

Draft: 9/22/09

Model 641

Adopted by the Health Insurance and Managed Care (B) Committee, 11-9-09

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 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. | Standard Format Outline of Coverage |
| Section 32. | Requirement to Deliver Shopper's Guide |
| Section 33. | 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 |

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)

~~Drafting Note: The definition of claim denied used in this reporting form is for HIPAA reporting purposes only, and is not intended to be applied to any other regulatory issues, such as market conduct examinations.~~

- 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.

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

| | <u>State Data</u> | <u>Nationwide Data¹</u> |
|--|-------------------|------------------------------------|
| <u>Total Number of Inforce Policies [Certificates] as of December 31st</u> | | |

Claims & Denial Data

| | | <u>State Data</u> | <u>Nationwide Data¹</u> |
|---|--|-------------------|------------------------------------|
| 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.

PROJECT HISTORY
APPENDIX E CLAIM DENIALS REVISIONS TO THE
LONG-TERM CARE INSURANCE MODEL REGULATION

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

Revisions relating to Appendix E (Claims Denial Reporting Form) of the Long-Term Care Insurance Model Regulation (#641).

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

The Appendix E Subgroup of the Senior Issues (B) Task Force drafted the revisions. The participating states were: South Dakota, Florida, Wisconsin, Arkansas, Nebraska, Nevada, Texas, and Pennsylvania. South Dakota was the Chair.

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

The Health Insurance and Managed Care (B) Committee has the following ongoing charges, which are delegated to the Senior Issues Task Force.

Develop appropriate regulatory standards and revisions to the NAIC models, consumer guides and training material, as necessary, on long term care insurance. Work with federal agencies as appropriate. Report annually (Delegated to Senior Issues Task Force);

Continue to study and evaluate evolving long-term care insurance product design, rating, suitability and other related factors, and review the existing Long-Term Care Model Act and Regulation to determine their flexibility to remain compatible with the evolving delivery of long-term care services and remain compatible with the evolving long-term care insurance marketplace. Report quarterly (Delegated to Senior Issues Task Force);

The Senior Issues Task Force authorized the formation of a Subgroup to work on revising the model regulation to address Appendix E in the Summer of 2009.

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

The model revisions were drafted by a Subgroup of the Senior Issues Task Force chaired by South Dakota. The following interested parties, organizations, and consumer representatives were on the email list: Amanda Matthiesen (America's Health Insurance Plans), Miriam Krol (American Council of Life Insurers), Genworth Life Insurance, Prudential Life Insurance, Melissa Lawler (American Academy of Actuaries), PriceWaterhouseCoopers, Congressional Research Service, MetLife, Aegon USA, Unum Provident, Bonita Kallestad (Western Minnesota Legal Services), Barbara Cude (University of Georgia), Birny Birnbaum (Center for Economic Justice), and John Hancock Life Insurance Company.

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

The Senior Issues (B) Task Force appointed a Subgroup at the 2009 Summer National Meeting, to be chaired by South Dakota. The Subgroup held an open conference call on August 6, 2009. Notice for

this conference call was emailed to Subgroup regulators and interested parties and posted on the NAIC website.

Prior to the August 6 conference call, Subgroup members and interested parties received and reviewed the current version of Appendix E. Industry representatives proposed draft revisions to Appendix E, which were also distributed to Subgroup members and interested parties. The Subgroup reviewed the industry's proposed revisions on the conference call, and also made additional revisions to Appendix E and to Section 15 of the model regulation. After the conference call, a final draft of the agreed-upon revisions was distributed to Subgroup members and interested parties. The Senior Issues (B) Task Force adopted the revisions at the 2009 Fall National Meeting and they were exposed for a 30 day public comment period prior to consideration by the Health Insurance and Managed Care Committee.

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

This project was in response to the discovery made during compilation of the 2008 LTC Data Call Analysis and Report, which was adopted by the Health Insurance and Managed Care Committee and the Market Regulation and Consumer Affairs (D) Committee, that companies were using different methodologies to report claim denial data on Appendix E, and therefore the usefulness of this reporting was limited. The Task Force agreed that *Appendix E* should be revised and created the Subgroup. Regulators, industry and consumer groups were in agreement regarding the need to make revisions to Appendix E.

There are two distinct methods of counting and reporting claim denials that are being used by companies – per claimant and per transaction. Neither method is predominantly used, as industry reported that roughly half the companies count and report by claimant and roughly half count and report by transaction. Therefore, industry suggested that the form be amended so that companies would indicate the manner of reporting. Some states were interested in requiring that companies be required to change their methodology so that all companies were using a uniform method. However, industry stated that this would be cost-prohibitive. The Subgroup agreed to make changes to Appendix E to include the manner of reporting.

Regulators also discussed the overall goal of improving tools for state regulators and others to assess the long-term care insurance marketplace. As such, the Subgroup decided to adopt additional revisions to Appendix E that would add a query regarding in-force policies by state and nationwide. This information is intended to assist in helping regulators better put the rest of the Appendix E data in context.

Additionally, the Subgroup noted that the current drafting note following Section 15F stated that the definition of claim denied in Appendix E was limited to HIPAA reporting purposes only. In accordance with the goal of making Appendix E more broadly useful to state regulators and others in assessing the marketplace, the Subgroup decided to delete this drafting note.

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