

Test Alert!

Massachusetts

Life, Accident, and Health Insurance

License Exam Manual

10/10/07

L&H

The information included in this release, in addition to your other Kaplan Financial materials, is designed to assist you in preparing for concepts that your exam may include. We urge you to read it carefully and take time to review the sample questions and rationales.

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KAPLAN FINANCIAL

Massachusetts has adopted a new examination outline since the date of the publication of the License Exam Manual. To prepare for the examination based on the new examination outline, you should study the material in this *TestAlert!* in addition to the material in the License Exam Manual. Refer to the License Exam Manual when reading this information.

On page ix, insert the following in the Introduction before the section “Preparing for the Exam”:

IMPORTANT: CHECK FOR UPDATES

Exam publishers sometimes change the topics on the exam unexpectedly or on short notice. To see whether we have issued an update for this product to accommodate a change in the exam, please go to www.kaplanfinancial.com, where you will see a heading for *TestAlerts!* Click on *View Insurance TestAlerts!* to see a list of updates we have issued for our license exam manuals. Then, click on your state to see a link to a portable document file that you can download to study with your license exam manual. (If you do not see a *TestAlert!* listed for your state, we have not issued one.)

We suggest you check now, sometime during your study period, when you’ve completed your study, and one last time just before you take your exam.

On page 218, insert the following before “I. Massachusetts Insurance Regulations”:

IMPORTANT: CHECK FOR UPDATES

Exam publishers sometimes change the topics on the exam unexpectedly or on short notice. To see whether we have issued an update for this product to accommodate a change in the exam, please go to www.kaplanfinancial.com, where you will see a heading for *TestAlerts!* Click on *View Insurance TestAlerts!* to see a list of updates we have issued for our license exam manuals. Then, click on your state to see a link to a portable document file that you can download to study with your license exam manual. (If you do not see a *TestAlert!* listed for your state, we have not issued one.)

We suggest you check now, sometime during your study period, when you’ve completed your study, and one last time just before you take your exam.

On page 229, insert the following content before “2. Solvency”;

- b. Foreign companies [175:151]** 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.

On page 235, insert the following content following paragraph “a” in “3. Prohibited acts [175:170; 177]”:

- 1.) 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.

On page 235, insert the following content before “4. Unfair or deceptive insurance practices”:

- c. **Premium refunds; motor vehicle insurance [175:176A]** An insurance agent or broker who receives a return of premium on a motor vehicle insurance policy must pay the full amount to the person whose policy has been canceled within 30 days. If the person is indebted to the agent or broker, only the amount exceeding the debt must be paid. A violation is grounds for license suspension or revocation.

On page 248, insert the following content before “B. PROHIBITED ADVERTISING OF LIFE AND HEALTH INSURANCE GUARANTY LAW [175:146B(19)]”:

10. **Preneed funeral contracts [Reg. 31.06]** When a preneed funeral contract is funded by a life insurance policy, several disclosures must be made at the time of the application and before accepting the applicant’s initial premium or deposit. Items that must be disclosed include:
- the fact that a life insurance policy is being used to fund the arrangement;
 - the nature of the relationships among the soliciting producer, the provider of the funeral or cemetery merchandise or services, the administrator, and any other person;
 - the relationship of the life insurance policy to the funding of the arrangement and the nature of any guarantees relating to the arrangement;

- the effect on the arrangement of any changes in the life insurance policy, including changes in the assignment, beneficiary designation or use of the proceeds, and any penalties the policyholder may incur;
- a list of the merchandise and services that are applied or contracted for in the arrangement and relevant information concerning the price of the funeral services, including an indication that the purchase price is either guaranteed at the time of purchase or to be determined at the time of need;
- relevant information concerning what occurs and whether any entitlements or obligations arise if there is a difference between the proceeds of the life insurance policy and the amount actually needed to fund the arrangement;
- any penalties or restrictions, including geographic restrictions, on the delivery of merchandise, services, or the arrangement guarantee; and
- that a sales commission or other compensation is being paid and the identity of the individuals or entities to whom it is paid.

On page 253, substitute the following content for “D. POLICY SUMMARY [REG. 31.04]” and “E. BUYER’S GUIDE [REG. 31.00 APPENDIX]”:

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- D. POLICY SUMMARY [REG. 31.04]** Insurers must provide a policy summary to prospective purchasers of policies that are not marketed with an illustration. The policy summary must consist of a separate document 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 the policy or before delivery of the policy.
 2. Information that must be included 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.
- E. BUYER’S GUIDE [REG. 31.05]** 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 the policy or before delivery of the policy.

On page 256, insert the following content before "M. GROUP LIFE INSURANCE CONVERSION RIGHTS [175:134(4); 134A]":

- 3. Accidental death benefits; waiver of premium [175:24]** 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.

On page 263, insert the following content before "III. MASSACHUSETTS LAW AND REGULATIONS PERTINENT TO ACCIDENT AND HEALTH INSURANCE ONLY":

- R. 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.

On page 266, insert the following content following "F. DISCLOSURE OF MENTAL OR NERVOUS CONDITION [175:108E]":

1. This rule does not prohibit an insurer from:
 - disclosing aggregate patient data if the data contain 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.

On page 267, substitute the following content for “1. Preexisting conditions; waiting periods [176N:2]”

1. Unfair discrimination; waiting periods [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. Health plans may not contain a preexisting conditions provision that excludes coverage for more than six months after the individual’s date of enrollment. A preexisting conditions provision may relate only to conditions that had manifested themselves during the six months immediately before the date of enrollment.
 - 1.) In determining whether a preexisting conditions provision applies to an eligible insured, health plans must credit the time a person was under a previous qualifying health plan if the previous coverage was continuous to a date no more than 63 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage and if the previous qualifying health plan coverage was reasonably actuarially equivalent to the new coverage.
- c. Health plans may not provide for a waiting period of more than four months beyond the eligible insured’s date of enrollment.
 - 1.) An eligible individual who has not had creditable coverage for the 18 months before the date of enrollment may not be subject to a waiting period.
 - 2.) If a health plan includes a waiting period, emergency services must be covered during the waiting period.
 - 3.) In applying a waiting period to an eligible insured, a health plan must credit the time the person was covered under a previous qualifying health plan if the person experiences only a temporary interruption in coverage.
- d. Health plans may not exclude late enrollees from coverage for more than 12 months from the date of the application for coverage.

On page 270, insert the following content before “4. Continuation of coverage after separation or divorce [175:110I; 176G:5A]:”

- 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.

On page 277, substitute the following content for paragraph “e.” under “4. Required disclosure provisions”:

- 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, commissions must not be greater than the renewal commissions paid by the issuer of the policy being replaced unless the benefits of the new policy are substantially and clearly greater than the replaced policy.

On page 277, substitute the following content for “5. Requirements for replacement”:

5. Requirements for replacement [Reg. 71.14]

- a. Application forms must include certain prescribed questions and statements to determine whether the applicant has other Medicare supplement coverage 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.

On page 278, insert the following content before “7. Open enrollment [176K:3; Reg. 71.10]”:

- 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 an insurance policy or to take out a policy with another carrier.

On page 279, insert the following content before “10. Required disclosures for Medicare-eligible applicants [Reg. 40.15]”:

- c. **Prescription drug coverage** A Medicare supplement insurance policy with benefits for outpatient prescription drugs in effect on December 31, 2005, may be renewed, at the policyholder’s option, for policyholders who do not enroll in Medicare Part D. After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs cannot be renewed after the policyholder enrolls in Medicare Part D.
 - 1.) Policyholders who are enrolled in a Medicare supplement insurance policy with outpatient prescription drug coverage and who enroll in Medicare Part D must be transferred to the issuer’s most comparable Medicare supplement policy without outpatient prescription drug coverage unless they:
 - choose coverage under another Medicare supplement policy without outpatient prescription drug coverage; or
 - elect to remain in the same Medicare supplement policy but with the outpatient prescription drug coverage eliminated.

On page 279, insert the following content before “N. SMALL GROUP HEALTH PLANS [211 CMR 66.01; CH. 175; 176A, B, D, G, I, J; 176J:9]”:

- 1. Rules for coordination of benefits [211 CMR 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 other parts of the plan provided to the contract holder.
 - 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.** 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 custodial parent;
 - second, the plan of the custodial parent’s spouse; and
 - third, the plan of the noncustodial parent.
 - 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.

On page 279, insert the following content before “2. Availability of coverage”:

- 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, sole proprietor, or 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%.

On page 280, substitute the following content for “4. Preexisting conditions and waiting periods [176]:5; Reg. 66.07]”:

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- 4. Preexisting conditions and waiting periods [176J:5; Reg. 66.07]**
- a. Carriers may not exclude an 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. 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.

On page 281, insert the following content before “O. MEDICAL EXAMINATIONS AND LAB TESTS [REG. 36.06]”;

- 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 that does not contain an exclusion for preexisting conditions 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.

On page 282, substitute the following content for paragraph “d.” under “1. Newborn and adopted children; disabled adult children [175:47C; 176:108(2)(a)(3); 176A:8(d); 176A:8; 176B:4C; 176B:6(c); 176G:4]”:

- 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 or for two years following loss of dependent status for federal tax purposes, whichever occurs first.
 - 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.

On page 283, insert the following content before “S. MASSHEALTH COMPREHENSIVE HEALTH CARE PLAN [118E:9A]”:

- 1. An application form may ask whether the applicant has taken a genetic test, but the applicant is not required to answer this question. An application requesting this information must contain language

informing the applicant that he is not required to answer 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, on the basis of sound actuarial principles or actual or reasonably anticipated experience.

On page 283, insert the following new content at the bottom of the page:

3. **Residency requirements [Reg. 130 CMR 503.002]** To be eligible for MassHealth, an applicant or member must 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 requirements for MassHealth are:
 - students younger than 19 whose parents live out of state; 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. 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
 - younger than 19 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 520.000]** 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;
 - \$3 for each prescription and refill for all other drugs covered by MassHealth;

- \$3 for nonemergency services covered by MassHealth provided in a hospital emergency department; and
 - \$3 for an acute inpatient hospital stay.
- a. Excluded individuals** Individuals who are not required to pay co-payments under MassHealth include:
- members younger than 19;
 - 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 \$200 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 non-pharmacy 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; and
 - emergency services.

Part II

New Sample Questions

There are no changes to questions at this time.

Part III

Answers and Rationales

There are no changes to answers or rationales at this time.

Part IV
Errata

There are no errata at this time.

To submit comments or suggestions, please send an email to errata@kaplan.com.



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