5)] Long-term care insurance policies must provide a free-look period of at least 10 days from the date of policy delivery.

MASSACHUSETTS LAW SUPPLEMENT PRACTICE FINAL

Student instructions: Following your thorough study of this supplement, take this 50-question sample examination. Grade your performance using the answer key provided. Carefully review the topics pertaining to those questions answered incorrectly.

I. General Insurance

1. When a producer collects money from a prospective insured, where should the money be placed?
   A. In his own bank account
   B. In a premium trust account
   C. In a joint agency account
   D. In a separate account

2. Pointing out to a prospective client that the life insurance policy you are presenting is covered by the Massachusetts Life and Health Insurance Guaranty Association is
   A. an excellent sales idea
   B. prohibited by law
   C. encouraged by the state Division of Insurance required to be part of every sales presentation
   D. allowed if the producer gives the Buyer's Guide

3. If the Commissioner finds that an individual is impersonating a producer, the violator may be assessed which of the following penalties?
   A. A $100 fine
   B. A $150 fine
   C. A $250 fine
   D. A $500 fine

4. Which of the following regarding an adviser's license is TRUE?
   A. It is issued by an admitted insurer.
   B. Its duration is 10 years.
   C. It may be issued to a partnership.
   D. No application is required to be submitted nor exam taken in order to become an adviser.

5. An applicant for insurance who knowingly shares a producer's commission in return for purchasing a policy is guilty of
   A. rebating
   B. twisting
   C. coercion
   D. collusion

6. All of the following statements are correct regarding Massachusetts' continuing education requirements EXCEPT
   A. 60 hours of approved continuing education must be completed during the first 3 years of licensure
   B. 45 hours of approved continuing education must be completed during the second 3-year term of licensure
   C. the requirements do not apply to persons licensed to sell variable contracts
   D. any excess credits earned during one reporting period may be carried forward to the next

7. An applicant whose application for a producer license has been denied and who desires a hearing with the Commissioner must file a written demand for a hearing within
   A. 15 days
   B. 30 days
   C. 45 days
   D. 60 days

8. A fine of not more than $1,000 and imprisonment for not more than 6 months best identifies the penalties for
   A. rebating
   B. larceny
   C. unfair claim practices
   D. misrepresentation

9. All of the following are powers and duties of the Commissioner EXCEPT
   A. issue cease and desist orders
   B. prosecute brokers who violate state insurance laws
   C. examine domestic insurance companies
   D. conduct complaint hearings

10. All of the following statements are correct regarding an insurance adviser EXCEPT
    A. an adviser must supply 3 references with the application for a license
    B. an adviser must be a Massachusetts resident
    C. an adviser must also be licensed as an insurance producer
    D. an adviser must pass a written licensing examination

11. Offering a valuable consideration to an applicant or insured that is not specified in an insurance policy best describes
    A. twisting
    B. hedging
    C. larceny
    D. rebating

12. Larceny is an unfair trade practice in Massachusetts. All of the following situations describe this practice EXCEPT
    A. a producer collects premiums from an insured and intentionally withholds them from an insurer
    B. a producer is overdue in sending premiums to an insurer after collecting them from an insured
    C. a producer combines collected premiums with his own funds in order to avoid paying an insurer
    D. a producer fails to refund premium due an insured

13. A producer who disregards overdue premium notices from an insurer may be guilty of
    A. misrepresentation
    B. larceny
    C. rebating
    D. perjury

14. In Massachusetts, a producer must be at least how many years of age?
    A. 18
    B. 19
    C. 20
    D. 21

15. An adviser's license renews every
    A. 2 years
    B. 3 years
    C. 4 years
    D. 5 years

16. A temporary license may be issued for no longer than
    A. 30 days
    B. 45 days
    C. 90 days
    D. 180 days

17. An individual who lets her producer license lapse may reinstate her license within how many months without taking another licensing exam?
    A. 6
    B. 12
    C. 24
    D. 36

18. A producer who changes his address must notify the Commissioner
    A. as soon as possible
    B. within 30 days
    C. within 45 days
    D. within 90 days

19. After a producer's initial 36-month license renewal period, how many continuing education credits must be earned before her next license renewal?
    A. 12
    B. 24
    C. 45
    D. 60

20. If an individual violates a cease and desist order issued by the Commissioner, he will be subject to a fine of
    A. $1,000
    B. $2,500
    C. $5,000
    D. $10,000

21. A person who commits a deceptive act or practice may be fined not more than
    A. $1,000
    B. $2,500
    C. $5,000
    D. $10,000

22. The Commissioner must inspect the financial records of each domestic company every
    A. year
    B. 2 years
    C. 5 years
    D. 10 years

23. A policy form may not be used in Massachusetts unless it has been approved by the Commissioner or on file for at least
    A. 30 days
    B. 90 days
    C. 6 months
    D. 1 year

24. When an insurer appoints a producer as its agent, the Commissioner must be notified
    A. within 15 days
    B. within 30 days
    C. within 45 days
    D. as soon as possible

25. A producer is required to maintain and retain a complaint record for
    A. 1 year
    B. 2 years
    C. 3 years
    D. 4 years

26. The federal regulation that permits an applicant for insurance coverage to dispute any adverse information that surfaces on a credit report is known as the
    A. Privacy Act
    B. Brady Bill
    C. Fair Credit Reporting Act
    D. Applicant Bill of Rights

27. Insureds of an insolvent insurer who sustain a loss in Massachusetts may have their claim paid by
    A. the Assigned Risk Plan
    B. the Insurance Commissioner
    C. the Massachusetts Life and Health Insurance Guaranty Association
    D. no agency; their claim would not be paid

28. If a party seeking to recover on an insurance policy has been damaged by an unfair or deceptive trade practice, the court may award additional punitive damages of up to
    A. 5% of the claim
    B. 10% of the claim
    C. 25% of the claim
    D. 50% of the claim

29. A producer must report to the Commissioner any administrative action taken against her by any governmental agency within
    A. 10 days
    B. 15 days
    C. 30 days
    D. 45 days

30. A producer doing business under an assumed name must notify the Commissioner
    A. within 30 days
    B. within 45 days
    C. within 90 days
    D. prior to using the assumed name

31. An insurance producer earning 55 continuing education credits during his second license renewal period
    A. will lose 10 credits
    B. may carry 10 credits over to their next renewal period
    C. needs 5 more credits to renew his license
    D. will be required to return any extra credits earned

32. A notice of a hearing concerning a license suspension must be delivered by
    A. messenger
    B. the Commissioner
    C. first-class mail
    D. registered mail

II. Life Insurance

33. Accelerated benefits provided by a life insurance policy that may provide benefits to pay for long-term care services
    A. are received tax free like all other life insurance proceeds
    B. could be taxable in some circumstances
    C. are paid only from policy dividends
    D. when paid, have no effect on the death benefit

34. A buyers' guide, which must be presented to life insurance policy applicants, is
    A. generally required to be given before premium is accepted
    B. a sales tool developed by each life insurance company
    C. a complete summary of the policy being presented
    D. always presented to the insured after the policy is issued

35. Which of the following parties is responsible for the payment of examination (audit) expenses?
    A. The insurer being examined
    B. The Division of Insurance
    C. The Commissioner of Insurance
    D. The auditing department of the corporation

36. The required free-look period for individual life insurance policies with face amounts less than $25,000 is
    A. 7 days
    B. 10 days
    C. 20 days
    D. 30 days

37. When a life insurance policy replacement occurs, the producer must provide the insured with a
    A. premium statement
    B. policy receipt
    C. copy of all sales materials
    D. replacement disclosure notice

38. Generally, the maximum period that a life insurance policy may be backdated is
    A. 1 month
    B. 3 months
    C. 6 months
    D. 9 months

39. When an existing life insurance policy is replaced, the replacement policy must have a free-look period of how many days?
    A. 10 days
    B. 15 days
    C. 20 days
    D. 30 days

40. Any person with access to the assets in an insurer's separate account for variable products must be bonded for at least
    A. $10,000
    B. $25,000
    C. $50,000
    D. $100,000

41. An authorization to conduct an AIDS-related medical examination may remain valid for no more than
    A. 30 days
    B. 90 days
    C. 180 days
    D. 365 days

III. Accident and Sickness Insurance

42. All of the following are permissible exclusions in a long-term care insurance policy EXCEPT
    A. self-inflicted injuries
    B. participation in a felony
    C. acts of war
    D. Alzheimer's disease

43. Medicare supplement policies may not include renewal provisions less favorable to the insured than
    A. conditionally renewable
    B. nonrenewable
    C. noncancellable
    D. guaranteed renewable

44. Health insurance policies issued in Massachusetts must provide a free-look period of at least
    A. 10 days
    B. 20 days
    C. 30 days
    D. 60 days

45. Under an individual or group health insurance policy, an insured's dependent children can generally be covered up to the age of
    A. 19
    B. 21
    C. 23
    D. 26

46. Under an individual or group health insurance policy, an insured's newborn child must be covered from
    A. the moment of birth
    B. the date the insurer receives any required additional premium
    C. 31 days after the child's birth
    D. the child's first birthday

47. The number of standardized Medicare supplement policies available in Massachusetts is
    A. 3
    B. 5
    C. 7
    D. 9

48. First-year commissions on Medicare supplements may not exceed
    A. 75% of the compensation paid in the second year
    B. 100% of the compensation paid in the second year
    C. 150% of the compensation paid in the second year
    D. 200% of the compensation paid in the second year

49. Medicare supplement policies in Massachusetts may contain
    A. waiting periods but not preexisting conditions exclusions
    B. preexisting conditions exclusions but not waiting periods
    C. both waiting periods and preexisting conditions exclusions
    D. neither waiting periods nor preexisting conditions exclusions

50. A provision in a long-term care policy issued in Massachusetts limiting preexisting conditions may not exceed
    A. 30 days
    B. 3 months
    C. 6 months
    D. 12 months

ANSWERS TO MASSACHUSETTS LAW PRACTICE FINAL

1. **B**	11. **D**	21. **A**	31. **B**	41. **B**
2. **B**	12. **B**	22. **C**	32. **D**	42. **D**
3. **A**	13. **B**	23. **A**	33. **B**	43. **D**
4. **C**	14. **A**	24. **A**	34. **A**	44. **A**
5. **A**	15. **B**	25. **B**	35. **A**	45. **D**
6. **C**	16. **D**	26. **C**	36. **B**	46. **A**
7. **B**	17. **B**	27. **C**	37. **D**	47. **A**
8. **D**	18. **B**	28. **C**	38. **C**	48. **D**
9. **B**	19. **C**	29. **C**	39. **C**	49. **D**
10. **C**	20. **D**	30. **D**	40. **D**	50. **C**