REQUEST FOR MODEL LAW DEVELOPMENT

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

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

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

Short Duration Long-Term Care Policies (B) Subgroup

2. NAIC staff support contact information:

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

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

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

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

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

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

If yes, please explain why

The Senior Issues (B) Task Force established the Short Term Health Policies Providing Long-Term Care Benefits (B) Subgroup to address the appropriate means of addressing these unique policies. The Short Term Health Policies Providing Long-Term Care Benefits (B) Subgroup noted that these long-term care (LTC) policies of short duration (of less than one

year) are excluded from the LTC Model but do not quite fall in the Accident and Sickness Model. The Subgroup surveyed the states serving on the Senior Issues (B) Task Force. Upon review and discussion of the responses to the Subgroup's survey and laws enacted in other states addressing this product; concerns with leaving this product in the Accident and Sickness Model include protections under the LTC model not present in the Accident and Sickness Model, including but not limited to, no third party premium notice; guaranteed renewability/non-cancellable; nonforfeiture benefits; elimination periods; and inflation protection. Therefore, the Subgroup recommends the Senior Issues Task Force establish a subgroup to create a separate model addressing LTC products of short duration that are excluded from the LTC model.

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

X Yes or ☐ No (Check one)

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

X 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood Low Likelihood

Explanation, if necessary:

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

☐ 1 X 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood Low Likelihood

Explanation, if necessary:

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

☐ 1 X 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood Low Likelihood

Explanation, if necessary:

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

No

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

No

LIMITED LONG-TERM CARE INSURANCE MODEL REGULATION

Table of Contents

Section 1. Purpose

The purpose of this regulation is to implement [cite section of law which sets forth the NAIC *Limited Long-Term Care Insurance Model Act*], to promote the public interest, to promote the availability of limited long-term care insurance coverage, to protect applicants for limited long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of limited long-term care insurance coverages, and to facilitate flexibility and innovation in the development of limited long-term care insurance.

Section 2. Authority

This regulation is issued pursuant to the authority vested in the commissioner under [cite sections of law enacting the NAIC *Limited Long-Term Care Insurance Model Act* and establishing the commissioner's authority to issue regulations].

Section 3. Applicability and Scope

Except as otherwise specifically provided, this regulation applies to all limited long-term care insurance policies delivered or issued for delivery in this state on or after the effective date by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations.

Drafting Note: This regulation, like the NAIC *Limited Long-Term Care Insurance Model Act*, is intended to apply to policies, contracts, subscriber agreements, riders and endorsements whether issued by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations. In order to include such organizations, regulations should identify them in accordance with statutory terminology or by specific statutory citation. Depending upon state law and regulation, insurance department jurisdiction, and other factors, separate regulations may be required. In any event, the regulation should provide that the particular terminology used by these plans, organizations and arrangements (e.g., contract, policy, certificate, subscriber, member) may be substituted for, or added to, the corresponding terms used in this regulation.

Section 4. Definitions

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

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

A. "Benefit trigger", for the purposes of independent review, means a contractual provision in the insured's policy of limited long-term care insurance conditioning the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment.

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

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

C. "Qualified actuary" means a member in good standing of the American Academy of Actuaries.

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

Section 5. Policy Definitions

No limited long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

A. "Activities of daily living" means at least bathing, continence, dressing, eating, toileting, and transferring.

B. "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

C. "Adult day care" means a program for six (6) or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

D. "Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

E. "Cognitive impairment" means a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

F. "Continence" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

G. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

H. "Eating" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

I. "Hands-on assistance" means physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living.

J. "Home care services" means medical and nonmedical services, provided to ill, disabled, or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

K. "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

L. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

M. "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

N. "Skilled nursing care," "personal care," "home care," "specialized care," "assisted living care" and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

O. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

P. "Transferring" means moving into or out of a bed, chair or wheelchair.

Q. All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "convalescent nursing home," "personal care facility," "specialized care providers," "assisted living facility," and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration or degree status of those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified, or registered, it shall also state what requirements a provider must meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified, or registered, or when the state licenses, certifies or registers the provider of services under another name.

Drafting Note: State laws relating to nursing and other facilities and agencies are not uniform. Accordingly, specific reference to, or incorporation of, the individual state law may be required in structuring each definition.

Drafting Note: This section is intended to specify required definitional elements of several terms commonly found in limited long-term care insurance policies, while allowing some flexibility in the definitions themselves.

Section 6. Policy Practices and Provisions

A. Renewability. The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual limited long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 8 of this regulation.

(1) A policy issued to an individual shall not contain renewal provisions other than "guaranteed renewable" or "noncancellable."

(2) The term "guaranteed renewable" may be used only when the insured has the right to continue the limited long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(3) The term "noncancellable" may be used only when the insured has the right to continue the limited long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

(4) The term "level premium" may only be used when the insurer does not have the right to change the premium.

B. Limitations and Exclusions. A policy may not be delivered or issued for delivery in this state as limited long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

(1) Preexisting conditions or diseases;

(2) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of cognitive impairment;

(3) Alcoholism and drug addiction;

(4) Illness, treatment or medical condition arising out of:

(a) War or act of war (whether declared or undeclared);

(b) Participation in a felony, riot or insurrection;

(c) Service in the armed forces or units auxiliary thereto;

(d) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or

(e) Aviation (this exclusion applies only to non-fare-paying passengers).

(5) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

(6) Expenses for services or items available or paid under another limited long-term care insurance, long-term care insurance or health insurance policy;

(7) (a) This subsection is not intended to prohibit exclusions and limitations by type of provider. However, no limited long-term care issuer may deny a claim because services are provided in a state other than the state of policy issued under the following conditions:

(i) When the state other than the state of policy issue does not have the provider licensing, certification, or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification, or registration; or

(ii) When the state other than the state of policy issue licenses, certifies, or registers the provider under another name.

(b) For purposes of this paragraph, "state of policy issue" means the state in which the individual policy or certificate was originally issued.

Drafting Note: Paragraph (7) is intended to permit exclusions and limitations for payment for services provided outside the United States and legitimate variations in benefit levels to reflect differences in provider rates. However, the issuer of limited long-term care insurance policies and certificates being claimed against in a state other than where the policy or certificate was issued must cover those services that would be covered in the state of issue, irrespective of any licensing, registration, or certification requirements for providers in the other state. In other words, if the claim would be approved but for the licensing issue, the claim must be approved.

(8) This subsection is not intended to prohibit territorial limitations.

C. Extension of Benefits. Termination of limited long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the limited long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the limited long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

D. Continuation or Conversion.

(1) Group limited long-term care insurance issued in this state, on or after the effective date of this section, shall provide covered individuals with a basis for continuation or conversion of coverage.

(2) For the purposes of this section, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate, and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to or contain incentives to use certain providers or facilities may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.

(3) For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

(4) For the purposes of this section, "converted policy" means an individual policy of limited long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.

(5) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy and shall be renewable annually.

(6) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(7) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

(a) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(b) The terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage:

(i) Providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

(ii) The premium for which is calculated in a manner consistent with the requirements of Paragraph (6) of this section.

(8) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another limited long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. The provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

(9) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

(10) Notwithstanding any other provision of this section, an insured individual whose eligibility for group limited long-term care coverage is based upon his or her relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

(11) For the purposes of this section a "managed-care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

E. Discontinuance and Replacement

If a group limited long-term care policy is replaced by another group limited long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

(1) Shall not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

(2) Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of limited long-term care services.

F. Premium Changes

(1) The premium charged to an insured shall not increase due to either:

(a) The increasing age of the insured at ages beyond sixty-five (65); or

(b) The duration the insured has been covered under the policy.

(2) The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under Section 26, the portion of the premium attributable to the additional coverage shall be added to, and considered part of, the initial annual premium.

(3) A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under Section 26, the initial annual premium shall be based on the reduced benefits.

G. Electronic Enrollment for Group Policies

(1) In the case of a group defined in [insert reference to Section 4E(1) of the NAIC *Limited Long-Term Care Insurance Model Act*], any requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:

(a) The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

(b) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention, and prompt retrieval of records; and

(c) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and "privileged information" as defined by [insert reference to state law comparable to Section 2W of the NAIC *Insurance Information and Privacy Protection Model Act* (#670)], is maintained.

(2) The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

Section 7. Unintentional Lapse

Each insurer offering limited long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

A. (1) Notice before lapse or termination. No individual limited long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation

shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's *full name* and *home address*. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this limited long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice." The insurer shall notify the insured of the right to change this written designation, no less often than once every two (2) years.

(2) When the policyholder or certificateholder pays premium for a limited long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in Subsection A(1) need not be met until sixty (60) days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

(3) Lapse or termination for nonpayment of premium. No individual limited long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to Subsection A(1), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing

B. Reinstatement. In addition to the requirement in Subsection A, a limited long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five (5) months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

Section 8. Required Disclosure Provisions

A. Renewability. Individual limited long-term care insurance policies shall contain a renewability provision.

(1) The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or noncancellable.

(2) A limited long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

B. Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual limited long-term care insurance policy, all riders or endorsements added to an individual limited long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider or endorsement.

C. Payment of Benefits. A limited long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of these terms and an explanation of the terms in its accompanying outline of coverage.

D. Limitations. If a limited long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."

E. Other Limitations or Conditions on Eligibility for Benefits. A limited long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in [insert citation to state law corresponding to Section 6C(2) of the *Limited long-Term Care Insurance Model Act*] shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits. "

F. Benefit Triggers. Activities of daily living and cognitive impairment shall be used to measure an insured's need for limited long-term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits. " Any additional benefit triggers shall also be explained in this section. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

Section 9. Required Disclosure of Rating Practices to Consumers

A. This section shall apply as follows:

(1) Except as provided in Paragraph (2), this section applies to any limited long-term care policy or certificate issued in this state on or after [insert date that is 6 months after adoption of the regulation].

(2) For certificates issued on or after the effective date of this regulation under a group limited long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC *Limited Long-Term Care Insurance Model Act*], which policy was in force at the time this regulation became effective, the provisions of this section shall apply on the policy anniversary following [insert date that is 12 months after adoption of the regulation].

B. Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subsection to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this section to the applicant no later than at the time of delivery of the policy or certificate.

Drafting Note: One method of delivery that does not allow for all listed information to be provided at time of application or enrollment is an application by mail.

(1) A statement that the policy may be subject to rate increases in the future;

(2) An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision;

(3) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(4) A general explanation for applying premium rate or rate schedule adjustments that shall include:

(a) A description of when premium rate or rate schedule adjustments will be effective (e. g., next anniversary date, next billing date, etc.); and

(b) The right to a revised premium rate or rate schedule as provided in Paragraph (3) if the premium rate or rate schedule is changed;

(5) (a) Information regarding each premium rate increase on this policy form or similar policy forms over the past ten (10) years for this state or any other state that, at a minimum, identifies:

(i) The policy forms for which premium rates have been increased;

(ii) The calendar years when the form was available for purchase; and

(iii) The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(b) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

(c) An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the limited long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

(d) If an acquiring insurer files for a rate increase on a limited long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers, on or before the later of the effective date of this section, or the end of a twenty-four-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with Subparagraph (a) of this paragraph.

(e) If the acquiring insurer in Subparagraph (d) above files for a subsequent rate increase, even within the twenty-four-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in Subparagraph (d), the acquiring insurer shall make all disclosures required by Paragraph (5), including disclosure of the earlier rate increase referenced in Subparagraph (d).

Drafting Note: Section 10 requires that the commissioner be provided with any information to be disclosed to applicants. Information about past rate increases needs to be reviewed carefully. If the insurer expects to provide additional information (such as a brief description of significant variations in policy provisions if the form is not the policy form applied for by the applicant or information about policy forms offered during or before the calendar years of forms with rate increases), the commissioner should be satisfied that the additional information is fairly presented in relation to the information about rate increases.

Drafting Note: It is intended that the disclosures in Section 9B be made to the employer in those situations where the employer is paying all the premium, with no contributions or coverage elections made by individual employees. In addition, if the employer has paid the entire amount of any premium increases, there is no need for disclosure of the increases to the applicant for a new certificate.

Drafting Note: States should be aware of, and review situations, where a group policy is no longer being issued but new certificates are still being added to existing policies.

C. An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under Subsection B(1) and (5). If, due to the method of application, the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

D. An insurer shall use the form in Appendix A to comply with the requirements of Subsections B and C of this section.

E. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least [forty-five (45) days] prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by Subsection B when the rate increase is implemented.

Section 10. Initial Filing Requirements

A. This section applies to any limited long-term care policy issued in this state on or after [insert date that is six (6) months after adoption of the regulation].

B. An insurer shall provide the information listed in this subsection to the commissioner [30 days] prior to making a limited long-term care insurance form available for sale.

(1) A copy of the disclosure documents required in Section 9;

(2) Complete rate schedule;

(3) An actuarial memorandum that shall include:

(a) A statement regarding actuary's qualifications;

(b) An explanation of the review performed by the actuary;

(c) A complete description of all pricing assumptions, including sources and credibility of data;

(d) Development of the anticipated life time loss ratio supported by an exhibit showing lifetime projection of earned premiums and incurred claims based upon the pricing assumptions;

(e) A statement that the premium rate schedule is expected to result in a lifetime loss ratio not less than 55%;

(f) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(g) A statement that the underwriting and claim adjudication processes have been reviewed and taken into consideration;

(h) A sensitivity analysis of the anticipated lifetime loss ratio to the changes in the individual assumptions (including sensitivity to the mix of business);

(i) A statement that the reserve requirements have been reviewed and taken in consideration;

(j) A description of the valuation assumptions with sufficient detail or sample calculation as to have a complete depiction of the reserve amounts to be held;

(k) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship; and

(l) An actuarial certification dated and signed by the actuary that all information presented in the actuarial memorandum is accurate and complete.

C. Retention Requirements

(1) An insurer offering a limited long-term care policy shall retain sufficient documentation from the initial pricing that a qualified actuary could recreate the initial rates at a later date.

(a) The documentation shall be sufficient to provide actual to expected analyses of: claims; incidence rates, persistency, mix of business, and loss ratios at the same level of detail used in the initial pricing.

(b) If an insurer retains a consultant to price a limited long-term care product, the insurer shall require that the documentation be provided to the insurer, rather than being retained solely by the consultant.

(c) If an insurer sells (cedes) complete risk responsibility for a limited long-term care product, the insurer (cedant) shall provide the buyer (reinsurer) with the initial pricing documentation.

(2) An insurer that requests a future premium rate schedule increase but has not retained the initial pricing documentation shall be limited to a lifetime loss ratio not less than [80%].

(3) The insurer shall retain the initial pricing documentation at least until one year after the final policyholder is no longer eligible for benefits under the policy.

Section 11. Prohibition Against Post-Claims Underwriting

A. All applications for limited long-term care insurance policies or certificates except those that are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

B. (1) If an application for limited long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

(2) If the medications listed in the application were known by the insurer or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

C. Except for policies or certificates which are guaranteed issue:

(1) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a limited long-term care insurance policy or certificate:

Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy.

(2) The following language, or language substantially similar to the following, shall be set out conspicuously on the limited long-term care insurance policy or certificate at the time of delivery:

Caution: The issuance of this limited long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

D. A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

Section 12. Minimum Standards for Home and Community Care Benefits in Limited long-Term Care Insurance Policies

A. A limited long-term care insurance policy or certificate shall not, if it provides benefits for home care or community care services, limit or exclude benefits:

(1) By requiring that the insured or claimant would need care in a skilled nursing facility if home care services were not provided;

(2) By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community, or institutional setting before home care services are covered;

(3) By limiting eligible services to services provided by registered nurses or licensed practical nurses;

(4) By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

(5) By excluding coverage for personal care services provided by a home health aide;

(6) By requiring that the provision of home care services be at a level of certification or licensure greater than that required by the eligible service;

(7) By requiring that the insured or claimant have an acute condition before home care services are covered;

(8) By limiting benefits to services provided by Medicare-certified agencies or providers; or

(9) By excluding coverage for adult day care services.

B. A limited long-term care insurance policy or certificate, if it provides for home or community care services, shall provide total home or community care coverage that is a dollar amount equivalent to at least one-half of the coverage available for nursing home benefits under the policy or certificate, at the time covered home or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

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

Drafting Note: Subsection C permits the home care benefits to be counted toward the maximum length of limited long-term care coverage under the policy. The subsection is not intended to restrict home care to a period of time which would make the benefit illusory.

Section 13. Requirement to Offer Inflation Protection

A. No insurer may offer a limited long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of limited long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(1) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than three percent (3%);

(2) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least three percent (3%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

(3) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

B. Where the policy is issued to a group, the required offer in Subsection A above shall be made to the group certificateholder.

C. (1) Insurers shall include the following information in or with the outline of coverage:

(a) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period.

(b) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(2) An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

Drafting Note: It is intended that meaningful inflation protection be provided. Meaningful benefit minimums or durations could include providing increases to attained age, or for a period such as at least 20 years, or for some multiple of the policy's maximum benefit, or throughout the period of coverage.

D. Inflation protection benefit increases under a policy that contains these benefits and shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

E. An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

F. (1) Inflation protection as provided in Subsection A(1) of this section shall be included in a limited long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection. The rejection may be either in the application or on a separate form.

(2) The rejection shall be considered a part of the application and shall state:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection.

Section 14. Requirements for Application Forms and Replacement Coverage

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another limited long-term care insurance policy or long-term care insurance policy, or certificate in force, or whether a limited long-term care policy, or long-term care insurance policy, or certificate is intended to replace any other accident and sickness, or limited long-term care policy, or long-term care insurance policy, or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent,

containing the questions may be used. With regard to a replacement policy issued to a group defined by [insert reference to Section 4(E)(1) of the *Limited Long-Term Care Insurance Model Act*], the following questions may be modified only to the extent necessary to elicit information about health or limited long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement.

(1) Do you have another limited long-term care insurance policy, or long-term care insurance policy, or certificate in force (including health care service contract, health maintenance organization contract)?

(2) Did you have another limited long-term care insurance policy, or long-term care insurance policy, or certificate in force during the last twelve (12) months?

(a) If so, with which company?

(b) If that policy lapsed, when did it lapse?

(3) Are you covered by Medicaid?

(4) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

B. Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold that are still in force.

(2) List policies sold in the past five (5) years that are no longer in force.

C. Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or limited long-term care or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

D. Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Notice shall be made within five (5) working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

E. Solicitations Other than Direct Response. Upon determining that a sale will involve replacement, an insurer; other than an insurer using direct response solicitation methods, or its agent; shall furnish the applicant, prior to issuance or delivery of the individual limited long-term care insurance policy, a notice regarding replacement of accident and sickness or limited long-term care or long-term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LIMITED LONG-TERM CARE INSURANCE OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or limited long-term care insurance or long-term care insurance and replace it with an individual limited long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or limited long-term care insurance or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this limited long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]:
(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing limited long-term care insurance or long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before your sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature of Agent, Broker or Other Representative)

[Typed Name and Address of Agent or Broker]
The above "Notice to Applicant" was delivered to me on:

_____ _____

(Applicant's Signature) (Date)

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LIMITED LONG-TERM CARE INSURANCE OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or limited long-term care insurance or long-term care insurance and replace it with the limited long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or limited long-term care insurance or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this limited long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing limited long-term care insurance or long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

Section 15. Reporting Requirements

A. Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of limited long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

B. Every insurer shall report annually by June 30 the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by Subsection A above. (Appendix B)

C. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of limited long-term care insurance.

D. Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year. (Appendix B)

E. Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year. (Appendix B)

F. For purposes of this section:

(1) "Policy" means only limited long-term care insurance;

(2) "Report" means on a statewide basis.

G. Reports required under this section shall be filed with the commissioner.

H. Annual rate certification requirements.

(1) This subsection applies to any limited long-term care policy issued in this state on or after [insert date that is six (6) months after adoption of the regulation].

(2) The following annual submission requirements apply subsequent to initial rate filings for individual limited long-term care insurance policies made under this section.

(a) An actuarial certification prepared, dated and signed by a member of the American Academy of Actuaries who provides the information shall be included and shall provide at least the following information:

(i) A statement of the sufficiency of the current premium rate schedule.

Drafting Note: In accordance with the 2014 amendments to Section 10 of the *Long-Term Care Insurance Model Regulation* (#641), in situations where the premium rates have been approved with less than the normal minimum margin for moderately adverse experience, any adverse experience should be reviewed to determine if the lower margins can be continued for new business.

(ii) For the rate schedules that are no longer marketed,

I. That the premium rate schedule continues to be sufficient to cover anticipated costs under best estimate assumptions; or

II. That the premium rate schedule may no longer be sufficient. In this situation, the insurer shall provide to the commissioner, within sixty (60) days of the date the actuarial certification is submitted to the commissioner, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience.

(ii) A description of the review performed that led to the statement.

(b) An actuarial memorandum dated and signed by a member of the American Academy of Actuaries who prepares the information shall be prepared to support the actuarial certification and provide at least the following information:

(i) A detailed explanation of the data sources and review performed by the actuary prior to making the statement in Paragraph (2)(a).

(ii) A complete description of experience assumptions and their relationship to the initial pricing assumptions.

Drafting Note: Actuarial Standard of Practice (ASOP) No. 18, the NAIC *Guidance Manual for the Rating Aspects of the Long-Term Care Insurance Model Regulation* (#641) and the Academy of Actuaries Practice Note "Long-Term Care Insurance, Compliance with the NAIC Long-Term Care Insurance Model Regulation Relating to Rate Stability" all provide details concerning the key pricing assumptions, underlying actuarial judgments and the manner in which experience should be monitored.

(iii) A description of the credibility of the experience data.

(iv) An explanation of the analysis and testing performed in determining the current presence of margins.

(c) The actuarial certification required pursuant to Paragraph (2)(a) must be based on calendar year data and submitted annually no later than May 1st of each year, starting in the second year following the year in which the initial rate schedules are first used. The actuarial memorandum required pursuant to Paragraph (2)(b) must be submitted at least once every three (3) years with the certification.

Drafting Note: The commissioner may wish to have the actuarial demonstration reviewed by an independent actuary in those instances where the demonstration does not certify to the maintenance of margins.

Section 16. Licensing

A producer is not authorized to sell, solicit or negotiate with respect to limited long-term care insurance except as authorized by [insert reference to state law equivalent to the NAIC *Producer Licensing Model Act*. (#218)].

Section 17. Discretionary Powers of Commissioner

The commissioner may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this regulation with respect to a specific limited long-term care insurance policy or certificate upon a written finding that:

A. The modification or suspension would be in the best interest of the insureds;

B. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

C. (1) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring limited long-term care; or

(2) The policy or certificate is to be issued to residents of a life care or continuing care retirement community, or some other residential community for the elderly, and the modification or suspension is reasonably related to the special needs, or nature of such a community; or

(3) The modification or suspension is necessary to permit limited long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

Drafting Note: This provision is intended to provide the commissioner with limited discretion and flexibility to accommodate specific and innovative limited long-term care insurance products which are shown to be in the public's best interest. This provision is intended to be used sparingly for this purpose.

Section 18. Reserve Standards

A. When limited long-term care benefits are provided, reserves shall be determined in accordance with [insert reference to state law equivalent to the *Health Insurance Reserves Model Regulation* (#10)].

Section 19. Premium Rate Schedule Increases

A. This section applies to any limited long-term care policy or certificate issued in this state, on or after [insert date, that is six (6) months after adoption of the regulation].

B. No rate increase may be requested by an insurer until the projected lifetime loss ratio, under best estimate assumptions, exceeds the anticipated lifetime loss ratio plus 2%.

C. An insurer shall provide notice of a pending premium rate schedule increase to the commissioner at least [30] days prior to the notice to the policyholders and shall include: An actuarial memorandum that shall include:

(1) A revised rate schedule;

(2) An actuarial memorandum that shall include:

(a) A statement regarding the actuary's qualifications;

(b) An explanation of the review performed by the actuary;

(c) A complete description of all pricing assumptions and any changes from the initial and any prior filing;

(d) An exhibit showing policy count, actual incurred claims, and earned premiums by duration both on a state and nationwide basis, and any revised projections based on the revised pricing assumptions;

(e) An exhibit showing actual to expected loss ratios by duration;

(f) A statement that the revised premium schedule is expected to result in a lifetime loss ratio not less than 55%;

(g) A sensitivity analysis of the anticipated lifetime loss ratio to the changes in the individual assumptions, including any revised assumptions, including sensitivity to the mix of business;

(h) A description of the valuation assumptions, including any revisions since the initial and any prior filing, with sufficient detail or sample calculation to have a complete depiction of the reserve amounts to be held;

(i) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such statement cannot be made, a complete description of the situation where this does not occur; and

(j) An actuarial certification dated and signed by the actuary that all information presented in the actuarial memorandum is accurate and complete.

D. An insurer that is granted a premium rate schedule increase shall retain similar documentation related to the rate increase request as is required in Section 10C.

Section 20. Filing Requirement

Prior to an insurer or similar organization offering group limited long-term care insurance to a resident of this state pursuant to [cite state law equivalent to Section 5 of the *Limited Long-Term Care Insurance Model Act*], it shall file with the commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory limited long-term care insurance requirements substantially similar to those adopted in this state.

Section 21. Filing Requirements for Advertising

A. Every insurer, health care service plan, or other entity providing limited long-term care insurance or benefits in this state shall provide a copy of any limited long-term care insurance advertisement intended for use in this state, whether through written, radio, or television medium to the commissioner, for review or approval by the commissioner, to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer, health care service plan, or other entity for at least three (3) years from the date the advertisement was first used.

B. The commissioner may exempt from these requirements any advertising form or material when, in the commissioner's opinion, this requirement may not be reasonably applied.

Section 22. Standards for Marketing

A. Every insurer, health care service plan, or other entity marketing limited long-term care insurance coverage in this state, directly or through its producers, shall:

(1) Establish marketing procedures and agent training requirements to assure that:

(a) Any marketing activities, including any comparison of policies, by its agents or other producers will be fair and accurate; and

(b) Excessive insurance is not sold or issued.

(2) Display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and policy the following:

"Notice to buyer: This policy may not cover all of the costs associated with limited long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

(3) Provide copies of the disclosure form required in Section 9C (Appendix A) to the applicant.

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for limited long-term care or long-term care insurance already has accident and sickness or limited long-term care insurance and the types and amounts of any such insurance.

(5) Every insurer or entity marketing limited long-term care insurance shall establish auditable procedures for verifying compliance with this Subsection A.

(6) If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the commissioner, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificateholder that the program is available, and the name, address, and telephone number of the program.

(7) For limited long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to Section 6A(3) of this regulation.

(8) Provide an explanation of contingent benefit upon lapse provided for in Section 27D(3) and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in Section 27D(4).

B. In addition to the practices prohibited in [insert citation to NAIC model *Unfair Trade Practices Act* (#880)], the following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy, or to take out a policy of insurance with another insurer.

(2) High pressure tactics. Employing any method of marketing having the effect of, or tending to induce the purchase of, insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase, or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(4) Misrepresentation. Misrepresenting a material fact in selling or offering to sell a limited long-term care insurance policy.

C. (1) With respect to the obligations set forth in this subsection, the primary responsibility of an association, as defined in [insert citation to Section 4E(2) of the NAIC *Limited Long-Term Care Insurance Model Act*], when endorsing or selling limited long-term care insurance shall be to educate its members concerning limited long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding limited long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

(2) The insurer shall file with the insurance department the following material:

(a) The policy and certificate,

(b) A corresponding outline of coverage, and

(c) All advertisements requested by the insurance department.

(3) The association shall disclose in any limited long-term care insurance solicitation:

(a) The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees, and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and

(b) A brief description of the process under which the policies and the insurer issuing the policies were selected.

(4) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

(5) The board of directors of associations selling or endorsing limited long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

(6) The association shall also:

(a) At the time of the association's decision to endorse, engage the services of a person with expertise in limited long-term care insurance, not affiliated with the insurer, to conduct an examination of the policies, including its benefits, features, and rates, and update the examination thereafter in the event of material change;

(b) Actively monitor the marketing efforts of the insurer and its agents; and

(c) Review and approve all marketing materials or other insurance communications used to promote sales, or sent to members, regarding the policies or certificates.

Drafting Note: The materials specified for filing in this section shall be filed in accordance with a state's filing due dates and procedures.

(7) No group limited long-term care insurance policy or certificate may be issued to an association, unless the insurer files with the state insurance department the information required in this subsection.

(8) The insurer shall not issue a limited long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies, annually that the association has complied with the requirements set forth in this subsection.

(9) Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of [insert citation to corresponding section of NAIC model *Unfair Trade Practices Act* (#880)].

Drafting Note: Remember that the NAIC model *Unfair Trade Practice Act* (#880) in your state applies to limited long-term care insurance policies and certificates.

Section 23. Suitability

A. Every insurer, health care service plan, or other entity marketing limited long-term care insurance (the "issuer") shall:

(1) Develop and use suitability standards and procedures to determine whether the purchase or replacement of limited long-term care insurance is appropriate for the needs of the applicant.

(2) Include in its suitability standards and procedures:

(a) Consideration of the advantages and disadvantages of insurance to meet the needs of the applicant; and

(b) Discussion with applicants of how the benefits and costs of limited long-term care insurance compare with long-term care insurance.

(3) Train its agents in its suitability standards and procedures; and

(4) Maintain a copy of its suitability standards and procedures and make them available for inspection upon request by the commissioner.

B. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

Section 24. Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates

If a limited long-term care insurance policy or certificate replaces another limited long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new limited long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

Section 25. Availability of New Services or Providers

A. An insurer shall notify policyholders of the availability of a new limited long-term policy series that provides coverage for new limited long-term care services or providers material in nature and not previously available through the insurer to the general public. The notice shall be provided within twelve (12) months that the date of the new policy series is made available for sale in this state.

Drafting Note: New limited long-term care services or providers that are material in nature shall not include changes to policy structure; or benefits or provisions that are minor in nature. Examples of when notification need not be provided include: changes in elimination periods, benefit periods and benefit amounts.

B. Notwithstanding Subsection A above, notification is not required for any policy issued prior to the effective date of this section or to any policyholder or certificateholder who is currently eligible for benefits, within an elimination period or on a claim, or who previously had been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

C. The insurer shall make the new coverage available in one of the following ways:

(1) By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age;

(2) By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits shall be based on premiums paid or reserves held for the prior policy or certificate;

(3) By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or

(4) By an alternative program developed by the insurer that meets the intent of this section if the program is filed with and approved by the commissioner.

Drafting Note: An example of an acceptable alternative program is underwriting concessions.

D. An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of this subsection, "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders who purchased such a new proprietary policy shall be notified when a new limited long-term care policy series that provides coverage for new limited long-term care services or providers material in nature is made available to that limited distribution channel.

E. Policies issued pursuant to this section shall be considered exchanges and not replacements. These exchanges shall not be subject to Sections 14 and 24, and the reporting requirements of Section 15A through E of this regulation.

F. Where the policy is offered through an employer, labor organization, professional, trade or occupational association, the required notification in Subsection A above shall be made to the offering entity. However, if the policy is issued to a group defined in Section 4E(4) of the *Limited Long-Term Care Insurance Model Act*, the notification shall be made to each certificateholder.

G. Nothing in this section shall prohibit an insurer from offering any policy, rider, certificate, or coverage change to any policyholder or certificateholder. However, upon request, any policyholder may apply for currently available coverage that includes the new services or providers. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

H. This section does not apply to life insurance policies or riders containing accelerated limited long-term care benefits.

I. This section shall become effective on or after [insert the effective date of the regulation].

Section 26. Right to Reduce Coverage and Lower Premiums

A. (1) Every limited long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:

(a) Reducing the maximum benefit; or

(b) Reducing the daily, weekly, or monthly benefit amount.

(2) The insurer may also offer other reduction options that are consistent with the policy or certificate design, or the carrier's administrative processes.

(3) In the event the reduction in coverage involves the reduction or elimination of the inflation protection provision, the insurer shall allow the policyholder to continue the benefit amount in effect at the time of the reduction.

B. The provision shall include a description of the process for requesting and implementing a reduction in coverage.

C. The premium for the reduced coverage shall:

(1) Be based on the same age and underwriting class used to determine the premium for the coverage currently in force; and

(2) Be consistent with the approved rate table.

D. The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.

E. If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by Section 7A(3) of this regulation.

F. The requirements of Subsections A through E shall apply to any limited long-term care policy issued in this state on or after [insert date that is twelve (12) months after adoption of the regulation].

G. A premium increase notice required by Section 9E of this regulation shall include:

(1) An offer to reduce policy benefits provided by the current coverage consistent with the requirements of this section;

(2) A disclosure stating that all options available to the policyholder may not be of equal value; and

H. The requirements of Subsection G shall apply to any rate increase implemented in this state on or after [insert date that is twelve (12) months after adoption of the regulation].

Drafting Note: Compliance with this section may be accomplished by policy replacement, exchange, or by adding the required provision via amendment or endorsement to the policy.

Section 27. Nonforfeiture Benefit Requirement

A. To comply with the option to offer a nonforfeiture benefit pursuant to the provisions of [insert reference to Section 8 of the NAIC *Limited Long-Term Care Insurance Model Act*]:

(1) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers, and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in Subsection D; and

(2) The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.

B. Should the offer made under [insert reference to Section 8 of the NAIC *Limited Long-Term Care Insurance Model Act*] be rejected, the insurer shall provide the contingent benefit upon lapse described in this section. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in Subsection C(4) shall still apply.

C. (1) After rejection of the offer made under [insert reference to Section 8 of the NAIC *Limited Long-Term Care Insurance Model Act*], for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the insurer shall provide a contingent benefit upon lapse.

(2) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(3) A contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding 50% of the insured's initial annual premium. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

(4) On or before the effective date of a substantial premium increase as defined in Paragraph (3) above, the insurer shall:

(a) Offer to reduce policy benefits provided by the current coverage consistent with the requirements of Section 26 so that required premium payments are not increased;

Drafting Note: The insured's right to reduce policy benefits in the event of the premium increase does not affect any other right to elect a reduction in benefits provided under the policy.

(b) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Subsection D. This option may be elected at any time during the 120-day period referenced in Subsection C(3); and

(c) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in Subsection C(3) shall be deemed to be the election of the offer to convert in Subparagraph (b) above.

D. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with Subsection C(3), are described in this subsection:

(1) For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up limited long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as

specified in Paragraph (3).

(2) The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Subsection E.

(3) The nonforfeiture benefit shall begin no later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three (3) years as well as thereafter.

(4) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

E. All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid-up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.

F. There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

G. To determine whether contingent nonforfeiture upon lapse provisions are triggered under Subsection C(3) or C(4), a replacing insurer that purchased or otherwise assumed a block or blocks of limited long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

Section 28. Standards for Benefit Triggers

A. A limited long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment.

B. (1) Activities of daily living shall include at least the following as defined in Section 5 and in the policy:

(a) Bathing;

(b) Continence;

(c) Dressing;

(d) Eating;

(f) Toileting; and

(f) Transferring.

(2) Insurers may use activities of daily living to trigger covered benefits in addition to those contained in Paragraph (1) as long as they are defined in the policy.

C. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however, the provisions shall not restrict, and are not in lieu of, the requirements contained in Subsections A and B.

D. For purposes of this section, the determination of a deficiency shall not be more restrictive than:

(1) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

(2) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

E. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses, or social workers.

F. Limited long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

Section 29. Appealing an Insurer's Determination that the Benefit Trigger is not Met.

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

(1) A person to whom a covered person has given express written consent to represent the covered person in an external review;

(2) A person authorized by law to provide substituted consent for a covered person; or

(3) A family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent.

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

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

(2) The insured's right to internal appeal in accordance with subsection C, and the right to submit new or additional information relating to the benefit trigger denial with the appeal request; and

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

(1) If the insurer's original determination is upheld upon internal appeal, the notice of the internal appeal decision shall describe any additional internal appeal rights offered by the insurer. Nothing herein shall require the insurer to offer any internal appeal rights other than those described in this subsection.

(2) If the insurer's original determination is upheld after the internal appeal process has been exhausted, and new or additional information has not been provided to the insurer, the insured has the right to contact their State Department of Insurance and their State Health Insurance Program (SHIP) office.

Section 30. Prompt Payment of Clean Claims

A. For purposes of this section:

(1) "Claim" means a request for payment of benefits under an in-force policy, regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.

(2) "Clean claim" means a claim that has no defect or impropriety, including any lack of required substantiating documentation, such as satisfactory evidence of expenses incurred, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

B. Within thirty (30) business days after receipt of a claim for benefits under a limited long-term care insurance policy or certificate, an insurer shall pay such claim if it is a clean claim, or send a written notice acknowledging the date of receipt of the claim and one of the following:

(1) The insurer is declining to pay all or part of the claim and the specific reason(s) for denial; or

(2) That additional information is necessary to determine if all or any part of the claim is payable and the specific additional information that is necessary.

C. Within thirty (30) business days after receipt of all the requested additional information, an insurer shall pay a claim for benefits under a limited long-term care insurance policy or certificate if it is a clean claim or send a written notice that the insurer is declining to pay all or part of the claim, and the specific reason or reasons for denial.

D. If an insurer fails to comply with Subsection B or C, such insurer shall pay interest at the rate of 1% per month on the amount of the claim that should have been paid but that remains unpaid forty-five (45) business days after the receipt of the claim with respect to Subsection B or all requested additional information with respect to Subsection C. The interest payable pursuant to this subsection shall be included in any late reimbursement without requiring the person who filed the original claim to make any additional claim for such interest.

E. The provisions of Section 30 shall not apply where the insurer has a reasonable basis supported by specific information that such claim was fraudulently submitted.

F. Any violation of this regulation by an insurer if committed flagrantly and in conscious disregard of the provisions of this regulation or with such frequency as to constitute a general business practice shall be considered a violation of the [insert reference to state law equivalent to the NAIC model *Unfair Trade Practices Act* (#880).]

G. The provisions of Section 30 supersede any other claim payment requirement found in [insert reference to state prompt payment law].

Section 31. Standard Format Outline of Coverage

This section of the regulation implements, interprets and makes specific, the provisions of [Section 6F of the *Limited Long-Term Care Insurance Model Act*] [cite provision of law requiring the commissioner to prescribe the format and content of an outline of coverage] in prescribing a standard format and the content of an outline of coverage.

A. The outline of coverage shall be a free-standing document, using no smaller than ten-point type.

B. The outline of coverage shall contain no material of an advertising nature.

C. Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

D. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

E. Format for outline of coverage:

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

LIMITED LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE
[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this limited long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] [a group policy] which was issued in the [indicate jurisdiction in which group policy was issued].

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

   (a) [For limited long-term care health insurance policies or certificates, describe one of the following permissible policy renewability provisions:

      (1) Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS [POLICY] [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

      (2) [Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS [POLICY] [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

   (b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

   (c) [Describe waiver of premium provisions or state that there are not such provisions.]

4. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

5. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return–"free look" provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

6. THIS IS NOT TRADITIONAL LONG-TERM CARE COVERAGE. THIS IS LIMITED LONG-TERM CARE COVERAGE AND DOES NOT MEET THE MINIMUM STANDARDS OF TRADITIONAL LONG-TERM CARE INSURANCE

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government, or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government, or any state government.

8. LIMITED LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered limited long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductibles, waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Non-institutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for limited long-term care and must be defined and described as part of the outline of coverage.]

[Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities and provider;

(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions and exceptions;

(e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 5 above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LIMITED LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of limited long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time;

(b) Any automatic benefit adjustment provisions;

(c) Whether the insured will be guaranteed the option to buy additional benefits, and the basis upon which benefits will be increased over time, if not by a specified amount or percentage;

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

12. ALZHEIMER'S DISEASE AND OTHER COGNITIVE IMPAIRMENTS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

13. PREMIUM.

[(a) State the total annual premium for the policy;

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

14. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

15. CONTACT YOUR STATE HEALTH INSURANCE ASSISTANCE PROGRAM OR STATE INSURANCE DEPARTMENT IF YOU HAVE GENERAL QUESTIONS REGARDING LIMITED LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LIMITED LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

Section 32. Penalties

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

Drafting Note: The intent of this section is to authorize separate fines for both the company and the agent in the amounts suggested above.

OPTIONAL PROVISION

Section [ ]. Permitted Compensation Arrangements

A. An insurer or other entity may provide commission or other compensation to an agent or other representative for the sale of a limited long-term care insurance policy or certificate only if the first-year commission or other first-year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

B. The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for a reasonable number of renewal years.

C. No entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing insurer on renewal policies.

D. For purposes of this section, “compensation” includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards, and finders’ fees.

Drafting Note: If a state believes that there is evidence that the limited long-term care insurance market is experiencing abusive marketing practices, the state may wish to consider adopting the optional agent compensation provision above.

The compensation provision, such as provided above, should not be enacted in lieu of the penalty and other consumer protection provisions contained in the regulation, but in addition to them.

APPENDIX A

Instructions: *Insurers shall provide all of the following information to the applicant regarding premium, premium adjustments, potential premium increases, and policyholder options in the event of a premium increase except as noted below. This form does not need to be provided in the event the policy does not reserve the right to increase rates.*

As used in this Appendix:

"Policy" shall mean policy, certificate, or rider, as applicable.
"Premium" shall include premium schedules, as applicable.
Companies may substitute whichever term is appropriate to reflect the limited long-term care insurance for which the applicant is applying.

Limited long-Term Care Insurance
Potential Premium Increase Disclosure Form

Important Notice: Your limited long-term care insurance company **may** increase the premium for your policy **every year**. You have certain rights and it's important that you understand them before you buy a limited long-term care insurance policy. Please read this information and be sure you understand it before you buy a policy.

This policy is guaranteed renewable*. Companies can increase the premiums for guaranteed renewable policies in the future. The company **cannot** increase your premiums because **you are** older or **your** health declines. It can increase premiums based on the experience of all individuals with a policy like yours.*

1. What Is Your Premium?

The agent/company has quoted you a premium of [$_____] for this policy. This is **not** a final premium. The premium might change during the underwriting process or if you choose different benefits. The premium you'll be required to pay for your policy will be [shown on the schedule page of] [will be attached to] your policy.

2. How Will I Know If My Premium Is Changing?

The company will send you a notice. The notice will include the new premium and when you will start paying it. It also will give you ways you could avoid paying a higher premium. One likely choice will be to keep your insurance policy, but with fewer or lower benefits than you bought. Another choice may be to stop paying premiums and have a "paid-up" policy with fewer or lower benefits than the policy you bought. You may have other choices.

APPENDIX B

Replacement and Lapse Reporting Form

For the State of _____ For the Reporting Year of _____

Company Name: _____ Due: June 30 annually
Company Address: _____ Company NAIC Number: _____
Contact Person: _____ Phone Number: (____)_____

Instructions

The purpose of this form is to report, on a statewide basis, information regarding limited long-term care insurance policy replacements and lapses. Specifically, every insurer shall maintain records for each agent on that agent's amount of limited long-term care insurance replacement sales as a percent of the agent's total annual sales and the amount of lapses of limited long-term care insurance policies sold by the agent as a percent of the agent's total annual sales. The tables below should be used to report the ten percent (10%) of the insurer's agents with the greatest percentages of replacements and lapses.

Listing of the 10% of Agents with the Greatest Percentage of Replacements

Agent's Name	Number of Policies Sold By This Agent	Number of Policies Replaced By This Agent	Number of Replacements As % of Number Sold By This Agent

Listing of the 10% of Agents with the Greatest Percentage of Lapses

Agent's Name	Number of Policies Sold By This Agent	Number of Policies Lapsed By This Agent	Number of Lapses As % of Number Sold By This Agent

Company Totals

Percentage of Replacement Policies Sold to Total Annual Sales ____%
Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year) ____%
Percentage of Lapsed Policies to Total Annual Sales _____%
Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) _____%

PROJECT HISTORY

LIMITED LONG-TERM CARE INSURANCE MODEL REGULATION

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

Changes were made to the *Long-Term Care Insurance Model Regulation* (#641) pursuant to the charge of the Short Duration Long-Term Care Policies (B) Subgroup.

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

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

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

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

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

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

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

The Short Duration Long-Term Care Policies (B) Subgroup made changes to various parts of Model #641. Interested parties, including industry and consumer groups, were able to comment on each draft. The Subgroup considered and accepted several comments made to the draft, including comments from industry and consumer groups. Interested parties that commented on the drafts included: America's Health Insurance Plans (AHIP); Aetna; and California Health Advocates (CHA).

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

The Short Duration Long-Term Care Policies (B) Subgroup met 14 times via open conference calls (March 7, 2018; Feb. 14, 2018; Jan. 24, 2018; Dec. 13, 2017, Nov. 15, 2017; Oct. 25, 2017; Oct. 4, 2017; Sept. 13, 2017; Aug. 16, 2017; July 12, 2017; June 21, 2017; May 31, 2017; May 10, 2017; and March 29, 2017). The Subgroup adopted the revisions to Model #641 on March 7, 2018.

The Senior Issues (B) Task Force held an exposure period from March 24, 2018, to May 4, 2018. A draft was circulated to interested parties, including industry and consumer groups, and was posted to the NAIC website. The Task Force considered each comment that was received. The Task Force adopted the revisions to Model #641 on June 7, 2018.

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

None.

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

None.