

LONG-TERM CARE INSURANCE MODEL REGULATION

Table of Contents

Section 1. Purpose

Section 2. Authority

Section 3. Applicability and Scope

Section 4. Definitions

Section 5. Policy Definitions

Section 6. Policy Practices and Provisions

Section 7. Unintentional Lapse

Section 8. Required Disclosure Provisions

Section 9. Required Disclosure of Rating Practices to Consumer

Section 10. Initial Filing Requirements

Section 11. Prohibition Against Post Claims Underwriting

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

Section 13. Requirement to Offer Inflation Protection

Section 14. Requirements for Application Forms and Replacement Coverage

Section 15. Reporting Requirements

Section 16. Licensing

Section 17. Discretionary Powers of Commissioner

Section 18. Reserve Standards

Section 19. Loss Ratio

Section 20. Premium Rate Schedule Increases

Section 20.1. Premium Rate Schedule Increases for Policies Subject to Loss Ratio Limits Related to Original Filings

Section 21. Filing Requirement

Section 22. Filing Requirements for Advertising

Section 23. Standards for Marketing

Section 24. Suitability

Section 25. Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates

Section 26. Availability of New Services or Providers

Section 27. Right to Reduce Coverage and Lower Premiums

Section 28. Nonforfeiture Benefit Requirement

Section 29. Standards for Benefit Triggers

Section 30. Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts

Section 31. Appealing an Insurer’s Determination that the Benefit Trigger Is Not Met

Section 32. Prompt Payment of Clean Claims

Section 33. Standard Format Outline of Coverage

Section 34. Requirement to Deliver Shopper’s Guide

Section 35. Penalties

Section []. [Optional] Permitted Compensation Arrangements

Appendix A. Rescission Reporting Form

Appendix B. Personal Worksheet

Appendix C. Disclosure Form

Appendix D. Response Letter

Appendix E. Sample Claims Denial Format

Appendix F. Potential Rate Increase Disclosure Form

Appendix G. Replacement and Lapse Reporting Form

Appendix H. Guidelines for Long-Term Care Independent Review Entities

Section 1. Purpose

The purpose of this regulation is to implement [cite section of law which sets forth the NAIC Long-Term Care Insurance Model Act], to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of 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 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 long-term care insurance policies, including qualified long-term care contracts and life insurance policies that accelerate benefits for long-term care 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. Certain provisions of this regulation apply only to qualified long-term care insurance contracts as noted.

Drafting Note: This regulation, like the NAIC 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.

Additionally, this regulation is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if:

- (1) The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;
- (2) The disability income policy is advertised, marketed or offered as insurance for long-term care services; or
- (3) Benefits under the policy may commence after the policyholder has reached Social Security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

Drafting Note: The passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) created a new category of long-term care insurance called Qualified Long-Term Care Insurance. This regulation is intended to provide requirements for all long-term care insurance contracts, including qualified long-term care insurance contracts, as defined in the NAIC Long-Term Care Insurance Model Act and by Section 7702B(b) of the Internal Revenue Code of 1986, as amended. The amendments to this regulation made in recognition of Section 7702B do not require nor prohibit the continued sale of long-term care insurance policies and certificates that are not considered qualified long-term care insurance contracts.

Section 4. Definitions

For the purpose of this regulation, the terms "long-term care insurance," "qualified long-term care insurance," "group long-term care insurance," "commissioner," "applicant," "policy" and "certificate" shall have the meanings set forth in Section 4 of the NAIC 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 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. For purposes of a tax-qualified long-term care insurance contract, as defined in Section 7702B of the Internal Revenue Code of 1986, as amended, “benefit trigger” shall include a determination by a licensed health care practitioner that an insured is a chronically ill individual.

Drafting Note: This definition is not intended to be a required definitional element of a 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. (1) “Exceptional increase” means only those increases filed by an insurer as exceptional for which the commissioner determines the need for the premium rate increase is justified:
- (a) Due to changes in laws or regulations applicable to long-term care coverage in this state; or
 - (b) Due to increased and unexpected utilization that affects the majority of insurers of similar products.
- (2) Except as provided in Sections 20 and 20.1, exceptional increases are subject to the same requirements as other premium rate schedule increases.
- (3) The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.
- (4) The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

Drafting Note: The commissioner may wish to review the request with other commissioners.

- C. “Incidental,” as used in Sections 20J and 20.1J, means that the value of the long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

Drafting Note: The phrase “value of the benefits” is used in defining “incidental” to make the definition more generally applicable. In simple cases where the base policy and the long-term care benefits have separately identifiable premiums, the premiums can be directly compared. In other cases, annual cost of insurance charges might be available for comparison. Some cases may involve comparison of present value of benefits.

- D. “Independent review organization” means an organization that conducts independent reviews of long-term care benefit trigger decisions.
- E. “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.

Drafting Note: For purposes of Section 31, it may be appropriate for certain licensed health care professionals, such as physical therapists, occupational therapists, neurologists, physical medicine specialists, and rehabilitation medicine specialists, to review a benefit trigger determination. However, some of these health care professionals may not meet the definition of a licensed health care practitioner under Section 7702B(c)(4) of the Internal Revenue Code. For tax-qualified long-term care insurance contracts, only a licensed health care professional who meets the definition of a licensed health care practitioner may certify that an individual is a chronically ill individual.

- F. “Qualified actuary” means a member in good standing of the American Academy of Actuaries.

- G. “Similar policy forms” means all of the long-term care insurance policies and certificates issued by an insurer in the same 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 Long-Term Care Model Act] are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

Section 5. Policy Definitions

No 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 health 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 long-term care insurance policies, while allowing some flexibility in the definitions themselves.

Drafting Note: The U. S. Treasury Department may, at some time in the future, develop additional or different policy definitions intended to satisfy the requirements of Section 7702B of the Internal Revenue Code of 1986, as amended, for qualified long-term insurance contracts. States should consider developing a mechanism to allow definitions that may be developed by the federal agency to be used in qualified long-term care insurance contracts.

Section 6. Policy Practices and Provisions

- A. Renewability. The terms “guaranteed renewable” and “noncancellable” shall not be used in any individual 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 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 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.
 - (5) In addition to the other requirements of this subsection, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.
- B. Limitations and Exclusions. A policy may not be delivered or issued for delivery in this state as 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 Alzheimer's Disease;
- (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 long-term care insurance or health insurance policy;
- (7) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.
- (8)
 - (a) This subsection is not intended to prohibit exclusions and limitations by type of provider. However, no 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 (8) 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 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.

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

- C. Extension of Benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the 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 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 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 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 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 long-term care policy is replaced by another group 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 long-term care services.

F. (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 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], 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 long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

- A. (1) Notice before lapse or termination. No individual 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 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 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 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 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.

Drafting Note: The language in Subsection B addressing the provision of proof of cognitive impairment or less of functional capacity has been amended to more precisely clarify the original intent in adopting the reinstatement provision.

Section 8. Required Disclosure Provisions

- A. Renewability. Individual 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. This provision shall not apply to policies that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

Drafting Note: The last sentence of this subsection is intended to apply to long-term care policies which are part of or combined with life insurance policies, since life insurance policies generally do not contain renewability provisions.

- (2) A 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 long-term care insurance policy, all riders or endorsements added to an individual 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 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 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 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 6D(2) of the 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. Disclosure of Tax Consequences. With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This subsection shall not apply to qualified long-term care insurance contracts.
- G. Benefit Triggers. Activities of daily living and cognitive impairment shall be used to measure an insured’s need for 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.
- H. A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in Section 33E3 that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.
- I. A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in Section 33E3 that the policy is not intended to be a qualified long-term care insurance contract.

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 long-term care policy or certificate issued in this state on or after [insert date that is 6 months after adoption of the amended regulation].
 - (2) For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended 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 amended 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) 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 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 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 forms in Appendices B and F 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 long-term care policy issued in this state on or after [insert date that is 6 months after adoption of the amended regulation] except that Subsection B(2)(d) and Subsection B(3) apply to any long-term care policy issued in this state on or after [insert date that is six (6) months after adoption of the amended regulation].
- B. An insurer shall provide the information listed in this subsection to the commissioner [30 days] prior to making a long-term care insurance form available for sale.

Drafting Note: States should consider whether a time period other than 30 days is desirable. An alternative time period would be the time period required for policy form approval in the applicable state regulation or law.

- (1) A copy of the disclosure documents required in Section 9; and
- (2) An actuarial certification consisting of at least the following:
 - (a) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;
 - (b) A statement that the policy design and coverage provided have been reviewed and taken into consideration;
 - (c) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;
 - (d) A statement that the premiums contain at least the minimum margin for moderately adverse experience defined in (i) or the specification of and justification for a lower margin as required by (ii).
 - (i) A composite margin shall not be less than 10% of lifetime claims.
 - (ii) A composite margin that is less than 10% may be justified in uncommon circumstances. The proposed amount, full justification of the proposed amount and methods to monitor developing experience that would be the basis for withdrawal of approval for such lower margins must be submitted.
 - (iii) A composite margin lower than otherwise considered appropriate for the stand-alone long-term care policy may be justified for long-term care benefits provided through a life policy or an annuity contract. Such lower composite margin, if utilized, shall be justified by appropriate actuarial demonstration addressing margins and volatility when considering the entirety of the product.

Drafting Note: For the justification required in (iii) above, examples of such considerations, if applicable to the product and company, might be found in Society of Actuaries research studies entitled “Quantification of the Natural Hedge Characteristics of Combination Life or Annuity Products Linked to Long-Term Care Insurance” (2012) and “Understanding the Volatility of Experience and Pricing Assumptions in Long-Term Care Insurance Programs” (2014).

- (iv) A greater margin may be appropriate in circumstances where the company has less credible experience to support its assumptions used to determine the premium rates.

Drafting Note: Actual margins may be included in several actuarial assumptions (e. g. mortality, lapse, underwriting selection wear-off, etc.) in addition to some of the margin in the morbidity assumption. The composite margin is the total of such margins over best-estimate assumptions.

- (e)
 - (i) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or
 - (ii) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

Drafting Note: In the event a series of increases is being applied to another policy form, intermediate premium levels are not to be used in this comparison.

Drafting Note: It is not expected that the insurer will need to provide a comparison of every age and set of benefits, period of payment or elimination period. A broad range of expected combinations is to be provided in a manner designed to provide a fair presentation for review by the commissioner.

- (f) A statement that reserve requirements have been reviewed and considered. Support for this statement shall include:
 - (i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; and
 - (ii) 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 a 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.
- (3) An actuarial memorandum prepared, dated and signed by a member of the Academy of Actuaries shall be included and shall address and support each specific item required as part of the actuarial certification and provide at least the following information:
 - (a) An explanation of the review performed by the actuary prior to making the statements in Paragraph (2)(b) and (c),
 - (b) A complete description of pricing assumptions; and
 - (c) Sources and levels of margins incorporated into the gross premiums that are the basis for the statement in Paragraph (2)(a) of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. Deviations in margins between ages, sexes, plans or states shall be clearly described. Deviations in margins required to be described are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating gross premium scales.
 - (d) A demonstration that the gross premiums include the minimum composite margin specified in Paragraph (2)(d).

- C. In any review of the actuarial certification and actuarial memorandum, the commissioner may request review by an actuary with experience in long-term care pricing who is independent of the company. In the event the commissioner asks for additional information as a result of any review, the period in Subsection B does not include the period during which the insurer is preparing the requested information.

Drafting Note: The commissioner may accept a review done for another state or states if such review is for the same policy form or where any differences in benefits and premiums are not material and such review was completed within eighteen months of the date of the actuarial certification in Subsection B(2) above.

Section 11. Prohibition Against Post-Claims Underwriting

- A. All applications for 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 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 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 long-term care insurance policy or certificate at the time of delivery:
- Caution: The issuance of this 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]**
- (3) Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the insurer shall obtain one of the following:
- (a) A report of a physical examination;
- (b) An assessment of functional capacity;
- (c) An attending physician's statement; or
- (d) Copies of medical records.
- 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.

- E. Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and shall annually furnish this information to the insurance commissioner in the format prescribed by the National Association of Insurance Commissioners in Appendix A.

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

- A. A long-term care insurance policy or certificate shall not, if it provides benefits for home health 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 health 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 health 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 health 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 health 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 long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health 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 health care coverage may be applied to the nonhome health 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 health care benefits to be counted toward the maximum length of long-term care coverage under the policy. The subsection is not intended to restrict home health care to a period of time which would make the benefit illusory. It is suggested that fewer than 365 benefit days and less than a \$25 daily maximum benefit constitute illusory home health care benefits.

Section 13. Requirement to Offer Inflation Protection

- A. No insurer may offer a 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 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 five percent (5%);
 - (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 five percent (5%) 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 policyholder; except, if the policy is issued to a group defined in [Section 4E(4) of the Long-Term Care Insurance Model Act] other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.
- C. The offer in Subsection A above shall not be required of life insurance policies or riders containing accelerated long-term care benefits.
- D. (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.
- E. Inflation protection benefit increases under a policy which contains these benefits 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.
- F. 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.
- G. (1) Inflation protection as provided in Subsection A(1) of this section shall be included in a 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 long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care 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 Long-Term Care Insurance Model Act], the following questions may be modified only to the extent necessary to elicit information about health or 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 long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?
 - (2) Did you have another 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. 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 long-term care insurance policy, a notice regarding replacement of accident and sickness 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:
- D. Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:
- E. 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.
- F. Life Insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of [cite to state's life insurance replacement regulation similar to the NAIC Life Insurance and Annuities Replacement Model Regulation]. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

**NOTICE TO APPLICANT REGARDING REPLACEMENT
OF INDIVIDUAL ACCIDENT AND SICKNESS 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 long-term care insurance and replace it with an individual 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 long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this 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 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 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 long-term care insurance and replace it with the 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 long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this 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 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 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 G)
- 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 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 G)

- 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 G)
- F. Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. (Appendix E)
- G. For purposes of this section:
 - (1) “Policy” means only long-term care insurance;
 - (2) Subject to Paragraph (3), “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;
 - (3) “Denied” means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and
 - (4) “Report” means on a statewide basis.
- H. Reports required under this section shall be filed with the commissioner.
- I. Annual rate certification requirements.
 - (1) This subsection applies to any long-term care policy issued in this state on or after [insert date that is six (6) months after adoption of the amended regulation].
 - (2) The following annual submission requirements apply subsequent to initial rate filings for individual 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 including:
 - (I) For the rate schedules currently marketed,
 - a. The premium rate schedule continues to be sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated; or
 - b. If the above statement cannot be made, a statement that margins for moderately adverse experience 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 so that the ultimate premium rate schedule would be reasonably expected to be sustainable over the future life of the form with no future premium increases anticipated. Failure to submit a plan of action to the commissioner within sixty (60) days or to comply with the time frame stated in the plan of action constitutes grounds for the commissioner to withdraw or modify its approval of the form for future sales pursuant to

[*Reference State form approval authority and administrative procedures rules*].

Drafting Note: In accordance with the 2014 amendments to Section 10, 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,
 - a. That the premium rate schedule continues to be sufficient to cover anticipated costs under best estimate assumptions; or
 - b. 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.
- (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 long-term care insurance except as authorized by [insert reference to state law equivalent to the NAIC Producer Licensing Model Act].

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 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 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 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 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 long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with [cite the standard valuation law for life insurance, which contains a section referring to "special benefits" for which tables must be approved by the commissioner]. Claim reserves shall also be established in the case when the policy or rider is in claim status.

Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

- (1) Definition of insured events;
- (2) Covered long-term care facilities;
- (3) Existence of home convalescence care coverage;
- (4) Definition of facilities;
- (5) Existence or absence of barriers to eligibility;
- (6) Premium waiver provision;
- (7) Renewability;

- (8) Ability to raise premiums;
- (9) Marketing method;
- (10) Underwriting procedures;
- (11) Claims adjustment procedures;
- (12) Waiting period;
- (13) Maximum benefit;
- (14) Availability of eligible facilities;
- (15) Margins in claim costs;
- (16) Optional nature of benefit;
- (17) Delay in eligibility for benefit;
- (18) Inflation protection provisions; and
- (19) Guaranteed insurability option.

Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

- B. When long-term care benefits are provided other than as in Subsection A above, reserves shall be determined in accordance with [insert reference to state law equivalent to the Health Insurance Reserves Model Regulation].

Drafting Note: HIPAA applies the reserve method to qualified long-term care contracts that is applied to all insurance contracts except life insurance contracts, annuity contracts, or noncancellable accident and health contracts.

Section 19. Loss Ratio

- A. This section shall apply to all long-term care insurance policies or certificates except those covered under Sections 10, 20 and 20.1.
- B. Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:
 - (1) Statistical credibility of incurred claims experience and earned premiums;
 - (2) The period for which rates are computed to provide coverage;
 - (3) Experienced and projected trends;
 - (4) Concentration of experience within early policy duration;
 - (5) Expected claim fluctuation;
 - (6) Experience refunds, adjustments or dividends;
 - (7) Renewability features;

- (8) All appropriate expense factors;
 - (9) Interest;
 - (10) Experimental nature of the coverage;
 - (11) Policy reserves;
 - (12) Mix of business by risk classification; and
 - (13) Product features such as long elimination periods, high deductibles and high maximum limits.
- C. Subsection B shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:
- (1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
 - (2) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of [cite to state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Life Insurance];
 - (3) The policy meets the disclosure requirements of Sections 6I, 6J, and 6K of the NAIC Long-Term Care Insurance Model Act;
 - (4) Any policy illustration that meets the applicable requirements of the NAIC Life Insurance Illustrations Model Regulation; and
 - (5) An actuarial memorandum is filed with the insurance department that includes:
 - (a) A description of the basis on which the long-term care rates were determined;
 - (b) A description of the basis for the reserves;
 - (c) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
 - (d) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;
 - (e) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
 - (f) The estimated average annual premium per policy and the average issue age;
 - (g) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

- (h) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

Drafting Note: The loss ratio reporting form for long-term care policies that was adopted in 1990 provides for reporting of loss ratios on group as well as individual policies. The amendment to Section 19 above which removes the word “individual”: (1) reflects the fact that loss ratios should be reported on all policies, and (2) establishes a 60% loss ratio for both group and individual policies. States may wish to apply a higher standard than 60% to group policies.

Section 20. Premium Rate Schedule Increases

Drafting Note: Section 20 applies to policies issued for effective dates prior to the date that is six (6) months after adoption of the amended regulation incorporating Section 20.1 (as adopted by the NAIC in 2014). Policies issued on or after that date should adhere to the requirements of Section 20.1 instead of Section 20. Section 20 and Section 20.1 are identical with the exceptions of Subsections A, C and G.

- A. This section shall apply as follows:
 - (1) Except as provided in Paragraph (2), this section applies to any long-term care policy or certificate issued in this state on or after [insert date that is 6 months after adoption of the amended regulation] and prior to [insert date that is six (6) months after adoption of the amended regulation incorporating Section 20.1].
 - (2) For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended 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 amended regulation].
- B. An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least [30] days prior to the notice to the policyholders and shall include:

Drafting Note: In states where the commissioner is required to approve premium rate schedule increases, “shall provide notice” may be changed to “shall request approval.” States should consider whether a time period other than 30 days is desirable. An alternate time period would be the time period required for policy form approval in the applicable state regulation or law.

- (1) Information required by Section 9;
- (2) Certification by a qualified actuary that:
 - (a) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;
 - (b) The premium rate filing is in compliance with the provisions of this section;
 - (c) The insurer may request a premium rate schedule increase less than what is required under this section and the commissioner may approve such premium rate schedule increase, without submission of the certification in Subparagraph (a) of this paragraph, if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required under Subparagraph (a) of this paragraph, the premium rate schedule increase filing satisfies all other requirements of this section, and is, in the opinion of the commissioner, in the best interest of policyholders.

Drafting Note: In any comparison of premiums under Section 10. B(2)(e) or Section 20. B(4), such lower premium or any subsequent higher premium based on a series of increases should not be used.

- (3) An actuarial memorandum justifying the rate schedule change request that includes:

- (a) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;
 - (i) Annual values for the five (5) years preceding and the three (3) years following the valuation date shall be provided separately;
 - (ii) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;
 - (iii) The projections shall demonstrate compliance with Subsection C; and
 - (iv) For exceptional increases,
 - (I) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and
 - (II) In the event the commissioner determines as provided in Section 4A(4) that offsets may exist, the insurer shall use appropriate net projected experience;
 - (b) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;
 - (c) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;
 - (d) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration;
 - (e) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates; and
 - (f) A demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin specified in Section 10B(2)(d) is projected to be exhausted.
- (4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and
 - (5) Sufficient information for review [and approval] of the premium rate schedule increase by the commissioner.
- C. All premium rate schedule increases shall be determined in accordance with the following requirements:
- (1) Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

- (2) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:
 - (a) The accumulated value of the initial earned premium times fifty-eight percent (58%);
 - (b) Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;
 - (c) The present value of future projected initial earned premiums times fifty-eight percent (58%); and
 - (d) Eighty-five percent (85%) of the present value of future projected premiums not in Subparagraph (c) on an earned basis;
 - (3) In the event that a policy form has both exceptional and other increases, the values in Paragraph (2)(b) and (d) will also include seventy percent (70%) for exceptional rate increase amounts; and
 - (4) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in the [insert reference to state equivalent to the Health Insurance Reserves Model Regulation Appendix A, Section IIA]. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.
- D. For each rate increase that is implemented, the insurer shall file for review [approval] by the commissioner updated projections, as defined in Subsection B(3)(a), annually for the next three (3) years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.
- E. If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in Subsection B(3)(a), shall be filed for review [approval] by the commissioner every five (5) years following the end of the required period in Subsection D. For group insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.
- F. (1) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in Subsection C, the commissioner may require the insurer to implement any of the following:
 - (a) Premium rate schedule adjustments; or
 - (b) Other measures to reduce the difference between the projected and actual experience.

Drafting Note: The terms “adequately match the projected experience” include more than a comparison between actual and projected incurred claims. Other assumptions should also be taken into consideration, including lapse rates (including mortality), interest rates, margins for moderately adverse conditions, or any other assumptions used in the pricing of the product. It is to be expected that the actual experience will not exactly match the insurer’s projections. During the period that projections are monitored as described in Subsections D and E, the commissioner should determine that there is not an adequate match if the differences in earned premiums and incurred claims are not in the same direction (both actual values higher or lower than projections) or the difference as a percentage of the projected is not of the same order.

- (2) In determining whether the actual experience adequately matches the projected experience, consideration should be given to Subsection B(3)(e), if applicable.

- G. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:
- (1) A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in Subsection H of this section; and
 - (2) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to Subsection C had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculations described in Subsection C(2)(a) and (c).
- H. (1) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapsation has occurred or is anticipated:
- (a) The rate increase is not the first rate increase requested for the specific policy form or forms;
 - (b) The rate increase is not an exceptional increase; and
 - (c) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse
- (2) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.
- (a) The offer shall:
 - (i) Be subject to the approval of the commissioner;
 - (ii) Be based on actuarially sound principles, but not be based on attained age; and
 - (iii) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.
 - (b) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:
 - (i) The maximum rate increase determined based on the combined experience; and
 - (ii) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%).
- I. If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of Subsection H of this section, prohibit the insurer from either of the following:

Drafting Note: States may want to consider examining their statutes to determine whether a persistent practice of filing inadequate initial premium rates would be considered a violation of the state's unfair trade practice act and subject to the penalties under that act.

- (1) Filing and marketing comparable coverage for a period of up to five (5) years; or
 - (2) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.
- J. Subsections A through I shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in Section 4C, if the policy complies with all of the following provisions:
- (1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
 - (2) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:
 - (a) [Cite state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Life Insurance];
 - (b) [Cite state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Individual Deferred Annuities], and
 - (c) [Cite state's section of the variable annuity regulation similar to Section 7 of the NAIC's Model Variable Annuity Regulation];
 - (3) The policy meets the disclosure requirements of [cite appropriate sections in the state's long-term care insurance law similar to Section 6I, 6J, and 6K of the NAIC's Long-Term Care Insurance Model Act];
 - (4) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:
 - (a) Policy illustrations as required by [cite state's life insurance illustrations regulation similar to the NAIC's Life Insurance Illustrations Model Regulation];
 - (b) Disclosure requirements in [cite state's annuity disclosure regulation similar to the NAIC's Annuity Disclosure Model Regulation]; and
 - (c) Disclosure requirements in [cite state's variable annuity regulation similar to the NAIC's Model Variable Annuity Regulation].
 - (5) An actuarial memorandum is filed with the insurance department that includes:
 - (a) A description of the basis on which the long-term care rates were determined;
 - (b) A description of the basis for the reserves;
 - (c) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
 - (d) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

- (e) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
 - (f) The estimated average annual premium per policy and the average issue age;
 - (g) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
 - (h) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.
- K. Subsections F and H shall not apply to group insurance policies as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act] where:
- (1) The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or
 - (2) The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed.

Section 20.1 Premium Rate Schedule Increases for Policies Subject to Loss Ratio Limits Related to Original Filings.

Drafting Note: Section 20.1 applies to policies issued for effective dates on or after the date that is six (6) months after adoption of the amended regulation incorporating Section 20.1 (as adopted by the NAIC in 2014. Policies issued prior to the date that is six (6) months after adoption of the amended regulation should adhere to the requirements of Section 20 instead of Section 20.1. Section 20 and Section 20.1 are identical with the exception of Subsections A, C and G.

- A. This section shall apply as follows:
- (1) Except as provided in Paragraph (2), this section applies to any long-term care policy or certificate issued in this state on or after [insert date that is six (6) months after adoption of the amended regulation incorporating Section 20.1].
 - (2) For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following [insert date that is twelve (12) months after adoption of the amended regulation].
- B. An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least [30] days prior to the notice to the policyholders and shall include:

Drafting Note: In states where the commissioner is required to approve premium rate schedule increases, “shall provide notice” may be changed to “shall request approval.” States should consider whether a time period other than 30 days is desirable. An alternate time period would be the time period required for policy form approval in the applicable state regulation or law.

- (1) Information required by Section 9;

- (2) Certification by a qualified actuary that:
- (a) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;
 - (b) The premium rate filing is in compliance with the provisions of this section;
 - (c) The insurer may request a premium rate schedule increase less than what is required under this section and the commissioner may approve such premium rate schedule increase, without submission of the certification in Subparagraph (a) of this paragraph, if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required under Subparagraph (a) of this paragraph, the premium rate schedule increase filing satisfies all other requirements of this section, and is, in the opinion of the commissioner, in the best interest of policyholders.

Drafting Note: In any comparison of premiums under Section 10B(2)(e) or Section 20B(4), such lower premium or any subsequent higher premium based on a series of increases should not be used.

- (3) An actuarial memorandum justifying the rate schedule change request that includes:
- (a) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;
 - (i) Annual values for the five (5) years preceding and the three (3) years following the valuation date shall be provided separately;
 - (ii) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;
 - (iii) The projections shall demonstrate compliance with Subsection C; and
 - (iv) For exceptional increases,
 - (I) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and
 - (II) In the event the commissioner determines as provided in Section 4A(4) that offsets may exist, the insurer shall use appropriate net projected experience;
 - (b) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;
 - (c) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;
 - (d) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration;
 - (e) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates; and

- (f) A demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin specified in Section 10B(2)(d) is projected to be exhausted.
 - (4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and
 - (5) Sufficient information for review [and approval] of the premium rate schedule increase by the commissioner.
- C. All premium rate schedule increases shall be determined in accordance with the following requirements:
- (1) Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;
 - (2) Premium rate schedule increases shall be calculated such that the sum of the lesser of (i) the accumulated value of actual incurred claims, without the inclusion of active life reserves, or (ii) the accumulated value of historic expected claims, without the inclusion of active life reserves, plus the present value of the future expected incurred claims, projected without the inclusion of active life reserves, will not be less than the sum of the following:
 - (a) The accumulated value of the initial earned premium times the greater of (i) fifty-eight percent (58%) and (ii) the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience;
 - (b) Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;
 - (c) The present value of future projected initial earned premiums times the greater of (i) fifty-eight percent (58%) and (ii) the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience; and
 - (d) Eighty-five percent (85%) of the present value of future projected premiums not in Subparagraph (c) of this paragraph on an earned basis;
 - (3) Expected claims shall be calculated based on the original filing assumptions assumed until new assumptions are filed as part of a rate increase. New assumptions shall be used for all periods beyond each requested effective date of a rate increase. Expected claims are calculated for each calendar year based on the in-force at the beginning of the calendar year. Expected claims shall include margins for moderately adverse experience; either amounts included in the claims that were used to determine the lifetime loss ratio consistent with the original filing or as modified in any rate increase filing;
 - (4) In the event that a policy form has both exceptional and other increases, the values in Paragraph (2)(b) and (d) will also include seventy percent (70%) for exceptional rate increase amounts; and
 - (5) All present and accumulated values used to determine rate increases, including the lifetime loss ratio consistent with the original filing reflecting margins for moderately adverse experience, shall use the maximum valuation interest rate for contract reserves as specified in the [insert reference to state equivalent to the Health Insurance Reserves Model Regulation Appendix A, Section IIA]. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

- D. For each rate increase that is implemented, the insurer shall file for review [approval] by the commissioner updated projections, as defined in Subsection B(3)(a), annually for the next three (3) years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.
- E. If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in Subsection B(3)(a), shall be filed for review [approval] by the commissioner every five (5) years following the end of the required period in Subsection D. For group insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.
- F. (1) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in Subsection C, the commissioner may require the insurer to implement any of the following:
- (a) Premium rate schedule adjustments; or
 - (b) Other measures to reduce the difference between the projected and actual experience.

Drafting Note: The terms “adequately match the projected experience” include more than a comparison between actual and projected incurred claims. Other assumptions should also be taken into consideration, including lapse rates (including mortality), interest rates, margins for moderately adverse conditions, or any other assumptions used in the pricing of the product. It is to be expected that the actual experience will not exactly match the insurer’s projections. During the period that projections are monitored as described in Subsections D and E, the commissioner should determine that there is not an adequate match if the differences in earned premiums and incurred claims are not in the same direction (both actual values higher or lower than projections) or the difference as a percentage of the projected is not of the same order.

- (2) In determining whether the actual experience adequately matches the projected experience, consideration should be given to Subsection B(3)(e), if applicable.
- G. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file a plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in Subsection H of this section.
- H. (1) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapsation has occurred or is anticipated:
- (a) The rate increase is not the first rate increase requested for the specific policy form or forms;
 - (b) The rate increase is not an exceptional increase; and
 - (c) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.
- (2) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its

affiliates.

- (a) The offer shall:
 - (i) Be subject to the approval of the commissioner;
 - (ii) Be based on actuarially sound principles, but not be based on attained age; and
 - (iii) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.
- (b) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:
 - (i) The maximum rate increase determined based on the combined experience; and
 - (ii) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%).

- I. If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of Subsection H of this section, prohibit the insurer from either of the following:

Drafting Note: States may want to consider examining their statutes to determine whether a persistent practice of filing inadequate initial premium rates would be considered a violation of the state's unfair trade practice act and subject to the penalties under that act.

- (1) Filing and marketing comparable coverage for a period of up to five (5) years; or
 - (2) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.
- J. Subsections A through I shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in Section 4C, if the policy complies with all of the following provisions:
 - (1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
 - (2) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:
 - (a) [Cite state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Life Insurance];
 - (b) [Cite state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Individual Deferred Annuities], and
 - (c) [Cite state's section of the variable annuity regulation similar to Section 7 of the NAIC's Model Variable Annuity Regulation];
 - (3) The policy meets the disclosure requirements of [cite appropriate sections in the state's long-term care insurance law similar to Section 6I, 6J, and 6K of the NAIC's Long-Term Care Insurance Model Act];

- (4) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:
 - (a) Policy illustrations as required by [cite state's life insurance illustrations regulation similar to the NAIC's Life Insurance Illustrations Model Regulation];
 - (b) Disclosure requirements in [cite state's annuity disclosure regulation similar to the NAIC's Annuity Disclosure Model Regulation]; and
 - (c) Disclosure requirements in [cite state's variable annuity regulation similar to the NAIC's Model Variable Annuity Regulation].
- (5) An actuarial memorandum is filed with the insurance department that includes:
 - (a) A description of the basis on which the long-term care rates were determined;
 - (b) A description of the basis for the reserves;
 - (c) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
 - (d) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;
 - (e) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
 - (f) The estimated average annual premium per policy and the average issue age;
 - (g) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
 - (h) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

K. Subsections F and H shall not apply to group insurance policies as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act] where:

- (1) The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or
- (2) The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed.

Section 21. Filing Requirement

Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state pursuant to [cite state law equivalent to Section 5 of the 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 long-term care insurance requirements substantially similar to those adopted in this state.

Section 22. Filing Requirements for Advertising

- A. Every insurer, health care service plan or other entity providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio or television medium to the Commissioner of Insurance of this state 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 23. Standards for Marketing

- A. Every insurer, health care service plan or other entity marketing 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 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 forms required in Section 9C (Appendices B and F) to the applicant.
 - (4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required.
 - (5) Every insurer or entity marketing 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 long-term care health insurance policies and certificates, use the terms “noncancellable” or “level premium” only when the policy or certificate conforms to Section 6 A(3) of this regulation.
 - (8) Provide an explanation of contingent benefit upon lapse provided for in Section 28D(3) and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in Section 28D(4).

- B. In addition to the practices prohibited in [insert citation to state unfair trade practices act], 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 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 Long-Term Care Insurance Model Act], when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding 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 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 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 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.
 - (d) Subparagraphs (a) through (c) shall not apply to qualified long-term care insurance contracts.

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 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 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 state unfair trade practices act].

Drafting Note: Remember that the Unfair Trade Practice Act in your state applies to long-term care insurance policies and certificates.

Section 24. Suitability

- A. This section shall not apply to life insurance policies that accelerate benefits for long-term care.
- B. Every insurer, health care service plan or other entity marketing long-term care insurance (the “issuer”) shall:
 - (1) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;
 - (2) Train its agents in the use of its suitability standards; and
 - (3) Maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.
- C. (1) To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take the following into consideration:
 - (a) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
 - (b) The applicant’s goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and
 - (c) The values, benefits and costs of the applicant’s existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

- (2) The issuer, and where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in Paragraph (1) above. The efforts shall include presentation to the applicant, at or prior to application, the “Long-Term Care Insurance Personal Worksheet.” The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix B, in not less than twelve (12) point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer’s personal worksheet shall be filed with the commissioner.
 - (3) A completed personal worksheet shall be returned to the issuer prior to the issuer’s consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.
 - (4) The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet in Appendix B is prohibited.
- D. The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.
 - E. Agents shall use the suitability standards developed by the issuer in marketing long-term care insurance.
 - F. At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled “Things You Should Know Before You Buy Long-Term Care Insurance” shall be provided. The form shall be in the format contained in Appendix C, in not less than twelve (12) point type.
 - G. 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. In the alternative, the issuer shall send the applicant a letter similar to Appendix D. 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.
 - H. The issuer shall report annually to the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

Section 25. Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates

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

Section 26. Availability of New Services or Providers

- A. An insurer shall notify policyholders of the availability of a new long-term policy series that provides coverage for new 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 of the date of the new policy series is made available for sale in this state.

Drafting Note: New 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 that purchased such a new proprietary policy shall be notified when a new long-term care policy series that provides coverage for new 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 to 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 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 long-term care benefits.
- I. This section shall become effective on or after [insert the effective date of the amended regulation].

Section 27. Right to Reduce Coverage and Lower Premiums

- A. (1) Every 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. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.
- G. The requirements of Subsections A through F shall apply to any long-term care policy issued in this state on or after [insert date that is twelve (12) months after adoption of the amended regulation].
- H. 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
 - (3) In the case of a partnership policy, a disclosure that some benefit reduction options may result in a loss in partnership status that may reduce policyholder protections.
- I. The requirements of Subsection H shall apply to any rate increase implemented in this state on or after [insert date that is twelve (12) months after adoption of the amended 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 28. Nonforfeiture Benefit Requirement

- A. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.
- B. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of [insert reference to Section 8 of the NAIC 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 E; 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.
- C. If the offer required to be made under [insert reference to Section 8 of the NAIC Long-Term Care Insurance Model Act] is 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 D(4) shall still apply.
- D.
 - (1) After rejection of the offer required under [insert reference to Section 8 of the NAIC 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 the percentage of the insured’s initial annual premium set forth below based on the insured’s issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

<u>Issue Age</u>	<u>Percent Increase Over Initial Premium</u>
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%

Triggers for a Substantial Premium Increase

<u>Issue Age</u>	<u>Percent Increase Over Initial Premium</u>
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

- (4) A contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured’s initial annual premium set forth below based on the insured’s issue age, the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio in Paragraph (6)(b) is forty percent (40%) or more. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

<u>Issue Age</u>	<u>Percent Increase Over Initial Premium</u>
Under 65	50%
65-80	30%
Over 80	10%

This provision shall be in addition to the contingent benefit provided by Paragraph (3) above and where both are triggered, the benefit provided shall be at the option of the insured.

- (5) 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 27 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 E. This option may be elected at any time during the 120-day period referenced in Subsection D(3); and

- (c) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in Subsection D(3) shall be deemed to be the election of the offer to convert in Subparagraph (b) above unless the automatic option in Paragraph (6)(c) applies.
- (6) On or before the effective date of a substantial premium increase as defined in Paragraph (4) above, the insurer shall:
 - (a) Offer to reduce policy benefits provided by the current coverage consistent with the requirements of Section 27 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 where the amount payable for each benefit is ninety percent (90%) of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in Subsection D(4); and
- (c) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in Subsection D(4) shall be deemed to be the election of the offer to convert in Subparagraph (b) above if the ratio is forth percent (40%) or more.
- (7) For any long-term care policy issued in this state on or after [insert date that is six (6) months after adoption of the amended regulation].
 - (a) In the event the policy or certificate was issued at least twenty (20) years prior to the effective date of the increase, a value of 0% shall be used in place of all values in the above table; and
 - (b) Values above 100% in the table in Paragraph (3) above shall be reduced to 100%.

E. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with Subsection D(3) but not Subsection D(4), are described in this subsection:

- (1) For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one percent per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (50).
- (2) For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up 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).
- (3) 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. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Subsection F.
- (4) (a) The nonforfeiture benefit shall begin not 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.

- (b) Notwithstanding Subparagraph (a), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:
 - (i) The end of the tenth year following the policy or certificate issue date; or
 - (ii) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.
- (5) 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.
- F. 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.
- G. There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.
- H. The requirements set forth in this section shall become effective twelve (12) months after adoption of this provision and shall apply as follows:
 - (1) Except as provided in Paragraph (2) and (3) below, the provisions of this section apply to any long-term care policy issued in this state on or after the effective date of this amended regulation.
 - (2) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this section shall not apply.
 - (3) The last sentence in Subsection C and Subsections D(4) and D(6) shall apply to any long-term care insurance policy or certificate issued in this state after six (6) months after their adoption, except new certificates on a group policy as defined in [insert reference to Section 4E(1) of the NAIC Long-Term Care Model Act] one year after adoption.
- I. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of Section 19, Section 20 or Section 20.1, whichever is applicable, treating the policy as a whole.
- J. To determine whether contingent nonforfeiture upon lapse provisions are triggered under Subsection D(3) or D(4), a replacing insurer that purchased or otherwise assumed a block or blocks of 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.
- K. A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:
 - (1) The nonforfeiture provision shall be appropriately captioned;
 - (2) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying contracts approved by the commissioner for the same contract form; and
 - (3) The nonforfeiture provision shall provide at least one of the following:

- (a) Reduced paid-up insurance;
- (b) Extended term insurance;
- (c) Shortened benefit period; or
- (d) Other similar offerings approved by the commissioner.

Section 29. Standards for Benefit Triggers

- A. A 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;
 - (e) 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. Long term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.
- G. The requirements set forth in this section shall be effective [insert date 12 months after adoption of this provision] and shall apply as follows:
 - (1) Except as provided in Paragraph (2), the provisions of this section apply to a long-term care policy issued in this state on or after the effective date of the amended regulation.

- (2) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the Long-Term Care Insurance Model Act] that was in force at the time this amended regulation became effective, the provisions of this section shall not apply.

Section 30. Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts

A. For purposes of this section the following definitions apply:

- (1) “Qualified long-term care services” means services that meet the requirements of Section 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.
- (2) (a) “Chronically ill individual” has the meaning prescribed for this term by section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:
 - (i) Being unable to perform (without substantial assistance from another individual) at least two (2) activities of daily living for a period of at least ninety (90) days due to a loss of functional capacity; or
 - (ii) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

Drafting Note: With respect to the activities of daily living (ADL) benefit trigger, HIPAA provides that tax-qualified contracts must take into account at least five of the six ADLs specified in Section 29B. This model regulation requires that eligibility for payment of benefits be no more restrictive than requiring a deficiency in the ability to perform not more than three ADLs, of the six listed. Thus, in this regard, a contract that complies with this regulation will also be tax-qualified. States do not need to alter their regulations from this model regulation with respect to the ADL trigger for tax-qualified contracts.

- (b) The term “chronically ill individual” shall not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner has certified that the individual meets these requirements.
- (3) “Licensed health care practitioner” means a physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the Secretary of the Treasury.
- (4) “Maintenance or personal care services” means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

Drafting Note: Terms used in the definition of a “chronically ill individual,” such as substantial assistance, loss of functional capacity, substantial supervision and severe cognitive impairment, are not defined by the Internal Revenue Code of 1986, as amended, although the meaning of the terms has been addressed by Treasury Department and Internal Revenue Service guidance. The requirement that an insured be certified as a chronically ill individual at least once every 12 months by a licensed health care practitioner does not preclude an insurer from requiring more frequent assessments of an insured’s condition in order to determine whether benefits are payable under a contract. However, states are also free to limit an insurer’s ability to perform more frequent assessments without affecting the tax-qualified status of the contract.

Qualified long-term care insurance contracts that pay benefits upon a loss of functional capacity must include a provision for triggering benefits that is different from that found in Section 29 of this model regulation. The Internal Revenue Service has stated that the 90-day requirement under this benefit trigger does not establish a waiting period before which benefits may be paid or before which services may constitute qualified long-term care services.

Under Section 7702B of the Internal Revenue Code, as amended, only “licensed health care practitioners” can certify that an insured is a chronically ill individual. This term includes only physicians (within the meaning of Section 1861(r)(1) of the Social Security Act), registered professional nurses and licensed social workers.

Section 7702B does not preclude a contract from specifying a subset of “licensed health care practitioners” who can perform certifications, e. g., only physicians within the meaning of Section 1861(r)(1) of the Social Security Act that are approved by the insurance company. The Secretary of the Treasury may in regulations expand the types of individuals who are considered “licensed health care practitioners.”

Section 7702B(c)(2) states that an individual will be considered chronically ill if he or she is certified by a licensed health care practitioner as having a level of disability similar (as determined under regulations prescribed by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services) to the level of disability described in Section 7702B(c)(2)(A)(i) (Section 30C of this regulation). At present, the Secretary of the Treasury has prescribed no such standard. Federal tax law does not require a qualified long-term care insurance contract to include this benefit trigger in the contract. In addition, this model regulation does not mandate inclusion of this undefined benefit trigger in policies at the present time. If the Treasury Department prescribes an additional benefit trigger in the future, consideration will be given at that time to making appropriate amendments to this regulation.

- B. A qualified long term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

Drafting Note: The federal tax requirements for the term “qualified long-term care services” has been added to assist states in regulating qualified long-term care insurance contracts, which are defined in Section 7702B(b) of the Internal Revenue Code of 1986, as amended. The Internal Revenue Code of 1986 is subject to amendment by Congress and to interpretation by the Treasury Department, the Internal Revenue Service and the courts.

Since a qualified long-term care insurance contract can provide insurance coverage “only” for qualified long-term care services, and such services are ones required by a “chronically ill individual,” benefits from such a contract can only be provided to an individual who is chronically ill. Federal tax law does not, however, prohibit the provision of coverage of some, but not all, qualified long-term care services. Thus, a contract may cover only nursing home services or limit benefits to those performed by eligible providers consistent with the requirements of federal tax law. Likewise, the federal tax law does not preclude a contract from specifying the need for hands-on assistance for purposes of determining whether the insured can perform an activity of daily living. Under this regulation, however, benefit triggers requiring greater degrees of impairment than the minimum standard established by federal tax law are permitted only to the extent otherwise consistent with this regulation and the model act.

- C. A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured’s inability to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity or to severe cognitive impairment.

Drafting Note: Section 7702B of the Internal Revenue Code of 1986, as amended, includes a provision for triggering benefits that is different from that found in Section 29 of this model regulation. The definitions used in the triggering of benefits in Section 7702B (substantial assistance, loss of functional capacity, substantial supervision and severe cognitive impairment) have been defined in guidance promulgated by the Department of the Treasury.

- D. Certifications regarding activities of daily living and cognitive impairment required pursuant to Subsection C shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury.
- E. Certifications required pursuant to Subsection C may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety-day period.
- F. Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

Section 31. Appealing An Insurer’s Determination That The Benefit Trigger Is Not Met.

Drafting Note: Consistent with the NAIC model law procedures revised and adopted by the NAIC in September 2008, these revisions to the Long-Term Care Insurance Model Regulation provide minimum regulatory standards for independent review of benefit trigger determinations. The regulatory provisions and procedures set forth in this section are the minimum national standard for benefit trigger independent review. Nothing in this regulation would, nor is it the intent of these revisions to, prohibit a state that supported these model revisions from enacting regulations that go beyond this minimum standard to provide for a larger role and greater involvement for insurance departments in the independent review process. In determining the use of these minimum standards for any federal legislation or regulations pertaining to long-term care insurance, policymakers should view these as minimum standards and not prohibit states from enacting standards that go beyond these minimums.

- 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 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
 - (3) The insured’s right, after exhaustion of the insurer’s internal appeal process, to have the benefit trigger determination reviewed under the independent review process in accordance with Subsection D.
- 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 insurer shall provide a written description of the insured’s right to request an independent review of the benefit determination as described in Subsection D to the insured and the insured’s authorized representative, if applicable.
 - (3) As part of the written description of the insured’s right to request an independent review, an insurer shall include the following, or substantially equivalent, language: “We have determined that the benefit eligibility criteria (“benefit trigger”) of your [policy] [certificate] has not been met. You may have the right to an independent review of our decision conducted by long-term care professionals who are not associated with us. Please send a written request for independent review to us at [address]. You must inform us, in writing, of your election to have this decision reviewed within 120 days of receipt of this letter. Listed below are the names and contact information of the independent review organizations approved or certified by your state insurance commissioner’s office to conduct long-term care insurance benefit eligibility reviews. If you wish to request an

independent review, please choose one of the listed organizations and include its name with your request for independent review. If you elect independent review, but do not choose an independent review organization with your request, we will choose one of the independent review organizations for you and refer the request for independent review to it. ”

Drafting Note: States that do not maintain a list of qualified independent review organizations to review long-term care benefit trigger decisions should modify the language in paragraph (3) accordingly.

- (4) If the insurer does not believe the benefit trigger decision is eligible for independent review, the insurer shall inform the insured and the insured’s authorized representative, if applicable, and the commissioner in writing and include in the notice the reasons for its determination of independent review ineligibility.
- (5) The appeal process described in Subsection C is not deemed to be a ‘new service or provider’ as referenced in Section 26, Availability of New Services or Providers, and therefore does not trigger the notice requirements of that section.

D. Independent Review of Benefit Trigger Determination.

- (1) Request. The insured or the insured’s authorized representative may request an independent review of the insurer’s benefit trigger determination after the internal appeal process outlined in Subsection C has been exhausted. A written request for independent review may be made by the insured or the insured’s authorized representative to the insurer within 120 calendar days after the insurer’s written notice of the final internal appeal decision is received by the insured and the insured’s authorized representative, if applicable.
- (2) Cost. The cost of the independent review shall be borne by the insurer.
- (3) Independent Review Process.
 - (a) Within five (5) business days of receiving a written request for independent review, the insurer shall refer the request to the independent review organization that the insured or the insured’s authorized representative has chosen from the list of certified or approved organizations the insurer has provided to the insured. If the insured or the insured’s authorized representative does not choose an approved independent review organization to perform the review, the insurer shall choose an independent review organization approved or certified by the state. The insurer shall vary its selection of authorized independent review organizations on a rotating basis.
 - (b) The insurer shall refer the request for independent review of a benefit trigger determination to an independent review organization, subject to the following:
 - (i) The independent review organization shall be on a list of certified or approved independent review organizations that satisfy the requirements of a qualified long-term care insurance independent review organization contained in this section;
 - (ii) The independent review organization shall not have any conflicts of interest with the insured, the insured’s authorized representative, if applicable, or the insurer; and
 - (iii) Such review shall be limited to the information or documentation provided to and considered by the insurer in making its determination, including any information or documentation considered as part of the internal appeal process.

- (c) If the insured or the insured's authorized representative has new or additional information not previously provided to the insurer, whether submitted to the insurer or the independent review organization, such information shall first be considered in the internal review process, as set forth in Subsection C.
 - (i) While this information is being reviewed by the insurer, the independent review organization shall suspend its review and the time period for review is suspended until the insurer completes its review.
 - (ii) The insurer shall complete its review of the information and provide written notice of the results of the review to the insured and the insured's authorized representative, if applicable, and the independent review organization within five (5) business days of the insurer's receipt of such new or additional information.
 - (iii) If the insurer maintains its denial after such review, the independent review organization shall continue its review, and render its decision within the time period specified in Subparagraph (i) below. If the insurer overturns its decision following its review, the independent review request shall be considered withdrawn.
- (d) The insurer shall acknowledge in writing to the insured and the insured's authorized representative, if applicable, and the commissioner that the request for independent review has been received, accepted and forwarded to an independent review organization for review. Such notice will include the name and address of the independent review organization.
- (e) Within five (5) business days of receipt of the request for independent review, the independent review organization assigned pursuant to this paragraph shall notify the insured and the insured's authorized representative, if applicable, the insurer and the commissioner that it has accepted the independent review request and identify the type of licensed health care professional assigned to the review. The assigned independent review organization shall include in the notice a statement that the insured or the insured's authorized representative may submit in writing to the independent review organization within seven (7) days following the date of receipt of the notice additional information and supporting documentation that the independent review organization should consider when conducting its review.
- (f) The independent review organization shall review all of the information and documents received pursuant to Subparagraph (e) that has been provided to the independent review organization. The independent review organization shall provide copies of any documentation or information provided by the insured or the insured's authorized representative to the insurer for its review, if it is not part of the information or documentation submitted by the insurer to the independent review organization. The insurer shall review the information and provide its analysis of the new information in accordance with Subparagraph (h).
- (g) The insured or the insured's authorized representative may submit, at any time, new or additional information not previously provided to the insurer but pertinent to the benefit trigger denial. The insurer shall consider such information and affirm or overturn its benefit trigger determination. If the insurer affirms its benefit trigger determination, the insurer shall promptly provide such new or additional information to the independent review organization for its review, along with the insurer's analysis of such information.

- (h) If the insurer overturns its benefit trigger determination:
 - (i) The insurer shall provide notice to the independent review organization and the insured and the insured's authorized representative, if applicable, and the commissioner of its decision; and
 - (ii) The independent review process shall immediately cease.
- (i) The independent review organization shall provide the insured and the insured's authorized representative, if applicable, the insurer and the commissioner written notice of its decision, within 30 calendar days from receipt of the referral referenced in Paragraph (3)(b). If the independent review organization overturns the insurer's decision, it shall:
 - (i) Establish the precise date within the specific period of time under review that the benefit trigger was deemed to have been met;
 - (ii) Specify the specific period of time under review for which the insurer declined eligibility, but during which the independent review organization deemed the benefit trigger to have been met; and
 - (iii) For tax-qualified long-term care insurance contracts, provide a certification (made only by a licensed health care practitioner as defined in Section 7702B(c)(4) of the Internal Revenue Code) that the insured is a chronically ill individual.
- (j) The decision of the independent review organization with respect to whether the insured met the benefit trigger will be final and binding on the insurer.
- (k) The independent review organization's determination shall be used solely to establish liability for benefit trigger decisions, and is intended to be admissible in any proceeding only to the extent it establishes the eligibility of benefits payable.
- (l) Nothing in this section shall restrict the insured's right to submit a new request for benefit trigger determination after the independent review decision, should the independent review organization uphold the insurer's decision.
- (m) The insurance department shall utilize the criteria set forth in Appendix H, Guidelines for Long-Term Care Independent Review Entities, in certifying or approving entities to review long-term care insurance benefit trigger decisions.

Drafting Note: States that do not maintain a list of qualified independent review organizations to review long-term care benefit trigger decisions or have another mechanism for certifying or approving independent review organizations, should replace the language in Subparagraph (m) with the following:

The insurance department shall accept another state's certification of an independent review organization, provided such state requires the independent review organization to meet substantially similar qualifications as those contained in Appendix H.

- (n) The commissioner shall maintain and periodically update a list of approved independent review organizations.

E. Certification of Long-Term Care Insurance Independent Review Organizations. The commissioner shall certify or approve a qualified long-term care insurance independent review organization, provided the independent review organization demonstrates to the satisfaction of the commissioner that it is unbiased and meets the following qualifications:

- (1) Have on staff, or contract with, a qualified and licensed health care professional in an appropriate field for determining an insured's functional or cognitive impairment (e. g. physical therapy, occupational therapy, neurology, physical medicine and rehabilitation) to conduct the review.

- (2) Neither it nor any of its licensed health care professionals may, in any manner, be related to or affiliated with an entity that previously provided medical care to the insured.
 - (3) Utilize a licensed health care professional who is not an employee of the insurer or related in any manner to the insured.
 - (4) Neither it nor its licensed health care professional who conducts the reviews may receive compensation of any type that is dependent on the outcome of the review.
 - (5) Be state approved or certified to conduct such reviews if the state requires such approvals or certifications.
 - (6) Provide a description of the fees to be charged by it for independent reviews of a long-term care insurance benefit trigger decision. Such fees shall be reasonable and customary for the type of long-term care insurance benefit trigger decision under review.
 - (7) Provide the name of the medical director or health care professional responsible for the supervision and oversight of the independent review procedure.
 - (8) Have on staff or contract with a licensed health care practitioner, as defined by Section 7702B(c)(4) of the Internal Revenue Code of 1986, as amended, who is qualified to certify that an individual is chronically ill for purposes of a qualified long-term care insurance contract.
- F. Maintenance of Records and Reporting Obligations by Independent Review Organizations. Each certified independent review organization shall comply with the following:
- (1) Maintain written documentation establishing the date it receives a request for independent review, the date each review is conducted, the resolution, the date such resolution was communicated to the insurer and the insured, the name and professional status of the reviewer conducting such review in an easily accessible and retrievable format for the year in which it received the information, plus two (2) calendar years.
 - (2) Be able to document measures taken to appropriately safeguard the confidentiality of such records and prevent unauthorized use and disclosures in accordance with applicable federal and state law.
 - (3) Report annually to the commissioner, by June 1, in the aggregate and for each long-term care insurer all of the following:
 - (a) The total number of requests received for independent review of long-term care benefit trigger decisions;
 - (b) The total number of reviews conducted and the resolution of such reviews (i. e., the number of reviews which upheld or overturned the long-term care insurer's determination that the benefit trigger was not met);
 - (c) The number of reviews withdrawn prior to review;
 - (d) The percentage of reviews conducted within the prescribed timeframe set forth in Subsection C(3)(i); and
 - (e) Such other information the commissioner may require.
 - (4) Report immediately to the commissioner any change in its status which would cause it to cease meeting any of the qualifications required of an independent review organization performing independent reviews of long-term care benefit trigger decisions.

Drafting Note: States may wish to consider the mechanism to be used for oversight of independent review entities' activities as they relate to the review of long-term care insurance benefit trigger decisions. Specifically, states will need to consider whether the oversight mechanism should be statutory, regulatory or contractually based (i. e. , in the state's contract with the independent review organization) to specify such details as the term of any state approval or certification of an independent review organization, privacy protections afforded protected health information, commitment to review benefit trigger decisions within the prescribed regulatory timeframe, notice requirements to the state should the independent review entity cease to meet the qualifications required of an independent review organization for long-term care insurance benefit trigger decisions, and to establish a reporting mechanism by which independent review organization report to the commissioner on the number of requests received for independent review of long-term care benefit trigger decisions in the aggregate and from each long-term care insurer, and the resolution of such review (e. g., uphold insurer benefit trigger denial, overturn insurer benefit trigger denial).

- G. **Additional Rights.** Nothing contained in this section shall limit the ability of an insurer to assert any rights an insurer may have under the policy related to:
 - (1) An insured's misrepresentation;
 - (2) Changes in the insured's benefit eligibility; and
 - (3) Terms, conditions, and exclusions of the policy, other than failure to meet the benefit trigger.
- H. **Applicability.** The requirements of this Regulation apply to a benefit trigger request made on or after [insert number of months after adoption of the regulation] under a long-term care insurance policy.
- I. **Conflict with Other Laws.** The provisions of this section supersede any other external review requirements found in [insert reference to state external review law].

Section 32. 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 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 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 32 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 Unfair Trade Practices Model Act.]
- G. The provisions of Section 32 supersedes any other claim payment requirement found in [insert reference to state prompt payment law].

Section 33. Standard Format Outline of Coverage

This section of the regulation implements, interprets and makes specific, the provisions of [Section 6G of the 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]

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 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. FEDERAL TAX CONSEQUENCES.

This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

OR

Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986 as amended. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

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

(a) [For 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.]

5. 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.]

6. 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.]

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. 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 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 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 6 above.]

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

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of 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 ORGANIC BRAIN DISORDERS.
- [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 THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

Section 34. Requirement to Deliver Shopper’s Guide

- A. A long-term care insurance shopper’s guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.
 - (1) In the case of agent solicitations, an agent must deliver the shopper’s guide prior to the presentation of an application or enrollment form.
 - (2) In the case of direct response solicitations, the shopper’s guide must be presented in conjunction with any application or enrollment form.
- B. Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under [cite for Section 6 of Long-Term Care Insurance Model Act].

Section 35. 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 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 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: The NAIC recognizes that long-term care insurance is in an evolutionary stage. The product market needs to be able to develop in order to be responsive to the needs of consumers. In addition, since long-term care insurance and long-term care insurance regulations are continually changing, a state should consider the fact that not all replacements are improper.

The NAIC also recognizes that currently, long-term care insurance products are being primarily sold to the senior citizen market, a market that has been identified as being susceptible to abusive marketing practices. In response, the NAIC has adopted consumer protection amendments in its model regulation for Medicare supplement insurance. The Medicare supplement insurance model regulation limits agents’ compensation in order to address the potential for marketing abuses resulting from the large difference between first year and renewal commissions.

If a state believes that there is evidence that the long-term care insurance market is experiencing similar abuses, it may wish to consider adopting the optional agent compensation provision above.

In considering these agent compensation limitations, states should recognize the emerging nature of the long-term care insurance market. Long-term care insurance is evolving along both health insurance indemnity and life insurance lines. A state may want to consider that, since life insurance products usually contain nonforfeiture and cash value accumulation features and are normally targeted to a younger age group than long-term care indemnity products, such life insurance products could be exempted from these compensation limitation requirements.

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

**RESCISSION REPORTING FORM FOR
LONG-TERM CARE POLICIES
FOR THE STATE OF _____
FOR THE REPORTING YEAR 19[]**

Company Name: _____

Address: _____

Phone Number: _____

Due: March 1 annually

Instructions:

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission: _____

Signature

Name and Title (please type)

Date

APPENDIX B

Long-Term Care Insurance Personal Worksheet

Drafting Note: Companies shall at a minimum provide all of the information shown below and in the same order. The company may include additional information related to this long-term care insurance coverage in relevant and readable language. Bracketed statements indicate the companies should choose the applicable statement, are allowed flexibility in inserting numerical ranges, etc.

Long-Term Care Insurance Personal Worksheet

This worksheet will help you understand some important information about this type of insurance. State law requires companies issuing this [policy] [certificate] [rider] to **give** you some important facts about premiums and premium increases and to **ask** you some important questions to help you and the company decide if you should buy this [policy] [certificate] [rider]. Long-term care insurance can be expensive and it may not be right for everyone.

Premium Information

The premium for the coverage you are considering will be [\$_____ per [insert payment interval] **or a total of** [\$_____ per year] [a one-time single premium of \$_____].

The premium quoted in this worksheet is not guaranteed and may change during the underwriting process and in the future while this [policy] [certificate] [rider] is in force.

Drafting Note: Companies will insert payment interval – monthly, quarterly, etc. and the appropriate dollar amount.

Type of Policy & The Company's Right to Increase Premiums on the Coverage You Choose:

[Noncancellable - The company **cannot** increase your premiums on this [policy] [certificate] [rider]].

[Guaranteed renewable - The company **can** increase your premiums on this [policy] [certificate] [rider] in the future if it increases the premiums for all [policies] [certificates] [riders] like yours in this state.]

[Paid-up - This [policy] [certificate] [rider] will be paid-up after you have paid all of the premiums specified in your [policy] [certificate] [rider]].

Drafting Note: Companies will insert the appropriate policy type and the associated bracketed statement. Premium guarantees shall not be shown on this form.

Premium Increase History

[Name of company] has sold long-term care insurance since [year] and has sold this [policy] [certificate] [rider] since [year].

[The company has never increased its premiums for any long-term care [policy] [certificate] [rider] it has sold in this state or any other state.]

[The company has not increased its premiums for this [policy] [certificate] [rider] or similar [policies] [certificates] [riders] in this state or any other state in the last 10 years.]

[The company has increased its premiums on this [policy] [certificate] [rider] or similar [policies] [certificates] [riders] in the last 10 years. A summary of those premium increases follows.]

Drafting Note: If the summary of premium increases is extensive, the company may disclose the required premium increase history via an addendum attached to this worksheet. The company may substitute the language below for the last sentence in the paragraph above and include the full summary as an attachment to this worksheet.

“Over the past 3 years, the company has increased premiums by ____%.” “A summary of premium increases in the last 10 years is attached to this worksheet.”

Companies that have increased premiums by 30% or more in the last ten years must include the following statement: “There was a 30% or greater premium increase in ____ [insert year].” “A summary of premium increases in the last 10 years is attached to this worksheet.”

Questions About Your Income

You do **not** have to answer the questions that follow. They are intended to make sure you have thought about how you’ll pay premiums and the cost of care your insurance does not cover. If you do not want to answer these questions, you should understand that the company might refuse to insure you.

What resources will you use to pay your premium?

Current income from employment Current income from investments Other current income Savings Sell investments Sell other assets Money from my family Other _____

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this [policy] [certificate] [rider] if the premiums will be more than 7% of your income.

Could you afford to keep this [policy] [certificate] [rider] if your spouse or partner dies first?

Yes No Had not thought about it Do not know Does not apply

[What would you do if the premiums went up, for example, by 50%?

Pay the higher premium Call the company/agent Reduce benefits Drop the [policy] [certificate] [rider] Do not know]

Drafting Note: The company is not required to use the bracketed question above if the coverage is fully paid up or is noncancellable.

What is your household annual income from all sources? (check one)

[Less than \$10,000] [\$10,000-19,999] [\$20,000-29,999] [\$30,000-50,000] [More than \$50,000]

Drafting Note: The companies may choose the income ranges to put in the brackets to fit its suitability standards.

Do you expect your income to change over the next 10 years? (check one)

No Yes, expect increase Yes, expect decrease

If you plan to pay premiums from your income, have you thought about how a change in your income would affect your ability to continue to pay the premium?

Yes No Do not know

Will you buy inflation protection? (check one)

Yes No

Inflation may increase the cost of long-term care in the future.

If you do not buy inflation protection, how will you pay for the difference between future costs and your daily benefit amount?

From my income From savings From investments Sell other assets Money from my family Other

The national average annual cost of long-term care in [insert year] was [insert \$ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert \$ amount] if costs increase 5% annually.

Drafting Note: The projected cost can be based on federal estimates in a current year. This figure should also be used when calculating the cost of long-term care in the “approximate cost \$____ for that period of care” question found below. In the above statement, the second figure will equal 163% of the first figure.

What [elimination period][waiting period][cash deductible] are you considering?

[Number of days _____ in [elimination period][waiting period]

Approximate cost of care for this period: \$ _____

(\$xxx per day times number of days in [elimination period] [waiting period], where “xxx” represents the most recent estimate of the national daily average cost of long-term care)]

[Cash Deductible \$ _____]

How do you plan to pay for your care during the [elimination period] [waiting period] [deductible period]? (check all that apply)

From my income From my savings/investments My family will pay

Questions About Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

[Less than \$20,000] [\$20,000-\$29,999] [\$30,000-\$49,999] [More than \$50,000]

Drafting Note: Companies may choose the asset ranges to put in the brackets to fit its suitability standards.

Do you expect the value of your assets to change over the next ten years? (check one)

No Yes, expect to increase Yes, expect to decrease

If you're buying this [policy] [certificate] [rider] to protect your assets and your assets are less than \$50,000, experts suggest you think about other ways to pay for your long-term care.

Disclosure Statement

The answers to the questions above describe my financial situation.

Or

I choose not to complete this information.

(Check one.)

I agree that the company and/or its agent (below) has reviewed this worksheet with me including the premium, premium increase history and potential for premium increases in the future. I understand the information contained in this worksheet. (This box must be checked.)

Drafting Note: For direct mail situations, the lead in sentence should be changed to “I agree that I have reviewed this worksheet including the premium....”

Signed: _____
(Applicant) (Date)

I explained to the applicant the importance of answering these questions.

Signed: _____
(Agent) (Date)

Agent’s Printed Name: _____]

[In order for us to process your application, please return this signed worksheet to [name of company], along with your application.]

[My agent has advised me that this long-term care insurance [policy] [certificate] [rider] does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____]
(Applicant) (Date)

Drafting Note: Choose the appropriate sentences depending on whether this is a direct mail or agent sale.

Someone from the company may contact you to discuss your answers and the suitability of this [policy] [certificate] [rider] for you.

Drafting Note: When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading “Disclosure Statement” to the end of the page may be removed.

APPENDIX C

**Things You Should Know Before You Buy
Long-Term Care Insurance**

**Long-Term
Care
Insurance**

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- [You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

Drafting Note: For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.

- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does **not** pay for most long-term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse’s nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

**Shopper’s
Guide**

- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners’ “Shopper’s Guide to Long-Term Care Insurance.” Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long-term care insurance are available through your state’s insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Facilities

- Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

APPENDIX D

Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for long-term care insurance included a “personal worksheet,” which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet “Shopper’s Guide to Long-Term Care Insurance” and the page titled “Things You Should Know Before Buying Long-Term Care Insurance.” Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

Drafting Note: Choose the paragraph that applies.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

Yes, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

Drafting Note: Delete the phrase in brackets if the applicant did not answer the questions about income.

No. I have decided not to buy a policy at this time.

APPLICANT’S SIGNATURE

DATE

Please return to [issuer] at [address] by [date].

APPENDIX E

**Claims Denial Reporting Form
Long-Term Care Insurance**

For the State of _____
For the Reporting Year of _____

Company Name: _____ Due: June 30 annually
Company Address: _____

Company NAIC Number: _____
Contact Person: _____ Phone Number: _____

Line of Business: Individual Group

Instructions

The purpose of this form is to report all long-term care claim denials under in force long-term care insurance policies. Indicate the manner of reporting by checking one of the boxes below:

- Per Claimant – counts each individual who makes one or a series of claim requests.
- Per Transaction – counts each claim payment request.

“Denied” means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition. It does not include a request for payment that is in excess of the applicable contractual limits.

Inforce Data

	State Data	Nationwide Data ¹
Total Number of Inforce Policies [Certificates] as of December 31st		

Claims & Denial Data

		State Data	Nationwide Data ¹
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Long-Term Care Claim Denied due to:		
8	<ul style="list-style-type: none"> • Long-Term Care Services Not Covered under the Policy² 		
9	<ul style="list-style-type: none"> • Provider/Facility Not Qualified under the Policy³ 		
10	<ul style="list-style-type: none"> • Benefit Eligibility Criteria Not Met⁴ 		
11	<ul style="list-style-type: none"> • Other 		

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.
2. Example—home health care claim filed under a nursing home only policy.
3. Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
4. Examples—a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

APPENDIX F

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 long-term care insurance for which the applicant is applying.

Long-Term Care Insurance Potential Premium Increase Disclosure Form

Important Notice: Your 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 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.

Turn the Page

***Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the \$1,000 annual premium for 10 years, so you have paid a total of \$10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or \$500 for a new annual premium of \$1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are \$10,000 (provided you have a least \$10,000 of benefits remaining under your policy.)

Turn the Page

<u>Contingent Nonforfeiture</u>	
Cumulative Premium Increase over Initial Premium That qualifies for Contingent Nonforfeiture	
(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)	
Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

[The following contingent nonforfeiture disclosure need only be included for those limited pay policies to which Sections 28D(4) and 28D(6) of the regulation are applicable].

In addition to the contingent nonforfeiture benefits described above, the following reduced “paid-up” contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced “paid-up” benefit AND the contingent benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced “paid-up” contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below;

<u>Triggers for a Substantial Premium Increase</u>	
<u>Issue Age</u>	<u>Percent Increase Over Initial Premium</u>
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect; AND
3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option your coverage will be converted to reduced “paid-up” status. That means there will be no additional premiums required. Your benefits will change in the following ways:

- a. The total lifetime amount of benefits your reduced paid up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.
- b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your “paid-up” policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced “paid-up” policy.

APPENDIX G

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 statewide basis information regarding long-term care insurance policy replacements and lapses. Specifically, every insurer shall maintain records for each agent on that agent's amount of long-term care insurance replacement sales as a percent of the agent's total annual sales and the amount of lapses of 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) ____%

APPENDIX H.

Guidelines for Long-Term Care Independent Review Entities

In order for an organization to qualify as an independent review organization for long-term care insurance benefit trigger decisions, it shall comply with all of the following:

- a. The independent review organization shall ensure that all health care professionals on its staff and with whom it contracts to provide benefit trigger determination reviews hold a current unrestricted license or certification to practice a health care profession in the United States.
- b. The independent review organization shall ensure that any health care professional on its staff and with whom it contracts to provide benefit trigger determination reviews who is a physician holds a current certification by a recognized American medical specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.
- c. The independent review organization shall ensure that any health care professional on its staff and with whom it contracts to provide benefit trigger determination reviews who is not a physician holds a current certification in the specialty in which that person is licensed, by a recognized American specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.
- d. The independent review organization shall ensure that all health care professionals on its staff and with whom it contracts to provide benefit trigger determination reviews have no history of disciplinary actions or sanctions including, but not limited to, the loss of staff privileges or any participation restriction taken or pending by any hospital or state or federal government regulatory agency.
- e. The independent review organization shall ensure that neither it, nor any of its employees, agents, or licensed health care professionals utilized for benefit trigger determination reviews receives compensation of any type that is dependent on the outcome of the review.
- f. The independent review organization shall ensure that neither it, nor any of its employees, agents, or licensed health care professionals it utilizes for benefit trigger determination reviews are in any manner related to, employed by or affiliated with the insurer, insured or with a person who previously provided medical care or long term care services to the insured.
- g. The independent review organization shall provide a description of the qualifications of the reviewers retained to conduct independent review of long-term care insurance benefit trigger decisions, including the reviewer's current and past employment history, practice affiliations and a description of past experience with decisions relating to long-term care, functional capacity, dependency in activities of daily living, or in assessing cognitive impairment. Specifically, with regard to reviews of tax qualified long-term care insurance contracts, it must demonstrate the ability to assess the severity of cognitive impairment requiring substantial supervision to protect the individual from harm, or with assessing deficits in the ability to perform without substantial assistance from another person at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity.
- h. The independent review organization shall provide a description of the procedures employed to ensure that reviewers conducting independent reviews are appropriately licensed, registered or certified; trained in the principles, procedures and standards of the independent review organization; and knowledgeable about the functional or cognitive impairments associated with the diagnosis and disease staging processes, including expected duration of such impairment, which is the subject of the independent review.
- i. The independent review organization shall provide the number of reviewers retained by the independent review organization and a description of the areas of expertise available from such reviewers and the types of cases such reviewers are qualified to review (e. g. , assessment of cognitive impairment or inability to perform activities of daily living due to a loss of functional capacity).

- j. The independent review organization shall provide a description of the policies and procedures employed to protect confidentiality of protected health information, in accordance with federal and state law.
- k. The independent review organization shall provide a description of its quality assurance program.
- l. The independent review organization shall provide the names of all corporations and organizations owned or controlled by the independent review organization or which own or control the organization, and the nature and extent of any such ownership or control. The independent review organization shall ensure that neither it, nor any of its employees, agents, or licensed health care professionals utilized are not a subsidiary of, or owned or controlled by, an insurer or by a trade association of insurers of which the insured is a member.
- m. The independent review organization shall provide the names and resumes of all directors, officers and executives of the independent review organization.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1988 Proc. I 9, 20-21, 629-630, 652, 656-661 (adopted).
1989 Proc. I 9, 24-25, 703, 754-755, 791-794 (amended).
1989 Proc. II 13, 23-24, 468, 476-477, 484-493 (amended and reprinted).
1990 Proc. I 6, 27-28, 477, 541-542, 545-556 (amended and reprinted).
1990 Proc. II 7, 16, 600, 617, 649 (amended).
1991 Proc. I 9, 17-18, 609-610, 662, 672-687 (amended and reprinted).
1992 Proc. I 86, 95, 914, 954, 963, 967-982, 987 (amended and reprinted).
1992 Proc. II 9, 11, 672, 687, 696 (amended).
1993 Proc. I 8, 136, 819, 843-844, 846-848 (amended).
1993 Proc. Ist Quarter 3, 34, 267, 274, 276 (amended).
1994 Proc. Ist Quarter 4, 39, 446-447, 451, 457-459 (amended).
1994 Proc. 4th Quarter 17, 26, 713-714, 722, 731, 737, 739-761 (amended and reprinted).
1995 Proc. 2nd Quarter 2, 36, 553, 651, 653-659 (amended).
1996 Proc. 2nd Quarter 10, 33, 731, 812, 825 (amended).
1997 Proc. Ist Quarter 54, 55, 56, 57, 700, 704-714 (amendments on life/long-term care).
1997 Proc. Ist Quarter 759, 771-772 (discussed amendments on personal worksheet).
1997 Proc. 2nd Quarter 25-26, 676 (amendments on personal worksheet adopted).
1998 Proc. Ist Quarter 15, 17, 769, 800, 894 (amended).
1999 Proc. 4th Quarter 18, 929, 969, 972, 978-991 (amended).
2000 Proc. 2nd Quarter 21-22, 162, 292-309 (amended).
2001 Proc. 4th Quarter 6, 14, 208, 285, 304-306 (amended).
2006 Proc. 4th Quarter 44, 61-122 (amended).
2009 Proc. 3rd Quarter Vol. I 95-102, 114-119, 211-222, 312-315 (amended).
2014 Proc. 2nd Quarter, 3-4, 3-16 to 3-43 (amended).
2016 Proc. 3rd Quarter (amended).

LONG-TERM CARE INSURANCE MODEL REGULATION

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column or Related State Activity column based on the definitions listed below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.

LONG-TERM CARE INSURANCE MODEL REGULATION

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LONG-TERM CARE INSURANCE MODEL REGULATION

KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

RELATED STATE ACTIVITY: Examples of Related State Activity include but are not limited to: older versions of the NAIC model, statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column **only** (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner**.

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama		ALA. ADMIN. CODE r. 482-1-091-.32 to 482-1-091-.36 (1990/2009) (previous version of model).
Alaska	NO CURRENT ACTIVITY	
American Samoa	NO CURRENT ACTIVITY	
Arizona		ARIZ. ADMIN. CODE §§ 20-6-1001 to 20-6-1024 (1992/2017) (previous version of model); BULLETIN 2009-5 (2009).
Arkansas		ARK. CODE R. § 13 (1990/2008) (previous version of model).
California	CAL. INS. CODE §§ 10230 to 10237.6 (1988/2017).	
Colorado		3 COLO. CODE REGS. § 702-4:4-4-1 (1997/2011); 3 COLO. CODE REGS. § 702-4:4-4-4 (2010/2013) (LTC partnership program); BULLETIN B-1-20 (2007); BULLETIN B-4.27 (2010/2012); BULLETIN B-4.30 (2012).

LONG-TERM CARE INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Connecticut		CONN. AGENCIES REGS. §§ 38a-501-8 to 38a-501-24 (1994/2013) (Individual); §§ 38a-528-1 to 38a-528-17 (1994/2013) (group) (previous version of model).
Delaware		18 DEL. CODE REGS. § 1404 (1990/2010) (portions of previous version of model). BULLETIN 23 (2006).
District of Columbia		D.C. MUN. REGS. tit. 26, § 2600.1 (2006/2008).
Florida		FLA. ADMIN. CODE ANN. r. 69O-157.001 to 69O-157.023 (1989/2012) (previous version of model); §§ 69O-157.101 to 69O-157.122 (2003/2013) (previous version of model).
Georgia		GA. COMP. R. & REGS. 120-2-16-.01 to 120-2-16-.34 (1989/2009) (previous version of model).
Guam	NO CURRENT ACTIVITY	
Hawaii		HAW. REV. STAT. §§ 431:10H-201 to 431:10H-402 (2000/2014) (previous version of model).
Idaho		IDAHO ADMIN. CODE r. 60.18.01.60 (1990/2007) (previous version of model); BULLETIN 2007-7.
Illinois		ILL. ADMIN. CODE tit. 50, §§ 2012.10 to 2012.150 (1990/2017) (previous version of model).
Indiana		760 IND. ADMIN. CODE 2-1-1 to 2-20-42 (2007) (previous version of model).

LONG-TERM CARE INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Iowa		IOWA ADMIN. CODE r. §§ 191-39.1 to 191-39.32 (1988/2009) (previous version of model). BULLETIN 2008-17 (2008); BULLETIN 2009-7 (2009).
Kansas		KAN. ADMIN. REGS. §§ 40-4-37 to 40-4-37v (1988/2009) (previous version of model); BULLETIN 1996-8 (1996).
Kentucky		806 KY. ADMIN. REGS. 17:081 (1993/2009) (previous version of model); 806 KY. ADMIN. REGS. 17:083 (2009).
Louisiana	LA. ADMIN. CODE tit. 37, §§ XIII.1901 to XIII.1961 (Regulation 46) (1993/2017).	BULLETIN 9-5-2006; BULLETIN 06-03 (2006); BULLETIN 12-28-2009 (2009).
Maine		425 ME. CODE R. (2004/2015) (previous version of model); BULLETIN 347 (2007); BULLETIN 63 (2009); BULLETIN 362 (2009); BULLETIN 361 (2009); BULLETIN 369 (2010); BULLETIN 381 (2011).
Maryland		MD. CODE ANN., INS. §§ 18-101 to 18-120 (1989/2009) (portions of previous version of model); §§ 15-401 to 15-407 (2011); MD. CODE REGS. 31.14.01.01 to 31.14.01.32 (1994/2014); 31.14.02.01 to 31.14.02.14 (1993/2014) (previous version of model); BULLETIN 13-2009 (2009); BULLETIN 2010-33 (2010).
Massachusetts		211 MASS. CODE REGS. 65.01 to 65:16 (1989/2005) (portions of previous version of model act and regulation).
Michigan		MICH. COMP. LAWS §§ 500.3901 to 500.3955 (1992/2001) (previous version of model).

LONG-TERM CARE INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Minnesota		MINN. STAT. §§ 62S.01 to 62S.33 (1997/2010) (previous version of model); MINN. STAT. §§ 62A.46 to 62A.56 (1986/2002); MINN. R. §§ 2745.0010 to 2745.0050 (1992) (non-qualified plans); BULLETIN 2007-5.
Mississippi		90-102 Miss. CODE R. (1990) (previous version of model).
Missouri		MO. CODE REGS. ANN. tit. 20, § 400-4.100 (1991/2003) (previous version of model).
Montana		MONT. ADMIN. R.6.6.3101 to 6.6.3120 (1991/2008) (previous version of model); BULLETIN 2007-4; Memorandum 223-2010 (2010).
Nebraska		210 NEB. ADMIN. CODE ch. 46 (1989/2001) (previous version of model); BULLETIN CB-114; BULLETIN CB-113; BULLETIN CB-133 (2014).
Nevada		NEV. ADMIN. CODE §§ 687B.005 to 687B.140 (1988/2009) (previous version of model); 3602 (2010); BULLETIN 2006-10; BULLETIN 010-020-AB (2010).
New Hampshire		N.H. CODE R. INS. 3601.01 to 3601.30 (2004/2015).
New Jersey		N.J. ADMIN. CODE §§ 11.4-34.1 to 11.4-34.32 (1989/2010) (previous version of model).
New Mexico		N.M. CODE R. §§ 13.10.15.1 to 13.10.15.53 (1997/2004) (previous version of model).
New York		N.Y. COMP. CODES R. & REGS. tit. 11, §§ 52.12 to 52.65 (Regulation 62) (1992/2002) (portions of previous version of model).

LONG-TERM CARE INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
North Carolina		N.C. GEN. STAT. § 108A-70.4 (2010); 11 N.C. ADMIN. CODE 12.1002 to 12.1029 (1990/2002); § 12.0555 (1989/1992) (previous version of model); BULLETIN 2011-B-6 (2011).
North Dakota		N.D. ADMIN. CODE 45-06-05-01 to 45-06-05-09 (1988/2004) (previous version of model); BULLETIN 2013-1 (2013); BULLETIN 2014-1 (2014).
Northern Marianas	NO CURRENT ACTIVITY	
Ohio		OHIO ADMIN. CODE § 3901-4-01 (1994/2008) (previous version of model); OHIO ADMIN. CODE § 3901-4-02 (2007/2013); § 3901-4-03 (2009).
Oklahoma		OKLA. ADMIN. CODE §§ 365:10-5-40 to 365:10-5-52 (1989/2009) (previous version of model); §§ 365:10-5-53 to 365:10-5-54 (2008/2009); BULLETIN 6-23-2008.
Oregon		OR. ADMIN. R. §§ 836-052-0500 to 836-052-0786 (1991/2015) (previous version of model). BULLETIN 2014-3 (2014).
Pennsylvania		31 PA. CODE §§ 89a.101 to 89a.129 (2002) (previous version of model); 40 PA. CONS. STAT. §§ 991.1101 to 991.1115 (1921/2014).
Puerto Rico	NO CURRENT ACTIVITY	
Rhode Island		27-44 R.I. CODE R. §§ 001 to 016 (1989/1998); REG. 44 (2008) (previous version of model); BULLETIN 2007-10 (2007); BULLETIN 2011-2 (2011).
South Carolina		S.C. CODE ANN. REGS. 69-44 (1989) (previous version of model); S.C. CODE ANN. § 38-72-66 (2014); BULLETIN 4-2009 (2009).

LONG-TERM CARE INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
South Dakota		S.D. ADMIN. R. 20:06:21:01 to 20:06:21:75 (1990/2015) (previous version of model). BULLETIN 2007-4 (2007); BULLETIN 2007-7 (2007).
Tennessee		TENN. COMP. R. & REGS. 0780-1-61 (1991) (previous version of model).
Texas		28 TEX. ADMIN. CODE §§ 3.3801 to 3.3850; (portions of previous version of model) (1990/2002); BULLETIN B-0020-12 (2012).
Utah		UTAH ADMIN. CODE r. 590-148 (1992/2012) (previous version of model). BULLETIN 2014-7 (2014).
Vermont		21-020 VT. CODE R. § 024 to 040 (2009/2010) (previous version of model). BULLETIN HCA-130 (2010).
Virgin Islands	NO CURRENT ACTIVITY	
Virginia		14 VA. ADMIN. CODE §§ 5-200-10 to 5-200-210 (1992/2015) (previous version of model). ADMIN. LETTER 1990-23 (1990) (requires NAIC Shopper’s Guide); ADMIN. LETTER 2007-3 (2007)
Washington		WASH. ADMIN. CODE 284-54-010 to 284-54-900 (1989/2008) (portions of previous version of model); WASH. ADMIN. CODE 284-83-400 to 284-83-425 (2011/2012).
West Virginia		W. VA. CODE R. §§ 114-32-1 to 114-32-24 (1993/2011) (previous version of model).
Wisconsin		WIS. ADMIN. CODE INS. § 3.46 (1991/2014) (previous version of model); WIS. ADMIN. CODE INS. § 3.455 (1991/2002).
Wyoming		WYO. CODE R. § 37 (1990/2003) (previous version of model).

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 1. Purpose

[See the commentary for the Long-Term Care Insurance Model Act, beginning at page 640-17, for general information on long-term care insurance regulatory concerns.]

Section 2. Authority

Section 3. Applicability and Scope

From the early stages of drafting the model act, the drafters contemplated a model regulation to complement the act. **1986 Proc. II 707.**

At the June 1988 meeting, the chair of the Long-Term Care Insurance Working Group reported that new issues had been assigned to the group. They would now consider the applicability of the regulation to continuing care retirement communities, home health benefits, gatekeeper mechanisms and long-term care coverage offered as riders to universal life insurance policies. **1988 Proc. II 602.**

In late 1995 an industry trade association contacted the NAIC because it was concerned about the regulatory oversight of life insurance used to fund long-term care. The association said some provisions in the Long-Term Care Insurance Model Act and Regulation should not apply to life/long-term care insurance. The Senior Issues Task Force agreed to consider the issue. **1996 Proc. 1st Quarter 712.**

A trade association representative said that life insurance policies that accelerate benefits for long-term care have not been widely embraced by the life insurance industry because of the large amount of conflicting regulatory oversight of these policies. By dealing with the conflicts and inappropriate regulations codifying current practices, it would make it easier for insurance companies to enter this marketplace. The flexibility of life/long-term care insurance policies is not available currently in many states because of the high degree of regulation. **1996 Proc. 2nd Quarter 810.**

A consumer representative expressed concern that it may not be appropriate to regulate life insurance under the long-term insurance regulation because of the hybrid nature of these policies and the inherent problems in regulation. **1996 Proc. 2nd Quarter 810-811.**

Amendments adopted in 1997 were recommended by the life insurance industry because the models as constructed were not an exact fit for life insurance products with long-term care riders. **1997 Proc. 1st Quarter 699.**

A second portion was added to the first drafting note in 2000 with the amendments adopted then. **2000 Proc. 2nd Quarter 293.**

In 1998 the Senior Issues Task Force was charged with the task of reviewing the Long-Term Care Insurance Model Act and Regulation for compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **1998 Proc. 2nd Quarter II 880.**

HIPAA created tax-qualified plans so the task force needed to determine how the NAIC models needed to be adjusted to clearly accommodate such plans. **1998 Proc. 2nd Quarter II 881-882.**

The chair of the working group asked interested parties how many companies still wrote a substantial percent of policies that were not tax-qualified. An association representative responded that her association had recently compiled results of a survey showing 80-90% of long-term care insurance business was in policies qualifying for favorable tax treatment under HIPAA. **1998 Proc. 4th Quarter II 765.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 3 (cont.)

Regulators discussed whether they should refer to “qualified” plans or “tax-qualified” plans. The working group agreed to use “tax-qualified” in the parts of the model that set standards for what to disclose to consumers. An interested party commented that some states have tax benefits and suggested use of the term “federally tax-qualified.” A regulator suggested that the model clarify that the terms are synonymous. **1999 Proc. 1st Quarter 612.**

An industry representative questioned the use of the phrase “created a new category of long-term care insurance” in the second drafting note under Section 3. He questioned whether the phrase “created a new category” was accurate. He said HIPAA created standards for qualified long-term care insurance contracts, rather than creating a new category of coverage. A regulator responded that in fact a new section in the model regulation was being created that applied only to qualified contracts and in that light it was a new category. **1999 Proc. 1st Quarter 612.**

Section 4. Definitions

New definitions A through D were added in 2000 with the amendment on rate stabilization. **2000 Proc. 2nd Quarter 293-294.**

Section 5. Policy Definitions

A. When drafting provisions regarding benefit triggers for coverage, the working group started with one section that defined the activity of daily living and then used a measurement to determine a person’s ability to perform that activity. The group later decided to define the activity and then use a separate section of the model to specify how the company is to determine a person’s ability to perform that activity of daily living. **1994 Proc. 3rd Quarter 607.**

One of the activities of daily living included in early drafts was “mobility” but this was found to be difficult to define and had not been included in earlier studies on activities of daily living. **1995 Proc. 1st Quarter 580.**

B. This definition was added at the same time as amendments to the home health care section were adopted in December 1991. **1992 Proc. IB 966.**

C. The definitions contained in Subsections C and D were adopted at the same time as the home health care benefit minimum standards. **1990 Proc. IB 541.**

D. One regulator questioned whether the definition of bathing was tied to the person’s ability to get in and out of a tub. The chair said this was not the intent and the definition was modified to clarify that it included the task of getting in and out of the tub or shower. **1995 Proc. 1st Quarter 579.**

E. The working group also discussed whether a measurement of cognitive impairment should be included in Section 27 or in the definition. There were numerous suggestions for definitions and elements to include in cognitive impairment. **1995 Proc. 1st Quarter 580.**

F. The working group was not satisfied with the definition of “continence” in Sidney Katz’ study or with the suggested model definition. One participant suggested this issue was more difficult because it dealt with issues of personal hygiene. **1994 Proc. 4th Quarter 716.**

Another difficulty in crafting this definition was determining what was a continence definition and what was a performance measure that should go in Section 27. One participant suggested personal hygiene should be covered in the definition of toileting instead. **1995 Proc. 1st Quarter 579.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 5 (cont.)

G. An early draft of the model included “appropriate” in the definition of dressing to deal with a person who is able to dress, but not necessarily able to dress for the season. A reply to that was that the phrase “appropriate” can create interpretation problems. **1994 Proc. 4th Quarter 715.**

H. The first definition of “eating” was modified because it only stated the person must be able to bring food to his or her mouth without saying anything about actually eating it. Another suggestion was that the definition should deal with the person’s ability to prepare food. This suggestion was not followed because food preparation was not included in the activities of daily living in the research performed by Dr. Katz. **1994 Proc. 4th Quarter 715.**

L. The definition of mental or nervous disorder does not include Alzheimer’s Disease. **1988 Proc. I 652.**

M. The definition of personal care was adopted at the same time as amendments to the home health care section were adopted in December 1991. **1992 Proc. IB 966.**

Q. A trade association asked that a drafting note be added under Subsection Q that stated, “This regulation is not intended to preclude qualified long-term care insurance contracts from using terms and definitions that are intended to satisfy the requirements of Section 7702B of the Internal Revenue Code.” The chair indicated he would rather add a note indicating that a state should develop a mechanism to allow definitions developed by federal agencies to be used in qualified contracts. **1999 Proc. 1st Quarter 612.**

Section 6. Policy Practices and Provisions

A. A last-minute addition to the model just before adoption provided for the commissioner to authorize nonrenewal on a statewide basis if the insurer demonstrates that the renewal will jeopardize solvency in the manner set forth in the regulation. **1988 Proc. I 656, 657.**

This provision remained in the model until 1990. It was removed at the time the consumer protection amendments were adopted. The concept is inherently contradictory to the concept of guaranteed renewability. **1991 Proc. IB 692.**

Interested parties urged adoption of a provision allowing conditionally renewable policies. The subgroup chose to include a section allowing renewal provisions no less favorable than guaranteed renewable. **1988 Proc. I 710.**

A definition of level premium was added to clarify when the term could be used. An industry trade association suggested the term could only be used when the insurer did not have the right to change the premium. **2000 Proc. 2nd Quarter 310.**

When the working group was considering amendments in response to the federal Health Insurance Portability and Accountability Act (HIPAA), Paragraph (5) was added. Staff noted a question about whether the amendments actually made the policies guaranteed renewable, and whether the provisions should apply to all long-term care policies. **1998 Proc. 3rd Quarter 719.**

An industry association representative commented that it was unclear under HIPAA whether the requirement for guaranteed renewability included noncancellable contracts. He suggested that guaranteed renewability of tax-qualified plans should be linked to the Internal Revenue Code because future guidance from the U.S. Treasury Department might clarify whether noncancellable contracts were encompassed within the guaranteed renewability requirements of HIPAA. **1999 Proc. 1st Quarter 611.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 6 (cont.)

B. Interested parties urged retention of the availability of territorial limitations. They said that the ability of the insurer to pay only those providers located in the United States and to pay providers at rates appropriate to their service area could be critical to cost containment and quality of care. They urged adoption of a drafting note following Subsection B(6) to express that concern clearly. **1988 Proc. I 710.**

Paragraphs (6) and (7) were added as part of the HIPAA amendments. **1999 Proc. 4th Quarter 981.**

C. This section was modified just before adoption to address concerns of the advisory committee. **1988 Proc. I 656, 658.**

D. The drafters original continuation and conversion section was one sentence in length. A drafting note indicated that further review and refinement would be made in the future. **1988 Proc. I 652, 658.**

The existing section was superseded by an entirely new Section 6D in December of 1988. The section now mandates provision for continuation or conversion. The regulation provides a right to continuation by whatever means and reasonably approximates a guaranteed renewable individual policy. One other significant provision of the section is that an individual will be able to continue coverage at entrance age and the benefits will be identical to or determined by the commissioner to be substantially equivalent. There was discussion on whether language should be included in the model to require a secondary carrier to reserve prior to its responsibility for continuing coverage. This is an item that the insurer should resolve, according to members of the working group. It was suggested that a future modification would be language requiring the insurer to notify certificate holders of their right to continuation or conversion of their policy at the time of termination. **1989 Proc. I 761-762.**

Conversion is the primary vehicle for assuring maintenance of coverage. Continuation is limited to a right to continue benefits where someone's eligibility is based on his or her relationship to another person and where that relationship has dissolved. A certificate holder is entitled to maintenance of coverage which is identical to coverage held previously and which is rated on initial entry age into the program. Upon the urging of the advisory committee, language was added to allow "substantially equivalent" benefits. **1989 Proc. I 764.**

Amendments to Section 6D(2) and (4) in June of 1989 accommodated continuation and conversion in the managed care environment. **1989 Proc. II 513-514.**

E. This section was added as part of the consumer protection amendments of 1990. A consumer representative asked whether this provision and the one on continuation and conversion required the offering of the same benefits. The task force chair responded that they did not necessarily provide the same coverage. **1991 Proc. IB 664.**

The task force considered whether inclusion of this new subsection was necessary. They decided it was; additionally, they concluded that the language was more stringent than existing group discontinuance and replacement provisions and that it is not duplicative of the continuation and conversion sections in the regulation. **1991 Proc. IB 716.**

F. The task force first considered proposals which would place a cap on the amount of increase in rates allowed in 1991. They were concerned that low prices would be charged for younger ages with dramatic increases later; and also concerned, on the other hand, with solvency issues. **1992 Proc. IB 986.**

The task force decided the issue of rate caps was tied to the nonforfeiture issue. However, the task force could discuss prohibiting attained age rating and adopted such a provision in 1991. **1992 Proc. IB 983.** The proposal adopted is now Section 6F(1). **1992 Proc. IB 970-971.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 6F (cont.)

When reviewing the draft of the new paragraph, one individual inquired whether age 65 was an absolute cut-off or whether those who continue to work until a later age should be excluded. After some discussion the task force concluded the cap should be set at 65. **1992 Proc. IB 960.**

One industry attendee at the task force meeting stated that the draft implies that rate adjustments for policies issued to individuals beyond age 65 are not allowed. An NAIC staff member responded that the goal is to make sure the rate structure does not actually display increases based on either age or duration. **1992 Proc. IB 961.**

After adoption of the amendment on attained age and durational rating, the task force continued to consider rate stabilization a high priority. **1992 Proc. IIB 688.**

The task force agreed to consider the concept of an annual and lifetime rate cap. A consumer representative stated that rate stabilization was of considerable public policy importance. One regulator commented that the task force should consider the long tail of these policies and the budget consequences. Another consumer representative emphasized that currently the risk is being placed entirely on the consumer who is unable to evaluate it. **1992 Proc. IIB 695.**

The working group members considered several discussion drafts distributed by interested parties. One was the development of a “dynamic” grid, which would contain basic assumptions regulators could use in reviewing long-term care insurance rate filings. A regulator suggested the approach of rate caps for certain ages and proposed a 50% lifetime cap and a 5% per year cap for policyholders over the age of 70. The working group agreed to consider other approaches to rate stabilization also. **1993 Proc. IB 851-852.**

A consumer representative listed several concerns he thought should receive consideration by the task force: (1) “low balling” (setting an artificially low initial rate and then increasing the premium significantly), (2) rate shock and the effect of lapses at all ages, (3) the predictability of rates, and (4) solvency due to the long tail of claims. Several attendees at the meeting urged the task force to undertake a full discussion of the principles and not rush into anything. Others told of rate increases of 150% or more for individuals over 80 years of age and urged the task force to address the issue immediately. **1993 Proc. IB 841.**

The task force considered a proposal which required non-cancelable policies after age 70. A consumer representative stated there needed to be protection at all ages, but the levels of protection at different ages could vary. The task force agreed to consider a level premium requirement, and whether such a requirement would also apply to extra benefits added to a policy as a result of inflation protection. An industry representative urged the task force to recognize uncertainties in the marketplace, solvency, medical breakthroughs, utilization patterns and judicial interpretation. Another stated that the task force should consider the complexity of the issue and the likelihood the companies will make mistakes on pricing. **1993 Proc. IB 823.**

At a later meeting of the task force, the members discussed the possibility of making all policies non-cancelable and the consensus was that this was not desirable, at least not at the present time. One issue that was discussed was whether any sort of rate cap would apply prospectively only and no conclusion was reached on this. Another concern was how to handle large rate increases for closed blocks of business. **1993 Proc. 2nd Quarter 761.**

By mid-1993 the task force had considered (1) totally non-cancelable policies, (2) making the institutional (hospital or nursing home) component of the premium non-cancelable while allowing the non-institutional component to increase, (3) requiring companies to offer reduced benefit packages at the same premium as was previously being paid, (4) limiting rate increases to 50% every three years, and (5) annual and lifetime rate caps. **1993 2nd Quarter 759.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 6F (cont.)

Members generally did not favor a strict non-cancelable approach. One regulator suggested a hybrid approach which would include two payment plans (1) a non-cancelable policy, or (2) a policy with five-year rate guarantees in which the rates could change every five years (but they would be limited to the new business rate). After considerable discussion, members agreed that the approach must be simple and therefore the annual and lifetime caps or absolute caps after a certain age are preferable. The task force also agreed to consider prohibiting attained age rating after age 50, rather than age 65 as the model required. **1993 Proc. 2nd Quarter 759.**

The preliminary recommendation of the task force was to limit annual and lifetime increases to specified maximums. Several possible caps were mentioned, but it was suggested that any combination of annual and lifetime limits between 5/50% and 10/100% should give insurers sufficient latitude. If absolute caps are needed at the older ages, attained age 75 may be a reasonable compromise. In addition, the task force recommended that the prohibition against attained age rating in Section 6F(2)(d) be lowered from age 65 to age 50. **1993 Proc. 2nd Quarter 757.**

When they were ready to draft the language, the members expressed a preference for the following rate stabilization measures: (1) initial rate guarantees of three years, (2) rate increases thereafter are limited to 10% per year and subsequent increases will be limited to two-year increments, (3) aggregate rate increases are limited to 100% of the initial rate, (4) the commissioner may waive the rate restrictions upon the insurer's demonstration of imminent financial insolvency, and (5) premiums may not be increased once the policyholder reaches age 78 (issue age 75). **1993 3rd Quarter 466.**

In the discussions related to nonforfeiture and to rate stabilization, regulators and interested parties repeatedly emphasized the close relationship between these two concepts. **1993 Proc. 3rd Quarter 482.**

One regulator asked whether the intent of rate stabilization was to impose responsibility on the companies up front in pricing their policies, and the chair responded that certainly was one intent. Another regulator said the goal of rating restrictions was to force accountability for poor underwriting decisions and initial under-pricing of the product. In another listing of goals, the chair said a fundamental issue was protection of older policyholders from large increases when they can least afford them. **1993 Proc. 3rd Quarter 481.**

In considering whether or not to add a provision making the policy non-cancelable at a certain age, a representative of a trade association emphasized the industry's concern about cost shifting. Consumer representatives spoke in favor of making a policy non-cancelable at age 80. The chair responded that a 10% cap on rate increases once the insured attains age 80 is a significant protection. One of the consumerists suggested adding a drafting note stating that the ultimate goal was to move toward a non-cancelable approach for all long-term care policies. **1993 Proc. 4th Quarter 711.**

One attendee asked if the working group was going to include anything in the model that would permit a reduction in benefits offer in lieu of a premium increase. A regulator responded that the draft did not specifically address this issue, but nothing in the model draft would prohibit such an offer from being extended to a policyholder. **1993 Proc. 4th Quarter 711.**

After discussion of options related to differing caps for group and individual policies, caps varying by age, as well as other variations, the working group decided to expose a draft with a five-year limit on rate increases, 25% for those under age 65, 15% for those age 65 through 79, and 10% for those policyholders age 80 and above, and removal of the lifetime cap on rate increases. The reasons for removing the lifetime cap were because the draft as proposed provided policyholders with sufficient protection and a lifetime cap would only serve to discourage younger buyers from purchasing long-term care policies. **1993 Proc 4th Quarter 709.**

As the working group considered a draft for exposure, the chair enumerated four issues for the working group to decide. They were (1) applicability to group policies, (2) applicability to existing policies, (3) commissioner's discretion to waive the requirements in prescribed instances, and (4) the effect of inflation protection on rate stabilization. **1993 Proc. 4th Quarter 711.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 6F (cont.)

The working group decided that the additional premium charged for inflation protection would be subject to the initial rate guarantee and rating restrictions, subject to the limits described. However, in those instances where the purchase of additional coverage was an option of the policyholder, the initial premium charged for the additional coverage would not be involved in the rate restrictions. **1993 Proc. 4th Quarter 708.**

A representative from a trade association said he did not believe Paragraph (3) of the draft was clear in its intent. He said that when a policyholder purchased additional coverage, the premium for that coverage usually was at the rate currently in effect for new policyholders. The chair clarified that if a person buys a policy with a built in benefit for inflation protection, that person should receive the protections of the rate guarantee. However, if the person had the option of purchasing additional benefits at certain intervals, the premium associated with the additional benefit should not be subject to the rate constraints as proposed at the time the additional coverage was purchased, but would be subject to them for subsequent rate revisions. **1993 Proc. 4th Quarter 708.**

In discussing the issue of giving the commissioner the discretion to waive the rate increase constraints, one regulator said allowing the insurer to increase rates would be unfair to the insurer's policyholders and likely cause more harm to the insurer's financial solvency. Another regulator said she was opposed to a commissioner's discretion in general, but would consider providing for discretion after a finding by the commissioner of changes in the legal climate, health delivery mechanisms, or state and federal legislation issues that would affect the entire market. These provisions would be applied on a global basis rather than on an individual insurer basis. **1993 Proc. 4th Quarter 712.**

One commissioner expressed concern that the provision giving the commissioner authority to amend the premium rate restrictions would limit the ability to only the three stated reasons. As a result of that concern, the working group agreed to change this provision to allow more flexibility to amend the model regulation on a global basis. **1994 Proc. 1st Quarter 446.**

The drafters considered whether it was appropriate to apply the requirements to existing policies. Commentators spoke of the difficulty of doing this and questioned the legality. Also they said companies had not priced the products currently marketed for these requirements and felt this would create legal problems for regulators who attempted to retroactively apply the requirements. **1993 Proc. 4th Quarter 711.**

Many of the comments on the exposure draft focused on whether the draft was intended to be prospective only or also to apply to in force business. It was pointed out that a retrospective application created problems with the contracts clause of the U.S. Constitution which essentially says that no state shall pass any law that impairs any obligation of existing contracts. As a result, Section 6 was revised to reflect that the provisions would apply on a prospective basis only. **1994 Proc. 1st Quarter 446, 455.**

Testimony provided on the issue of group policies suggested they should be exempt from the requirements of this draft. Groups are protected by the Employee Retirement Income Security Act, and group policies have higher loss ratios. Group policies are generally issued to younger age groups, making it difficult for companies to comply with lifetime rate caps. **1993 Proc. 4th Quarter 711.**

Many of the comments on the exposure draft centered on the issue of whether the limits should apply to all group policies, all but employer groups, or to no group policies. Some regulators and consumer representatives believed that the model should apply to association groups. One suggested that unless the model applied to group business, insurers would create associations in an effort to avoid the requirements of the draft. Another regulator said he had heard most group policies were actually individual policies paid for entirely by the individual certificate holder. Insurers responded by explaining that pricing and rate guarantees were different in a group setting than for individual policies. They said group policies typically have higher loss ratios, administrative costs are less, and there are significant differences in marketing. The exemption of group policies would create an unlevel playing field, they suggested. **1994 Proc. 1st Quarter 456.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 6F (cont.)

In the draft adopted by the working group in 1993 the chair explained that the revisions were made to require the rating restrictions on all policies and certificates issued on or after the effective date of the regulation. The working group decided to exclude existing employer contracts for new certificates added to those contracts. The chair emphasized that this did not exempt new employer contracts, and only dealt with a new certificate issued to an existing employer group contract. **1994 Proc. 1st Quarter 446.**

While discussing life/long-term care issues, an interested party suggested that because of the differences in rate structures, life insurance policies with long-term care benefits should be exempted from the rate stability provisions. Life insurance rates are almost always guaranteed not to rise, so the issue does not apply. The task force agreed to this suggestion. **1996 Proc. 2nd Quarter 811.**

A Paragraph (8) was adopted as part of the life/long-term care amendments to clarify that the premium rate restrictions set forth in the then-existing Section 6F did not apply to life insurance policies that accelerated benefits for long-term care. The task force considered and added additional language that specifies the premium restrictions do not apply as long as maximum premiums, minimum interest rates and maximum costs of insurance are specified over the entire duration of the life insurance policy. **1996 Proc. 4th Quarter 1086.**

The task force chair pointed out that no state had yet adopted the rate stability provisions in the model and he stated the model may have gone too far and created too large an impact on premiums. Several regulators agreed that discussion needed to be reopened on this issue. **1997 Proc. 1st Quarter 760.**

In June 1997 the chair convened a meeting of the Senior Issues Task Force to look at the issue of rate stability in the long-term care insurance market. It was the desire of the task force to have an open discussion to determine if a rate stabilization problem existed, and if so, whether adjustments to the model regulation were needed. **1997 Proc. 2nd Quarter 756.**

A working group member said most policies were sold to insureds in their 60s and 70s. These individuals are normally on fixed incomes, and can least afford a substantial rate increase. He was concerned about how to prevent rate increases of a large magnitude from occurring late in the policy life, and also questioned what alternatives were available to prevent large rate increases for these insureds. He said the task force should consider the design of the products to determine if adjustments could be made. He said alternatives could be developed, perhaps through portability to an insurer-sponsored risk pool for insureds who experience a substantial rate increase. He also offered that the insured may be able to continue benefits with either a reduced premium or with no premium at all. **1997 Proc. 2nd Quarter 757.**

A consumer representative expressed concern that products sold now would eventually have rate increases that would create lapses in the future, especially when those products were needed the most. She questioned why blocks of business were closed so quickly, and she noted the added emphasis on long-term care insurance as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **1997 Proc. 2nd Quarter 757.**

Another reason for reviewing the rate stabilization issue was that no state had adopted the standards adopted in June 1994. **1997 Proc. 3rd Quarter 1350.**

An insurance department actuary described how rates are set and the effect of a lapse. He said the premium level is extremely sensitive to the accuracy of the assumptions of lapses and death rates. He said it appeared the pricing of a policy was lapse-supported and, if the lapses were not as estimated, a price increase would be needed. **1997 Proc. 3rd Quarter 1350.**

A commissioner asked if long-term care insurance was more sensitive than other types of insurance to the type of assumptions the insurer used to determine rates. The actuary responded that this was the case, due to the back-end nature of the claims and the fact that the claims came late in the life of the policy. **1997 Proc 3rd Quarter 1350-1351.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 6F (cont.)

The actuary referred to the level payment principle and explained that a significant reserve is created during the early years of the policy, which is used to supplement the policy in later years when the annual premium is insufficient to fund the claims for that year. The theory behind lapse-supported pricing is that the fund amount is used so that premiums are lower for all policy years. He added that, if nonforfeiture is added to a policy, then more premium needs to be collected in order to pay off the nonforfeiture benefit upon lapse by the policyholder. **1997 Proc. 3rd Quarter 1351.**

A representative from an insurer described the rating problem from an insurance company's point of view. He said the key drivers of the premium rate increases were untested assumptions, using an inadequate rating structure such as the one used for Medicare supplement insurance, inadequate long-term care insurance experience, and using quinquennial age rate bands. These practices resulted in underpricing of policies by one third to one half. Also the first generation of long-term care insurance policies had higher utilization than expected. He said that underwriting practices have evolved substantially and he opined that now companies have better data and use less aggressive termination assumptions. **1997 Proc. 3rd Quarter 1351.**

An insurer representative said part of the solution to the rate stabilization problem was better upfront pricing. He said this is a fine line, because insurers do not want to price potential insureds out of the market, but the initial rates needed to be adequate to provide sufficient reserves for future benefits. A consumer representative expressed concern that consumers were buying the cheapest policy they could find, and then facing large rate increases later in the life of the policy. She also expressed concern that the insurers that do price adequately upfront are being squeezed out of the market because the premiums for their policies are more expensive. **1997 Proc. 3rd Quarter 1351.**

A regulator opined that unless the insurer is really motivated to keep rates stable through proper underwriting, using adequate assumptions and agent training, nothing will change. An interested party asked what could be used as a tool to motivate the company to set initial rates that are adequate. A trade association representative opined the idea of contingent nonforfeiture will change the mind set of the company. This will allow for tinkering with rates but discourage the large rate increases that rate stability is designed to prevent. **1997 Proc. 3rd Quarter 1353.**

A regulator stated there needed to be a distinction between the concepts of rate caps and rate stabilization. He said that the issue of rate stabilization could be defined as a collection of activities that will maximize the probability that premium rates will be unchanged for the life of the contract, provide maximum economic value to the insured, and encourage economic value and stability for insurers. **1997 Proc. 3rd Quarter 1342.**

The task force identified several different approaches that could be used separately or collectively to satisfy the need for rate stabilization. These methods could be directed at appropriate product design, product pricing, underwriting, claim adjudication, policy reserve levels and methodology, and consumer education. If, despite all reasonable efforts, rate increases became unmanageable for insureds, then those insureds should be given useable options for maintaining some level of long-term care insurance coverage. Another consequence of insured options and rate stabilization would be to encourage insurers to make every effort to prevent unmanageable premium increases. **1997 Proc. 3rd Quarter 1342.**

One regulator noted that a rate filing he had received referred to multiple rate increases that would be necessary in the future. Another regulator opined that initial premiums were being set too low and it was a bait and switch tactic, which resulted in harm to consumers. **1997 Proc. 4th Quarter 937.**

The task force chair summarized other options to assist in rate stability: increasing the requirement for more agent training, both in becoming licensed and in continuing education; additional disclosure to consumers; and a method of assisting states in evaluating the actuarial material submitted by insurance companies to accompany their product filings. The assistance could be in a variety of forms, from a technical manual or guidelines that states could review, to a central clearinghouse that would perform actuarial review for the states. **1997 Proc. 4th Quarter 936.**

An industry spokesperson said that with the removal of rate caps and mandatory nonforfeiture, and with numeric percentages similar to those proposed by the industry, the insurance industry would support the model in total. **1997 Proc. 4th Quarter 907.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 6F (cont.)

The proposal adopted by the task force eliminated the rate caps that had been added to Section 6F. A Paragraph F(2) was added to address upgrading coverage and to clarify that the purchase of additional coverage was not considered a rate increase but changes the amount of the initial premium. **1998 Proc. 1st Quarter 894.**

G. A group was appointed in 1995 to study disclosures contained in the long-term care insurance models. One issue identified for further study was the signature requirement upon enrollment. Representatives from the insurance industry urged that consent be allowed through other means, such as by telephone or electronic means. Some regulators expressed concern with the concept, but industry representatives stated the signature requirement was very costly to companies. **1995 Proc. 4th Quarter 894.**

A regulator asked if the proposed language would narrow the commissioner's ability to be able to confirm only enrollment and coverage amounts. Another regulator opined that the language in the original amendment was broad enough to allow oversight of the entire process. Another regulator said it was necessary to demonstrate that enrollment had occurred and coverage was in place. **1996 Proc. 2nd Quarter 823.**

A regulator summarized that the primary concern of the group had been the absence of a signature requirement in the group application. Language was added that alleviated the concerns of the group and provided for the identification and rapid retrieval of information in the event of an inquiry or complaint against the insurer. A regulator asked what happens in the event the consumer makes an inadvertent error in the electronic application process and the certificate holder cannot see the error. Another regulator responded that the confirmation statement will show the information given to the insurer. An interested party suggested that the certificate delivered, along with the payroll deduction evidence, should be sufficient to verify enrollment. **1996 Proc. 2nd Quarter 821.**

In response to continued concerns about verification of coverage, the working group added language to Paragraph (1)(a) requiring that a verification of enrollment be provided to the enrollee. **1996 Proc. 2nd Quarter 822, 824.**

Section 7. Unintentional Lapse

This section was added to the model in December of 1992 upon the urging of consumer representatives. **1993 Proc. IB 846.**

A. There were two alternatives the task force considered to require insurers to protect policyholders who forgot to pay their premium. The two components could be in the conjunctive or in the alternative. The industry proposal provided for third party notice *or* reinstatement; the consumer proposal advocated third party notice *and* reinstatement. **1992 Proc. IIB 685.**

The application should designate an alternative person to receive notice; the purpose of the designation was to allow that individual to pay the premium for the policy if the policyholder forgot to pay the premium. **1992 Proc. IIB 694.**

Early drafts of the notice subsection required notification of lapse to three persons. In later drafts that number was reduced to one. One task force member suggested the model say "*at least one person*" so that individuals who wished to designate more than one would have the ability to do so. **1993 Proc. IB 853.**

An advisory committee recommended the inclusion of language exempting insureds who paid by automatic payroll or pension deduction plan. The task force was in agreement, but wanted language to clearly show that the requirements would apply at all times except when an insured paid by payroll or pension deduction. **1993 Proc. IB 854.**

B. After consideration of the reinstatement issue, the task force members agreed that the model should contain reinstatement language. They decided that reinstatement should be available for five months after termination. **1992 Proc. IIB 685.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 7 (cont.)

One item that received extensive discussion before adoption was the standard of proof for cognitive impairment or loss of functional capacity. It was noted that the proof should be based on the impairment at the time of the loss and not at any other time. It was also indicated that the provision was not meant to require insurers to include such a trigger in their policies or certificates if they did not already have one. **1993 Proc. IB 843.**

When drafting amendments on life/long-term care issues, the task force considered reinstatement issues. The regulators expressed concern that the protections afforded by the existing long-term care insurance regulation not be lost. Concern was also expressed regarding anti-selection if insurance companies were required to reinstate the life insurance policy when the lapse occurred and the insured had cognitive impairment. The chair emphasized that language to be inserted in Subsection B must maintain the original intent of the provision, which is to protect long-term care insureds from losing coverage due to lapse when they need it most. **1996 Proc. 2nd Quarter 811.**

The language drafted for inclusion in the regulation clarified that proof must be given to the carrier that the policyholder became functionally impaired before the grace period expired and that cognitive impairment or loss of functional capacity caused the unintentional default in the premium payment. The task force decided to add a drafting note including a reference to the fact that contracts that contain the language may be considered qualified long-term care contracts under federal law. **1996 Proc. 4th Quarter 1086.**

A consumer representative expressed concern regarding the shifting of burden of proof of cognitive impairment to the consumer. An industry representative said the intent of the amendment was simply to clarify the intent of the reinstatement provision. Another consumer representative asked how an individual with a cognitive impairment can prove his condition. A regulator suggested that language be added to further clarify that the unintentional default in the premium payment was a result of cognitive impairment. Another interested party opined that the lack of a causal link between cognitive impairment and unintentional default of the premium would result in denial of benefits. The task force decided to consider the issue further. **1996 Proc. 4th Quarter 1080-1081.**

Consumer representatives and insurance industry representatives met to draft compromise language that removed the responsibility of proving cognitive impairment from the insured. The language presented to the task force was satisfactory to both groups and was then adopted by the task force. **1997 Proc. 1st Quarter 774.**

Section 8. Required Disclosure Provisions

A. Paragraph (2) was added with the rate stabilization amendment of 2000. It requires disclosure of the fact of potential rate increases unless the insurer did not have the right to change the premium. **2000 Proc. 2nd Quarter 289.**

E. The working group stressed that a “post-confinement-type” product is acceptable, provided it is clearly labeled as proposed in Section 8E adopted in December 1988. **1989 Proc. I 754.**

F. The joint accelerated benefits working group recommended amendments to the model to deal with several issues related to long-term care financed by accelerated benefits on life insurance policies. One recommendation from the group was to add a provision requiring disclosure of tax consequences. **1991 Proc. IB 687-688.**

H. This provision was added as the model was being revised to comply with the provisions of the Health Insurance Portability and Accountability Model Act of 1996 (HIPAA). **1999 Proc. 4th Quarter 982.**

This provision was added as a result of HIPAA. Staff noted that it was not required by that federal law, but was important. **1998 Proc. 3rd Quarter 719.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 9. Required Disclosure of Rating Practices to Consumer

The task force discussed some of the recent model amendments that were adopted as an attempt to influence rate stabilization through rate caps and nonforfeiture options. The former chair of the task force had spoken in favor of providing a disincentive for lapse driven pricing that would be acceptable to regulators, consumers and the insurance industry. **1998 Proc. 2nd Quarter II 882.**

One regulator commented that long-term care insurance policies with rich benefits and low initial premiums will not serve consumers. The problem includes inadequate underwriting. He opined that one definition of proper underwriting was not selling policies to people close to claim status. Inappropriate underwriting will result in rate increases. **1998 Proc. 2nd Quarter II 882.**

A new working group was formed to consider issues related to rate stability beyond contingent nonforfeiture. The chair pointed out the problem when people buy long-term care insurance in their 60s when it is affordable but then have trouble keeping up with the premiums because they find rate increases have made it too expensive when they are in their 70s and 80s and need the coverage. **1998 Proc. 3rd Quarter 717.**

The working group discussed the fact that the model currently allows policies to be noncancellable or guaranteed renewable. Noncancellable means that benefits cannot change and premiums cannot change, but guaranteed renewable means premiums can go up by class of policyholders while benefits do not change. One member observed that long-term care insurance products have only been on the market about fifteen years so companies cannot predict what claims will cost. **1998 Proc. 3rd Quarter 718.**

The chair opined that some companies have a noncancellable mentality; they have been selling long-term care insurance for a long time with no premium increases. At the opposite extreme, some companies impose rate increases often. For example, one company's premium went from \$800 in the mid-1980s to \$7,000 in the mid-1990s. He called this "beat the market mentality." He described this as a desire for market share. They provide risk benefits and, as a consequence, claims go up and costs go up. **1998 Proc. 3rd Quarter 718.**

The working group discussed potential solutions. Commissions on rate increases should be eliminated to discourage starting with low initial premiums. Loss ratios should be eliminated. They lead to a cost-plus system that leads companies to want larger claims to bring larger margins. Make information public about companies that raise their rates. **1998 Proc. 3rd Quarter 718.**

A regulator expressed concern that insurance departments not become "*de facto* rating agencies" for long-term care insurance. He encouraged education so consumers could identify good carriers or products. He also spoke in favor of a regulation that would prohibit carriers from having frequent rate increases. **1998 Proc. 4th Quarter II 1040.**

An initial draft of a new Section 9 was released in February 1999. **1999 Proc. 1st Quarter 801, 829-830.**

The chair of the group encouraged the members to move forward with discussion on rate stability. He reminded the group that when it had adopted amendments to the contingent nonforfeiture on lapse provision, everyone had agreed that further work was needed with respect to rate stability. **1999 Proc. 2nd Quarter 662.**

Just before adoption of the amendments, a regulator summarized them: the amendments concern rate stability, rate filing and consumer disclosures on prior rate history. Initial loss ratios are eliminated, limits on expense allowances for subsequent rate increases are established, reimbursement of unnecessary rate increases is required, review by the commissioner of administration and claims procedures is authorized, policyholders are allowed the option to escape the effects of rate spirals by guarantee of the right to switch to currently sold coverage without underwriting, the commissioner is authorized to ban companies from the market that persist in filing inadequate initial premiums, actuarial certification regarding rate adequacy is required, and insurers must disclose the last ten years of their rate history to consumers as they make their decision to buy coverage. **2000 Proc. 2nd Quarter 162.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 9 (cont.)

A. Near the end of the drafting process an effective date provision was added to clarify to which policies the amended regulation applied. **2000 Proc. 2nd Quarter 289.**

B. While discussing rate stabilization, the working group discussed how to get information about rate history to consumers. The chair presented a form for a hypothetical rate history. A consumer advocate said the form was too complicated and did not tell how one company's product related to another's. She advocated publishing information annually in a comparative rate guide. The chair asked whether a list of carriers that have had rate increases versus carriers that have not would be helpful. An interested party noted that the number of years that a carrier has been selling long-term care insurance was also relevant and should be disclosed. Another interested party noted that the number of years between rate increases was also important. **1999 Proc. 3rd Quarter 1304.**

At one meeting, the chair described a system he was constructing for his state to verify premium rates against the associated rating assumptions filed with the state. He was contacted by several industry representatives with information about the complexity and difficulty of constructing such a system, and no longer believed such a system was feasible. **1999 Proc. 4th Quarter 1312.**

The amendments developed in 2000 were in two parts: the rating practices issues developed by the actuaries and the consumer protection amendments offered by the working group on long-term care insurance. These amendments focus primarily on disclosures to consumers regarding potential future rate increases for all long-term care insurance policies, other than non-cancelable policies. The amendments included the creation of a new disclosure form regarding potential rate increases. **2000 Proc. 1st Quarter 337.**

Shortly before adoption of the provisions, changes were made to require insurers to provide all the information listed to the applicant at the time of application or enrollment unless the application process does not allow for it (i.e., mail applications). In those limited cases, an insurer shall provide all of the information listed in the subsection to the applicant no later than at the time of delivery of the policy or certificate. **2000 Proc. 2nd Quarter 290.**

The group discussed extensively the provisions regarding acquired blocks of business. Some spoke in favor of requiring disclosure of any increases. One regulator asked why a company would buy a bad block if it had to disclose rate increases. Another expressed concern about the twenty-four month language, because it seemed an insurer could avoid disclosure and continue to sell the policies. The chair noted that acquired business is closed business; neither insurer is selling those policies. **2000 Proc. 2nd Quarter 291.**

C. Shortly before adoption of the revised model, which required an applicant to sign an acknowledgement that the insurer disclosed the potential for rate revisions, changes were made to require that the applicant must sign at the time of application, unless the method of application did not allow for signature at that time. In that case, the applicant must sign no later than at the time of delivery of the policy or certificate. **2000 Proc. 2nd Quarter 290.**

D. An insurer must use the forms in Appendixes B and F to satisfy the disclosure requirements; however, the applicant only has to sign Appendix B. **2000 Proc. 2nd Quarter 312.**

E. When originally drafted, the consumer had a right to request a new rate schedule when there was an upcoming rate increase. The draft was changed to require notice and delivery of a new rate schedule automatically. **2000 Proc. 2nd Quarter 290.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 10. Initial Filing Requirements

B. The chair of the working group on long-term care issues asked why regulators would allow the inadequate pricing of products and subsequent rate increases to occur. He explained that, when pricing a product, actuarial assumptions are made and listed in the actuarial memorandum accompanying the rate filing. The assumptions include morbidity charges, interest rates, and lapse and persistency rates. All of this information is put into a pricing system and what comes out at the end are premium rates and policy reserves. Generally speaking, a regulatory actuary can see the assumptions, see the results, see in the certification that the two are reasonably connected, and over time become comfortable with actuarial memoranda from certain carriers. Conversely, discomfort with other companies can arise if the regulatory actuary does not see that the assumptions are connected to the premium rate. The carriers that properly price products generally have a strategy that they do not ever want to impose a rate increase; therefore they implement an effective strategy to keep the premium level. **1999 Proc. 3rd Quarter 972.**

Section 11. Prohibition Against Post Claims Underwriting

This section was added in December 1989, in response to abuses which had occurred. The NAIC proposal was drafted to include the following concepts: (1) a caution statement, (2) a requirement that the questions should be clear and unambiguous, (3) a requirement for an attending physician's statement for individual applicants over 80 years of age. **1990 Proc. IB 561-562.**

The task force considered strengthening this section (**1992 Proc. IIB 684**) but instead chose to adopt an addition to the model act on incontestability. **1993 Proc. IB 845.**

B. Considerable input was received on whether to require insurers to ask a long-term care insurance applicant which prescriptions have been prescribed and for which medical conditions they are prescribed. If the questions weren't mandatory, insurers might not inquire about prescription drugs because it increased their exposure. One task force member asked what would happen if an applicant forgot about a prescribed medicine. It was concluded this was not a rescindable event. **1990 Proc. IB 561.**

C. It was suggested that the exposure draft language requiring an extensive caution statement should be shortened for the application, and the longer version should be required in the outline of coverage. The task force agreed to apply the requirement for a caution statement to all policies except guaranteed issue, to permit substantially similar language, and to require it be displayed prominently. **1990 Proc. IB 561-562.**

The task force considered several options regarding physician statements. It was suggested that the requirement should not be limited to a physician's statement, but the language should be broader to include medical records. First the task force considered requiring one of these for anyone over age 75. Later the age was raised to 80. A representative of a consumer group commented that his organization's members might feel discriminated against if they were required, solely because of their age, to submit attending physician's statements. **1990 Proc. IB 565.**

E. It is important that companies report rescissions on an annual basis to the insurance departments. Nine states currently require such reporting, and through the task force did not intend to duplicate current practices, the reporting was not widespread enough to abandon the addition of this requirement in the model. **1990 Proc. IB 566.**

The rescission reporting form was necessitated by Section 11E of the regulation. A number of states requested development of the form. **1991 Proc. IIB 765.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 12. Minimum Standards for Home Health Care Benefits in Long-Term Care Insurance Policies

The amendments adopted in December 1989 included this new section. The objective was to assure that the home health care benefit is not illusory, but to allow flexibility at the same time. The amendment does not allow home health care services to be predicted on a “medically necessary” standard. The section also does not allow limiting benefits to only those delivered by licensed practical nurse or registered nurses. The benefits should not be limited to acute as opposed to chronic care. The level of home care shall be tied to total benefits contained in the policy. In other words, an insurer who provides home health care in long-term care policies must provide 12 months of coverage which may include a home health care benefit. Although flexibility should be provided for the development of the product, regulators have a duty to place appropriate safeguards on the product so the public is not harmed. **1990 Proc. IB 571.**

Two things must be accomplished with this regulatory framework: (1) Make sure there are minimum standards, and (2) Prohibit gatekeeping mechanisms that result in an illusory benefit. The task force considered ways to measure the medical necessity in a consistent way. They considered an assessment analysis being developed by the Health Care Financing Administration or the use of activities of daily living (ADLs). **1990 Proc. IB 571.**

Amendments to the home health care section were considered for adoption. The first draft did the following: (1) listed the types of care that must be included in policies that contain home care services benefits, (2) expanded the list of prohibitions against limiting or excluding benefits, (3) tied the home care benefit maximum to the same dollar amount and duration of benefits that for institutional care, and (4) required that all long-term care policies or certificates must contain a provision outlining eligibility for benefits. Some of these proposals were controversial; the task force decided to go ahead and adopt the noncontroversial provisions in December 1991. **1992 Proc. IB 982-983.**

The task force declined to include a provision that would require a dual option. **1992 Proc. IB 983.**

The task force decided to consider the issue of whether long-term care policies should be required to contain home health care benefits. One person suggested that policies not containing home health care benefits should be labeled that they are not a long-term care insurance policy. **1992 Proc. IB 983.**

At the time of adoption of amendments to this section, the task force agreed that they would not specify the types of home health care that must be included in a long-term care insurance product that contains benefits for home health care services. **1992 Proc. IB 962.**

The task force agreed to add a new Subsection B to require that the home health care component be at a certain minimum level. **1992 Proc. IB 962.**

Section 13. Requirement to Offer Inflation Protection

Early on the group recognized the need for a provision on inflation protection. The working group started collecting information on the inflation adjustment features already available on the market and their cost. **1989 Proc. II 515.**

This entire section was added in December 1989. As coverage was increasingly marketed to younger groups, the need for inflation protection was demonstrated. The task force considered the various alternative ways of providing protection. The advisory committee suggested mandating an offer of inflation protection without detail on the type of protection, and offered to study the issue of what would be appropriate. **1990 Proc. IB 562-563.**

A. A health insurance association representative reported that about half of the policies now being offered include an inflation feature. About half of those provide for an annual rate of increase (not compounded). The negative impact of mandating a specified approach is higher price. The task force chair urged a requirement of at least a 5% increase annually. A product with lower than 5% was no protection at all. **1990 Proc. IB 562-563.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 13 (cont.)

The task force decided to require a mandated dual option with no specific benchmarks. **1990 Proc. IB 562.**

One task force member suggested that, in light of the impact on premiums, inflation protection should probably be *prohibited* at a certain age. **1990 Proc. IB 566.**

At the time the amendments were adopted, one insurance representative expressed concern that the draft required an offer of inflation protection over the life of the policy. The task force chair noted that technical issues remained on whether the inflation adjustment should be required over the lifetime of the policy or for some reasonable specified time. A consumer advocate noted his organization would favor a reasonable limitation such as attained age. The issue requires further analysis. **1990 Proc. IB 542.**

The December 1990 minutes of the task force contain an extensive report by the a technical actuarial committee regarding inflation protection and nonforfeiture values. **1991 Proc. IB 662.**

When adopting amendments in December 1990, the task force considered the addition of language to the inflation protection provision to set a specific percentage for compounding. The task force was attempting to balance the public policy considerations of requiring a set rate, or of requiring compounding it all, versus the cost involved. The actuarial committee had recommended compounding at a rate of 7%, but the amount finally agreed upon was 5%, compounded annually. A consumer advocate expressed concern about how complex the provisions on inflation protection were and about the possibility that figures could be manipulated as they were presented to consumers. She expressed the opinion that it is extremely critical that disclosure be clear. The committee discussed the cost disincentives to purchase, but also were mindful of the issue of whether consumers had any meaningful protection at all without inflation protection. **1991 Proc. IB 664-665.**

E. The task force decided to revisit the issue of inflation protection in 1991. One person suggested a practice which should be considered by the task force: Policies are available with a “term” component until individuals reach age 65, and thereafter premiums are level. Another added that prefunding is an issue and suggested the task force examine the offers currently being made in the marketplace. **1991 Proc. IIB 767.**

The task force discussed whether they believed it was necessary to reaffirm that in new Subsections E, F, and G the offer of inflation protection was made to the group policyholder (rather than the certificateholder) in group situations other than discretionary groups. The task force concluded it was not necessary to reiterate this because it was addressed in other subsections of Section 11. **1992 Proc. IB 960.**

In the fall of 1991 the task force considered a draft proposal for amendments to the inflation protection section. It was designed to require an offer also to persons in claim status. **1992 Proc. IB 986.**

F. The new Subsection F adopted in December 1991 was not intended to require a level premium. The purpose of the section was to create an expectation that the premium would remain constant. That is different from the methodology developed by an insurer that can be changed if the experience of the policy turns out to be different. The goal of the task force was to stop short of requiring a non-cancelable policy. The purpose of this section was to introduce a new concept that would create a higher degree of certainty for the consumer that the premium would remain the same in the future. It was the hope that insurers would carefully calculate premium up front. **1992 Proc. IB 959-960.**

G. One industry association commented that they would have concerns if the task force concluded all policies should contain inflation protection. Insurance industry members were requested to provide information detailing circumstances in which inflation protection might not be desirable or feasible. **1991 Proc. IIB 767.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 13G (cont.)

In response to a query about situations where an individual would be better off if no inflation protection existed, one advisory committee member cited a situation in which a 70-year-old individual would be better off choosing a policy with no inflation protection, given the difference in cost of two policies, one with a \$70 a day benefit and the other with a \$100 a day benefit. **1992 Proc. IB 991.**

One issue to be resolved by the task force was whether inflation protection should be mandated or should be a mandated offer. **1992 Proc. IB 991.**

The approach most favored was one where companies would be required to obtain a signed rejection from the consumer on an offer of inflation protection. Then all policies would include inflation protection unless the consumer rejects that protection. **1992 Proc. IB 986.**

For a time the task force considered requiring two rejections, but the inclusion of a requirement that companies make a second offer of inflation protection was removed from the draft because of difficulties with that approach. **1992 Proc. IB 983.**

There was substantial discussion on whether the language concerning the signed rejection addressed individuals who would drop the policy in error. However, the task force agreed to adopt the language presented. **1992 Proc. IB 983.**

It was decided to prepare language for the specific format of the signed rejection. They wanted something stronger than the “Yes, I accept inflation protection,” “No, I reject inflation protection,” suggested by one association. **1992 Proc. IB 960.**

When the model was undergoing amendment in 1999, the last sentence of Paragraph (1) was added. **1999 Proc. 4th Quarter 982.**

Section 14. Requirements for Application Forms and Replacement Coverage

The earlier drafts of the Notice to Applicant Regarding Replacement contained a requirement to include the telephone number of the insurance department. **1987 Proc. II 737.**

Interested parties urged the task force to delete the requirement for a telephone number. Rather, they recommended that a sentence referring consumers to their insurance department be added to Provision One and that it be expanded to explain the role the department may be expected to perform. This would adequately alert consumers to their option to seek help from the insurance department without creating unnecessary cost and administrative problems for both companies and departments. **1988 Proc. I 711.**

The draft which was adopted deleted the information regarding the insurance department and its telephone number. **1988 Proc. I 659.**

A. In the drafting of consumer protection amendments in 1990, a series of questions were listed which should be asked in the application process. There was discussion on the necessity for the Medicaid question. The task force chair was of the opinion that it was valuable information which should be considered in order to determine whether coverage should be written. The chair of the advisory committee stated that it might be preferable to develop a clear disclosure statement on the policy stating that if a person is eligible for Medicaid, he or she should probably not purchase the coverage. The Section 14 requirement does not really explain the significance of the question. **1991 Proc. IB 692.**

F. A trade association representative suggested that, if a life insurance policy is replaced by a life/long-term care insurance policy, then the life insurance policy replacement procedure should be followed. If a life/long-term care insurance policy is replaced by a life insurance policy, the long-term care insurance replacement procedure should be used. She offered to draft language to clarify the procedures. **1996 Proc. 2nd Quarter 812.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 14F (cont.)

This provision was added simply to clarify the procedure that should be followed in the event of a replacement. The task force agreed to adopt the language suggested. **1996 Proc. 4th Quarter 1086.**

Section 15. Reporting Requirements

This section was added with the consumer protection amendments to assist the commissioner in measuring compliance with the regulation's provisions. **1991 Proc. IB 690-691.**

B. Section 15 required every insurer to report annually to the insurance department the company's replacement and lapse rates and the ten percent of the insurer's agents with the greatest percentages of replacements and lapses. The only amendments added to Section 15 in 2001 were cross-references to Appendix G, the new replacement and lapse reporting form. The new reporting form did not add any substantive reporting requirements to the model; it only reflected the current requirements under Section 15. **2001 Proc. 4th Quarter 285.**

F. Subsection F was added as part of the amendment package drafted in 1998-1999. There was protracted discussion about exactly what was meant by the reporting requirement in the Health Portability and Accountability Act of 1996 (HIPAA) in terms of what a carrier needed to report. A consumer advocate argued that claims denied for failure to meet a waiting period or because of an applicable preexisting condition exclusion, which did not need to be reported under HIPAA, should be reported so that states could get a complete picture. She urged the NAIC to draft a reporting form for this purpose. **1999 Proc. 1st Quarter 612.**

G. During discussion of Subsection F requirements, the regulators realized they needed to define "claims" for purposes of this section. **1999 Proc. 1st Quarter 612.**

Section 16. Licensing

As one of the possible alternatives to limits on agents commissions, this section was added in 1991 to implement special licensing requirements for agents. The section did not require a separate test; special test questions regarding long-term care insurance on existing exams would satisfy the special testing requirement. **1991 Proc. IB 662.**

During a 1997 discussion on rate stabilization and nonforfeiture, the Senior Issues Task Force talked about the idea of modifying the agents' education requirements. One regulator questioned whether long-term care insurance was so unique that it required a separate license. **1997 Proc. 4th Quarter 938-939.**

The chair noted Section 16 contained a general testing requirement, and asked if more language was to be added to Section 16 to make it clear that it was either a separate long-term care test or a long-term care component of a general licensing test. **1997 Proc. 4th Quarter 939.**

A regulator said the proposal for additional agent training was an excellent one, and suggested asking this to be a charge in 1998. **1997 Proc. 4th Quarter 936.**

This section was revised in 2000 to reflect the licensing requirements of the Gramm-Leach-Bliley Act of 1999, as adopted in the Producers Licensing Model Act 2000 amendments. After the NAIC adopted provisions for a separate long-term care insurance examination, only three states adopted that provision. A regulator recommended adding more long-term care insurance questions to the health section of an agent licensing exam instead of having a separate section. The section as drafted prior to 2000 was contrary to the producer licensing model in light of the Gramm-Leach-Bliley Act. **2000 Proc. 2nd Quarter 291.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 17. Discretionary Powers of Commissioner

A meeting between the long-term care subgroup and the advisory committee was held just prior to adoption to address issues pending between the groups. This section was a result of that meeting, and was designed to provide flexibility in the development of innovative products. **1988 Proc. I 656.**

An advisory committee expressed concern about the possibility of delay in the administrative hearing process and its preferential effect. **1988 Proc. I 652.**

The provision adopted affords the commissioner the authority to exercise a degree of discretion in allowing the kind of product development and testing the advisory committee deemed essential to the future of long-term care insurance. **1988 Proc. I 711.**

Section 18. Reserve Standards

Developing reserve standards for long-term care products is a challenging problem for regulators and the industry alike. On the one hand, insurers are being encouraged to enter the field of long-term care financing in order to provide an alternative to the current public sector financing of long-term care, but on the other hand, the actuarial basis for developing premiums and statutory reserves is limited at best. Three separate situations should be considered: stand-alone long-term care products; long-term care benefits attached to life insurance policies, either directly through a rider with separate identifiable premiums; and long-term care insurance benefits attached to life insurance without identifiable premiums or charges. A further distinction needs to be made between active life reserves and claim reserves. **1989 Proc. I 787-788.**

The Life and Health Actuarial Task Force prepared amendments for adoption in June 1989 to provide for reserve standards. The document prepared for adoption defines reserve standards relating to long-term care benefits contained in accident and health policies and also applies to long-term care benefits provided with life policies or riders. The actuarial task force also agreed to develop actuarial tables relating to long-term care. The possible need for nonforfeiture benefits, in connection with long-term care benefits, also needs to be studied. **1989 Proc. II 476.**

B. While drafting the 1999 amendments, the reference to the reserves law was clarified and the drafting note added. **1999 Proc. 4th Quarter 983.**

Section 19. Loss Ratio

A. This subsection was included in the 2000 amendments. **2000 Proc. 1st Quarter 1109.**

The 2000 amendments eliminated the use of loss ratios for most policies. A regulator explained that currently companies use a fixed loss ratio, which is the ratio of claims to premiums, as a basis to calculate rates for long-term care insurance products. This fixed loss ratio method effectively establishes a cap on premiums that a company can charge and artificially limits initial premiums; however, by increasing claims, a company can increase expenses. The fixed loss ratio method creates an incentive for insurers to increase claims so they can receive higher expenses. This leads to rate increases in the future. **2000 Proc. 1st Quarter 335-336.**

Under the amendments adopted in 2000, there would not be a fixed loss ratio requirement on initial filings as is the current practice. However, penalties would be imposed in the future if there are rate increases. **2000 Proc. 1st Quarter 336.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 19 (cont.)

A regulator explained that, for an initial rate filing, the proposed change would apply to new policy forms filed after the effective date. For individuals the new rating system would apply only to new policies issued after the effective date of the amendments, which would include a new policy issued under the existing policy form. For groups, the proposal would apply to new policies issued after the effective date of the amended regulation and would apply to new certificates issued under an existing policy after a certain point in time. **2000 Proc. 1st Quarter 336.**

Eliminating the initial loss ratio in long-term care insurance rate filings was a major departure from current regulatory practice. Regulators believed that the current regulatory structure did not address the issue of inadequate initial pricing. With the package of amendments adopted in 2000, the incentives to price adequately are materially enhanced. **2000 Proc. 2nd Quarter 162.**

B. When the regulation was presented for adoption, the chair of the Long-Term Care Insurance Subgroup made special comments on the loss ratio provisions of the model regulation. **1988 Proc. I 652.**

The 60% loss ratio was of concern to the advisory committee, which felt it was high. They urged the addition of a drafting note and submission of the provision to the Life and Health Actuarial Task Force for review. **1988 Proc. I 711.**

The loss ratio section was originally conceived as an optional rating provision to serve as a benchmark for those states deciding to use loss ratios to determine reasonableness of benefits in relation to premiums. However, that was changed before the regulation was adopted. **1988 Proc. I 660-661.**

The drafters considered adoption of language excepting life insurance riders from loss ratio reporting requirements. An industry representative stated that loss ratios are not applicable to life insurance in general and for that reason they should be excepted from the reporting requirements. The drafters agreed that the proposed language was confusing, but that having no loss ratio or rate regulation was not acceptable. They agreed that loss ratio standards may be inappropriate to some extent, but there must be language dealing with a reasonable relationship between the charges and corresponding benefits. A workable substitute for the model language should be developed. **1989 Proc. II 477.**

The task force continued to consider the issue of requiring loss ratio calculations for life insurance products containing long-term care insurance benefits. Two suggested approaches were presented by industry representatives but one task force member commented that neither approach addressed all of the task forces concerns and suggested the task force develop its own approach. **1991 Proc. IIB 767.**

The task force considered a proposal from the Joint Accelerated Benefits Advisory Committee concerning the applicability of loss ratios to life insurance policies that accelerate benefits for long-term care insurance. The proposal exempted life insurance policies that accelerate the death benefit where the payment of such long-term care benefits does not result in a decrease in at the total amount of benefits payable under the policy. **1991 Proc. IIB 832.**

One insurer representative stated that the reason behind the exemption from loss ratio requirements is that loss ratios cannot be calculated for life insurance policies. The task force chair suggested a definition of an accelerated benefit policy be added to the regulation to avoid confusion. The task force should avoid adopting an exemption that is not clearly defined. **1991 Proc. IIB 832-833.**

The model regulation only specified that individual policies should meet a 60% loss ratio, but the loss ratio reporting forms required experience to be reported on group policies. The task force considered whether a change should be made in the model regulation and whether an explanatory note should be added. **1992 Proc. IIB 697.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 19 (cont.)

In September 1992 an amendment was adopted to Section 19 to remove the reference to “individual” long-term care policies. The loss ratio reporting form clearly requires group ratios to be reported, so the model regulation was changed for consistency. The change clarified that the 60% loss ratio applied to both individual and group policies. Some members of the task force suggested the loss ratio for groups should be higher, and the task force chair suggested that states would probably apply a higher loss ratio to group insurance. The drafting note at the end of Section 19 was also added. **1992 Proc. IIB 695-696.**

Subsection C was added in 1997 when the task force was considering amendments on the issue of life insurance policies that accelerate benefits for long-term care expenses. **1997 Proc. 1st Quarter 711.**

Section 20. Premium Rate Schedule Increases

[See discussion of rate stabilization at the beginning of Section 9 for background information.]

B. A consumer advocate asked what is meant by “lifetime” as used in Paragraph (3) of this subsection. The chair responded that lifetime refers to the life of the policy form as opposed to the life of a single individual, and that it was common for carriers to use thirty to thirty-five years in the projections that they filed with the states. **2000 Proc. 2nd Quarter 1113.**

C. While reviewing a first draft of the new Section 20, one regulator commented that the components of the ratios needed to be defined. **1999 Proc. 1st Quarter 801.**

The chair explained the new proposal: if an increase in rates was needed, 58% of the initial premium and 85% of the increased portion of the premiums must be available to cover claims on a lifetime present value basis. A regulator asked if this penalty structure would lead to all policies being noncancellable. The chair responded this would be ideal, but no insurer could issue noncancellable policies in today’s marketplace because there is so much uncertainty. Another regulator asked about states that do not have actuaries on staff and the chair responded that it should be easier for those states because they can use the 58%—85% formula. **2000 Proc. 1st Quarter 336.**

The derivation for the 58% loss ratio minimum was the traditional 60% loss ratio reduced by a 2% allowance for policy fee expenses. **2000 Proc. 2nd Quarter 1113.**

G. A regulator noted that the approach in Section 20 seems to cap the number of rate increases instead of the initial premium filings. There was discussion about whether this might put an insurer out of business. An industry spokesperson disagreed, saying an insurer would go out of business only if it filed inadequate initial rates on a continuous basis. **2000 Proc. 1st Quarter 336.**

Section 21. Filing Requirement

This section was added to the initial model just before its adoption. The long-term care subgroup met with the advisory committee to consider amendments to the Long-Term Care Insurance Model Act and decided to amend the regulation to address the extraterritoriality issue. The regulation was amended to require a filing from insurers prior to the offering of group long-term care insurance which would include evidence that the policy has been approved in the state where offered and that statutory and regulatory long-term care insurance requirements here are substantially similar to those adopted in the state in which it is offered. **1988 Proc. I 656.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 22. Filing Requirement for Advertising

The task force considered two alternatives: a requirement to file advertising or a requirement to retain the advertising for three years rather than to file it with the department. One reason to consider not filing was a concern that companies would place some significance on the mere fact of filing the material with the department. There was discussion concerning the fact that a “filed” stamp in some states was tantamount to approval and there was further discussion on whether this causes serious difficulty for departments. One commissioner expressed the opinion that the requirement should be at least as stringent as that for Medicare supplement advertisements. The task force voted to require filing of advertising for review or approval to the extent required by state law, identical to the Medicare supplement requirement. In addition, the task force agreed to require companies to retain the materials for at least three years from the first date of use of the advertisement. **1991 Proc. IB 715-716.**

Section 23. Standards for Marketing

In June of 1990, the chair of the task force on long-term care stated that he had become increasingly uncomfortable with the potential for marketing abuse in the area of long-term care insurance. He suggested a member of substantive amendments to the models to address the problem. **1990 Proc. II 619.**

A. The last half of Paragraph (4) was added as part of the amendments in response to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under HIPAA the requirement that an applicant be asked suitability questions does not apply to tax-qualified plans. The chair commented that it did not seem correct to say that marketers of tax-qualified plans did not need to research suitability. **1998 Proc. 4th Quarter II 766.**

Paragraph (3) was added with the 2000 amendments. The requirement is in addition to the Section 9 requirement to provide the disclosure form at the time of application. An industry spokesperson commented that this was unnecessary, but the working group decided that the section on marketing standards should be separate and distinct from the application process. **2000 Proc. 2nd Quarter 311.**

An interested party commented that Subsection A(8), which provides an explanation of contingent benefit upon lapse for marketing purposes, was unnecessary since it will be explained during application in the appropriate appendices. The working group believed this provision should also remain in the model. **2000 Proc. 2nd Quarter 311.**

B. Subsection B(4) was adopted because HIPAA contained a prohibition against material misrepresentation for tax-qualified plans. The working group was asked to consider applying it to all policies. **1998 Proc. 4th Quarter II 766.**

C. Subsection C was added to the model in December 1992. **1993 Proc. IB 847.**

The purpose of the amendment was to place responsibilities on an association in its endorsement or sale of a long-term care insurance policy. **1992 Proc. IIB 685.**

The concern of the consumer groups represented was that there should be disclosure of the financial arrangements between associations and the insurers selling through the associations. **1992 Proc. IIB 694.**

The issue of what kind of financial information to disclose is problematic. The task force suggested requiring the association that is endorsing or selling long-term care insurance policies to provide ratings of the insurers. Task Force members agreed further work needed to be done on the issue of financial disclosure. **1993 Proc. IB 843.**

While preparing the draft the task force considered what enforcement mechanism could be added. The first alternative would require the insurer issuing the policy to file and disclose the information required, and failure to comply would constitute an unfair trade practice. The second alternative would place the burden of compliance on the association, but most states would probably require a legislative change to bring the association itself under the jurisdiction of the insurance commissioner. **1993 Proc. IB 853.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 23C (cont.)

Consumer representatives and task force members expressed a preference for requiring the insurers, as opposed to the associations, to comply. It was also suggested that insurers be required to certify to the insurance department that they have complied with the section. **1993 Proc. IB 852-853.**

The enforcement mechanism included in the draft adopted consisted of a filing requirement and a certification requirement. The task force expressed an intention to pursue the addition of an unfair trade practice violation after coordination with the subcommittee dealing with that issue. **1993 Proc. IB 843.**

In 1993 an amendment was adopted to the section on association responsibilities and to the Unfair Trade Practices Act. The new Paragraph (9) added a violation to the Unfair Trade Practices Act to that section. **1993 Proc. 1st Quarter 276.**

The provisions of the Health Insurance Portability and Accountability Act (HIPAA) does not require associations to meet certain marketing requirements in the model. Paragraph (6)(d) was added to exempt associations from those requirements. **1998 Proc. 4th Quarter II 766.**

Section 24. Suitability

As part of the consumer protection amendments of 1990, a provision was added to the model requiring simply that an agent make reasonable efforts to determine the appropriateness of a recommended purchase. **1991 Proc. IB 710.**

In mid-1993 a working group was appointed to consider the suitability of purchases of long-term care insurance. The group's first thought was to revise the Long-Term Care Shopper's Guide and prepare a worksheet to assist purchasers in their decision-making process. The chair of the working group indicated that the shopper's guide could be enhanced by a lengthier discussion about the appropriateness of purchasing long-term care insurance. **1993 Proc. 2nd Quarter 752, 759.**

By the time the working met next in August of 1993, the group had realigned the response to its charge. Instead of amending the shopper's guide, the working group planned to develop a worksheet to be used by purchasers and by senior counseling programs to determine whether purchasers have appropriate and sufficient resources to buy a policy. The goal was to produce a document that was easily understood and that could be reproduced by states and counseling programs. **1993 Proc. 3rd Quarter 465-466.**

In determining what kind of suitability standards would enhance the existing provisions in the NAIC Long-Term Care Insurance Model Act and Regulation, the working group reviewed a chart indicating that the majority of purchasers did so to avoid dependence. The group also reviewed a report that indicated companies do not avoid selling to low-income individuals. Members concluded that it would be appropriate to develop a suitability standards section for the model regulation.

An NAIC staff member indicated that some time earlier the NAIC had considered including language requiring agents to ascertain a purchaser's income and asset levels, but at that time the members had concerns about purchasers divulging that information to an agent. Members expressed concern also about identifying strict dollar amounts above or below which an individual should purchase coverage. **1993 Proc. 3rd Quarter 468-469.**

One regulator said he had analyzed the debate on the nonforfeiture issue and through that process had learned that many policies are sold inappropriately to individuals. He said the working group should impose more stringent suitability standards. He had originally thought agents should be required to obtain certain relevant information, but now he understood why this might not be prudent. He said he favored an approach creating a minimum suitability standard—not a specific dollar amount, but a question about whether prospective purchasers were above or below a certain income level. **1993 Proc. 3rd Quarter 467.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 24 (cont.)

The chair said she was concerned about setting a minimum standard because there were reasons other than economics why individuals should not purchase a policy. She also expressed reluctance to set a standard that required a suitable sale, and then did not allow agents to obtain the necessary information to accomplish that. **1993 Proc. 3rd Quarter 467.**

By late 1993 the working group had developed a new section for the long-term care regulation and a worksheet to help an individual determine whether insurance was affordable. The worksheet (which became Appendix B) helped the person articulate the reasons for purchasing long-term care insurance and then used a chart to determine whether there was money to cover its cost after payment of expenses for necessities. The draft of model language required insurers to train their agents in the use of listed standards for determining whether the individual was a suitable candidate for purchase of long-term care insurance. **1993 Proc. 4th Quarter 714-717.**

One regulator responded to the draft by saying it was appropriate to require agent training; he said it was not possible to educate all the consumers. He supported adding a provision placing the burden or proof regarding suitability on the insurer and agent. **1993 Proc. 4th Quarter 712-713.**

The working group considered replacing the language adopted in 1990 that required an agent to “make reasonable efforts” to determine appropriateness. An industry representative opined that this was a dramatic shift from the existing model language. Another suggested that an agent would need a clearer definition of what was required and would need protection if the applicant gave incorrect or incomplete information. A consumer representative emphasized the importance of keeping the agent from delving too deeply into information about the consumer’s finances. The chair said the draft contained numbers for minimum assets and income to respond to that concern, but she was not comfortable with that either because the numbers may not be good for very long. **1993 Proc. 4th Quarter 713.**

An agents’ association representative spoke in favor of making the standards as objective as possible. His concern was the possibility of the insurance department second-guessing the agents and insurers after they have acted in good faith in a manner they thought was appropriate. **1994 Proc. 1st Quarter 453.**

A. One attendee asked if it was the intent of the drafters to apply the model provisions to life insurance products with long-term care riders. The group was informed that one state’s program differentiated based on the trigger. If the trigger for accelerated benefits did not specify that the payment would be used for long-term care, the life product was not covered by the rules on long-term care insurance. If the benefits were limited to long-term care, the product would be covered by the rules. **1994 Proc. 2nd Quarter 601.**

The working group considered as its next meeting how to deal with life insurance policies that had long-term care insurance riders. One company representative said that the rider typically was 5% of the total purchase price, and for that reason she did not feel the suitability standards were appropriate. She said if the working group decided to address long-term care riders there would have to be many changes to the personal worksheet. The working group decided to exclude from the personal worksheet requirement those life policies with a long-term care rider where neither the benefit nor the eligibility for the benefits was conditioned upon the receipt of long-term care. **1994 Proc. 3rd Quarter 621.**

A representative from a life insurer said she had been under the impression life insurance would be excluded from the model regulation and she did not see that in the draft. A regulator responded that the motion was to exclude all life policies that were not considered long-term care policies by the definition in the Long-Term Care Insurance Model Act. She said a typical accelerated benefits rider in a life insurance policy was triggered by one of four situations: (1) terminal illness; (2) specific disease; (3) permanent nursing home confinement; (4) long-term care benefits, using benefit triggers. She said it was the intent of the working group that situation number four would be covered under the suitability standards. **1994 Proc. 3rd Quarter 613-614.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 24 (cont.)

The chair asked an insurer representative to explain her view of why life insurance policies with long-term care riders should not be included in the model. She described the life insurance sales process and said that the rider to provide long-term care benefits was generally 5% to 7% of the premium, so it was difficult to imagine an unsuitable purchase because of the low cost. She also pointed out that life insurance was a much more mature market and she was not aware of any complaints on the issue of suitability. A consumer representative expressed concern that life insurance was increasingly being exempted from long-term care insurance provisions. A regulator expressed concern that use of the disclosure form would add to the impression the coverage was long-term care insurance. The working group voted to exclude all life insurance policies with long-term riders from the draft. **1994 Proc. 4th Quarter 737.**

B. The working group decided to revise the draft regulation to require that insurers develop suitability standards and train their agents in their use. The chair asked how the department would evaluate insurance companies' standards, and another working group member responded that unless the standards were egregiously inadequate, the department would accept them because the standards had been the responsibility of the insurer. **1994 Proc. 1st Quarter 454.**

The working group decided it was inappropriate to set dollar amounts for a suitable purchase. The draft of the model under consideration in early 1994 contained components that would help a company develop standards for its own use in determining suitability. The standards would be used to train the sales force and the agents would be required to use the standards. **1994 Proc. 1st Quarter 454.**

A representative from an association asked about the situation where a person did not want to divulge financial information. He asked what the agent's responsibility was, and a regulator responded that the company's standards might allow the agent to infer affordability by looking at the home and furnishings. A consumer representative suggested the model require insurers to file their suitability standards so that the commissioner would know they had been developed. The chair expressed concern that filing implied review or approval and said the department could review the company's suitability standards during a market conduct examination. **1994 Proc. 1st Quarter 450.**

Another issue discussed by the working group was whether companies should maintain their suitability standards for inspection by the commissioner or be required to file them. The chair asked if it would be appropriate to make the suitability standards available to the public on request. An industry response was concern about giving that information to the competition. **1994 Proc. 3rd Quarter 621.**

The working group agreed that the material on the personal worksheet was a minimum requirement. An insurer might need a more extensive set of questions in its screening to implement its own suitability standards. One regulator asked if there would be a filing of the personal worksheet to allow regulators to review the questions that were added by the insurers. Another responded that, if the personal worksheet were legally part of the application, it could be reviewed when the application was filed, but the working group decided against making the worksheet part of the application. **1994 Proc. 3rd Quarter 619.**

The working group considered whether the personal worksheet should be made part of the application. Concerns raised were that this would allow the insurer to rescind the policy if the income had been misstated. The chair said if the working group did decide to make the worksheet part of the application, it would not be allowed to be used as the basis for rescission. Another concern was the administrative burden of refile every time the worksheet changed. The working group decided to require that the personal worksheet form be presented to the consumer no later than at the time of application and that the policy not be issued without receipt of the form. The group agreed that a completed worksheet included one where the applicant had checked the box saying he did not want to fill out the form. A consumer representative expressed concern that agents might encourage applicants to choose the box saying they did not want to provide information because that would be easier. **1994 Proc. 3rd Quarter 621.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 24B (cont.)

The question of whether to make the personal worksheet part of the application was discussed further. The purpose would be to assure that the information would be reviewed by the insurance department. Insurers saw this as a problem because in some states it took a long time to get approval of a policy form. Several suggested it would be appropriate to file the personal worksheet without making it part of the application, and the working group agreed this was a solution to the problem. **1994 Proc. 3rd Quarter 614.**

The working group was asked if the standards would apply to the group market. An insurance representative said he thought the group market needed to be treated separately because the company did not get information from the employee, and was concerned with how the mechanics would be handled in a group situation. **1994 Proc. 2nd Quarter 600.**

The working group heard information to help it decide whether to apply the suitability standards to group policies. The group heard about the group insured population, reasons why purchases are made, and about the group long-term care insurance enrollment process. The premium was generally paid by the employee, although there might be a partial contribution by the employer, but coverage was offered to spouses, parents and parents-in-law and that type of coverage was underwritten. In response to a question about cost, he said there were some economies for group sales so his company generally charged about 30% less in the group market. Another insurer representative said that in the small group market, employees were more likely to be underwritten. **1994 Proc. 3rd Quarter 620.**

The chair asked industry representatives to answer the question: “Why do you believe the suitability standards should not apply to group insurance?” One responded that, in soliciting group insurance, the company does not develop a personal relationship with the insured, but rather deals with the employer. Another responded that, if the sale was not agency based, it was very difficult to get the kind of information that would be required under the suitability standards. He suggested that association groups should have the same treatment as employer groups. Another responded that an association that targets the seniors market is much different from an employer group. The personal worksheet was designed to help an older person; affordability was not an issue in the employer market, so it was inappropriate to ask questions about whether the individual could afford the coverage. Another insurer said the sales process was much different in a group market. He did not believe the personal worksheet was appropriate for the employer group market because of a concern about confidentiality. One regulator said he saw a need to make a distinction between the employer group and association groups. He said association groups in many states came close to marketing the way individual policies are marketed. **1994 Proc. 3rd Quarter 620.**

The chair said the working group had several options: (1) no exemption for the group market; (2) exempt the entire group market; (3) exempt active employees; (4) exempt active employees and their spouses; (5) exempt employer groups; or (6) exempt guaranteed issue policies. He said he was comfortable with exempting the group market from a requirement to use the personal worksheet, but he felt they should get the disclosure form. Another regulator saw a need for parents and relatives to get the information. One attendee suggested exempting individuals who were below a certain age from the personal worksheet requirements whether they were in the individual or group market. One company representative opined that it was a violation of age discrimination laws to treat older employed persons differently than younger employed persons. Another person suggested that exempting active employees and their spouses would alleviate the problem and another suggested exempting persons who were actively at work, even if they were in the individual market. The working group agreed to exempt long-term care insurance policies sold through an employer group to active employees and their spouses from a requirement to obtain a personal worksheet from each applicant. The worksheet would be provided to people of all ages. **1994 Proc. 3rd Quarter 620.**

E. Since the personal worksheet required financial information, there was a need to include a provision preventing other use of this information by the agent or the company. A regulator suggested the draft say the information was confidential. **1994 Proc. 3rd Quarter 614.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 24 (cont.)

G. An industry representative asked the working group to add a sentence to the end of Subsection G that said an applicants' returned letter or verification "shall be conclusive evidence of the insurer's compliance." A regulator asked why this situation was different from any other regulatory requirement of a company, and the response was that the insurer was serving more as a counselor than an insurer. Another insurer representative pointed out that the company would be able to avoid liability if an individual were to say the suitability standards were not appropriate and he should have been able to obtain coverage. A regulator opined that if a company was looking for assurance that its standards were appropriate, this provision would not provide it. Regulators agreed specific language was not needed in the regulation. **1994 Proc. 4th Quarter 731.**

H. The working group decided to consider adding a requirement for insurers to compile statistical data on the number of letters sent, the number who chose to confirm after receiving a suitability letter, and the number who declined to provide information, as compared to the total number of application. **1994 Proc. 3rd Quarter 622.**

Section 25. **Prohibition Against Preexisting Condition and Probationary Periods in Replacement Policies or Certificates**

Comments received on this section of the draft advocated eliminating any prohibition against new preexisting condition requirements on replacement policies. There was discussion on whether waiting periods, probation periods and elimination periods should be retained in the draft. It was suggested that waiting periods refer to the time period that must pass before coverage is effective and that elimination periods refer to the time period which must be met once a policy is purchased and before any collection of benefits. The task force agreed that probationary periods are essentially equivalent to waiting periods and concluded that reference to elimination periods should be removed from the draft. In the Medicare supplement area elimination periods are appropriate, but not in the long-term care insurance area, so the phrase was removed from the draft. **1991 Proc. IB 716.**

Section 26. **Nonforfeiture Benefit Requirement**

[See the commentary for the nonforfeiture requirement in the Long-Term Care Insurance Model Act, beginning on page 640-26 for early discussions of the concept of nonforfeiture benefits for long-term care insurance.]

Once a nonforfeiture benefit requirement was included in the model act, discussion turned to how to implement the requirement. The task force considered principles for the development of nonforfeiture benefits: (1) the shortened benefit period approach should always be included as an option; (2) the shortened benefit period approach must meet or exceed minimum standards prescribed by law. The task force also recommended that the commissioner permit additional forms of nonforfeiture benefits to be offered subject to those benefits meeting or exceeding minimum standards prescribed by the commissioner. However, the task force preferred providing nonforfeiture benefits in the form of long-term care payments rather than cash. The regulators were urged to provide flexibility to change rating requirements and policy provisions in response to federal legislation, which could greatly change the way long-term care is delivered. **1993 2nd Quarter 750.**

The NAIC's discussions on nonforfeiture and rate stabilization were carried on concurrently. One working group member emphasized that for rate stabilization to be successful, an established nonforfeiture scheme should be in place. **1993 Proc. 2nd Quarter 758.**

After some discussion of public-private partnerships, it was agreed to add a drafting note that would state that there might be situations where the public-private partnerships should be exempt from the mandatory inclusion of nonforfeiture benefits. **1994 Proc. 4th Quarter 724.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 26 (cont.)

A report on nonforfeiture said the critical issue was to balance the dual objectives of meaningful benefits with affordable cost. Of particular interest was at what duration and amount to start benefits and how rapidly to increase them. While there were other considerations which should be taken into account, comparisons should be made between the scale ultimately adopted and the “asset share scale” to ensure that reasonable equity between terminating and persisting policyholders was maintained. **1993 2nd Quarter 753.**

A. The model contained a requirement in Subsection A that every policy or certificate contain nonforfeiture benefits. That sentence was deleted when the 1998 amendments were adopted. **1998 Proc. 1st Quarter 802.**

B. While reviewing issues of rate stabilization in the summer of 1997, discussion turned to the nonforfeiture benefit. One regulator stated that the addition of a limited nonforfeiture benefit was intended by the task force when it adopted the concept of mandatory nonforfeiture in long-term care insurance. The real reason that cash benefits were not added to the nonforfeiture provision was so that the insured would not be forced into getting nothing of value upon lapse. **1997 Proc. 2nd Quarter 757.**

Another regulator suggested that mandatory nonforfeiture may need to be revisited. When the issue was addressed earlier, the standards may not have fit the marketplace. Another regulator said her state had attempted to place mandatory nonforfeiture into its regulation, but only a mandatory offer of nonforfeiture was eventually included. **1997 Proc. 2nd Quarter 757.**

An insurer representative stated that nonforfeiture benefits have been selected by less than one percent of insureds, and that the selection of nonforfeiture added 25 percent to the policy premium. **1997 Proc. 3rd Quarter 1351.**

A representative from one state described the provisions in place in his state. He described an industry suggestion for contingent nonforfeiture, where the policyholder had the opportunity to elect a nonforfeiture benefit in the event a policy's rates were increased above a certain threshold. **1997 Proc. 3rd Quarter 1352.**

An interested party opined that the cost of contingent nonforfeiture would be less than a voluntary nonforfeiture benefit. He suggested a contingent nonforfeiture would provide some residual benefit, without adding substantial cost to the policy. An insurer association representative said that contingent nonforfeiture would address the concern about companies deliberately underpricing the cost of coverage. **1997 Proc. 3rd Quarter 1353.**

During a nonforfeiture discussion, one suggestion put on the table was to allow a consumer to buy down, or reduce benefit levels in lieu of accepting a rate increase and retaining the original benefit levels. **1997 Proc. 3rd Quarter 1353.**

An interested party suggested that a contingent nonforfeiture benefit could be developed based on a formula including the attained age of the policyholder, the duration of the policy, equity interest, and other factors. **1997 Proc. 3rd Quarter 1353.**

The task force identified the concept of contingent nonforfeiture as an idea with promise. The benefit would be a shortened benefit period similar to the dollar amount in the original policy, with a reduced benefit period. The trigger would be based on a cumulative increase over the lifetime of the policy, based on the initial premium. **1997 Proc. 3rd Quarter 1342-1343.**

The working group considered an industry suggestion for a period of time when the contingent nonforfeiture option could be utilized by the insured. The industry representative said there should be a time period following the effective date of the triggering event during which the insured must elect the contingent nonforfeiture benefit. The insurance industry supported an election period of 90 days. One regulator said his state's provision is five months, and he said a longer election period would provide consumers more time to make a decision. **1997 Proc. 3rd Quarter 1343.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 26B (cont.)

A regulator suggested there were several ways to pay for contingent nonforfeiture: (1) include the cost in the initial premium; (2) decrease profits for the insurer; (3) increase losses for the insurer; or (4) increase rates. An insurer representative responded that he disliked rate increases because they resulted in more lapses, which caused more increases, etc. in a spiral. **1997 Proc. 4th Quarter 937.**

A regulator clarified that every time there is a rate increase, even though the contingent nonforfeiture benefit has already been triggered, the insured would have the opportunity to elect the contingent nonforfeiture benefit again. **1997 Proc. 4th Quarter 941.**

Three different approaches were discussed as triggers for the contingent nonforfeiture benefit. An industry trade association proposed a trigger when the insured's issue age 65 premium increased by 50 percent or more over any three-year period. An alternative was suggested by one state that takes the insured's rates at age 65 and triggers contingent nonforfeiture when the rates are increased by 50 percent or more over the lifetime of the insured. Another state suggested a graduated system based on the insured's age, with different levels of rate increases over the insured's lifetime triggering contingent nonforfeiture benefits. **1997 Proc. 4th Quarter 935.**

A regulator said it was important to the process that any amended models have industry support at the state level. **1997 Proc. 4th Quarter 907.**

D. The provisions of the new Subsection D adopted in 1998 contained brackets for premium changes at younger ages and then changed every year to age 90. The task force noted it was trying to protect the older population from significant rate increases that could result in lapse with no benefits for premiums previously paid. **1998 Proc. 1st Quarter 894.**

E. When originally developing nonforfeiture benefits, there was a strong preference of the task force that only one scale of nonforfeiture values be used. There were two choices theoretically possible: (1) as a percent of the benefit period (so that the actual benefit would vary according to the duration of benefit provided), or (2) as a fixed benefit period (so that all insured would receive the same nonforfeiture benefit, regardless of the actual duration of the benefits that would have been available during the premium-paying period). Given that the nonforfeiture benefits purchased by asset shares increase for all attained ages as the underlying benefit period increases, it seemed most appropriate to express the nonforfeiture benefit as a percentage of the benefit period. **1993 2nd Quarter 753.**

A report containing proposed principles for the development of nonforfeiture benefits said one issue remaining was whether to vary nonforfeiture scales by issue age. Generally, a nonforfeiture scale that reflected realistic asset shares would generate positive values at earlier durations for older issue ages, but would have steeper slopes for the younger issue ages. In other words, the nonforfeiture scales would generally start out lower for younger issue ages, but would increase more rapidly so that the nonforfeiture scale would eventually be higher for these issue ages. **1993 2nd Quarter 753.**

Questions were raised in the actuarial report to the task force as to whether the nonforfeiture benefits should be fixed at the time of issue, or whether some adjustment should be allowed subsequent to the time of issue, *e.g.*, prior to the time of entry into nonforfeiture status or prior to the time nonforfeiture benefit payments begin.

It should be remembered that most lapses are projected to occur before even one year of institutional care would be provided as a nonforfeiture benefit. Subjecting these lapsing policyholders to the risk that this benefit could be reduced may result in situations where the benefit is diminished to inappropriately low levels. **1993 2nd Quarter 754.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 26E (cont.)

It was estimated that the cost of providing a nonforfeiture benefit actuarially equivalent to the asset share would raise the premium 7%–13% at issue age 75 to 64%–232% at issue age 35, depending on whether or not inflation protection was provided. In terms of dollar amounts, the premium for a plan of benefits increased from approximately \$100–\$200 for policies without inflation protection to \$600–\$1000 for policies with inflation protection. **1993 2nd Quarter 754.**

The report emphasized a number of points in regard to the increased costs for nonforfeiture benefits: (a) A 20% increase in the assumed costs for insureds in nonforfeiture states was assumed. This assumption was made to recognize the additional risk to the insurance company for the noncancellable nature of these risks. Further study may lead to the conclusion that this represents an unfair subsidy of the persisting policyholder by those who lapse. (b) The 60% loss ratio may not be appropriate if nonforfeiture benefits are mandated. The use of a higher loss ratio would lower the cost of this benefit. (c) Some adjustment in the nonforfeiture scale for policies incorporating inflation protection should be considered. In particular, adjustments at the younger age may be appropriate. (d) Consideration might be given to providing some flexibility in the application of inflation protection. For example, the benefits could be structured so that the inflation protection is frozen when the insureds go into benefit status. The benefit could be “unfrozen” after the insureds have not received any long-term care benefits for a specified period of time. (e) Interest rates incorporated into the pricing of the product will have to be closely monitored in order to avoid situations where excessive premiums result because interest assumptions are too low. **1993 2nd Quarter 754.**

In addition to the shortened benefit period form of nonforfeiture benefit, the actuarial group also considered extended term insurance, reduced paid-up insurance and cash surrender value. Desirable features of a cash surrender value are: (1) Flexibility to the policyholder; (2) Minimized risks for the insurer and persisting policyholders; and (3) Low administrative expense for the insurer. Difficulties associated with cash surrender values include: (1) A death benefit should also be required, but this would make the premium higher; (2) The availability of a cash surrender value may induce lapses; (3) The providing of cash is contrary to the purpose of long-term care policies, which is to provide benefits in the event of institutionalization or receiving home health care; and (4) Income tax implication of a cash surrender value are not clear. **1993 Proc. 2nd Quarter 754-755.**

The regulators suggested that one specific scale of nonforfeiture values that applies to most benefit plans should be created. That would mean that all durations of benefits, elimination periods, etc., would be specified rather than creating differing scales for various levels of benefits. **1993 Proc. 2nd Quarter 758.**

Another issue considered by the task force was whether the standards set in the model should be minimum or absolute standards. At a hearing in August of 1993, a representative of an insurance trade association spoke for minimum standards, while a consumer representative favored absolute standards. She stated simplicity was needed in the nonforfeiture standards since this would better assure consistency in implementation. **1993 Proc. 2nd Quarter 485.**

An actuary was retained to study the technical issues related to nonforfeiture and to prepare a report for the task force. His report discussed the effect on rate filing reviews and raised questions relative to loss ratios. The report suggested some ways to mitigate premium increases, such as a longer elimination period while under a shortened benefit period, different benefit periods for nursing or home health care, and other benefit design possibilities. The report also discussed the interpretation and use of a scale produced by asset shares. **1993 Proc. 3rd Quarter 474-480.**

The working group minutes for the December 1993 meeting contain charts and graphs to help the group in its consideration of shortened benefit period scale adjustment factors, including scales with and without inflation protection. **1993 Proc. 4th Quarter 694-701.**

In response to the memo, the chair said the working group was looking for an equitable scale so that those who lapse do not subsidize other policyholders and are not subsidized extensively themselves. **1994 Proc. 1st Quarter 463.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 26E (cont.)

One regulator wrote a memo expressing his concerns about the direction being taken by the working group. He urged consideration of the “benefit bank” approach because it was easier to use than the shortened benefit period. He also encouraged development of a *minimum* scale, which would be fair to those continuing coverage. The regulator also expressed concern that the provisions adopted should be understandable to consumers. **1994 Proc. 1st Quarter 465-466.**

Another attendee asked why the benefit bank approach had been disregarded. The response was that the benefit bank was not as theoretically sound and it made comparisons of policies by consumers much more difficult. The increase in premiums resulting from the benefit bank approach would be even higher than the scale under current consideration. **1994 Proc. 1st Quarter 464.**

The working group discussed another earlier recommendation: Nonforfeiture scales should differ only for differing benefit periods. One industry representative in attendance said each of the recommendations of the working group displayed a move to richer benefits and increased prices, which would discourage consumers from buying the product. An industry association representative suggested that policies with different benefit periods for different benefits would be difficult to explain to consumers and difficult to administer. The chair said he did not think benefit periods should vary because of age because the variances calculated were not especially great and the working group was interested in promoting consistency in the benefits offered. **1994 Proc. 1st Quarter 464.**

The working group talked extensively about developing different benefit scales for differing benefit periods. Those not in favor of this approach pointed out that this moved away from the goal of developing a simple, easily understood nonforfeiture benefit. **1994 Proc. 1st Quarter 462.**

The working group chair said he thought the benefit bank approach had significant advantages over the shortened benefit approach in terms of simplicity, ease of understanding, ability to handle changed circumstances, and more limited impact on affordability of the product. Another regulator said he felt if the goal was simplicity and ease of comparison, he did not think this was a viable approach. The chair said he was not willing to discard the benefit bank approach in view of its superiority in a real-world setting, but he acknowledged the need to move ahead with the shortened benefit approach. **1994 Proc. 1st Quarter 463.**

An association representative was asked to report on several issues. He stated that the use of asset shares and equity as the origin of nonforfeiture minimum standards lead to multiple scales based on different risk criteria and benefit arrangements. This makes a nonforfeiture benefit more difficult to explain. Several insurers suggested an alternative minimum standard where the benefits are based on the total amounts paid over the period of coverage. A regulator responded that the essential difference was that the scale in the NAIC draft provided that the policyholder who lapsed after ten years obtained 20% of the benefit purchased as a paid-up benefit. The benefit bank proposal placed all premiums paid over the period of coverage in a benefit bank. Upon lapse, the nonforfeiture benefit could be estimated by dividing the benefit bank by the daily benefit. For example, a policyholder who paid \$1,000 annually for ten years for a policy providing a \$100 daily benefit would receive 100 days of coverage upon lapse, assuming the full \$100 daily benefit was utilized. **1994 Proc. 2nd Quarter 604.**

When reporting on the progress of the working group assigned to draft a nonforfeiture benefit provision for the model regulation, the regulator said the working group had focused its efforts in designing and implementing a shortened benefit period approach for nonforfeiture benefits. He indicated the group had drafted a regulation that defines and implements the benefit with a table using an asset share for determining the values of the benefit. He said the industry was strongly opposed to this approach and preferred a benefit bank. **1994 Proc. 2nd Quarter 603-604.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 26E (cont.)

By August of 1994 the working group was considering two alternative approaches to the nonforfeiture benefit. In addition to the approach they had been considering with a prescribed scale for the shortened benefit period, a draft was submitted with a benefit bank equal to 100% of all premiums paid. The alternative draft had first contained 80% of all premiums paid, but the group decided it would have to be at least 100%. They also discussed attempting to create a factor on the basis of the age-weighted percentages utilizing factors that attempt to approximate the underlying asset share percentage. **1994 Proc. 3rd Quarter 605.**

One of the concerns was about a benefit structure when nonforfeiture benefits were paid up to an amount equal to 100% of all premiums paid. The chair questioned how its benefit could be communicated so that the consumer would understand that there is no cash surrender value. **1994 Proc. 3rd Quarter 601.**

A regulator asked if the proposal was to consider all the premiums paid, or total premiums less claims paid. The response was that the proposal was for total premiums paid irrespective of any claim payments. It was also noted that the proposal attempted to deal with the problem of a person who had purchased at a young age with a small premium by requiring a 30-day minimum benefit period. **1994 Proc. 3rd Quarter 596.**

After discussion, the working group agreed to recommend that the prescribed nonforfeiture scale should begin no later than the third policy year and should apply equally to institutional and non-institutional care. **1993 Proc. 4th Quarter 703-704.**

The working group reviewed its earlier decision to require a nonforfeiture benefit no later than the end of the third year following issue. Some in attendance argued for a five-year period, while others thought three years provided a meaningful benefit. One industry representative suggested three years would promote abuse by agents. The chair said policing agents was a better solution than adopting a different time period. **1994 Proc. 1st Quarter 464.**

The working group discussed whether or not inflation protection should be included after the shortened benefit period status began. Several working group members expressed concern about the provision and its impact on the cost of the benefit. **1994 Proc. 1st Quarter 462.**

A decision was made in September of 1994 to discontinue inflation protection at the point that premium payments cease. Several comments were made pointing out that providing inflation protection after lapse increased the cost of the nonforfeiture benefit. It was also noted that the level of nonforfeiture benefits could have implications for the policyholder's eligibility for Medicaid. **1994 Proc. 3rd Quarter 600.**

Paragraph (4) was modified during the discussion of the 2000 amendments on rate stabilization. References to the contingent benefit on lapse were moved within Paragraph (4) and modified. **2000 Proc. 2nd Quarter 304.**

G. One of the principles agreed upon by the working group was that there should be no difference in the nonforfeiture benefits mandated for group and individual policies. One regulator expressed concern that the inclusion of high nonforfeiture values in group policies would discourage employer group products with a significant employer contribution. Another regulator pointed out that the current tax law is a significant deterrent for policies with employer contributions and that until the tax code is changed, employers are not likely to pay premiums on behalf of employees. She expressed concern about the applicability of nonforfeiture values for a certificateholder that converts from a group policy. An insurer representative said that the conversion could be based on the original purchase date of the group coverage. **1994 Proc. 1st Quarter 463.**

K. Subsection K was added as part of the 1999 amendments. **1999 Proc. 4th Quarter 985.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 27. Standards for Benefit Triggers

A working group was appointed in June 1994 to evaluate and determine if development of standard benefit triggers was appropriate and feasible in long-term care insurance policies. This charge arose out of a variety of problems dealing with claim payment issues for consumers. **1994 Proc. 2nd Quarter 599.**

One of the goals of the drafters was to create a level playing field for all policies and allow consumers to know what they are purchasing and what to expect if they need benefits under the policy. **1994 Proc. 3rd Quarter 606.**

Attendees at a working group meeting discussed the “medical necessity” test used in many long-term care insurance policies. Regulators, consumer representatives and insurance industry representatives all expressed discomfort with this method and the difficulties it posed. **1994 Proc. 3rd Quarter 612.**

The drafters agreed that it was important to define activities of daily living and to define the level of assistance needed to trigger inability to perform the activity. It was suggested to the working group that it should standardize not only the definitions, but also the level of impairment that triggers benefits. **1994 Proc. 3rd Quarter 608.**

The working group discussed the pricing implication of a movement toward activities of daily living as benefit triggers. A consulting actuary said the insurance industry did not have significant data relative to pricing implications. He used data available from other settings to give some indication to the working group. **1994 Proc. 3rd Quarter 607.**

One comment received by the working group was that bathing should be considered an activity of daily living, and that it was often one of the first things an individual could not perform without assistance. The comments also pointed out the need to deal with direct assistance versus stand-by assistance. **1994 Proc. 3rd Quarter 607.**

The drafters decided to use an existing state regulation as the starting point for its deliberation. A consumer representative opined that, in addition to the performance of activities of daily living, the group needed to add cognitive impairment as a benefit trigger. **1994 Proc. 3rd Quarter 608.**

The chair of the working group opined that there were three issues to consider: (1) definition of the activities of daily living, (2) the number of activities of daily living that trigger benefits, and (3) the level of impairment that determines a person’s ability to perform. **1994 Proc. 4th Quarter 719.**

Medical personnel from one insurer agreed that the issue of level of assistance was important, as some companies test for a person needing stand-by assistance to trigger the benefit and others use a test that determines a person’s need for direct assistance in his or her ability to perform the activity. A consumer representative stated that this was the primary problem in the marketplace that needed to be addressed. **1994 Proc. 4th Quarter 719.**

The working group discovered that an industry standard of sorts for activities of daily living existing in a Sidney Katz study. The group was encouraged to start with the Katz definitions and use them for benefit triggers as there had been a great deal of research done on these triggers and their use. **1994 Proc. 4th Quarter 719.**

A. One of the tasks of the drafters revising the model to include benefit triggers was to decide how many deficiencies of activities of daily living would be required to trigger benefits. The model was drafted to require benefits when a person was unable to perform three out of the six activities of daily living, but it would allow companies to use a more lenient standard such as two out of six. The chair noted this would apply to home health care benefits as well as nursing home benefits. One participant reported on studies showing an increase in utilization of as much as 42% if two out of six, instead of three out of six, activities of daily living were used. **1995 Proc. 1st Quarter 577.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 27A (cont.)

One consumer representative suggested drafting the model with a two out of six trigger for home health care, and a three out of six trigger for nursing home care. A regulator asked if it was appropriate to allow companies to offer a four out of six activities trigger at a lower cost. The consumer representative said it was not possible for consumers to make informed decisions in this marketplace. **1995 Proc. 1st Quarter 578.**

C. After drafting a provision that specified six activities of daily living and requiring a benefit trigger of no more than three of the six, the drafters agreed that they wanted to allow provisions that were innovative and less restrictive. Subsection C was designed to provide for that flexibility. **1995 Proc. 1st Quarter 578.**

D. After discussion of whether the standard for assistance should be stand-by or hands-on assistance, the drafters decided to use hands-on assistance as a measure to determine a person's deficiency in performing activities of daily living. **1995 Proc. 2nd Quarter 651, 654.**

Section 28. Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts

Section 28 was added as part of the revisions developed in response to the Health Insurance Portability and Accountability Act (HIPAA). This section describes benefit triggers for qualified long-term care insurance contracts. Staff noted that the structure for chronically ill individuals was difficult, and said that the U.S. Treasury Department would issue definitions, but states might not want to wait for them. **1998 Proc. 3rd Quarter 719.**

An interested party expressed a preference for waiting until Treasury offered further guidance before amending the models, but acknowledged that, since these were not forthcoming, it was a good idea to proceed. **1998 Proc. 4th Quarter II 766.**

A. The drafting note in the amendments states that the eligibility for benefits "shall not be more restrictive" than the inability to perform at least two of five activities of daily living (ADLs). The NAIC standard for nonqualified plans was three out of six ADLs. **1998 Proc. 4th Quarter II 766.**

Staff suggested that the model might not need to be amended with respect to ADLs quite as much as first thought. The standard under federal law was that benefits would be triggered when the insured could not perform at least two of five ADLs, and six ADLs were specified. The six in the federal law were the same six as were defined in the model act. Thus, since the six ADLs are identical in the model and the federal law, the model's requirement that no more than three of six be used as a trigger was consistent with the two of five in the federal law. **1999 Proc. 1st Quarter 613.**

A regulator questioned the need to include the definitions as used in HIPAA. Most of the states represented at the meeting opined that they would need that level of detail in their own state regulation. The working group decided to retain the definitions. **1999 Proc. 2nd Quarter 662.**

E. HIPAA required that a tax qualified plan not pay until a licensed health care practitioner has certified with respect to ADLs that the insured was unable to perform at least two ADLs for a period of at least ninety days. The regulators discussed two basic questions: who performs the certifications and how often can they be required. They questioned whether the insurer could require that the certification be done by a designee of the insurer. The working group also discussed how often a certification could be required. **1999 Proc. 1st Quarter 613.**

The regulators agreed that once there is a ninety-day certification and the insured is in claims status, the carrier cannot retroactively rescind the certification. An industry representative opined that this was unclear in regard to tax status in the federal law. It was unclear in the tax code whether the carrier could continue to pay the claim if the carrier knew the insured no longer could be certified in the future. **1999 Proc. 1st Quarter 613.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 28E (cont.)

Later there was discussion regarding whether a carrier had the ability to require that certifications of inability to perform ADLs had to be performed by health care professionals hired by the insurer. A consumer advocate said it was dangerous to force people to use carrier providers that are paid by the insurer. She stated that tax-qualified plans are indemnity products, not managed care products. She believed it was a conflict of interest for the carrier that is liable to pay benefits to have control of the process regarding whether the benefits can be accessed. **1999 Proc. 2nd Quarter 662.**

F. A regulator questioned whether there should be an outside appeal if the carrier turned down the plan of care and assessment performed by the consumer's personal physician. Another regulator opined that the working group showed endeavor to maintain a delicate balance in that regulators wanted carriers to perform due diligence and pay valid claims only. Also he pointed out that the Unfair Trade Practices Act contained provisions regarding excessive requirements for qualifying for claims. **1999 Proc. 1st Quarter 613.**

Section 29. Standard Format Outline of Coverage

The outline of coverage was added to the model in December 1988. It should be delivered at the point of solicitation. **1989 Proc. I 776, 791.**

Just before adoption of the outline of coverage, an amendment was added to clarify the phrase "other than acute care unit" by adding examples. **1989 Proc. I 754.**

It was suggested to the working group that they consider adopting a guideline specifying the size or type for printing. **1989 Proc. I 761.**

Part of the outline of coverage was moved from number 9 to number 3 in December 1992 and new language was added. **1993 Proc. IB 846.**

The purpose of this new language was to address the concern that consumers were confused when presented with explanations about level premiums. **1992 Proc. IIB 686.**

The disclosure language was intended to inform consumers about future premium increases. **1992 Proc. IIB 692.**

An industry spokesperson suggested that the language be revised to say that premiums could increase *or decrease*. The task force expressed a strong preference for leaving the language as is, that is, to disclose that the premium may increase. The task force agreed that the principal purpose of the disclosure was to alert consumers to the fact that premiums may increase. It was also suggested that the language be expanded to tell the consumer that the premiums would only be increased in accordance with the states' approval requirements. The task force did not agree to the suggestion. **1993 Proc. IB 854.**

When reviewing rate stabilization, regulators examined the outline of coverage to see if anything could be done to make the outline of coverage better. The chair asked whether anything could be added to the outline of coverage that would make clear that there were unknown things that may occur in the future that could affect rates. One regulator suggested wording to the effect that premium may go up in the future should be highlighted to bring the attention of the reader to that fact. **1997 Proc. 4th Quarter 939.**

When the 2000 amendments on rate stabilization were added, a new Paragraph 5 was added under the outline of coverage to specifically state whether the company has the right to change the premium. Initially drafted with a requirement that the notice be four points larger than the rest of the outline of coverage, the final version simply said it should be larger. A second paragraph under 5 required a description of contingent benefit upon lapse. Interested parties said this was confusing and misleading for consumers, since the benefits may never be triggered. It may encourage the consumer to cash out the policy. The working group decided to delete the language. **2000 Proc. 2nd Quarter 312.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 29 (cont.)

When benefit triggers were added to the model regulation in 1995, the outline of coverage was modified by adding a separately identifiable provision under Paragraph 9 entitled “Eligibility for Payment of Benefits.” A regulator suggested that a similar separately identifiable provision be used in the policy so the policyholder could easily find the benefit provisions in his or her policy. **1995 Proc. 2nd Quarter 652.**

The language of Paragraph 15, added in 2000, originally called for referring insureds to the state to discuss terms of the long-term care insurance policy. The drafters agreed to change it to refer instead to the states’ senior health insurance assistance program for questions regarding long-term care insurance. Specific questions about the policy or certificate should be referred to the insurer. **2000 Proc. 2nd Quarter 312.**

Section 30. Requirement to Deliver Shopper’s Guide

After development of a shopper’s guide, the task force then concluded that it was important to deliver the guide to all employer groups as well as individuals and had extensive discussion on whether direct mail marketers should deliver the guide at the time of application. The section added to the model required delivery of the guide to all prospective applicants of long-term care insurance. **1990 Proc. II 617.**

A new item three was added in 1999 as part of the amendments to conform the model to the federal Health Insurance Portability and Accountability Model Act of 1996 (HIPAA). **1999 Proc. 4th Quarter 989.**

Section 31. Penalties

Penalties were suggested as an alternative to levelized agent commissions. One commissioner suggested that the task force adopt licensing, reporting and penalty provisions because of the chilling effect they would have on inappropriate company and agent behavior. **1991 Proc. IB 654.**

Section []. [Optional] Permitted Compensation Arrangements

At one point in the process of drafting consumer protection amendments, a section on agents commission was included in the draft. Before adoption it was removed from the model and made an optional provision. The task force chair spoke in favor of including the section in the model; being of the opinion that the alternatives of penalties, reporting and agent testing did not entirely address the twisting and churning concerns. One state regulator said he was generally opposed to regulatory interference in the agent/company relationship, but recognized that the long-term care insurance and Medicare supplement markets were special because of the consumers to whom the products were sold. **1991 Proc. IB 665.**

Several states spoke in favor of levelized commissions, or asked that the issue be revisited in the future if not adopted in the 1990 draft. **1991 Proc. IB 665.**

One problem with inclusion of a section limiting agents’ commissions was that, in the opinion of one regulator, most old nursing home policies should be replaced. The group considered several alternatives to limits on commissions. **1991 Proc. IB 716.**

The task force considered ways that could be developed to provide disincentives for inappropriate replacements. There were several ways that the task force considered: (a) Use the same language as in the Medicare supplement insurance regulation which would limit the differential in the first year to twice the commissions paid in the second year; (b) implement a straight level commission structure; (c) explore alternatives such as special licensing requirements, agent and company fines, enhancement of replacement forms and increased disclosure. **1991 Proc. IB 693.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section [] (cont.)

The task force voted to develop a drafting note which would suggest that states consider adopting a level commission approach if the market abuses of inappropriate replacements are not adequately addressed by implementation of the licensing, penalty and reporting requirements in the consumer protection amendments. **1991 Proc. IB 662.**

Appendix A

The recision reporting form was necessitated by Section 11E of the regulation. A number of states requested development of the form. **1991 Proc. IIB 765.**

Appendix B

When considering the draft worksheet, one regulator said the tone of the worksheet was “you need it—buy it” and she suggested a change to remove the presumption of need. Another regulator said he liked the statement at the top that talked about \$30,000 in assets, but he wondered where that number came from. The chair said the purpose of the worksheet was to help consumers make an informed choice. It was a self-screening tool. **1993 Proc. 4th Quarter 713.**

An early worksheet draft included a section on affordability where the applicant could list his or her income and expenses to see if there was money to pay the cost of long-term care insurance. One regulator said that it was important to make a point that premium payments would need to be made for a long time and might increase substantially. An insurer objected because many of the companies have not raised premiums. The working group agreed the language should be left in the draft because it pointed out that premiums could increase without painting with too broad a brush. **1993 Proc. 4th Quarter 713, 715-716.**

The chair summarized the task of the working group; either decide a level of assets below which long-term care insurance should not be purchased or provide information to consumers so they could determine for themselves whether the purchase is appropriate. He did not think either alternative would be easy. Another member of the working group said he preferred the approach used in securities regulation where clear disclosure allowed consumers to determine if the product was right for them. **1994 Proc. 1st Quarter 453.**

The chair said it seemed the goals of the drafters were at cross-purposes. If consumers were encouraged not to provide too much financial information, how could agents be held responsible for unsuitable sales? A working group member said she leaned toward a shorter disclosure document rather than the extensive document the working group had discussed earlier. She said sometimes there was so much information provided that many people did not read it. One regulator suggested a simple statement to the effect of: if your income is below \$X, this product is probably not for you. If your income is above \$X, consider these factors. An industry representative pointed out there were many reasons for senior citizens to choose to purchase long-term care insurance, even if their income or assets were below a specified amount. A regulator agreed that the draft did take into account the possibility of purchase for other reasons because it asked about the applicant’s goals and needs. **1994 Proc. 1st Quarter 454.**

A consumer representative said it was very difficult to set a floor under which the product could not be sold. Consumers, for a variety of reasons, might choose to purchase long-term care insurance even if their assets or income fell below that number. She said if an agent was allowed to delve into the financial affairs of a policy applicant, there should be good standards developed to protect the consumer. She cautioned that there needed to be some flexibility for people who were unwilling to fill out any kind of form or questionnaire about their income. **1994 Proc. 2nd Quarter 599.**

A regulator opined that one of the problems with the earlier worksheet had been the difficulty for the consumers to gather all the information requested. He suggested some standard benchmarks. Another regulator suggested “yes” and “no” questions or a range. This would give the agent information without getting into specifics. **1994 Proc. 2nd Quarter 600.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Appendix B (cont.)

One company representative objected to the sentence on the personal worksheet that said long-term care insurance is expensive. He said it should also say long-term care is expensive. He also pointed out long-term care insurance is not expensive if the purchaser is under age 65 or is part of an employer group. He also questioned the statement that suggested no more than 7% of a person's income should be spent on long-term care insurance. He wondered how much of an individual's income should be spent on Medicare supplement insurance or on life insurance. He also commented on the bullet that asked if the individual would be able to afford the policy if premiums went up by 25%. He reminded the group that a rate stabilization provision had just been adopted that would limit rate increases, so the scenario described was not likely to happen. The chair of the working group invited those in attendance to provide research data on what point long-term care insurance was a suitable purchase. **1994 Proc. 2nd Quarter 601.**

One insurer representative asked if it was permissible for a company to revise the numbers in the personal worksheet if they did not match the suitability standards the company had developed. Another individual suggested the worksheet did not fit well when the applicant was buying insurance for someone else, for example, an individual buying coverage for a parent. **1994 Proc. 2nd Quarter 601.**

One issue that was the subject of repeated discussion by the drafters was whether to include numbers in the income and assets guidelines. A consumer representative pointed out the variety of suggestions presented to the working group, from those with very specific standards to one with no numeric standards at all. She said the NAIC draft was a good approach because it gave some kind of reference point without setting a hard and fast rule. One attendee asked where the 7% and \$30,000 figures came from and an industry representative said government regulators should not be setting benchmarks that had no basis in fact. A regulator responded that the draft didn't say an individual couldn't purchase the policy, it was just a caveat to consider if income and assets were below the benchmarks. **1994 Proc. 3rd Quarter 622.**

The working group considered changing the personal worksheet to include questions about other than financial reasons for purchasing a policy. One regulator suggested these would allow the insurer to take these other reasons into account when determining suitability. Another regulator responded that insurers should base suitability on objective standards and the applicant could override the company's standards for these other reasons. The working group decided to base the requirement for a suitability letter on whether or not the individual met the financial standards, irregardless of whether he or she wished to purchase for other reasons. **1994 Proc. 3rd Quarter 619.**

By September of 1994 the working group had reached agreement on the major issues and was refining the personal worksheet. In response to a question, a member of the working group explained the intent of the bracketed language on single premiums. She said the language would only appear for a life policy with a single premium. Another regulator suggested bracketing the last part of the personal worksheet to make it clear what would be used if no agent was involved in the sale. An insurer representative asked how much flexibility was available to the company in the development of its personal worksheet. If the company set its suitability standard at \$20,000, could the boxes just allow for checking "under \$20,000" or "over \$20,000"? Another insurer representative pointed out that its standards might set an income between two of the numbers on the worksheet. A regulator suggested bracketing the figures so companies could insert the figures needed, but other regulators were concerned that limits were needed so the agent didn't use this as a way to obtain information about high income, for example, which would encourage the sale of annuities and other types of policies. **1994 Proc. 3rd Quarter 613.**

The working group was asked to make the personal worksheet more flexible. One suggestion was to omit the requirement the worksheet be in a specified format. Another suggestion was to put the income numbers in brackets so that the company could tailor the range to its needs. The drafters agreed to bracket all but the first and last increment so that companies could tailor them to their individual needs. It was not felt necessary to do the same thing to the assets ranges. **1994 Proc. 4th Quarter 737.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Appendix B (cont.)

The draft under consideration contained a question asking whether the applicant would still be able to afford the policy if rates went up 25%. One insurer asked what he was supposed to do with this information. The chair opined that nobody would check “yes” because it seemed like an invitation to raise rates. The working group decided to replace that with a single question asking if the applicant would still be able to afford the policy if the rates went up. This sentence would be bracketed in the draft so that if the rate was guaranteed the sentence would not be included. **1994 Proc. 4th Quarter 738.**

For a time the personal worksheet contained a question asking if the company had increased its rates on the policy. A regulator pointed out that if it was a new policy, the company would not have increased its rate, but this would give a wrong impression of the stability of the rates. **1994 Proc. 3rd Quarter 619.**

Concern was expressed about the paragraph in Appendix B that talked about the last increase in the policy. Companies may change forms so often the information will not be used, and it would give a wrong impression. The working group decided to leave in the provision because it could provide valuable information but did make several changes in wording. **1994 Proc. 4th Quarter 731.**

An insurance industry representative asked the task force to consider appointing a group to study technical adjustments to the suitability section of the Long-Term Care Insurance Model Regulation. The chair agreed to consider the proposal. **1996 Proc. 2nd Quarter 814.**

The industry representative stated that minor changes were needed in the personal worksheet required by the suitability section of the model. First, he suggested modifying the premium section to allow insurers to reference more than one policy form. He also suggested moving the question about the source of funds to pay premiums into the “premiums” section from the “income” section. He stated this seemed a more logical place for this question. **1996 Proc. 3rd Quarter 1020.**

A regulator asked if multiple forms are being filed currently, and the industry representative responded affirmatively. The regulator asked if the personal worksheet would be filed with each policy if it was amended to allow information about more than one policy form. The industry representative stated that the amended personal worksheet would be filed with each policy. A regulator suggested it would be easier to have one form for each policy form. The industry representative said it would be easier to have a single form, alleviating the problem of an agent inadvertently distributing the wrong form. **1996 Proc. 3rd Quarter 1020.**

A regulator asked if other insurers were concerned about this problem. A representative from another insurer responded that the personal worksheet was designed to determine the suitability of the insured to purchase long-term care insurance, not to determine the suitability of a specific product. The insurer who made the suggestions said consumers would be helped by disclosure of information about all policy forms, instead of just one form. **1996 Proc. 3rd Quarter 1020.**

Members of the working group asked how many plans would be allowed on one personal worksheet. The industry representative who suggested the amendments said he did not know the optimal number, but he believed the maximum number of policies allowed on a personal worksheet should be four. **1996 Proc. 4th Quarter 1085.**

A regulator proposed listing in columnar format the policies available and allowing the agent to check off the applicable policy and corresponding rate increase information. Another regulator expressed concern that a carrier may have so many policies that the list would spill over to a second page. The working group asked staff to prepare a draft showing the listing of the policies, limiting the number of policies that could be listed to four. **1996 Proc. 4th Quarter 1085.**

The working group directed that the draft be prepared with the last sentence in the first paragraph standing alone in a separate paragraph. **1996 Proc. 4th Quarter 1085.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Appendix B (cont.)

When reviewing the new personal worksheet, the working group chair opined that it seemed cluttered. It was the intent of the working group that the final product be two pages, while this draft was three pages. A suggestion that the form incorporate two columns, which would allow four different policy forms to be listed, made the first page of the personal worksheet very crowded. **1996 Proc. 4th Quarter 1084.**

A regulator suggested rewording the question about the source of premium payments and changing the potential reply “savings” to read “savings/investments” to reflect the choices in the investments section of the worksheet. She also noted the print is small and may be difficult for seniors to read. **1996 Proc. 4th Quarter 1084.**

Another regulator stated that the recommended changes provided too many numbers and may be confusing for consumers to read. There was substantial discussion about putting up to four forms and the related rating information in the same paragraph. Following discussion the working group decided to add a drafting note to reflect the fact that only two policy forms may be used on the same personal worksheet, if both policy forms have the same rating history. If a policy form has a different rating history, then only one policy form may be used on a single worksheet. **1996 Proc. 4th Quarter 1084.**

Before adoption of the personal worksheet, it was also edited for readability. **1997 Proc. 1st Quarter 771.**

When rate stabilization amendments were added in 2000, the Personal Worksheet was revised to include a rate history on the first page. The working group considered including the information from Appendix F in the same form, but decided two shorter forms was preferable to one long one. **2000 Proc. 2nd Quarter 312.**

Appendix B was reordered and new information was added regarding type of policy, the company’s right to increase premiums, rate increase history, inflation protection and elimination periods. The consumer must sign the disclosure statement acknowledging that rates for the policy may increase in the future. **2000 Proc. 2nd Quarter 290.**

Appendix C

The working group drafting the suitability amendments decided to produce an information sheet to help consumers. A consumer representative said he thought what was missing was how this information relates to Medicaid. An individual from a Medicaid agency applauded the group’s effort on the description of Medicaid. She said it was important not to encourage people to transfer their assets and buy long-term care insurance to cover only the period until they qualified for Medicaid. She said that would not meet the goal of the federal law. The consumer advocate disagreed, saying these benefits had been paid for through taxes, and encouraged individuals to use the law to get their rights. Another person expressed the opinion that agents were often trained to sell long-term care insurance by saying that an individual would not want to be on Medicaid. She said it did individuals a great disservice to scare them that way. **1994 Proc. 2nd Quarter 601.**

A consumer representative continued to express concern about the negative references to Medicaid on the disclosure form, as well as the personal worksheet. A representative from the federal government acknowledged that nursing homes were not required to take Medicaid patients and agreed this was a type of discrimination properly reflected in the disclosure form.

The consumer representative said he knew discrimination did exist; he just did not think it should be emphasized in official publications. The federal representative said the implication that some people did not want to go on Medicaid was probably accurate because it was a welfare program and some people did not want to be on welfare. **1994 Proc. 3rd Quarter 614.**

A consumer representative suggesting adding “free” in front of the word counseling in the last bullet of Appendix C, and including the telephone numbers for the insurance department and department of aging. The chair said this suggestion had been considered before, but it would necessitate 50 different printings so that it could be state specific. **1994 Proc. 3rd Quarter 613.**

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Appendix D

The working group decided to add a requirement to the suitability standards requiring the insurer to send a letter to an individual who was not a suitable candidate for long-term care insurance under the insurer's standards saying that he or she may want to reconsider this purchase. The same letter would be sent to the individual who had elected not to provide information, to give one more chance to the individual whose agent might have discouraged completion of the form. One insurer representative suggested that, if the regulator scheme required reporting the number of forms utilized, regulators would be able to pinpoint agents who discouraged applicants from filling out the forms. The working group also agreed to allow, in the alternative, another method of verification, such as a telephone call. **1994 Proc. 3rd Quarter 621.**

The working group considered if it was a problem to hold up processing of the application by mailing a suitability letter. One regulator suggested issuing the policy and then using the 30-day free look period to decide if the individual wanted to keep a policy that had been deemed unsuitable. It seemed to the drafters that the message was, "You don't meet our standards, but here is your policy." The group decided instead that the suitability letter should make clear that an individual did not have insurance until the form was returned and the medical review completed. **1994 Proc. 3rd Quarter 619.**

An insurer representative asked if a company could continue to process an application while waiting for a response to the suitability letter. He suggested taking out language that said the company had suspended review of the application. Another added that, if the company suspended underwriting while waiting for the response, it would slow down the process. A regulator suggested adding the word "final" so review could continue during this process. **1994 Proc. 3rd Quarter 613.**

Appendix E

When drafting Section 15F, the regulators concluded it would be helpful to draft a reporting form. One question that was difficult to address was whether denial of payment due to a preexisting condition limitation or an elimination period should be reported as denied claims.

One regulator expressed the opinion that, any time a carrier denied a request for payment, it should be classified as a denied claim. An industry representative opined that if a claim was made prior to the end of the elimination period, it was not denied, but rather put on hold until the end of the elimination period. **1999 Proc. 4th Quarter 971-972.**

There was some discussion of referring to claims "not paid" rather than "denied" when referencing the preexisting condition and elimination period situations. A regulator suggesting adding a note that the definition of claim denied used on the reporting form was to be used only for that purpose and had no effect on other regulatory issues, such as market conduct examinations. He was concerned that insurers would use the definition to deny information to regulators during market conduct examinations by saying the claims were not denied claims for market conduct examination purposes. **1999 Proc. 4th Quarter 972.**

Appendix F

When the 2000 amendments on rate stabilization were added, the new appendix was added to explain contingent benefit upon lapse and contingent nonforfeiture. The group discussed whether this information should be included in Appendix B, but a consumer advocate urged the group to create two forms. Two short forms was better than one long one. **2000 Proc. 2nd Quarter 312.**

Appendix G

A consumer advocate submitted a letter to the task force regarding reporting requirements for long-term care insurance companies. She expressed concern that the NAIC Long-Term Care Insurance Model Regulation required annual reporting of replacement, lapse, denied claims and agent replacement activity, but contained only one reporting form that was specific to denied claims. The chair stated that Section 15 of the model regulation required the reporting of the specific data. He asked the NAIC staff to reconcile the requirements in the model and in the current reporting form to determine what data was

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Appendix G (cont.)

actually captured and to offer recommendations as to how the states could accurately capture this information. **2001 Proc. 1st Quarter 183.**

Interested parties drafted a long-term care replacement and lapse reporting form as a starting point for discussions. **2001 Proc. 2nd Quarter 172-173.**

The draft form was released for comment at the 2001 Summer National Meeting. No comments were received on the draft. The 2001 Fall National Meeting was cancelled due to the terrorist attacks on Sept. 11, 2001. At the Winter National Meeting the task force adopted Appendix G and the amendments to the model regulation. **2001 Proc. 4th Quarter 285.**

Chronological Summary of Actions

December 1987: Model regulation adopted.

December 1988: Outline of coverage added, revision of continuation and conversion section. Addition to Section 8 requires disclosure of limitations of policy.

June 1989: Modifications of continuation and conversion section. Reserve requirements added.

December 1989: Adopted amendments to prevent post claims underwriting. Minimum standards for home health care benefits added to model. Inflation protection required.

June 1990: Added Section 30 to require delivery of shopper's guide.

December 1990: Added consumer protection amendments similar to those adopted for Medicare supplement coverage to help prevent abuses in marketplace.

December 1991: Amended model to prohibit attained age or duration rating and to add a rescission reporting form. Also modified sections on home health care and inflation protection.

September 1992: Amended Section 19 to remove reference to loss ratios of individual policies.

December 1992: Adopted amendments requiring third party notice and premium disclosure. Adopted new subsection on standards for marketing to association groups.

June 1993: Paragraph added to association responsibilities subsection to reference unfair trade practices act.

June 1994: Adopted amendments to Section 6F to restrict increases in premium rates.

March 1995: Adopted new Section 24 on suitability standards to replace provision on appropriateness and added Appendices B, C and D to implement the new requirements. Added Section 26 to implement the nonforfeiture benefit requirement in the model act.

September 1995: Adopted new Section 27 on standards for benefit triggers. Added new definition and made changes to outline of coverage.

September 1996: Added Section 6G to set standards for electronic enrollment of groups.

September 1997: Amended Sections 3, 6, 7, 14 and 19 relative to life insurance that accelerates benefits to cover long-term care expenses.

December 1997: Amended personal worksheet (Appendix B).

June 1998: Deleted Section 6F provisions adopted in 1994 to restrict increases in premium rates and replaced with clarification that more coverage or a reduction in benefits is not a premium rate change. Changed nonforfeiture benefits in Section 26 to mandated offer and added requirements for contingent nonforfeiture.

March 2000: Model amended to comply with the requirements of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), included adoption of a new Section 28.

August 2000: Model amended on issues of rating practices and consumer protection. Added Sections 9, 10 and 20, as well as Appendix F.

March 2002: Added Appendix G and references to it in Section 15.