NAIC Guidance Manual for Rating Aspects of the Long-Term Care Insurance Model Regulation

March 11, 2005
The NAIC is the authoritative source for insurance industry information. Our expert solutions support the efforts of regulators, insurers and researchers by providing detailed and comprehensive insurance information. The NAIC offers a wide range of publications in the following categories:

**Accounting & Reporting**
Accountants, members of the insurance industry and educators will find relevant information about statutory accounting practices and procedures.

**Consumer Information**
Consumers, educators and members of the insurance industry will find important answers to common questions in guides about auto, home, health and life insurance.

**Financial Regulation**
Accountants, financial analysts and lawyers will find handbooks, compliance guides and reports on financial analysis, state audit requirements and receiverships.

**Legal**
State laws, regulations and guidelines apply to members of the legal and insurance industries.

**NAIC Activities**
Insurance industry members will find directories, newsletters and reports affecting NAIC members.

**Special Studies**
Accountants, educators, financial analysts, members of the insurance industry, lawyers and statisticians will find relevant products on a variety of special topics.

**Statistical Reports**
Insurance industry data directed at regulators, educators, financial analysts, insurance industry members, lawyers and statisticians.

**Supplementary Products**
Accountants, educators, financial analysts, insurers, lawyers and statisticians will find guidelines, handbooks, surveys and NAIC positions on a wide variety of issues.

**Securities Valuation Office**
Provides insurers with portfolio values and procedures for complying with NAIC reporting requirements.

**White Papers**
Accountants, members of the insurance industry and educators will find relevant information on a variety of insurance topics.

For more information about NAIC publications, view our online catalog at: [www.naic.org/store_home.htm](http://www.naic.org/store_home.htm)

© 2003, 2009 National Association of Insurance Commissioners. All rights reserved.

ISBN: 978-1-59917-253-8

Printed in the United States of America

No part of this book may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic or mechanical, including photocopying, recording, or any storage or retrieval system, without written permission from the NAIC.
Companion Products

The following companion products provide additional information on the same or similar subject matter. Many customers who purchase the *Guidance Manual for Rating Aspects of The Long-Term Care Insurance Model Regulation* also purchase one or more of the following products:

**Compendium of State Laws on Insurance Topics**

Two individual Compendium charts — *Long-Term Care Insurance Act Provisions* (HS-10) and *Long-Term Care Insurance Regulation Provisions* (HS-15) — combine the states' statutes and regulations on this topic in a clear, concise format. The Compendium is available for purchase as a three-volume set; by individual volume; by individual chart; and by quarterly update.

**Long-Term Care Experience Report**

Based on the Long-Term Care Experience Reporting Form B, these reports contain 1) countrywide company-specific experience for all forms combined, with the experience segmented by duration; and 2) countrywide company-specific experience displayed on a form-by-form basis. With the exception of policy forms developed since 1991, the experience reported in Form B is cumulative from 1991 or earlier. Annual reports are available since 1992. Updated annually.

**Model Laws, Regulations and Guidelines**

The *Long-Term Care Insurance Model Act* (MDL-640) establishes standards for long-term care insurance and facilitates flexibility and innovation in the development of long-term care insurance coverage. The *Long-Term Care Insurance Model Regulation* (MDL-641) sets regulatory standards for rates, nonforfeiture values and suitability. It also details requirements for advertising and marketing.

**A Shopper's Guide to Long-Term Care Insurance**

Presents current and potential users of long-term care insurance with valuable information. For those considering the purchase of long-term care insurance, buyers' guidelines are incorporated in a consumer-friendly, easy-to-read format. Includes an overview of long-term care insurance, as well as payment and purchasing options, worksheets and shopping tips. Also contains a comprehensive contact list for every state insurance department. A PDF version is available for licensing. Updated annually.

---

**How to Order**

Phone: 816.783.8300  prodserv@naic.org  http://store.naic.org

International orders must be prepaid, including shipping charges. Please contact an NAIC Customer Service Representative, Monday - Friday, 8:30 am - 5 pm CT.
# Table of Contents

<table>
<thead>
<tr>
<th>Section I. Introduction</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Purpose of the Manual</td>
<td>1</td>
</tr>
<tr>
<td>B. Changes in the Long-Term Care Insurance Regulation Process</td>
<td>1</td>
</tr>
<tr>
<td>C. Changing Roles</td>
<td>4</td>
</tr>
<tr>
<td>D. Questions and Answers</td>
<td>5</td>
</tr>
<tr>
<td>E. Caveat</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section II. What Is Long-Term Care Insurance?</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Definition of Long-Term Care Insurance</td>
<td>7</td>
</tr>
<tr>
<td>B. What Entities May Issue Long-Term Care Insurance</td>
<td>8</td>
</tr>
<tr>
<td>C. Combination Products</td>
<td>8</td>
</tr>
<tr>
<td>D. Questions and Answers</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section III. When Do the New Regulations Apply?</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Effective Dates of New Regulation</td>
<td>11</td>
</tr>
<tr>
<td>B. Questions and Answers</td>
<td>12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section IV. Disclosure to Consumers</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Consumer Disclosure Forms Relating to Rating</td>
<td>14</td>
</tr>
<tr>
<td>B. Similar Policy Forms</td>
<td>14</td>
</tr>
<tr>
<td>C. Rate Increase History</td>
<td>15</td>
</tr>
<tr>
<td>D. Rate Increase History Examples</td>
<td>15</td>
</tr>
<tr>
<td>E. Questions and Answers</td>
<td>23</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section V. Initial Filing</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Materials That Accompany a Filing</td>
<td>26</td>
</tr>
<tr>
<td>B. Policy Form</td>
<td>26</td>
</tr>
<tr>
<td>C. Disclosure Materials</td>
<td>26</td>
</tr>
<tr>
<td>D. Premium Rate Schedule</td>
<td>27</td>
</tr>
<tr>
<td>E. Actuarial Certification</td>
<td>27</td>
</tr>
<tr>
<td>F. Right to Request Further Information</td>
<td>28</td>
</tr>
<tr>
<td>G. Questions and Answers</td>
<td>29</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section VI. Rate Increase Filing</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Materials That Accompany a Rate Increase Filing</td>
<td>33</td>
</tr>
<tr>
<td>B. Additional Aspects if Contingent Benefit Upon Lapse Is Triggered</td>
<td>36</td>
</tr>
<tr>
<td>C. Exceptional Rate Increases</td>
<td>37</td>
</tr>
<tr>
<td>D. Questions and Answers</td>
<td>38</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section VII. Monitoring Experience</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. At Time of Filing For a Rate Increase</td>
<td>43</td>
</tr>
<tr>
<td>B. After Filing For a Rate Increase</td>
<td>43</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section VIII. Rate Increase Consequences</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Review of Administration and Claim Practices Authorized</td>
<td>45</td>
</tr>
<tr>
<td>B. Option to Escape Rate Spirals by Converting to Currently Sold Insurance</td>
<td>45</td>
</tr>
<tr>
<td>C. Commissioner May Prohibit Issue of New Policies</td>
<td>46</td>
</tr>
<tr>
<td>Appendix</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>Sample Actuarial Certification – Initial Filing</td>
</tr>
<tr>
<td>2</td>
<td>Sample Actuarial Certification – Rate Increase</td>
</tr>
<tr>
<td>3</td>
<td>Sample Actuarial Certification – Exceptional Rate Increase</td>
</tr>
<tr>
<td>4</td>
<td>Sample Loss Ratio Demonstration for a Hypothetical Rate Increase</td>
</tr>
<tr>
<td>5</td>
<td>Actuarial Memorandum Checklist</td>
</tr>
<tr>
<td>6</td>
<td>A Shopper’s Guide to Long-Term Care Insurance</td>
</tr>
<tr>
<td>7</td>
<td>Additional LTCI Provisions</td>
</tr>
<tr>
<td>8</td>
<td>NAIC Long-Term Care Insurance Model Act</td>
</tr>
<tr>
<td>9</td>
<td>NAIC Long-Term Care Insurance Model Regulation</td>
</tr>
</tbody>
</table>
Section I. INTRODUCTION

A. PURPOSE OF THE MANUAL

This manual is intended to be used to evaluate compliance with the revised rating requirements contained in the Long-Term Care Insurance (LTCI) Model Regulation (Model Regulation) that was adopted by the NAIC in August 2000 and for the contingent benefit upon lapse provision adopted in 2005.

The direct application of this guidance manual is limited to those states that have passed the revised NAIC LTCI Model Regulation without modification. However, many aspects of the manual may apply to states that have modified the Model Regulation, and other portions may be readily adaptable to fit such modifications. No attempt will be made in this manual to describe such modifications, however. **Of course, in cases where any portion of this manual is inconsistent with an actual law or regulation of a state, such law or regulation would prevail.**

While the manual is written for state regulators involved in LTCI rate review, it is anticipated that insurers will review this material in order that they make the filing process as expeditious as possible. Therefore, the regulator should not be surprised if an insurer follows the manual directly. Of course, the regulator is responsible for detecting practices that do not comply with the requirements of his or her state’s statutes and regulations.

B. CHANGES IN THE LONG-TERM CARE INSURANCE REGULATION PROCESS

Most state laws and regulations require that premiums for LTCI be such that “benefits will be reasonable in relation to premiums.” The NAIC LTCI Model Regulation that was in effect prior to August 2000 used a minimum fixed loss ratio as the method to determine that a specific set of premiums was reasonable. The NAIC LTCI Model Regulation that was passed in August 2000 changes the standard of reasonableness for LTCI issued after the effective date of new state statutory requirements.

1. Fixed Loss Ratios

Premiums for LTCI have been determined within a fixed loss ratio structure for decades. The regulatory evaluation of reasonableness using fixed loss ratios is designed to check that premium rates are not too high. The new LTCI Model Regulation moves away from fixed loss ratios applied to initial premiums. Loss ratios are still used by the insurer when determining a rate increase and by the regulator to help evaluate the reasonableness of a rate increase. Before describing these changes, a simplified discussion of fixed loss ratios as a regulatory tool is presented below. The discussion does not address interest discounting, mortality rates or lapse rates.

The two significant consequences of using fixed loss ratios are the following:

- Maximum Initial Allowed Premium
- Fixed Expense Margins as a Percent of Premium

(a) Maximum Initial Premium

A loss ratio equals claims divided by premiums, so a minimum loss ratio standard requires that a minimum portion of the premium will be paid in claims. Claims typically increase over time from issue so a minimum loss ratio is easier to meet over time versus in the initial years from issue. A 60% initial loss ratio requirement means that if the claims are expected to be $600, then the premium cannot be greater than $1,000 \( \frac{600}{1000} = .60 \). If the premium is greater than $1,000 and the claims are $600, then the minimum loss ratio would not be satisfied (suppose the premium were $1,200, then the loss ratio would be \( \frac{600}{1200} = .50 \) which does not meet the 60% minimum).
The pricing actuary of an insurer performs the following steps (or similar steps) to develop a premium that is acceptable to the insurer and complies with a minimum loss ratio. Suppose the minimum acceptable loss ratio is 60%.

i. Determine the benefits to be provided.
ii. Analyze the claim costs for the benefits to be provided.
iii. Divide the expected claims by the loss ratio to determine the maximum initial premium ($600/.60=$1000).
iv. Determine the final premium based on a variety of business requirements such as profitability, market share, commissions, and insurer expenses.
v. If the resulting premium is greater than $1,000, re-evaluate requirements in step iv.

The first significant consequence of a fixed loss ratio standard is the cap on the initial premium that can be charged. If the insurer believes that the insured is better served by charging a premium higher than the maximum, because of long-term stability of premiums, it would be prohibited from doing so. This is because the actuary must certify that the premium meets the loss ratio standard and the potential circumstances that would lead to the need for higher rates are not within the normal bounds of calculating expected claims.

(b) **Fixed Expense Margins**

Fixed loss ratios produce a fixed expense margin as a percentage of premium. This is illustrated in the following table.

<table>
<thead>
<tr>
<th></th>
<th>A = Original Pricing</th>
<th>B = Re-Pricing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Costs</td>
<td>$600</td>
<td>$1,200</td>
</tr>
<tr>
<td>Loss Ratio</td>
<td>.60</td>
<td>.60</td>
</tr>
<tr>
<td>Premium</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Expense Ratio</td>
<td>.40</td>
<td>.40</td>
</tr>
<tr>
<td>Expense Margin</td>
<td>$400</td>
<td>$800</td>
</tr>
</tbody>
</table>

(Expense Margin = Premium x Expense Ratio)

The expected annual claims in Column A are $600, so with a 60% loss ratio standard, the maximum premium is $1,000. The portion of the premium available for expenses and profit is 40%, which equals $400.

In Column B, after a few years of experience have come in, the best estimate of the claims are twice the expected amount in Column A or $1,200, so the maximum premium is $2,000 and the maximum expenses and profit are $800. Therefore, since some insurer expenses are fixed (such as salaries and rent), the insurer could increase the profit when claims are higher. The portion of the premium available for expenses and profit is increased when claims are higher after issue than was assumed in the original pricing.

When subject to fixed loss ratios, the certification the actuary provides for LTCI premium filings is that the ratio of expected claims to premiums will satisfy the loss ratio, the premium will not be greater than a maximum and expense margins will increase with claims. This makes it easier for premiums to increase over time, because the maximum allowed premium may be too low to be sustainable over the life of the contract, and the insurer is “rewarded” with higher expense margins if claims turn out to be higher than originally anticipated.

2. **A New Way of Protecting the Consumer**

LTCI has been purchased primarily by consumers who are in their 60s and 70s, so most are on a fixed income. Even if purchased at younger ages, these insureds will spend many of their premium paying years...
on fixed incomes. Claims under LTCI policies tend to be infrequent until insureds reach their late 70s and become much more frequent as the insureds reach their 80s and 90s.

There have been cases where the premium for LTCI has proven to be inadequate (for any number of reasons), which has caused large rate increases leading to significant loss of LTCI coverage. As a result, seniors have paid premiums for years only to see significant rate increases at the ages when they have increased need for the coverage. Seniors have often lost their insurability and cannot purchase another policy. Also, if a senior cannot afford the increase and lets the policy lapse, he or she loses all the premiums paid. The insurer may benefit by having fewer remaining policyholders to file claims.

The requirements of the new Model Regulation change the insurers’ incentives and should greatly increase the probability that LTCI premiums will remain unchanged for the life of the contract.

3. Certification of Adequacy

The new way of regulating LTCI consists of several steps:

(a) The initial loss ratio requirement is eliminated as the test that initial premiums are not excessive. It is replaced by a determination that initial premiums are not excessive because of market competition and that they are not inadequate because of the actuarial certification;

(b) The economic value to the insurer of an increase in renewal premiums is significantly reduced;

(c) The required disclosure of past rate increases makes the “rate increase option” less desirable to insurers and provides meaningful disclosure to potential insureds;

(d) Regulatory oversight increases when a premium increase is filed; and

(e) Insurers that persistently offer coverages at inadequate rates can be prohibited from issuing new policies.

(a) Initial Premiums

The Actuarial Certification to be provided with the initial premium filing must certify to the anticipated adequacy of premiums over the life of the contract, even under moderately adverse conditions.

(b) Economic Value of Rate Increases Is Reduced

To justify an increase, the insurer must show that the lifetime claims are expected to equal 58% of the lifetime initial premiums plus 85% of the increased portion of the premium. This differs from current standards that allow the expense load to be the same on initial premiums and increased premiums. Now, the expense load on the increased portion of premiums will be limited to 15%.

(c) Disclosure of Rate Increases Will Affect Attractiveness of New LTCI

The requirement to disclose past rate increases on similar LTCI business will mean that those insurers without any increases will appear to be better options to applicants than those insurers with rate increases. Insurers are likely to seek alternatives to raising the rates, even if experience is very bad, if rate increases will damage their marketing efforts. The insurer that has had rate increases, but does not expect future ones, must convince the consumer that its pricing is adequate.

(d) Increased Monitoring

If a rate increase is approved, the insurer must then provide the department annually with the developing experience under the form. If the developing experience shows that the rate increase was not needed, then a portion of it must be undone. If further rate increases are requested, the department can review underwriting and claims adjudication processes or take action for a block that is in a rate spiral.
(e) Marketing Limits
A continued pattern of filing inadequate initial rates (presumably based on a pattern of rate increase requests by an insurer) can lead to the insurer being required to cease offering new LTCI in the state.

C. CHANGING ROLES

To implement these changes, the regulator, the actuary and the insurer must change how they approach LTCI. The initial rate filing contains the proposed premiums, the prescribed documents, and the Actuarial Certification. The Actuarial Certification includes the actuary’s opinion on the adequacy of the proposed rates as well as other statements and information the regulator should evaluate.

In the event of a rate increase, the insurer will need to change the disclosures and the actuary will file a new Actuarial Certification and new projections of future experience. The regulator will review the filed materials and then will review the performance of premium and claim experience over the next several years in comparison to the projections.

1. Regulator

An understanding of the basic concepts of LTCI is critical for any regulator who reviews policy forms and rates. An excellent source is “A Shopper’s Guide to Long-Term Care Insurance” (Shopper’s Guide) published by the NAIC, which is included as Appendix 6 of this manual. Also, Appendix 7 has definitions of LTCI terms that are not defined in the Shopper’s Guide.

The regulator should review the proposed premium rates based on the benefits provided and, if possible, compare them to the premiums used by other insurers to see if large differences exist, keeping in mind that factors other than benefits can affect claim cost and premium level. The Actuarial Certification of adequacy should be reviewed for completeness placing special emphasis on any limitations included in it. If the regulator has questions about the rates, the certification, or the insurer’s ability to perform as certified, then further correspondence with the insurer is appropriate. The regulator should also review records of prior rate increases for LTCI within the last 10 years to ensure that they are included in the disclosure documents.

The regulator should review any filing for a rate increase and evaluate the reasonableness of the requested increase. A review of prior rate increases by the insurer may be helpful.

Following a rate increase, the developing experience on the business must be filed annually by the insurer for a minimum of three years. The regulator should then review the comparison of the expected experience with the actual developing experience. If experience continues to deteriorate under a policy form, the regulator should find out what the insurer’s plans are for future rate levels. If the regulator observes a pattern of inadequate pricing by an actuary or otherwise believes that the assumptions are not likely to cover moderately adverse experience, the regulator should consider discussing the issue with other regulators or contacting the Actuarial Board for Counseling and Discipline (ABCD) for advice and consultation.

Because it is expected that there will be fewer increases under this new system, the workload on the regulator should decrease in most cases.

2. Actuary

The focus will be on adequacy of premiums, not satisfaction of a loss ratio (unless the filing relates to a premium increase). The actuary will have an increased need to review all aspects of the insurer operations related to LTCI (see the list below). Future expected claims must be developed based on moderately
adverse future conditions. The initial premiums will be developed to be adequate for the insureds’ lifetimes, not to meet a loss ratio. Actuarial Standard of Practice 18 on LTCI requires that various aspects of the expected experience must be considered and included. If at some time in the future the actuary is aware that the company has changed certain practices, or certain pricing assumptions are not being realized, etc., such that the new business rates no longer contain adequate margin, the actuary has an obligation to address the situation.

3. **Insurer**

Reasonable measures should be taken to assure that premiums will remain level once a policy is issued. The economics of having fully adequate initial premiums versus relying on rate increases to cover adverse experience have been changed. This will place increased pressure on the insurer to perform well in all areas of LTCI, such as the following:

- a. Initial premiums;
- b. Benefit structures;
- c. Underwriting;
- d. Claim adjudication;
- e. Marketing;
- f. Agent training; and
- g. Compliance with state laws and regulations.

Because company practices may change in response to changing market or environmental conditions, or today’s expectations may be different from those of years past, it is important for the company to be cognizant of current rates and their compliance with model standards. The company should, at least annually, review the assumptions and margins in the current new business rates to ensure adequacy.

D. **QUESTIONS AND ANSWERS**

1. **How is LTCI rating different from rating for medical insurance?**

Some people apply rating principles from medical insurance to LTCI, but those principles are often not applicable to LTCI. Below is a comparison of rating characteristics of the two products.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Medical</th>
<th>Long-Term Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of claim</td>
<td>High frequency, especially for office visits and prescription drugs.</td>
<td>Low frequency. Historically, insureds have been reluctant to use institutional care. Home health care services are becoming more frequent.</td>
</tr>
<tr>
<td>Average claim amount</td>
<td>Some high cost claims, but larger numbers of low cost claims.</td>
<td>High average claim amounts because benefits usually are for extended time periods.</td>
</tr>
<tr>
<td>Benefit period duration</td>
<td>Claims for a particular illness usually occur within a year or less.</td>
<td>Duration often extends beyond one year.</td>
</tr>
<tr>
<td>Reliability of data</td>
<td>Medical insurance has been available for many years, and data are considered very reliable.</td>
<td>LTCI is relatively new coverage and data for insured populations are still being developed.</td>
</tr>
<tr>
<td>Premium payment period</td>
<td>Premiums are often subsidized by the employer during the working life of the individual. Medicare</td>
<td>Most insureds are purchasing this coverage after age 50. Insureds will spend most of their premium paying years on fixed incomes.</td>
</tr>
</tbody>
</table>
### Characteristic Medical Long-Term Care

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Medical</th>
<th>Long-Term Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>supplement premiums are usually paid while the individual is on a fixed income.</td>
<td>Over each issue age for block of issued policies.</td>
</tr>
<tr>
<td>Averaging of premium</td>
<td>Over employer group or block of issued policies</td>
<td></td>
</tr>
<tr>
<td>Premium rating basis</td>
<td>Premiums usually increase each year with age and medical trend.</td>
<td>Premiums are usually sold on an issue-age basis, and are required to be sold on an issue-age basis for ages 65 and older.</td>
</tr>
</tbody>
</table>

Each of the usual medical regulatory considerations should be reviewed carefully to see whether it should be applied. Due to the high cost nature of the claims and the fixed incomes of the insureds, special consideration should be given to the regulation of LTCI to minimize the likelihood of future rate increases.

2. **What is the difference between issue-age pricing and attained-age pricing?**

Under an attained-age rating structure, individuals pay rates that correspond to the risk at their particular age and do not reflect any pre-funding of risk for older ages. Rates may vary by single ages or age bands.

Premium rates for issue-age policies are determined to “pre-fund” escalating claim costs as the insured gets older without an increase in premium rates. This means paying more than necessary to cover the risk in the early policy years and less than necessary to cover the risk in the later years. Active life reserves must be established because level premiums are higher than necessary to cover claim costs in the early years of a policy, and lower than necessary to cover the higher claim costs at later ages.

3. **What if a state requires prior approval of premium rate increases?**

A drafting note following the initial paragraph under Section 20B of the Model Regulation states:

> In states where the Commissioner is required to approve premium rate schedule increases, ‘shall provide notice’ may be changed to ‘shall request approval.’

E. **CAVEAT**

While this manual is intended to be reasonably comprehensive, it is impossible to anticipate every possible set of circumstances. This manual is only one of a number of references that should be used in testing compliance of a LTCI premium filing with the state’s laws and regulations. Generally, the state’s regulations (or laws) will be consistent with the Model Regulation, which contains useful drafting notes. In addition, Actuarial Standard of Practice 18 and any practice notes issued by the American Academy of Actuaries (AAA) should be reviewed. Another important resource is judgment. Appropriate judgment is an important element of each and every step of the tests discussed herein. In particular, there are certain to be circumstances wherein a guideline requirement may not apply. This manual should not be considered to be a limit on appropriate actuarial methodologies.

In using judgment, a major concern is “gaming,” that is, complying with the letter of the law, but pushing the limits and definitions beyond common sense. The possibility of gaming should be avoided by insurers and actuaries. They should apply good judgment in complying with a state’s requirements. The regulator should also use judgment in determining whether gaming is taking place.
Section II. WHAT IS LONG-TERM CARE INSURANCE?

A. DEFINITION OF LONG-TERM CARE INSURANCE

As defined in Section 4 of the NAIC Long-Term Care Model Act (Model Act), long-term care insurance means any insurance policy or rider that is advertised, marketed, offered or designed to provide coverage 1) for not less than 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid or other basis, and 2) 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.

1. What does the definition include?

Long-term care insurance includes contracts (policies, riders, and certificates of coverage) in each of the following formats:

(a) Contracts that provide LTCI under:
- Stand-alone policies
- Group and individual annuities
- Life insurance policies or riders

(b) Contracts regardless of long-term care tax qualification:
- That are intended to be tax-qualified under the federal Health Insurance Portability and Accountability Act (HIPAA)
- Those that are not intended to be tax-qualified under HIPAA

(c) Contracts regardless of type of long-term care benefits:
- Covering institutional long-term care benefits only
- Covering non-institutional long-term care benefits only
- Covering institutional and non-institutional care

(d) Other insurance contracts that are advertised, marketed or offered as LTCI

2. What does the definition exclude?

LTCI does not include any insurance contract that is offered primarily to provide:

(a) Basic Medicare supplement coverage
(b) Basic hospital expense coverage
(c) Basic medical-surgical expense coverage
(d) Hospital confinement indemnity coverage
(e) Major medical expense coverage
(f) Disability income or related asset protection coverage
(g) Accident only coverage
(h) Specified disease or specified accident coverage
(i) Limited benefit health coverage

Also, LTCI does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.
B. WHAT ENTITIES MAY ISSUE LONG-TERM CARE INSURANCE?

Long-term care insurance may be issued by:

- Insurers;
- Fraternal benefit societies;
- Nonprofit health, hospital and medical service corporations;
- Prepaid health plans;
- Health maintenance organizations; and
- All similar organizations.

C. COMBINATION PRODUCTS

1. What is a combination product?

A “combination product” is a product that combines LTCI with other products. For example, LTCI may be combined with life insurance, annuities or any of the accident and health products listed in Section A above. The LTCI may be part of the policy itself or may be a rider to the policy.

2. Does the Model Regulation apply to combination products?

LTCI included in combination products is covered by the Model Act and the Model Regulation if it meets the definition of LTCI in the Model Act.

3. What special exceptions exist for combination products?

Because of the nature of combination products and other regulations that may apply, LTCI included in certain combination products is exempt from parts of the Model Regulation. The most notable exemption pertains to Section 20, Premium Rate Schedule Increases. To qualify for exemption from Section 20, a combination product must meet five conditions similar to those previously required for exemption from Section 19, Loss Ratio, and one new condition that the long-term care benefits provided be “incidental.” For this purpose, “incidental” means that the long-term care benefits provided must be less than 10% of the total value of the benefits provided over the life of the policy.

The five conditions that must all be met are listed here:

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 LTCI law similar to Sections 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 law 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, shall include a description of the type(s) 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.

D. QUESTIONS AND ANSWERS

1. Does the LTCI Model Regulation apply to disability income policies?

As indicated above in Section IIA2(f) of this manual, LTCI does not include policies that primarily provide disability income or related asset protection coverage. However, a policy is regulated as LTCI if it satisfies the definition of LTCI, even if it is called disability income. This issue was addressed in a drafting note in Section 3, Applicability and Scope, of the Model Regulation. The applicable model language is shown below.
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.

2. **Does the LTCI Model Regulation apply to riders as well as policies?**

   Yes, riders that meet the definition of LTCI are subject to the regulation.

3. **Does the LTCI Model Regulation apply to home health care only riders?**

   Yes, the definition of LTCI in the Model Regulation does not differentiate between care that is provided on an institutional basis or a non-institutional basis. Therefore, home health care only riders that meet the definition of LTCI would be subject to the regulation.

4. **How are long-term care benefits determined to be incidental?**

   “Incidental” means that the long-term care benefits provided must be less than 10% of the total value of the benefits provided over the life of the policy. The Model Regulation has the following drafting note to help clarify how long-term care benefits may be determined to be incidental.

   **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.
Section III. WHEN DO THE NEW REGULATIONS APPLY?

This section of the guidance manual explains the following:

- When the new rating provisions of the NAIC Long-Term Care Insurance Model Regulation become effective;
- What regulators should expect from insurers; and
- What insurers and regulators might do to maximize the value of the new regulations.

This section focuses on the consumer disclosures required by Section 9 of the Model Regulation, the initial form filing requirements of Section 10, the loss ratio requirements of Section 19, and the rate increase requirements of Section 20. An overview of the requirements is given in the chart below. Following the chart are a series of questions and answers intended to illustrate the more common situations to be expected.

A. EFFECTIVE DATES OF NEW REGULATION

To determine which sections apply, the dates when the policy form was originally available for sale in a state and when a policy or certificate was issued need to be taken into consideration.

<table>
<thead>
<tr>
<th>When Policy Form Was Available</th>
<th>When Policy or Certificate Was Issued</th>
<th>Sec. 9 Consumer Disclosure</th>
<th>Sec. 10 Initial Filing</th>
<th>Sec. 19 Loss Ratio</th>
<th>Sec. 20 Rate Increases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to [6 months after adoption of the amended regulation]</td>
<td>Prior to [6 months after adoption of amended regulation]</td>
<td>N/A</td>
<td>N/A</td>
<td>Applies same as before</td>
<td>N/A</td>
</tr>
<tr>
<td>On or after [6 months after adoption of the amended regulation]</td>
<td>Applies²</td>
<td>Applies to new business if and when rates for new business are increased</td>
<td>N/A</td>
<td>Applies²</td>
<td></td>
</tr>
<tr>
<td>On or after [6 months after adoption of the amended regulation]</td>
<td>Any time</td>
<td>Applies</td>
<td>Applies</td>
<td>N/A</td>
<td>Applies</td>
</tr>
</tbody>
</table>

¹Note that some states may adopt modified language or may interpret Section 10 of the LTCI Model Regulation to require the initial filing for any policy or certificate issued on or after the appropriate number of months (i.e., 6 or 12 depending on individual or specified group business) after adoption of the amended regulation regardless of when the policy form was first available.

²If a certificate is issued under certain group policies on or after the date of adoption of the amended regulation, Sections 9 and 20 apply on the first group policy anniversary on or after 12 months after adoption of the amended regulation.

The certain group policies referenced above are those that:

1. Were issued to an eligible group defined in Section 4E(1) of the NAIC Long-Term Care Insurance Model Act. These include policies issued to one or more employers or labor organizations, or to a trust or trustee of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organization; and
2. Were in force at the time the amended regulation was adopted.
B. QUESTIONS AND ANSWERS

Each of these questions and answers assumes that your state adopted the new provisions of the NAIC Model Regulation on July 1, 2001, and that Sections 9, 10 and 20 are effective six months after adoption on Jan. 1, 2002. Exceptions for group LTCI are covered in the question about group insurance.

1. An insurer reviews the new regulations and concludes that it would like to continue to use its existing policy form and its current rates beyond January 2002.

(a) Is this permissible?

Yes. There is nothing in the Model Regulation that requires an insurer to change its rates or policy forms.

(b) What must the insurer do?

(1) The insurer may continue to sell its existing policy form using its existing rates.

(2) Before Jan. 1, 2002, the insurer must develop the new consumer disclosure materials required by Section 9 and file those materials in a timely manner.

(3) The new consumer disclosure materials must be used for all policies issued on and after Jan. 1, 2002.

(4) Based on Section 28 of the Model Regulation, Nonforfeiture Benefit Requirements, the insurer must provide contingent benefits upon lapse for all policies issued on or after Jan. 1, 2002.

(c) Is there anything else that the insurer should do?

If the insurer has completed the requirements in Question 1(b) above, the insurer has complied with the law and nothing else is required. However, it would be prudent for the insurer to conduct an actuarial review of its rates and assure itself that it would be in position to comply with Section 20, Premium Rate Schedule Increases, in the event of a future rate increase on the policy form. The rate increase provisions limit increases and provide other consequences if insurers continue to charge inadequate rates.

(d) What can the regulator do to ensure that the insurer conducts this review?

The model does not require an insurer to do such a review. The regulator could remind insurers of potential consequences and encourage those insurers that continue to use older rates and forms to voluntarily file the actuarial opinion required by Section 10 for any forms the insurers continue to sell after a period of time (e.g., one year after the effective date). If the regulator is concerned about the adequacy of the rates, the state’s general statutory authority may allow the regulator to require the filing of an actuarial memorandum and may allow withdrawal of the regulator’s approval of the form for future sales if the actuarial memorandum does not adequately demonstrate adequacy of the rates.

2. Should states require certification under the revised standards on existing forms?

It is widely interpreted that the Model Regulation does not require such filing; however, some states may adopt modified language or may interpret that such filings are required. Even if not required, the regulator may request information under the state’s general statutory authority. As stated in Section 10B of the Model Regulation, the Actuarial Certification required as part of an initial filing applies only to new LTCI
policy forms “[made] available for sale” at least six months after adoption of the amended regulation. The model provides no authority to require certifications on a retroactive basis for existing policy forms. Question 1 above encourages insurers to review existing forms that it plans to continue to use and encourages regulators to remind insurers of the value of such a review. However, as indicated in Question 1 above, other statutory requirements may apply.

3. **An insurer plans to develop new forms and rates. What must the insurer do?**

The insurer must file the new policy form and rates with the consumer disclosure materials required by Section 9 and the Actuarial Certification required by Section 10.

4. **Because insurers can continue to sell previously approved policy forms and rates after the new regulations are effective, doesn’t this mean that future rate increases could involve some policies that are subject to Section 20 of the Model Regulation, and some policies that are subject to Section 19? If so, what complications does this involve?**

Yes. Insurers would be under two standards. If rate increases were needed, an insurer could bifurcate a policy form and determine different rate increases for the older and newer policies. Alternately, an insurer might want to treat the entire form under the newer standard. While the law will vary by state, that treatment may be permitted. Some states’ statutory requirements incorporate the concept of a class, which may affect the way rate increases are handled.

5. **Is the effective date for the new regulation different for group insurance?**

There is only one difference. If a certificate is issued under certain group policies on or after the date of adoption of the amended regulation, Sections 9 and 20 apply on the first group policy anniversary on or after 12 months after adoption of the amended regulation. The certain group policies referenced above are those that:

a. Were issued to an eligible group defined in Section 4E(1) of the NAIC Long Term Care Insurance Model Act. These include policies issued to one or more employers or labor organizations, or to a trust or trustee of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organization; and

b. Were in force at the time the amended regulation was adopted.

6. **What if an insurer wishes to apply Section 20 requirements to its entire block of existing business for ease of administration?**

An insurer may wish to apply the new requirements of Section 20 to a block of business comprised of some older policies covered by older regulations and some newer policies covered by Section 20. It may be possible to do this without violating the old or new regulations. While the law will vary by state, that treatment may be permitted. The insurer and the regulator should review the state’s unfair trade practices act with regard to unfair discrimination.
Section IV. DISCLOSURE TO CONSUMERS

The NAIC Long-Term Care Insurance Model Regulation includes several requirements intended to assist insurers in providing consumers with adequate information at the time of purchase. This section of the guidance manual is intended to address only the disclosures relating to rating.

A. CONSUMER DISCLOSURE FORMS RELATING TO RATING

The regulation includes two consumer disclosure forms designed to provide information about the insurer’s rating practices and to inform consumers about the rate increase potential of the LTCI that they are purchasing.

1. The Long-Term Care Insurance Personal Worksheet provides the consumer with information about the insurer’s rating practices. It also addresses suitability of purchase, sources of premium payments and the consumer’s ability to afford a rate increase. This form is found in Appendix B of the Model Regulation.

2. The Long-Term Care Insurance Potential Rate Increase Disclosure Form provides consumers with information about initial rates, potential for rate revisions and administrative practices for rate adjustments. It also informs the consumer about his or her rights in the event of a rate increase. This form is found in Appendix F of the Model Regulation. Appendix F was amended to recognize that an additional disclosure requirement for limited pay products is necessary to reflect the additional CBL option available from the changes to Section 28 of the Model Regulation.

Both forms are in a standardized format. In general, only the bracketed information should change. However, there may be instances where some deviation from the standard language and/or the bracketed language is necessary to avoid inconsistency, ambiguity or misrepresentation. The only time that deviations in the language should be allowed is when the information provided would be incorrect, ambiguous or inconsistent without such deviation. Examples of instances where the standard language should be modified are found below in Subsection D.

Insurers are required to file the disclosure forms with the initial rate filing, and whenever rates are modified. Insurers that decide to continue the use of an existing policy form after the effective date should file the disclosure documents with the Commissioner at least 30 days prior to their use.

The rate increase history section of the Long-Term Care Insurance Personal Worksheet is intended to provide the consumer with an unbiased look at an insurer’s rating practices. The rate increase history includes information about the policy form that the applicant is applying for and about any similar policy forms. Based on the date of the application, this will include history prior to adoption of the new Model Regulation for at least 10 years.

B. SIMILAR POLICY FORMS

Similar policy forms are defined in the regulation as all LTCI insurance policies and certificates issued by an insurer that have the same long-term care benefit classification as the policy being considered.

For this purpose, benefit classifications are: 1) institutional LTCI benefits only; 2) non-institutional LTCI benefits only; and 3) comprehensive LTCI benefits.

Group certificates that meet the definition in Section 4E(1) of the Model Act are only similar to other group certificates with the same LTCI benefit classification.

The classification into institutional only, non-institutional only, or comprehensive should be determined based on the total benefits contained in the product provided to the insured. The category should not be determined based

© 2003, 2009 National Association of Insurance Commissioners
on policy format, such as whether the benefit was added via a rider or part of the basic policy. Below is a chart further explaining classification determination. As indicated in the prior paragraph, this chart should be applied separately for Specific Group Business (as defined in Section III B of the manual) and for all other business.

<table>
<thead>
<tr>
<th>Rider</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Institutional</td>
</tr>
<tr>
<td>Institutional</td>
<td>Institutional</td>
</tr>
<tr>
<td>Non-Institutional</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Institutional &amp; Non-institutional</td>
<td>N/A</td>
</tr>
<tr>
<td>None</td>
<td>Institutional</td>
</tr>
</tbody>
</table>

C. RATE INCREASE HISTORY

When the rate increase history includes forms that have had a premium rate increase, the insurer can provide explanatory information. This information should be short, clear and readily understandable by consumers. The explanation should provide a fair representation of the reasons why rate increases occurred. Insurers should not be prohibited from providing information on the number of policies affected by premium rate increases. The regulator should consider whether such information would be useful to applicants. When provided, the information should represent the insurer’s in force policies at the time of the rate increase. Information that spans a number of years should not be allowed as it may understate the proportion of policies affected by the rate increase.

If the information presented is unclear or appears to be incomplete, the regulator should ask the insurer for additional information.

D. RATE INCREASE HISTORY EXAMPLES

Following are generalized examples of the Rate Increase History section of the Long-Term Care Insurance Personal Worksheet. These examples are not comprehensive, but are intended to give general guidance on the appearance and content of this section.

**Long-Term Care Insurance Personal Worksheet**

**Rate Increase History Section**

**Example 1 - Insurer has never increased rates.**

<table>
<thead>
<tr>
<th>Rate Increase History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurer X has sold long-term care insurance since 1992 and has sold this policy since 1998. The insurer has never raised its rates for any long-term care policy it has sold in this state or any other state.</td>
</tr>
</tbody>
</table>

**Example 2 - Insurer has increased rates on a form more than 10 years ago.**

<table>
<thead>
<tr>
<th>Rate Increase History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurer X has sold long-term care insurance since 1984 and has sold this policy since 1997. The insurer has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.</td>
</tr>
</tbody>
</table>
Example 3 - Insurer has increased rates on a form in the last 10 years. One rate increase was a 10% increase for all cells. The other rate increase varied from 5 to 15%. The insurer may provide an explanation of the rate increase as long as the information is presented in a fair manner. Following are several examples showing explanations that may be acceptable or unacceptable, depending on the state statutory requirements.

Rate Increase History (Acceptable per Model Regulation)

<table>
<thead>
<tr>
<th>Years</th>
<th>Available Rate History</th>
<th>Form</th>
<th>for Purchase</th>
<th>Rate History</th>
<th>Rate Increase(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993-1996</td>
<td>5%-15% rate increase in 1996</td>
<td>LTC300</td>
<td>1993-1996</td>
<td>10% rate increase in 1998</td>
<td></td>
</tr>
</tbody>
</table>

The rate increase on form LTC300 was caused by home health care benefits often exceeding the amount that the policyholder was charged for the care. This caused claim experience to be higher than anticipated. This plan design is no longer available.

Below are alternative explanations that are equally acceptable and could be substituted for the last paragraph in the above Rate Increase History:

a) In 1996, form LTC300 had 50,000 policies in force out of 125,000 total long-term care policies in force. In 1998, form LTC300 had 43,000 policies in force out of 200,000 total long-term care policies in force.

b) The rate increase on form LTC300 was caused by higher than expected use of home health care benefits. In 1996, form LTC300 had $1,500,000 in annualized premium in force out of $5,000,000 total long-term care annualized premium in force. In 1998, form LTC300 had $1,300,000 annualized premium in force out of $12,200,000 total long-term care annualized premium in force.

c) In 1996, form LTC300 included 25% of our long-term care policies in force. In 1998, form LTC300 included 22% of our long-term care policies in force.

Rate Increase History (Unacceptable per Model Regulation)

<table>
<thead>
<tr>
<th>Years</th>
<th>Available Rate History</th>
<th>Form</th>
<th>for Purchase</th>
<th>Rate History</th>
<th>Rate Increase(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993-1996</td>
<td>5%-15% rate increase in 1996</td>
<td>LTC300</td>
<td>1993-1996</td>
<td>10% rate increase in 1998</td>
<td></td>
</tr>
</tbody>
</table>

The rate increase on form LTC300 was beyond the control of the insurer due to higher than anticipated use of home health care benefits. [Italics added.]
Below are examples of additional explanations that might not be acceptable to a state.

- The rate increase on form LTC300 was caused by higher than expected use of home health care benefits. In 1996, form LTC300 had $1,500,000 in annualized premium in force. Our insurer has sold $40,000,000 in annualized premium since 1996. In 1998, form LTC300 had $1,300,000 annualized premium in force out of $20,500,000 total long-term care annualized premium sold since 1998. {Italics added.}

- Form LTC300 represents only 3% of our insurance business. {Italics added.}

**Example 4 - Insurer has increased rates on more than one form in the last 10 years. On one form, the increase was on the home health care rider only. The insurer may note that the increase affected only the home health rider. The increase percentage should be determined by looking at the total policy premium (base policy plus home health rider).**

### Rate Increase History

Insurer X has sold long-term care insurance since 1988 and has sold this policy since 1996. The insurer has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).

<table>
<thead>
<tr>
<th>Policy Form</th>
<th>Years Available</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC001</td>
<td>1988–1996</td>
<td>20% rate increase in 1993</td>
</tr>
<tr>
<td>LTC002</td>
<td>1995–present</td>
<td>0%–5% rate increase in 1998</td>
</tr>
</tbody>
</table>

On policy form LTC002, the base plan rates were not changed. Only rates on the home health care rider were increased. The rate increase amounts shown above for policy form LTC002 indicate the change in the total premium rate, not just the change in the premium rate attributable to the health care rider.

**Example 5 - Insurer has increased rates in five states in the last 10 years. This increase must be disclosed in all states.**

### Rate Increase History

Insurer X has sold long-term care insurance since 1993 and has sold this policy since 1996. The insurer has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).

<table>
<thead>
<tr>
<th>Policy Form</th>
<th>Years Available</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC00A</td>
<td>1996–present</td>
<td>15% rate increase in 1998</td>
</tr>
</tbody>
</table>

Policy form LTC00A is sold in 38 states. Rates were increased in 5 state(s).
**Example 6** - Insurer increased rates on a form. After monitoring experience, the insurer decreased rates on the form.

**Rate Increase History**

Insurer X has sold long-term care insurance since 1988 and has sold this policy since 1996. The insurer has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).

<table>
<thead>
<tr>
<th>Years</th>
<th>Policy Form</th>
<th>Available for Purchase</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td>1988–1997</td>
<td>LTC700</td>
<td>15% rate increase in 1993</td>
<td></td>
</tr>
<tr>
<td>1988–1997</td>
<td>LTC700</td>
<td>0%–10% rate decrease in 1997</td>
<td></td>
</tr>
</tbody>
</table>

After rates were increased on form LTC700, monitoring of experience showed that the increase brought some rates to a level that was higher than necessary. Rates were reduced to reflect this.

**Example 7** - Insurer increased rates on a nursing home only form, but has never increased rates on a comprehensive policy or on a non-institutional policy. The disclosure for the comprehensive and non-institutional policies could use the language stating that they have had no increase. For an institutional policy, the increase would have to be disclosed.

**Rate Increase History (Institutional Policy)**

Insurer X has sold long-term care insurance since 1987 and has sold this policy since 1996. The insurer has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).

<table>
<thead>
<tr>
<th>Years</th>
<th>Policy Form</th>
<th>Available for Purchase</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990–1995</td>
<td>LTC001</td>
<td>25% rate increase in 1993</td>
<td></td>
</tr>
</tbody>
</table>

**Rate Increase History (Non-Institutional or Comprehensive Policy)**

Insurer X has sold long-term care insurance since 1987 and has sold this policy since 1997. The insurer has not raised its premium rates on this policy form or similar policy forms in the last 10 years.
**Example 8** - Insurer increased rates on a home health rider, but has never increased rates on an institutional policy or on a comprehensive policy. The disclosure for institutional policy forms that cannot have home health riders could use the language stating that they have had no increase. For a non-institutional or an institutional policy form to which a non-institutional rider may be attached, the increase would have to be disclosed. Additionally, the increase would have to be disclosed for comprehensive policies because institutional policies that have a non-institutional rider attached would be similar to comprehensive policies (see chart in Section IV. B. of the manual).

### Rate Increase History (Non-Institutional Policy, Comprehensive Policy, or Institutional Policy with Non-Institutional Rider)

Insurer X has sold long-term care insurance since 1987 and has sold this policy since 1996. The insurer has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).

<table>
<thead>
<tr>
<th>Policy Form</th>
<th>Years Available for Purchase</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC100</td>
<td>1988–1992</td>
<td>3%–7% rate increase in 1994</td>
</tr>
</tbody>
</table>

The increase on form LTC100 was on a rider providing coverage for home health care. The rates on the base policy were not modified. The rate increase amounts shown above for policy form LTC100 indicate the change in the total premium rate, not just the change in the premium rate attributable to the home health care rider.

### Rate Increase History (Institutional)

The insurer has sold long-term care insurance since 1987 and has sold this policy since 1997. The insurer has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.
**Examples 9 – 11 involve insurers where business has been acquired.**

**Example 9** - Insurer A has not increased rates on any form except as follows. Insurer A acquired form LTC010 from Insurer B (non-affiliated) in 1999. Insurer B raised rates 30% in 1996. Insurer A raised rates on LTC010 20% in 2000.

Insurer A - Since the rate increase in 2000 was within 24 months of acquisition, Insurer A does not have to disclose it. However, they may if they choose. The insurer may use either of the types of disclosures below. Below are examples of acceptable disclosures for one of Insurer A’s existing policy forms.

**Rate Increase History (Insurer A)**

Insurer A has sold long-term care insurance since 1986 and has sold this policy since 1986. The insurer has never raised its rates for any long-term care policy it has sold in this state or any other state.

**or**

**Rate Increase History (Insurer A)**

Insurer A has sold long-term care insurance since 1986 and has sold this policy since 1986. The insurer has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).

<table>
<thead>
<tr>
<th>Years</th>
<th>Policy Available for Purchase</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC010</td>
<td>1995–1998</td>
<td>2000 - 20% increase</td>
</tr>
</tbody>
</table>

Policy form LTC010 was originally issued by another insurer. The business was acquired by the insurer in 1999.

Insurer B - All increases must be disclosed, including increases on sold business that are made in the 24 months following acquisition. Below is an example of an acceptable rate increase history for one of Insurer B’s remaining policy forms.

**Rate Increase History (Insurer B)**

Insurer B has sold long-term care insurance since 1988 and has sold this policy since 1998. The insurer has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).

<table>
<thead>
<tr>
<th>Years</th>
<th>Policy Available for Purchase</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC010</td>
<td>1995–1998</td>
<td>1996 - 30% increase 2000 - 20% increase</td>
</tr>
</tbody>
</table>

Policy form LTC010 had higher benefit utilization than expected. This business was sold to another insurer in 1999.

Insurer A - Since Insurer A raised the rates on the acquired business more than once, they must disclose all rate increases that they implemented. Below is an example of an acceptable rate history for one of Insurer A’s existing policy forms.

Rate Increase History (Insurer A)

Insurer A has sold long-term care insurance since 1986 and has sold this policy since 1986. The insurer has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).

<table>
<thead>
<tr>
<th>Years</th>
<th>Policy Form</th>
<th>Available Rate for Purchase</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC010</td>
<td>1995–1998</td>
<td>2000 - 20% increase</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2001 - 15% increase</td>
<td></td>
</tr>
</tbody>
</table>

Policy form LTC010 was originally issued by another insurer. The business was acquired by the insurer in 1999.

Insurer B - Must disclose all increases including increases on sold business that are made in the 24 months following acquisition. Does not have to disclose the second increase made by Insurer A. Below is an example of an acceptable rate increase history for one of Insurer B’s remaining policy forms.

Rate Increase History (Insurer B)

Insurer B has sold long-term care insurance since 1988 and has sold this policy since 1998. The insurer has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).

<table>
<thead>
<tr>
<th>Years</th>
<th>Policy Form</th>
<th>Available Rate for Purchase</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC010</td>
<td>1995–1998</td>
<td>1996 - 30% increase</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2000 - 20% increase</td>
<td></td>
</tr>
</tbody>
</table>

Policy form LTC010 had higher benefit utilization than expected. This business was sold to another insurer in 1999.
Example 11 – Same facts as example 9, except Insurer A had raised rates on one of their own forms more than 10 years ago. This is a case where the bracketed language from the regulation must be modified in order for the insurer to make a factually correct statement. The language “the insurer has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years” should be changed to read “The insurer has not raised its rates for this policy form or similar policy forms it has sold in this state or any other state in the last 10 years.” As in example 9, the insurer may choose to disclose the rate increase.

Rate Increase History (Insurer A)

Insurer A has sold long-term care insurance since 1987 and has sold this policy since 1997. The insurer has not raised its rates for this policy form or similar policy forms it has sold in this state or any other state in the last 10 years.

or

Rate Increase History (Insurer A)

Insurer A has sold long-term care insurance since 1986 and has sold this policy since 1986. The insurer has raised its premium rates on this policy form or similar policy forms it has sold in the last 10 years. Following is a summary of the rate increase(s).

<table>
<thead>
<tr>
<th>Years Available for Purchase</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC010 1995–1998</td>
<td>2000 - 20% increase</td>
</tr>
</tbody>
</table>

Policy form LTC010 was originally issued by another insurer. The business was acquired by the insurer in 1999.

Insurer B would have the same disclosure as in example 9.

Examples 12-14 involve combination products.

Example 12 – An insurer sells a disability income policy with a long-term care rider. The rates for the disability income base policy were increased by 20%. The insurer has never raised rates on long-term care. In this case, the insurer would not show any rate history since the increase was solely on the disability income policy. The insurer could modify the bracketed language as follows: “The insurer has sold long-term care insurance since 1996 and has sold this policy since 1996. The insurer has never raised its rates for any long-term care policy it has sold …” changes to “The insurer has sold long-term care insurance since 1996 and has sold this rider since 1996. The insurer has never raised its rates for any long-term care policy or rider it has sold.”

Rate Increase History

The insurer has sold long-term care insurance since 1996 and has sold this rider since 1996. The insurer has never raised its rates for any long-term care policy or rider it has sold in this state or any other state.
Example 13 – An insurer sells a disability income policy with a long-term care rider. They sell no other long-term care coverage. The rates for the long-term care rider were increased by 30%. Because the increase was on the long-term care rider, the insurer must disclose the rate increase for any policy form or rider developed in the future having similar benefits. The insurer could modify the bracketed language as follows: “The insurer has sold long-term care insurance since 1996 and has sold this policy since 1996” changes to “The insurer has sold long-term care insurance since 1996 and has sold this rider since 1996.”

Rate Increase History

The insurer has sold long-term care insurance since 1996 and has sold this rider since 1996. The insurer has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).

<table>
<thead>
<tr>
<th>Years for Purchase</th>
<th>Policy Form</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC010</td>
<td>1996–present</td>
<td>2000 - 30% increase on rider rates</td>
</tr>
</tbody>
</table>

Rider form LTC010 is a rider attached to disability income policies.

Example 14 – An insurer sells a disability income policy that has long-term care benefits in the base policy. The policy is considered a long-term care policy under the regulation’s definition. The rates for the policy were increased by 25%. Regardless of the reason for the rate increase, the insurer must disclose the rate increase for any similar policy.

Rate Increase History (this policy or any similar LTC policy)

Insurer X has sold long-term care insurance since 1996 and has sold this rider since 1996. The insurer has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).

<table>
<thead>
<tr>
<th>Years for Purchase</th>
<th>Policy Form</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td>DILTC1</td>
<td>1996–present</td>
<td>2000 - 25% increase</td>
</tr>
</tbody>
</table>

Policy form DILTC1 includes disability income benefits and long term care benefits.

E. QUESTIONS AND ANSWERS

1. What is the difference between institutional and non-institutional long-term care benefits?

   Generally, institutional benefits are based on each day that the insured is confined to a facility and is receiving services. Non-institutional benefits are usually based on specific services or visits, not days.

2. When does the rate history start?

   The rate history is shown for a period extending back 10 years from the date that an application is taken.
3. **Does the regulation require disclosure only of premium schedule increases that occur after the effective date of the regulation?**

   No. All premium schedule increases in the last 10 years must be disclosed regardless of whether they occurred before or after the effective date of the regulation.

4. **Does the 10-year time frame date back to when the premium schedule increases were approved or when they were implemented?**

   The time frame should be based on the date a premium schedule increase was implemented.

5. **When does an insurer have to file disclosure forms?**

   The forms must be filed during the initial filing and any other time that rates are modified in this state or any other state. Where an insurer is filing for premium rate schedule increases in a number of states, it is expected that the disclosures will be updated at least every year. Insurers must also file disclosure forms for any plans that were approved prior to the effective date of this regulation but are going to be marketed after the effective date.

6. **When does an insurer have to provide disclosure forms to an applicant?**

   The disclosure forms must be provided to the applicant at the time of application unless the method of application does not allow for it. Methods that do not allow for delivery at time of application include application by mail, electronic application, and interactive voice response (IVR) application. With these methods of application, the disclosure must be provided no later than when the policy or certificate is delivered.

7. **When does an insurer have to provide disclosure forms to a policyholder?**

   Every policyholder affected by the premium rate increase must be given updated disclosure forms at the same time as the notification of the rate increase.

8. **Does an insurer have to list every plan code that had a rate increase?**

   If an insurer has different plan codes under the same plan series (e.g. LTC001-01, LTC001-02, etc.), the insurer can show the rate increase under that plan series. However, if the rate increase varies by plan code, the insurer needs to disclose the full range of the premium increase. If the plans are substantially different, the insurer should show each plan separately.

9. **Can an insurer list all long-term care forms in its rate increase history including forms with no rate increase?**

   No. The rate increase history should include only policy forms where rates were increased. Depending on the state, an insurer may be able to provide an explanation of the increase indicating how much of its long-term care business was affected by the premium schedule increase. However, any information concerning policies or premiums in force should be for the year that the rate increase was implemented.

10. **An insurer raised rates on a home health rider attached to a nursing home only policy. With what types of plans does this increase need to be disclosed?**

    Comprehensive plans and other types of plans with non-institutional riders would be required to disclose the increase. For an applicant applying for a long-term care policy with a rider providing non-institutional care, the increase would need to be shown. For an applicant applying for an institutional-only policy with no non-institutional care, the insurer would not be required to disclose the increase.
11. **If an insurer increases rates on a home health rider attached to an institutional only policy, how is the rate increase percentage calculated?**

The rate increase would be calculated based on the total premium rate. If the average increase on the rider was 15% and the premium rate for the home health rider is 20% of the total premium rate, then a 3% (3% = 15% x 20%) rate increase would be disclosed.

12. **If the state permits information relating to the number of policies affected by the rate increase, are there useful rules to apply?**

To show what percentage of policies have received rate increases, an insurer may show annualized premium in force or policies in force for both the portion of its LTCI business subject to the rate increase and its total LTCI business. However, the amounts should be only for the insurer’s long-term care business. An insurer cannot express percentages or other numbers that incorporate all of the insurer’s business including policies that provide no long-term care coverage. The numbers for policies in force or annualized premium in force should be shown for the year of the rate increase only. Annualized premiums for a specific rate increase should be based on the in force premiums immediately preceding implementation of the rate increase and should not include the relevant rate increase. An insurer may not show numbers that reflect a span of years. The intention is to provide the consumer with a picture of how much of the insurer’s long-term care business was affected at the time of the rate revision.
Section V. INITIAL FILING

The regulator should determine whether the information presented in filings is consistent with the guidance in this manual to the extent appropriate. Your state may not have adopted all sections of the model. Therefore, reviewing the insurer’s initial filing should be consistent with your state’s statutes and regulations. Each of the items in the filing should meet or exceed minimum standards contained in your state’s statutes and regulations related to LTCI.

A. MATERIALS THAT ACCOMPANY A FILING

In most situations, the filing will include the following, provided in accordance with state filing requirements:

- Policy Form
- Disclosure Materials
- Premium Rate Schedule
- Actuarial Certification

An insurer may file a new set of premium rates to be used for new sales. If the sales will be of an existing policy form, the filing must also include disclosure materials and the Actuarial Certification. Because the state would have already received a copy of the form, the insurer may or may not be required to resubmit a copy of it.

The model provides no authority to require certifications on a retroactive basis for existing policy forms that have no change in premiums for new business. However, the regulator may request information and ultimately withdraw approval of forms and rates under the state’s general statutory authority if appropriate.

B. POLICY FORM

The policy form should be provided in the filing to enable the regulator to review the benefits provided by the policy form and any riders that may be attached. Depending on state laws relating to contracts, the policy form may or may not need to describe contingent benefits upon lapse (CBL). The Model Regulation does not require it. For those states that do, the policy will need to be amended or endorsed to describe the benefit. In either case, CBL is assumed to be available in the event of substantial rate increases, as it will have been disclosed in the Potential Rate Increase Disclosure Form.

C. DISCLOSURE MATERIALS

The LTCI Model Regulation sets out certain required disclosures that are to be provided to consumers at specified times. These disclosures are discussed in Section IV of this manual.

Based on the revised Model Regulation, the following disclosure materials associated with the initial rate filing will be required:

- History of the insurer’s rating practices to be provided in the Rate Increase History Section of the Long-Term Care Insurance Personal Worksheet (Appendix B of the NAIC LTCI Model Regulation; and

- The Potential Rate Increase Disclosure Form (Appendix F of the NAIC LTCI Model Regulation).

The disclosure materials should clearly state that the rates may be adjusted in the future for in force contracts, unless the policy form is noncancelable.
D. PREMIUM RATE SCHEDULE

An initial filing must include a premium rate schedule, which should include rates for all options and riders to be offered by the insurer. The insurer should disclose any premium schedules not being provided along with an explanation of why these schedules were not included. (One such example is a rider that was previously filed, has met all the state statutory requirements, and has not had any rate changes.)

The filing for forms that include LTCI in conjunction with other types of insurance (e.g., life or disability coverage) may include the LTCI coverage as a separate rider. Such a rider would be subject to the LTCI Model Regulation, and the premium rate schedule for that rider would need to be filed.

The LTCI coverage may be a non-separable portion of the policy form. The insurer may provide details to justify that the LTCI benefits are “incidental.” Where there is no such justification, the entire product would be subject to these rules for initial filings, and the premium rate schedule for the entire product would need to be filed.

E. ACTUARIAL CERTIFICATION

The review of the Actuarial Certification involves the review of required materials, the review of the specific language used by the actuary and a review, if necessary, of the actuary’s qualifications. A sample Actuarial Certification is in Appendix 1.

1. Required Materials

The Actuarial Certification will include a number of specified sections. Of particular importance are the five sections identified below that relate to the actuarial work and the actuary’s opinion. The language in the Actuarial Certification addressing the first two of these sections should follow exactly the recommended wording. For the third section identified below, the Actuarial Certification should have the recommended wording but may include a “reliance statement.” The last two sections, describing the contract reserves and premium rate schedule relationships, may have many variations.

(a) In my opinion, the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated.

(b) I have reviewed and taken into consideration the policy design and coverage provided.

(c) I have reviewed and taken into consideration the insurer’s current or planned underwriting and claims adjudication processes.

The certification should include statements related to these items. The actuary may include a statement that he or she relied upon someone else employed or representing the insurer for this information. The information that was provided to the actuary should be a document available to the regulator. However, since the resource document may include significant proprietary information, in those cases where the regulator cannot guarantee confidentiality, the regulator may consider consulting other states (with confidentiality rules) or other methods of review to satisfy the state’s requirements for adequate review of insurer filings.

NOTE: The wording for the reliance should apply only to the review of the underwriting and claims adjudication processes.

(d) A complete description of the basis for contract reserves that are anticipated to be held, along with statements that:
(1) The assumptions used for reserves contain reasonable margins for adverse experience, and

(2) The net valuation premium for renewal years does not increase.

In addition, the certification should include either

(i) A statement that the difference between the gross premiums and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or

(ii) A complete description of the situations where this does not occur.

(e) Either 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 or a comparison of the premium schedules that are currently available with an explanation of the differences.

Both the contract reserve review and the comparison of premium rates are intended to be broadly based. The draft actuary’s certification in Appendix 1 uses the term “consistently in excess” while the Model Regulation in Section 10B(2)(d)(iv)(I) requires “the underlying gross premiums maintain a reasonably consistent relationship.” While it is not expected that every age, every elimination period, and every benefit option will be analyzed, a simple overall aggregation for the contract reserve review may not be sufficient. There should not be large fractions of the expected new issues where rates would have inadequate margins.

2. Review of the Language Used in the Certification

In addition to the comments about specific sections above, the Actuarial Certification should be read carefully to determine whether it is a clean opinion or a qualified opinion. A qualified opinion often uses wording such as the following: “except for the matter referred to in the preceding paragraph…” This is an indication that the information described in the preceding paragraph modifies the actuary’s opinion and in some manner weakens the certification. The regulator should carefully read any qualifying language and discuss the specific meaning of the qualification with the actuary. Based on the degree and significance of the qualification, the certification may be rejected as not compliant with statutory requirements.

3. Review of the Actuary’s Qualifications

The first thing is to verify that the signatory is a member of the American Academy of Actuaries. Membership in the AAA is a minimum requirement (unless the individual has been otherwise approved by the Commissioner), but it should be noted that not all members are qualified to perform all actuarial tasks. The AAA has qualification standards that a member must satisfy in order to issue a prescribed statement of actuarial opinion, such as an Actuarial Certification under the NAIC LTCI Model Regulation. If the regulator is in doubt about the actuary’s qualification, he may contact the ABCD and request guidance.

The American Academy of Actuaries also has Actuarial Standards of Practice, which apply to various aspects of the work required to sign the Actuarial Certification.

F. RIGHT TO REQUEST FURTHER INFORMATION

The regulator normally should be able to satisfy himself or herself with the adequacy of the premium rates, the reserves levels in comparison to the minimum requirements in the state of filing, and the disclosure to be provided. The regulator may need to review additional information about pricing assumptions. The Model Regulation gives the regulator the right to ask the insurer for more information. A state may require that an actuarial memorandum include all of the items listed in Appendix 5 or other items. Additional information concerning selected items from the list in Appendix 5 is provided in Question 1 of Section VI.D.
G. QUESTIONS AND ANSWERS

1. Why aren't loss ratios referenced in this section of the LTCI Model Regulation?

Initial premium rate schedules are not subject to any minimum loss ratio standard in order to allow insurers to include margins for adverse experience and to avoid the need to file for rate increases.

2. The LTCI Model Regulation had a 60% loss ratio. Is that no longer used?

The 60% loss ratio standard still applies to business written prior to the effective date of Sections 10 and 20. It still applies to initial and revised premium rate schedules for that business (see Section 19 of the Model Regulation).

3. What has changed in the actuary’s responsibilities?

In the past the actuary provided a certification that the assumptions underlying the premiums produced a benefits-to-premium ratio at or above the minimum loss ratio. Thus, the more aggressive the assumptions, the lower the premium and the easier it was to meet the loss ratio standard.

Under the new basis in Section 10, the Actuarial Certification contains two very important statements representing the actuary’s opinion. These statements should not vary from the recommended wording. Through these statements the actuary is opining that the premium rate schedule contains sufficient margin to allow for anticipated costs under expected conditions as well as under moderately adverse conditions. The opinion also states that the actuary reasonably expects that no future premium increases will be necessary.

4. What is the importance of the information filed on contract reserves?

The contract reserves provide for pre-funding of higher morbidity costs in the later durations. The contract reserves should be based on assumptions that generally mirror the pricing assumptions except that they contain additional margins. Some assumptions are limited by reserve standards (e.g. interest rates and termination rates). The contract reserve assumptions will create a “net valuation premium” for the first year and for all renewal years. In most cases, this valuation premium for renewal years will be level. The only exceptions are for attained-age based premium schedules under age 65, and when states permit the use of a two-year full preliminary term reserve. The NAIC Health Insurance Reserves Model Regulation includes a requirement for use of a one-year preliminary term reserve. The Actuarial Certification should include information about the reserve assumptions.

The Actuarial Certification also includes a statement about the level of the gross premium (the filed rate schedule). The certification should either state that the gross premium exceeds the sum of the net valuation premium for renewal years plus the average assumed renewal expenses or provide a detailed description of the circumstances where this does not occur. The detailed description may be small changes to the contract reserve assumptions that, if incorporated, would cause the gross premium to exceed the sum of the adjusted reserve premium plus the average assumed renewal expenses. Examples of this approach are included in Appendix 1. If the changes are truly small, the review by the regulator is not much different than if the actuarial certification had included the direct statement. The detailed description may involve a less direct manner of relating gross premium assumptions to contract reserve assumptions. The regulator may wish to request additional information on gross premium assumptions under Section 10C.
5. **When reviewing the Actuarial Certification, what should the regulator look for?**

The regulator should look for or the use of: (1) the recommended language; (2) additional “except for” language; and (3) “reliance” language.

If the regulator determines that the recommended language has been modified, or if the regulator has any other concerns with the Actuarial Certification, he or she should discuss the concerns with the certifying actuary. If the regulator is not satisfied, the regulator may wish to consult with other regulators, or contact the ABCD for guidance. The regulator may also wish to review Section F, Right to Request Further Information, and may ask for additional information related to the specific area(s) of concern.

6. **What does “moderately adverse experience” mean?**

There is no specific definition in the Model Regulation. Ultimately the actuary must determine a reasonable answer for the particular circumstances of each filing, relying on the guidance that is available. This phrase is used in the Actuarial Standards of Practice (ASOPs) and its reference here is intended to be consistent with those standards.

7. **What can I do if I think the assumptions are not reasonable for even moderately adverse conditions?**

The first thing would be to discuss your concerns with the actuary. That discussion may address your concerns fully. If not, you may want to talk to another state actuary who has experience with LTCI.

If you are unable to satisfy yourself through these approaches, you may contact the ABCD for its counsel on your concerns. To do this, you should write or call a member of the ABCD, which is listed in the yearbook and on the AAA website (www.actuary.org), and outline your concerns.

After all of these efforts, in the event you have not been satisfied, you can ask the ABCD to contact the actuary. If you feel that this is needed, you will be given directions in how to take formal action.

8. **What if initial rates were too high? How would regulators know?**

One of the critical tenets on which the new approach to rate stabilization has been built is that the market for LTCI is competitive. Thus if initial rates are “too high,” the consumer will decide to purchase coverage from a different insurer.

9. **How are rate guarantees handled under these rules?**

Rate guarantees were not specifically addressed in the development of the rate adequacy revisions to the model. It is not likely that a rate guarantee period of 5 years or less would have any effect on the Actuarial Certification. Where the rate guarantee period is longer, the actuary may be asked to address the rate guarantees under Section 10C of the Model Regulation.

10. **How are limited pay plans handled under these rules?**

Limited pay plans were not specifically addressed in the development of the rate adequacy revisions to the model. Most limited pay plans are options with the same benefits but a special higher premium schedule, and they are a very small percentage of sales. The assumptions described by the actuary in defining the reserve basis should be reviewed to assure that the impact of any limited pay options have been taken into account.
For example, the morbidity, mortality and interest assumptions should generally be the same (or very similar) as those used for lifetime pay plans. Persistency of most short limited pay plans (5 or 10 years) is very high reflecting the consumer decision to pay more in the early years. Where the limited pay is to age 65 or 70 and the issue age is under 50, the persistency will be closer to that for lifetime pay products.

11. **Are there any other issues that I should be aware of as a regulator?**

LTCI is a developing coverage as companies, consumers and regulators learn more about what is needed and what can be provided on a sound basis. For example, a key concept in today’s products is the place where care is given. Products sold in the 1980s generally provided coverage only for care given in a nursing home. Over the years, coverage has been more frequently provided in other settings: adult day care, assisted living facilities and at home. Now, there are policies that provide coverage without reference to place, wherever care is given.

It is a basic fact of LTCI that each aspect – policy design, initial premiums, underwriting, marketing, claim adjudication, and so on must be sound for the whole package to be sound. There are examples in the history of LTCI where only a single flaw caused significant premium rate increases, disgruntled insureds and lost coverage.

For example, if a new liberal benefit is offered and underwriting has not been reviewed and possibly revised, then claims may be higher than expected. If so, premiums will increase, and potentially, many insureds could lose coverage right when they most need it.

A key point is that all aspects of a LTCI policy need to be considered. All policy aspects should be reviewed to determine whether modifications are needed so that actual claims have a high probability of matching expected claims. This hopefully enables premiums to be stable “for the lifetime of the policyholder.”

12. **What should be considered if an insurer offers unisex rates?**

LTCI premium rates may be offered on a unisex basis although the expected experience varies by gender. The insurer’s expected mix of business by gender should be reviewed. Claim and active life reserves may be established using unisex morbidity and mortality subject to meeting minimum reserve requirements. For unisex assumptions, adjustments may be needed to reflect the expected mix of genders at each age.

13. **How does the regulator compare rates of different forms to determine that the company complies with the required standard that new business rates are not less than the premium rate for existing similar forms currently available from the insurer except for benefit differences?**

The comparison must be performed on a consistent basis. This means that it may be inappropriate to simply compare the two rate schedules directly. When the premium rate schedule for a new policy form is less than the premium rate schedule for an existing similar policy form also currently available from the insurer, and it is not clear whether this is a reasonable difference attributable to benefits, the regulator may wish to ask the company actuary to use one set of pricing assumptions to evaluate all forms. This is done for each form as if it were a new issue (the duration of the business is not directly considered at this point). This is not for the intent of determining the rate, but simply to determine the benefit differences between the forms. This analysis will give a benefit comparison between forms—say coverage A is 1.15 of coverage B. This relationship is then used to compare the rate schedule relationships. The model provides that the relationship should account for benefit differences.
Following is an example showing a comparison of product benefits used to determine the rate comparison.

Summary of material benefit differences:

<table>
<thead>
<tr>
<th>DETERMINATION OF PLAN RELATIVITIES</th>
<th>Plan A</th>
<th>Plan B</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHC benefits</td>
<td>1.0</td>
<td>1.0</td>
<td>No difference in coverage</td>
</tr>
<tr>
<td>Nursing home</td>
<td>1.0</td>
<td>1.0</td>
<td>No difference in coverage</td>
</tr>
<tr>
<td>Waiver of premium</td>
<td>1.0</td>
<td>.92</td>
<td>Plan B does not have PW</td>
</tr>
<tr>
<td>Restoration</td>
<td>1.10</td>
<td>1.0</td>
<td>Plan A has restoration</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1.10</td>
<td>.92</td>
<td></td>
</tr>
</tbody>
</table>

Plan A is 19.6% richer (1.10/.92) than Plan B. When comparing premiums at various ages, Plan A premiums should be 19.6% higher than Plan B premiums.

The actuary needs to use judgment in deciding which benefit factors would be additive and which would be multiplicative. A benefit that affects the entire policy, i.e., restoration, should be multiplicative, but two mutually exclusive coverages, i.e., nursing home or home health care services, may be considered to be additive.
Section VI. RATE INCREASE FILING

The prior chapters of this manual have related to the initial filing of premium rates and disclosures to applicants for long-term care insurance policy forms under the new LTCI Model Regulation. It is anticipated that the new rules for developing premium rate schedules will allow insurers to include greater margins and reduce the potential need for rate increases. However, the Model Regulation does provide for the filing, review and approval of premium rate increases, as well as the monitoring of ongoing experience in the event of a rate increase for policy contracts issued subject to the new Model Regulation.

This chapter covers the information to be filed and the basis for the regulator’s review of premium rate increase submissions under the new Model Regulation. Later chapters provide information relating to monitoring, additional regulatory oversight and potential regulatory actions for significant rate increases.

A. MATERIALS THAT ACCOMPANY A RATE INCREASE FILING

The information to accompany a filing for a rate increase is defined in Section 20 of the Model Regulation. The information includes:

- **New Premium Rate Schedule**
- **New Disclosure of Rate Increase History** document that reflects the filed increase. The insurer should also provide a list of all similar policy forms that are available for sale in which applicants will be informed of this rate increase.
- **New Actuarial Certification**
- **Actuarial Memorandum** justifying the new rate schedule\(^1\) which includes:
  - Lifetime projection of earned premiums and incurred claims that illustrate the rate schedule’s compliance with the loss ratio standards;
  - Disclosure of how reserves have been accounted for if the rate increase triggers contingent benefit upon lapse;
  - Disclosure of why the rate increase is necessary, including which pricing assumptions were not realized and why; and
  - Statement that the policy design, underwriting, and claims adjudication practices have been taken into consideration.
- **Rate Comparison 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…”

---

\(^1\) There are different rules for “exceptional increases.” These are explained in a separate section at the end of this chapter.
1. **New Premium Rate Schedule**

The complete new rate schedule should be filed, including rates for all variations in elimination periods and benefit periods. The percentage increase for each issue age should be provided from both the existing rate (to review the changes to disclosure documents) and the original rate. These percentages should be compared to the levels that trigger Contingent Benefit upon Lapse (CBL). See below for additional issues if CBL is triggered.

2. **New Disclosure of Rate Increase History**

Section 9 of the Model Regulation outlines the disclosure documents that each insurer must provide to all applicants. One part of this is a history of any rate increase on similar policy forms that has occurred within the 10-year period prior to the application date. This disclosure will need to be updated to reflect the actual rate increase that results from the filing. The Commissioner should establish the time frame within which the insurer must change its disclosure documents after the approval of any rate.

3. **Actuarial Certification**

The Actuarial Certification should be reviewed for the specific language used by the actuary. It is possible that the actuary will not be the same person as the one who signed the original certification. A change in the actuary of record should be explained. A sample Actuarial Certification for a rate increase is in Appendix 2.

4. **Actuarial Memorandum**

The review of the actuarial memorandum relating to a rate increase will be more extensive since it contains additional information, actual experience, a loss ratio demonstration and an explanation of the original assumptions that were not realized in support of the requested rate increase.

The actuarial memorandum should be reviewed for completeness. The method and assumptions used in determining projected values should be reviewed in light of reported experience. The assumptions used for the loss ratio demonstration should be consistent with prior actuarial experience, adjusted for known changes in such items as underwriting or claims adjudication that have been made or are anticipated by the insurer. The assumptions for future claims used in the loss ratio demonstration should include the actuary’s margins for moderately adverse claims and persistency experience.

The morbidity assumption and reported morbidity experience may not be credible for any LTCI policy form by itself. Combining experience of different forms with similar benefits may result in more credible historical claims as the basis for future claim costs.

Any assumptions that deviate from those used for pricing other forms currently available for sale should be disclosed and justified.

The lifetime projection of earned premiums and incurred claims (including margin for future adverse experience) shall illustrate that the lifetime loss ratio requirement will be satisfied with the filed rate schedule increase. This lifetime projection must include annual values for at least the five years preceding and three years following the increase. A simplified loss ratio demonstration (not including any detail or justification of assumptions) is in Appendix 4. Please note that this is not the only method or format for providing the required projection and values. The handling of projected lapses that qualify for CBL is described later.
The memorandum should clearly show that it uses the interest rate(s) required to be used by Section 20C(4) of the Model Regulation to demonstrate that the new premium rate scale meets the loss ratio requirements. Any net excess of the expected earnings over the valuation rate would be considered as a part of the provision for moderately adverse experience in the new rates.

The persistency assumption for the future (for both claim costs and premiums) should take into account:

(a) The amount of the proposed rate increase;
(b) The impact of reserves transferred to fund any CBL benefits (triggered proportions of the total in force business subject to rate increases should be shown as well as the percentage for each triggered age or age group that are expected to accept the CBL offer);
(c) Historical renewal lapse rates; and
(d) The actuary’s margin for adverse persistency experience.

The memorandum should describe the analysis done by the actuary comparing prior assumptions with experience. This analysis should cover all important assumptions showing the positive as well as adverse deviations from the expected. The amount of the original pricing margin that is lost when the new assumptions are used should be estimated. Any actions the insurer has taken or is planning to take to offset even greater rate increases should be noted to the extent the actions were relied on by the actuary in developing the new rates.

The memorandum should contain a statement that the policy design (benefits and benefit triggers, etc.), underwriting (to the extent it is still anticipated to affect claim costs) and claims adjudication practices have been taken into consideration by the actuary in the development of assumptions and projections.

For certain group business or particular policy forms it may be necessary to have the same rate for both new issues and in force business. In these cases the actuary’s projections will need to apply the loss ratios to the business subject to a rate increase to show the rate as if there were no new business. A separate rate for new business would be developed consistent with the anticipated loss ratio at issue of the original policy form and the revised assumptions. These two rates would then be combined into a single rate. Actual new business results should then be reviewed as part of the review of projected results for the three-year period following the rate increase.

5. Rate Comparison Statement

Section 20B(4) of the Model Regulation requires that a rate increase filing provide the following:

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…

It should be noted that the new business premium rates are not subject to the minimum loss ratio requirements that are applicable to rate increases.

In most situations the insurer will be able to provide a statement that rates after the rate increase are not greater than the new business rates. In some cases, the differences in benefits will be large enough that this comparison cannot be verified by simply comparing the rates. The insurer should provide information justifying significant variations.
In some circumstances the policy forms subject to the rate increase will end up with rates higher than new business rates of another policy form for the same issue age. This will generally result when the future premiums for older policy forms are a much smaller proportion of total premiums while new or newer policy forms will collect more premiums that include the rate increase. The insurer should be able to justify this result to the regulator by including a comparison of the resulting renewal rate with new business rates at the higher (current) age for sample insureds. Although this circumstance demonstrates one reason why the rate increase rates would be higher than new business rates, it may not be a sufficient reason to allow the deviation from the standard. A closed, reducing block of business that has been in force for many years is likely to have this circumstance, which may be the result of initial under-pricing and insurer inaction.

Where the rate increase is applicable to a policy form that is currently being offered, the renewal rates will be limited by the loss ratio standards. The insurer may wish to use higher rates for new sales (which are not subject to loss ratio minimums). Assuming that new sales of the policy form (at rates higher than the renewal rates) are allowed after the rate increase, the insurer will need to eliminate the experience of these new issues for purposes of comparing actual to projected experience following the rate increase. It should be noted that the experience for these new issues should be included when determining future rate increases.

B. ADDITIONAL ASPECTS IF CONTINGENT BENEFIT UPON LAPSE IS TRIGGERED

As noted earlier, the new rates are to be compared to the original rates and the ratio compared to the table for triggering CBL provisions under Section 28 of the Model Regulation. For any issue age where the percentage equals or exceeds the table value, the insurer also will need to provide those policyholders with an explanation of their options and the date the CBL option expires.

Due to the increased popularity of limited pay long-term care insurance, [in 2005] the NAIC expanded the contingent benefit upon lapse provision to address an identified need to improve the value of contingent benefits for limited pay policies. An additional test of a substantial premium increase and separate reduced paid-up benefit calculations were added for these policies in Section 28 of the Model Regulation. These new provisions become effective six months after their adoption. The insurer will need to provide policyholders with an explanation of their options and the date the CBL option expires should this test be triggered.

There are several aspects to be considered:

1. Approval of the process for informing policyholders of their CBL option;
2. Determination of the proportion of policyholders receiving a rate increase for which the CBL is triggered; and
3. Adjustments made in the actuarial memorandum for CBL and the monitoring of actual versus expected use of CBL following the rate increase.

Sections 28D(5) and D(6) of the Model Regulation provide specifics for the notification of policyholders of their rights at the time of a rate increase. Since it is possible that some but not all policyholders subject to a rate increase will trigger the CBL, the regulator should review the different materials to be provided in each situation.

Sections 20G and H of the model become effective if the CBL is triggered for the majority of the policyholders (anything over 50%) subject to the rate increase. The regulator should determine the percentage of policyholders for which the CBL is triggered. The determination of this percentage shall include limited pay policies that trigger the additional substantial premium increase test following the effective date of this provision.
Section 20B(3)(b) provides an exception to the normal rule that active life reserves are not to be reflected in the demonstration that the lifetime loss ratio projection is satisfied. The expected number of changes from premium paying insured (full benefit) to CBL insured (with a reduced or shortened benefit period) should be a part of the actuarial memorandum. The projected value of all future payments for those under CBL, including comparable margins for adverse, should be recognized as immediate benefits in the rate increase calculation subject to a maximum of the total active life reserve held for these insureds. A separate reserve for CBL insureds in this amount should be established and the insurer should adjust the active life reserve for premium-paying policies to reflect this transfer. During the three years when projections are monitored, the review should include an examination of the number of policyholders who actually accepted the CBL offer. The reserve established for any additional CBL insureds should be reflected as additional benefits in the updated projections. If the number of CBL insureds is lower, the excess reserve for CBL benefits established at the time of the rate increase should reduce total benefits in the updated projections. The actual claims experience of CBL insureds after the transfer is not to be combined with the experience to be monitored.

C. EXCEPTIONAL RATE INCREASES

Section 4A of the Model Regulation defines exceptional increases. Most rate increases will not be exceptional. If an insurer files a rate increase as an exceptional increase, it should provide justification for one of the two possible bases upon which the insurer may rely.

The regulator should review the justification provided before reviewing the remainder of the rate increase request, since the limitations are different. Approval of the basis for the review should be based on a finding that either:

1. The insurer has reflected a change in federal or the state's laws or regulations applicable to LTCI; or
2. The insurer has documented a rationale for increased and unexpected utilization (higher number of claims or longer periods for insureds in claim status) that affects the majority of insureds with similar products.

There are additional issues the regulator may wish to consider as part of this review.

- Would it be beneficial to request a review by an independent actuary or to coordinate with other states? This could be especially important in making a determination under 2 above.
- Are there offsets to increases that result from the new laws, regulations or even the basis for higher utilization? If so, the insurer should reflect any potential offset.

Insurers are required to file much of the same information for an exceptional increase (new premium rate schedule, new rate history disclosure) as for a non-exceptional increase, with a few slight modifications. There is a difference in the actuarial filing. The certification would be slightly different in wording. (See Appendix 3 for a sample.) The actuarial memorandum would be shorter. There is no requirement to justify differences from initial assumptions or to provide lifetime projections. Instead, the actuary should demonstrate that future claim costs (resulting from the causes the insurer has used to justify the need for an exceptional increase and from any relevant expected changes in insurer experience) are 70% of the future projected additional premium. Experience to date and the future projections of premiums from the original rate (with the expenses and claims to be covered) are not to be included in the demonstration. However, the regulator may request such experience and other information to evaluate the appropriateness of the insurer’s estimate of potential offsets to higher claim costs.
D. QUESTIONS AND ANSWERS

1. What would be a common list of information a regulator might expect to see in an actuarial memorandum for a rate increase?

A state may wish to require that an actuarial memorandum include some or all of the items listed in Appendix 5. Selected items from that list are discussed below.

(a) Morbidity
The overall pattern of claim costs for LTCI is well known – claim costs increase with increasing age – but there is no industry standard morbidity table.

(b) Lapse
If the LTCI policy does not contain a nonforfeiture provision, the pricing will reflect a “lapse-supported” pricing methodology. The more insureds that leave the block (either by death or voluntary termination), the lower future costs will be. This means that the assumptions that the insurer makes about future expected lapses (voluntary) and deaths are critical to the pricing of LTCI. The lower the expected lapses and deaths, the more conservative the pricing.

Most current filings have ultimate (after the first 5 years or so) lapse rates of 4% or less. This means that fewer than 4% of the insureds that remain will drop their policy. If this assumption is higher than 3–4%, then the insurer should be questioned about the source of its assumption. Remember that the higher this number, the lower the premium and therefore, the less conservative it is.

(c) Mortality
The mortality assumption (death rates) is critical for the same reason that the voluntary lapse rate is critical. If more insureds are assumed to die than actually do, then the premiums could be inadequate. The NAIC Health Insurance Reserves Model Regulation requires the use of an annuity mortality table. The use of a life mortality table would be less conservative.

(d) Interest
Section 20C(4) requires that the interest rates used for discount purposes in determining rate increases be the maximum valuation interest rate for contract reserves as specified in the states’ equivalent to the NAIC Health Reserves Model Regulation. Since this rate may vary from year to year, Section 20 allows the use of an average interest rate if the manner in which it has been determined is disclosed. The regulator should review the filing to determine compliance with the moderately adverse standard based on all assumptions, including the interest assumptions, which may be different from those used for testing loss ratio compliance.

(e) Reserves – Policy and Claim
The reserves, both policy and claim, should be reviewed by the regulatory actuary for reasonableness and adequacy.

2. How are active life reserves utilized under the revised model?

Normally, active life reserves are not included in the rate increase analysis. Section 20B(3)(b) provides an exception to this rule by allowing a transfer of the active life reserves to be reflected as a claim for those insureds transferred from the active life pool to the CBL paid-up pool. The expected number of changes from premium paying (full benefit) insured to CBL insured (with a reduced or shortened benefit period) should be a part of the actuarial memorandum. The projected benefits for those under CBL should be recognized at the time of the rate increase, and the insurer should adjust the active life reserve for these potential benefits. During the three years when projections are monitored, the review should include an examination of the number of policyholders who actually accepted the CBL offer. Any difference
between the reserve needed for continuing full coverage and the reserve for CBL coverage for the additional (or lower) number of CBL insureds should be reflected in the updated projections.

3. **What differences in the rate increase filing should be expected when an insurer sells both continuous-pay and limited-pay products?**

The regulator should review the experience to determine whether limited-pay premium experience has been combined with the experience for continuous-pay policies. In general, limited-pay policies may not have credible experience on their own. Rate increases can only be charged to those insureds paying current and future premiums. This means that projected future costs that incorporate higher claim cost assumptions will need to be separated into those for paid-up policies and those for premium paying policies. If these increased costs are combined, the continuous-pay plans would be subsidizing paid-up insureds, and may be considered “unfair discrimination.”

4. **What other differences should the regulator review between continuous-pay and limited-pay products?**

Limited-pay products have two CBL options. The first (or normal) option is the same as for continuous-pay products and is required if the policy is issued without nonforfeiture benefits. The second (or added) option is a reduced paid-up benefit that applies only to limited-pay products and is required even if the policy includes a SBP nonforfeiture benefit.

The added CBL option recognizes the gradual change from premium paying to paid-up status of these products. It is triggered 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.

<table>
<thead>
<tr>
<th>Issue Age</th>
<th>Percent Increase Over Initial Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65</td>
<td>50%</td>
</tr>
<tr>
<td>65-80</td>
<td>30%</td>
</tr>
<tr>
<td>Over 80</td>
<td>10%</td>
</tr>
</tbody>
</table>

Actual benefits from this CBL option are a reduced paid-up policy where the periodic payment is reduced (versus the normal CBL, which reduces the maximum paid when a claim occurs). The reduced amount is determined by 90% of the ratio of (a) to (b) where:

(a) is the number of months of premiums paid to the date of lapse, and
(b) is the number of months in the original premium-paying period.

The added CBL option can only be exercised if the ratio of (a) to (b) is 40% or more and the lapse date is within 120 days of the first due premium following the date of the rate increase.

5. **Is it possible for both CBL options to be triggered by the same rate increase for a limited-pay policy?**

Yes. The policyholder will then have the choice of the “normal CBL” or the “added CBL” and the Model Regulation provides that, if the policyholder does not make a choice, the added CBL is the automatic option.
6. What should be considered if an insurer offers unisex rates?

Rate increases should continue to be based on unisex rates. Claim and active life reserves may have been established using unisex morbidity and mortality but adjustments may be needed to reflect the actual mix of claims and in force policies.

7. In Section 4A(4) of the Model Regulation, the definition for exceptional increase references “potential offsets.” What are some examples of “potential offsets”?

Consider the example of a state passing a new requirement that all LTCI policies cover home health services, even if policies previously provided only institutional care.

(a) If a policy has a maximum benefit period expressed in years, not dollars, to which all benefits (non-institutional and institutional) are subject, a potential offset would occur because benefits paid under lower cost non-institutional benefits (e.g., home health care) would reduce the amount of time remaining for higher cost institutional benefits.

(b) If an insurer retains the same benefit triggers (e.g., Activities of Daily Living) for home health as for institutional care, costs attributable to increased utilization for home health care (which could be anticipated to be higher than utilization for institutional care) could be offset somewhat by the fact that per visit home health care charges are lower than institutional charges.

8. What happens if the regulator believes that the requested rate increase is too high?

The regulator should review the assumptions in the actuarial memorandum for reasonableness. For example, the insurer could be projecting lapse rates or mortality rates that are significantly lower than what was used in the original pricing assumptions. The regulator should examine which assumptions are reasonable, the original assumptions or the assumptions in the rate increase filing. The filing may be subject to the state’s filing review and approval process. The regulation does not guarantee that the requested increase will be approved. Other state statutory requirements may apply.

The regulator should discuss his or her concerns with the actuary. That discussion may resolve your concerns. If not, you may want to talk to another state actuary who has experience with LTCI.

If you are unable to satisfy your concerns through these approaches, you may contact the Actuarial Board for Counseling and Discipline for its counsel on your concerns.

9. If an insurer wishes to offer the CBL to policyholders when the actual rate increase would not trigger the requirements to offer CBL, is this okay?

So long as the method for determining those policyholders to be offered CBL is not discriminatory and includes all those policyholders who must be offered CBL (based on the resulting rate exceeding the initial rate by the percentage specified in the Model Regulation), the company is allowed to make the offer.

Therefore, the phrase “the majority of policies are eligible for contingent benefits upon lapse” in Section 20G and Section 20H(1)(c) should be interpreted to mean only those who must be offered CBL based on the Model Regulation. Otherwise, companies would not be encouraged to expand the number of policies to be offered CBL in the event of a rate increase.

The phrase “adjust rates to reflect how reserves have been incorporated in the event CBL is triggered” in Section 20B(3)(b) should be interpreted to mean that CBL has been offered to a policyholder or certificate holder and the offer is accepted (or deemed accepted by the failure to pay further premiums during the 120-day offer period).
10. **Can a regulator request more annual values of the lifetime projection than just the five preceding and three projected years?**

The basis of the model relies on professional judgment and certifications. However, in those states where the regulator will perform an extensive review before approving rate increases, the model provides the authority for the regulator to request additional information needed for such a review. To reduce the time frame, such requests may be part of the filing requirements for that state.

It is recommended that a state performing a detailed review request that the historical experience and projections of future experience provided by the company both include detail for each (calendar) year. This level of detail could illustrate the pattern of emerging experience being assumed. It is also helpful to request the originally anticipated pricing experience by calendar year. It may be insightful to see the difference of actual versus pricing experience.

11. **Can a regulator request projected experience under the assumption that premium rates are not increased?**

In those states where the regulator will perform an extensive review before approving rate increases, the model provides the authority for the regulator to request additional information needed for such a review. It may be of interest to see the projections with and without the requested rate increase. It is not always intuitively obvious of the result. The rate increase will affect persistency as well as claim experience assumptions.

12. **Is pooling of experience required or permitted?**

As noted previously, morbidity experience will likely be pooled to increase the credibility of the company’s experience. Unless state law requires it, pooling is not required; however, it is encouraged that forms with similar benefits be pooled. When reviewing pooled experience, the reviewer needs to be careful to not jump to conclusions that the rate increase supported by an analysis of the aggregate data is an increase to be applied uniformly over all policy forms. This is generally not the case and in most cases the company will not be asking for a uniform increase. In such situations the reviewer should ask the company to evaluate the benefit differences between forms on a constant morbidity basis. This should show the relativity between the benefits of the different forms. The rates between forms may be increased on a non-uniform basis so as to establish a closer relationship of the premiums to these theoretical relationships and to measure compliance with the required standard that new business rates are not less than premium rates for existing forms, except for benefit differences. Note that some in-force policy forms (not currently for sale) may be excluded from a rate increase and still comply with the model.

13. **How does the regulator compare rates of different forms to determine that the company complies with the required standard that new business rates are not less than the premium rate for existing forms except for benefit differences?**

The comparison must be performed on a consistent basis. This means that it may be inappropriate to simply compare the two rate schedules directly. When the premium rate schedule for a new policy form is less than the premium rate schedule for an existing similar policy form also currently available from the insurer, and it is not clear whether this is a reasonable difference attributable to benefits, the regulator may wish to ask the company actuary to use one set of pricing assumptions to evaluate all forms. This is done for each form as if it were a new issue (the duration of the business is not directly considered at this point). This is not for the intent of determining the rate, but simply to determine the benefit differences between the forms. This analysis will give a benefit comparison between forms—say coverage A is 1.15 of coverage B. This relationship is then used to compare the rate schedule relationships. The model provides that the relationship should account for benefit differences.
Following is an example showing a comparison of product benefits used to determine the rate comparison.

Summary of material benefit differences:

<table>
<thead>
<tr>
<th>DETERMINATION OF PLAN RELATIVITIES</th>
<th>Plan A</th>
<th>Plan B</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHC benefits</td>
<td>1.0</td>
<td>1.0</td>
<td>No difference in coverage</td>
</tr>
<tr>
<td>Nursing home</td>
<td>1.0</td>
<td>1.0</td>
<td>No difference in coverage</td>
</tr>
<tr>
<td>Waiver of premium</td>
<td>1.0</td>
<td>.92</td>
<td>Plan B does not have PW</td>
</tr>
<tr>
<td>Restoration</td>
<td>1.10</td>
<td>1.0</td>
<td>Plan A has restoration</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1.10</td>
<td>.92</td>
<td></td>
</tr>
</tbody>
</table>

Plan A is 19.6% richer (1.10/.92) than Plan B. When comparing premiums at various ages, Plan A premiums should be 19.6% higher than Plan B premiums.

The actuary needs to use judgment in deciding which benefit factors would be additive and which would be multiplicative. A benefit that affects the entire policy, i.e., restoration, should be multiplicative, but two mutually exclusive coverages, i.e., nursing home or home health care services, may be considered to be additive.
Section VII. MONITORING EXPERIENCE

The Long-Term Care Insurance Model Regulation requires monitoring of experience following a rate increase. The monitoring is required to ensure that rates are not increased more than is necessary. Since the rate increase is based on a lifetime loss ratio, the anticipated level of future claims plays a role in determining the amount of rate increase necessary.

The following outlines the experience that the regulator should see at each point in the process. It also attempts to provide some guidance on how to determine if the experience adequately matches the original projection.

A. AT TIME OF FILING FOR A RATE INCREASE

When an insurer files for a rate increase, it is required to provide a lifetime projection of earned premiums and incurred claims. This projection must include annual values for at least the five years preceding and at least three years following the valuation date. These annual values will be used to monitor whether future experience adequately matches the projected experience.

The projections must include the development of the lifetime loss ratio (unless it is an exceptional increase). This information needs to include enough detail to demonstrate compliance with the loss ratio requirements of the regulation. This means that insurers will need to show the accumulated and discounted premiums separately for the original premium, the exceptional increase premium and the premium from a non-exceptional rate increase. The information should demonstrate that the accumulated claims plus the discounted claims are more than the sum of the following:

1. 58% of the accumulated and discounted original premium,
2. 70% of the accumulated and discounted exceptional increase premium, and
3. 85% of the accumulated and discounted premium from a non-exceptional rate increase.

B. AFTER FILING FOR A RATE INCREASE

All insurers must submit annual filings for review during the three years following a rate increase. The information included in this filing will be similar to that in the rate increase filing except that it will have additional years of actual experience replacing projected experience. Regulators should look at the actual durational loss ratios following the rate increase and compare them to what was anticipated in the rate increase filing. If an insurer has a rate increase on a form where new business is still being sold, the regulator may want to request that experience be shown separately for the business in force at the time of the rate increase and for the new business since the rate increase. This will make it easier to see how actual experience compares with expected experience.

When comparing the durational loss ratios to what was expected, the regulator should not expect that experience will be at the level of the expected loss ratios. The experience should be somewhat below those levels. This is due to the requirement that the actuary must certify at the time of the rate increase filing that the rates are adequate under moderately adverse conditions.

Regulators also should compare the actual earned premiums and incurred claims to the expected premiums and claims that were included in the rate increase filing. If the difference in actual experience and projected is in opposite directions (i.e. premiums are higher and claims are lower), the regulator may want to request additional information. For example, the insurer could be asked to do revised projections by adding the expected margins for adverse claims to actual claims which allows for an improved comparison since these margins are a part of the projected incurred claims. If the regulator determines that actual experience does not adequately match projected experience the insurer may be required to implement a premium rate schedule adjustment, a benefit increase or...
other measures to reduce the difference between actual and expected values. If the regulator is unsure whether actual experience adequately matches expected experience, the insurer may be required to submit annual filings for a period of time beyond the three-year requirement.

Note that for a policy form where any premium rate increased by more than 200%, the insurer must submit a filing every five years following the end of the required period.
Section VIII. RATE INCREASE CONSEQUENCES

The NAIC Model Regulation includes three new provisions that give the Commissioner new regulatory tools to deal with large single or cumulative increases, rate spirals, and insurers that persistently file inadequate initial premium rates. Two of the three new provisions have a requirement that a majority of the policies or certificates to which a rate increase is applicable be eligible for contingent benefit upon lapse. This condition is included as a measure of a rate increase that is considered significantly large enough to warrant the action indicated.

A. REVIEW OF ADMINISTRATION AND CLAIM PRACTICES AUTHORIZED

If a majority of the policies or certificates to which a rate increase is applicable are eligible for contingent benefit upon lapse, an insurer must file a plan for improved administration or claims processing that is designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases. The plan is subject to Commissioner approval.

As an alternative to filing a plan, an insurer may demonstrate that appropriate administration and claims processing have been implemented or are in effect.

If the insurer fails to satisfy one of these requirements, the Commissioner may impose the conditions applicable following a determination that a rate spiral exists (see next section).

B. OPTION TO ESCAPE RATE SPIRALS BY CONVERTING TO CURRENTLY SOLD INSURANCE

Section 20H(1) of the Model Regulation requires that the following three criteria be met before a rate spiral may be considered to exist:

1. The rate increase is not the first rate increase requested for the specific policy form or forms;
2. The rate increase is not an exceptional increase (See Section VI C for exceptional rate increase); and
3. The majority of the policies or certificates to which the increase is applicable are eligible for contingent benefit upon lapse.

If these three criteria are met, the next step in determining whether a rate spiral exists is for the regulator to review the following for all policies included in the filing:

1. Projected lapse rates; and
2. Past actual lapse rates during the 12 months following each increase.

The regulator may determine that a rate spiral exists if significant adverse lapse:

1. Has occurred;
2. Is anticipated in the filings; or
3. Is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase.
If the regulator determines 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.

The offer shall:

1. Be subject to the approval of the Commissioner;

2. Be based on actuarially sound principles, but not be based on attained age. One acceptable approach is for the insurer to demonstrate that the combination of a higher issue age and lower duration, versus the original issue age and higher duration, is appropriate under the new form to match the active life reserve held under the original policy form. This active life reserve for the new form would approximate the transfer of the actual funding from the original form while reflecting the future benefits and premiums of the new form.

and

3. Provided that maximum benefits under any new policy accepted by an insured be reduced by comparable benefits already paid under the existing policy.

When an insurer is required to provide this offer, the insurer must maintain separate experience of the replacement insureds (those under the form with the rate spiral) and the original insureds (those insureds under the form with which the rate spiral insureds are combined). Future rate increases on the combined business are limited to the lesser of:

1. The increase based on the combined experience; or

2. The increase based solely on the experience of the original lives plus an additional flat 10%.

This limits the adverse impact that the replacement insureds may have on the original insureds with both the original and the replacement insureds receiving the same percentage increase. This two-part limit on rate increases may cause the actuary to qualify the actuarial certification. In this case, the regulator should determine what measures the insurer is taking to avoid future rate increases.

In determining the above limitations to a rate increase, it is important to note that in performing this analysis the assumptions used in the two projections may not necessarily be the same. As an example, the utilization assumption used in future years may be different for the original lives than what was used for the combined experience, which includes replacement insureds that may have been subject to different underwriting standards.

C. COMMISSIONER MAY PROHIBIT ISSUE OF NEW POLICIES

If the Commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates, then in addition to the remedy provided in B above, the Commissioner may take one of the following more severe steps:

1. Prohibit the insurer from filing and marketing comparable coverage for a period of up to five years. This penalty will essentially put the insurer out of the long-term care business in the state.

2. Prohibit the insurer from offering all other similar coverage thus limiting the marketing of new applications to the form subject to the recent increase.

These penalties are intended as a last resort in dealing with a situation that cannot otherwise be rectified.
Sample Actuarial Certification
for
Long-Term Care Insurance Initial Premium Rate Schedule
In Accordance with Section 10 of the NAIC Model Regulation

(For an actuary who is an insurer employee)

I, [name of actuary], am [title] of [name of insurer] and a member of the American Academy of Actuaries. I meet the Academy’s qualification standards for rendering this opinion and am familiar with the requirements for filing long-term care insurance premiums.

Attached are the premium rate schedule(s) to be used for new sales of the policy forms and riders as specified therein.

In my opinion the initial premium rate schedule(s) [is/are] sufficient to cover anticipated costs under moderately adverse experience and the premium rate schedule(s) [is/are] reasonably expected to be sustainable over the life of the [form/forms] with no future premium increases anticipated.

I have reviewed and taken into consideration the policy design and coverage provided.

I have reviewed and taken into consideration the insurer’s [current/planned] underwriting and claims adjudication processes. {I have relied upon information provided to me by [name and title of insurer officer] for a written description of these processes.}

In forming my opinion, I have used actuarial assumptions and actuarial methods and such tests of the actuarial calculations as I considered necessary, and have provided a copy of the supporting documentation to the insurer.

The premium rate schedule(s) [is/are] consistently in excess of the sum of the net valuation premium for renewal years and the average renewal expenses assumed in the pricing.

{Example of an alternative to above statement paragraph} The premium rate schedule(s) would be consistently in excess of the sum of the net valuation premium for renewal years and the average renewal expenses assumed in the pricing if:

(i) the maximum termination rates allowed by the NAIC Health Insurance Reserves Model Regulation were used in place of the 2% rate assumed in the actual reserve basis, and
(ii) the maximum interest rate allowed by the NAIC Health Insurance Reserves Model Regulation was used in place of the 3.5% rate assumed in the actual reserve basis.

[Attached is a description of the valuation basis for contract reserves which generates the net valuation premium for renewal years. / The basis for contract reserves has been previously filed and there is no anticipation of any changes.]

The premium rate schedule(s) [is/are] consistently equal to or in excess of the premium rate schedule for other similar policy forms (except for reasonable differences attributable to benefits) which [name of insurer] will be making available to the same broad class of applicants.
Attached is a comparison of the premium schedules for similar policy forms that [name of insurer] will be making available to the same broad class of applicants. Significant differences in the premium schedules are explained.

[Signature of Actuary]

[Name of Actuary (typed or written)]

[Address of Actuary]

[Telephone Number of Actuary]
APPENDIX 2. SAMPLE ACTUARIAL CERTIFICATION – RATE INCREASE

Sample Actuarial Certification
for
Long-Term Care Insurance Premium Rate Increase
In Accordance with Section 20 of the NAIC Model Regulation

(For an actuary who is an insurer employee)

I, [name of actuary], am [title] of [name of insurer] and a member of the American Academy of Actuaries. I meet the Academy’s qualification standards for rendering this opinion and am familiar with the requirements for filing long-term care insurance premiums and filing for increases in long-term care insurance premiums.

Attached are:

1. The premium rate schedule(s) to be used for renewals of the policy forms and riders as specified therein. Where necessary, separate schedules of higher premium rates to be used for new sales of the policy forms and riders are noted.

2. An actuarial memorandum, also signed by me, which provides:
   a) the assumptions on which this certification is based;
   b) the adjustments to prior assumptions with an explanation of the reasons previous assumptions were not realized;
   c) a lifetime projection of the prior premium rate schedules and incurred claims plus future expected premiums and claims which demonstrates that the revised premium rate schedule meets the loss ratios standards and necessary details of this state; and
   d) disclosure of the manner, if any, in which reserves have been recognized.

In my opinion the revised premium rate schedule(s) [is/are] sufficient to cover anticipated costs under moderately adverse experience and the premium rate schedule(s) [is/are] reasonably expected to be sustainable over the life of the [form/forms] with no future premium increases anticipated.

I have reviewed and taken into consideration the policy design and coverage provided, and the insurer’s [current/planned] underwriting and claims adjudication processes. {I have relied upon information provided to me by [name and title of insurer officer] for a written description of these processes.}

In forming my opinion, I have used actuarial assumptions and actuarial methods and such tests of the actuarial calculations as I considered necessary. Based on these assumptions, or statutory requirements where necessary, the premium rate filing is in compliance with the loss ratio standards of this state.

[Attached is a description of the new valuation basis for contract reserves which generates the net valuation premium for renewal years. / The basis for contract reserves has been previously filed and there is no anticipation of any changes.]

[Signature of Actuary]

[Name of Actuary (typed or written)]

[Address of Actuary]

[Telephone Number of Actuary]
Sample Actuarial Certification
for
Long-Term Care Insurance Exceptional Premium Rate Increase
In Accordance with Section 20 of the NAIC Model Regulation

(For an actuary who is an insurer employee)

I, [name of actuary], am [title] of [name of insurer] and a member of the American Academy of Actuaries. I meet the Academy’s qualification standards for rendering this opinion and am familiar with the requirements for filing long-term care insurance premiums and filing for increases in long-term care insurance premiums.

Attached are:

1. The premium rate schedule(s) to be used for renewals of the policy forms and riders as specified therein. Where necessary, separate schedules of higher premium rates to be used for new sales of the policy forms and riders are noted.

2. An actuarial memorandum, also signed by me, which provides:
   a) the assumptions on which this certification is based;
   b) the adjustments to prior assumptions consistent with the established basis for this to be approved as an exceptional increase;
   c) a projection of the future additional premiums based on the rate schedule increases and future additional incurred claims which demonstrates that the increase in the premium rate schedule meets the loss ratios standards and necessary details of this state; and
   d) disclosure of the manner, if any, in which reserves have been recognized.

In my opinion the revised premium rate schedule(s) [is/are] sufficient to cover anticipated costs under moderately adverse experience and the premium rate schedule(s) [is/are] reasonably expected to be sustainable over the life of the [form/forms] with no future premium increases anticipated.

I have reviewed and taken into consideration the policy design and coverage provided, and the insurer’s [current/planned] underwriting and claims adjudication processes. [I have relied upon information provided to me by [name and title of insurer officer] for a written description of these processes.]

In forming my opinion, I have used actuarial assumptions and actuarial methods and such tests of the actuarial calculations as I considered necessary. Based on these assumptions, or statutory requirements where necessary, the premium rate filing is in compliance with the loss ratio standards of this state.

[Attached is a description of the new valuation basis for contract reserves which generates the net valuation premium for renewal years. / The basis for contract reserves has been previously filed and there is no anticipation of any changes.]

[Signature of Actuary]

[Name of Actuary (typed or written)]

[Address of Actuary]

[Telephone Number of Actuary]
APPENDIX 4. SAMPLE LOSS RATIO DEMONSTRATION FOR A HYPOTHETICAL RATE INCREASE

Insurer XYZ  
Policy Form LTC2001  
Actual and Projected Experience

<table>
<thead>
<tr>
<th>Experience Period</th>
<th>Original Level</th>
<th>Original Premium</th>
<th>Increased Premium</th>
<th>Original Incurred Claims</th>
<th>Increased Incurred Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001-2003</td>
<td>$10,000,000</td>
<td>$0</td>
<td>$1,194,225</td>
<td>$13,563,842</td>
<td>$1,604,225</td>
</tr>
<tr>
<td>2004</td>
<td>$4,000,000</td>
<td>$0</td>
<td>$826,096</td>
<td>$4,982,093</td>
<td>$1,028,922</td>
</tr>
<tr>
<td>2005</td>
<td>$3,720,000</td>
<td>$0</td>
<td>$960,337</td>
<td>$4,127,111</td>
<td>$1,139,163</td>
</tr>
<tr>
<td>2006</td>
<td>$3,459,600</td>
<td>$0</td>
<td>$1,143,185</td>
<td>$3,908,401</td>
<td>$1,291,486</td>
</tr>
<tr>
<td>2007</td>
<td>$3,217,428</td>
<td>$0</td>
<td>$1,328,952</td>
<td>$3,412,711</td>
<td>$1,429,859</td>
</tr>
<tr>
<td>2008</td>
<td>$2,992,208</td>
<td>$0</td>
<td>$1,347,159</td>
<td>$3,066,101</td>
<td>$1,380,427</td>
</tr>
</tbody>
</table>

Subtotal Actual Experience: $33,394,875

<table>
<thead>
<tr>
<th>Projection Period</th>
<th>Original Level</th>
<th>Original Premium</th>
<th>Increased Premium</th>
<th>Original Incurred Claims</th>
<th>Increased Incurred Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$2,782,753</td>
<td>$631,685</td>
<td>$1,365,615</td>
<td>$2,715,689</td>
<td>$616,461</td>
</tr>
<tr>
<td>2010</td>
<td>$2,587,961</td>
<td>$587,467</td>
<td>$1,384,324</td>
<td>$2,405,325</td>
<td>$546,009</td>
</tr>
<tr>
<td>2011</td>
<td>$2,406,803</td>
<td>$546,344</td>
<td>$1,403,289</td>
<td>$2,130,431</td>
<td>$483,608</td>
</tr>
<tr>
<td>2012-2020</td>
<td>$15,335,385</td>
<td>$3,481,132</td>
<td>$13,527,106</td>
<td>$10,972,085</td>
<td>$2,490,663</td>
</tr>
<tr>
<td>2021-2050</td>
<td>$14,754,202</td>
<td>$3,349,204</td>
<td>$59,164,021</td>
<td>$5,393,467</td>
<td>$1,224,317</td>
</tr>
</tbody>
</table>

Subtotal Projected Experience: $23,616,996

Minimum Present Value Incurred Claims = 58% of (4) [$57,011,871] plus 85% of (5) [$5,361,058] = $37,623,784
Dual Loss Ratio Test met since total incurred claims (6) {$37,627,824} exceeds the minimum.

Col. (1) Earned Premiums from Original Premium Schedule only
Col. (2) Increased portion of Premium with 22.7% increase implemented on 1/1/2009
Col. (3) Incurred Claims (Do NOT include Policy Reserves)
Cols. (4)-(6) Accumulated/Discounted values of columns (1)-(3) to 1/1/2009 with 5% interest
APPENDIX 5. ACTUARIAL MEMORANDUM CHECKLIST

1. Scope and Purpose
2. Summary of:
   a. Benefits
   b. Renewability
   c. Marketing Methods
   d. Issue Age Limits
   e. History of Rate Adjustments
3. Premium Modalization Rules
4. Premium Classes
5. Expected Average:
   a. Annual Premium
   b. Issue Age
6. Distribution of Business, including number of policyholders
7. Underwriting Description
8. Statements Regarding Consideration of:
   a. Policy Design
   b. Underwriting
   c. Claims Adjudication Practices
9. Actuarial Assumptions:
   a. Morbidity
   b. Lapse rates
   c. Mortality
   d. Expenses
   e. Commissions
   f. Interest
   g. Trend Assumption
   h. Area Factors
   i. Contingency and Risk Margins
10. Experience – Past and Future, including claim liability and reserves
11. Loss Ratios
    a. Minimum Requirement
    b. Anticipated
    c. Lifetime
12. Rate Increase Analysis
    a. Why a rate adjustment is necessary (including calculation)
    b. Which pricing assumptions were not realized and why
    c. Other actions taken by the insurer that may have been relied upon by the actuary
    d. Disclosure of how reserves have been incorporated into increase whenever the rate
        increase would trigger contingent benefit upon lapse
13. Description of Basis for Active Life Reserves
    a. Method
    b. Morbidity
    c. Lapse
    d. Mortality
    e. Interest
14. Proposed Effective Date
A Shopper's Guide to
LONG-TERM CARE INSURANCE
About the NAIC …

The National Association of Insurance Commissioners (NAIC) is the oldest association of state government officials. Its members consist of the chief insurance regulators in all 50 states, the District of Columbia and five U.S. territories. The primary responsibility of the state regulators is to protect the interests of insurance consumers, and the NAIC helps regulators fulfill that obligation in a number of different ways. This guide is one example of work done by the NAIC to assist states in educating and protecting consumers.

Another way the NAIC lends support to state regulators is by providing a forum for the development of uniform public policy when uniformity is appropriate. It does this through a series of model laws, regulations and guidelines, developed for the states’ use. States that choose to do so may adopt the models intact or modify them to meet the needs of their marketplace and consumers. As you read through this guide, you will find several references to such NAIC model laws or regulations related to long-term care insurance. You may check with your state insurance department to find out if these NAIC models have been enacted in your state.

NAIC Executive Office
444 North Capitol Street NW, Suite 701
Washington, DC 20001
Phone: 202-471-3990

NAIC Central Office
2301 McGee Street, Suite 800
Kansas City, MO 64108-2604
Phone: 816-842-3600
Fax: 816-783-8175

NAIC Securities Valuation Office
48 Wall Street, 6th Floor
New York, NY 10005-2906
Phone: 212-398-9000

www.naic.org
Revised 2009
# Table of Contents

About This Shopper's Guide ............ 2

What is Long-Term Care? ............ 3

How Much Does Long-Term Care Cost? .... 4
  Nursing Home Costs ............ 4
  Assisted Living Facility Costs .... 4
  Home Care Costs ............ 4

Who Pays for Long-Term Care? ............ 4
  Individual Personal Resources .... 4
  Medicare ............ 5
  Medicare Supplement Insurance .... 5
  Medicaid ............ 5
  Long-Term Care Insurance .... 6

Who May Need Long-Term Care? .... 6

Do You Need Long-Term Care Insurance? .... 7

How Can You Buy Long-Term Care Insurance? .... 9
  Individual Policies ............ 9
  Policies From Your Employer .... 9
  Federal Government .......... 10
  State Government .......... 10
  Association Policies .......... 10
  Policies Sponsored by Continuing Care Retirement Communities .......... 10
  Life Insurance Policies .......... 10
  Long-Term Care Insurance Partnership Plans .......... 11

What Types of Policies Can I Buy? .... 12

How Do Long-Term Care Insurance Policies Work? .... 14
  How Benefits Are Paid .......... 14
  Pooled Benefits and Joint Policies .......... 16
  What Services Are Covered .......... 16
  Where Services Are Covered .......... 17
  What Services Are Not Covered (Exclusions and Limitations) .......... 18
  How Much Coverage You Will Have .......... 18
  When You Are Eligible for Benefits (Benefit Triggers) .......... 19
  Types of Benefit Triggers .......... 19
  When Benefits Start (Elimination Period) .......... 20
  What Happens When Long-Term Care Costs Rise (Inflation Protection)? .......... 22
  Additional Benefits .......... 24
  Other Long-Term Care Insurance Policy Options You Might Choose .......... 24
  What Happens If You Cannot Afford the Premiums Anymore? .......... 25
  Will Your Health Affect Your Ability to Buy a Policy? .......... 26
  What Happens If You Have Pre-Existing Conditions? .......... 26
  Can You Renew Your Long-Term Care Insurance Policy? .......... 27
  How Much Do Long-Term Care Insurance Policies Cost? .......... 27
  What Options Do I Have to Pay the Premiums on the Policy? .......... 29
  If You Already Own a Policy, Should You Switch Plans or Upgrade the Coverage You Have Now? .......... 30
  What Shopping Tips Should You Keep in Mind? .......... 31
  References .......... 35
  Glossary .......... 36

Worksheet 1: Information About the Availability and Cost of Long-Term Care in Your Area .......... 42
Worksheet 2: How to Compare Long-Term Care Insurance Policies .......... 44
Worksheet 3: Facts About Your Long-Term Care Insurance Policy .......... 49
Worksheet 4: Long-Term Care Riders to Life Insurance Policies .......... 51
Personal Worksheet .......... 53
List of State Insurance Departments, Agencies on Aging and State Health Insurance Assistance Programs .......... 56
About This Shopper’s Guide

The National Association of Insurance Commissioners (NAIC) has written this guide to help you understand long-term care and the insurance options that can help you pay for long-term care services. The decision to buy long-term care insurance is very important and one you shouldn’t make in a hurry. In most states, state law requires insurance companies or agents to give you this guide to help you better understand long-term care insurance and decide which, if any, policy to buy. Some states produce their own guide.

Take a moment to look at the table of contents and you’ll see the questions this guide answers and the information that is in it. Then, read the guide carefully. If you see a term you don’t understand, look in the glossary starting on page 36. (Terms in bold in the text are in the glossary.) Take your time. Decide if buying a policy might be right for you.

If you decide to shop for a long-term care insurance policy, start by getting information about the long-term care services and facilities you might use and how much they charge. Use the first worksheet that starts on page 42 to write down this information. Then, as you shop for a policy, use Worksheet 2, starting on page 44. There you can write down the information you collect to compare policies and buy the one that best meets your needs.

If you have questions, call your state insurance department or the insurance counseling program in your state. The telephone numbers are listed starting on page 56 of this guide.
What Is Long-Term Care?

Someone with a prolonged physical illness, a disability or a cognitive impairment (such as Alzheimer’s disease) often needs long-term care. Many different services help people with chronic conditions overcome limitations that keep them from being independent. Long-term care is different from traditional medical care. Long-term care helps one live as he or she is now; it may not help to improve or correct medical problems. Long-term care services may include help with activities of daily living, home health care, respite care, hospice care, adult day care, care in a nursing home, or care in an assisted living facility. Long-term care may also include care management services, which will evaluate your needs and coordinate and monitor the delivery of long-term care services.

Someone with a physical illness or disability often needs hands-on or stand-by assistance with activities of daily living (see page 19). People with cognitive impairments usually need supervision, protection or verbal reminders to do everyday activities. The way long-term care services are provided is changing. Skilled care and personal care are still the terms used most often to describe long-term care and the type or level of care you may need.

People usually need skilled care for medical conditions that require care by medical personnel such as registered nurses or professional therapists. This care is usually needed 24 hours a day, a physician must order it, and it must follow a plan. Individuals usually get skilled care in a nursing home but may also receive it in other places. For example, you might get skilled care in your home with help from visiting nurses or therapists. Skilled care includes physical therapy, caring for a wound, or supervising the administration of intravenous medication.

NOTE: Medicare and Medicaid have their own definitions of skilled care. Please refer to The Guide to Health Insurance for People with Medicare or The Medicare Handbook to find out how Medicare defines skilled care. Contact your local social services office for questions about Medicaid’s definition of skilled care. For copies of these publications, contact your state insurance department or State Health Insurance Assistance Program listed on pages 56-64.

Personal care (sometimes called custodial care) helps one with activities of daily living (ADLs.) These activities include bathing, eating, dressing, toileting, continence and transferring. Personal care is less involved than skilled care, and it may be given in many settings.
How Much Does Long-Term Care Cost?

Long-term care can be expensive. The cost depends on the amount and type of care you need and where you get it. Below are some average annual costs for care provided in a nursing home, in an assisted living facility and in your own home.

**Nursing Home Costs**

In 2007, the national average cost of nursing home care was about $181 per day (for a semi-private room).¹ This cost does not include items such as therapies and medications, which could make the cost much higher.

**Assisted Living Facility Costs**

In 2007, assisted living facilities reported charging an average fee of $2,714 per month (for a one-bedroom unit), or $32,568 per year, including rent and most other fees.² Some residents in the facilities may pay a lot more if their care needs are higher.

**Home Care Costs**

In 2007, the national average cost of part-time basic home care (home health aide three times a week) averaged $16,000 per year.³ Skilled care provided by a nurse is more expensive than care provided by a home health aide. Annual costs for home health care will vary based on the number of days per week the caregiver visits, the type of care required and the length of each visit. Home health care can be expensive if round-the-clock care is required. These costs are different across the country. Your state insurance department or the insurance counseling program in your state may have costs for your area. (See directory starting on page 56.)

Who Pays For Long-Term Care?

People pay for long-term care in a variety of ways. These include: using the personal resources of individuals or their families, long-term care insurance, and some assistance from **Medicaid** for those who qualify. **Medicare**, **Medicare supplement insurance**, and the health insurance you may have at work usually will not pay for long-term care.

**Individual Personal Resources**

Individuals and their families generally pay for part or all of the costs of long-term care from their own funds. Many use savings and investments. Some people sell assets, such as their homes, to pay for their long-term care needs.
**Medicare**

Medicare’s skilled nursing facility (SNF) benefit does not cover most nursing home care. Medicare will pay the cost of some skilled care in an approved nursing home or in your home, but only in specific situations. The SNF benefit only covers you if a medical professional says you need daily skilled care after you have been in the hospital for at least three days and you are receiving that care in a nursing home that is a Medicare-certified skilled nursing facility. While Medicare may cover up to 100 days of skilled nursing home care per benefit period when these conditions are met, after 20 days beneficiaries must pay a coinsurance fee. In 2008, that coinsurance was $128 per day. While Medicare may pay for nursing home care sometimes, it doesn’t cover the costs of care in assisted living facilities.

While many people would like to receive care in their own homes, Medicare does not cover homemaker services. In addition, Medicare doesn’t pay for home health aides to give you personal care unless you are homebound and are also getting skilled care, such as nursing or therapy. The personal care must also relate to the treatment of an illness or injury, and you can only get a limited amount of care in any week.

You should not rely on Medicare to pay for your long-term care needs.

**Medicare Supplement Insurance**

Medicare supplement insurance is private insurance that helps pay for some of the gaps in Medicare coverage, such as hospital deductibles and excess physician charges above what Medicare approves. Medicare supplement policies do not cover long-term care costs. However, four Medicare supplement policies—Plans D, G, I and J—do pay up to $1,600 per year for services to people recovering at home from an illness, injury or surgery. The benefit will pay for short-term, at-home help with activities of daily living. You must qualify for Medicare-covered home health services before this Medicare supplement benefit is available.

**Medicaid**

Medicaid is the government-funded program that pays nursing home care only for individuals who are low income and who have spent most of their assets. Medicaid pays for nearly half of all nursing home care on an aggregate basis, but many people who need long-term care never qualify for Medicaid assistance. Medicaid also pays for some home- and community-based services. To get Medicaid help, you must meet federal and state guidelines for income and assets. Many people start paying for nursing home care out of their own funds and “spend down” their income until they are eligible for Medicaid. Medicaid may then pay part or all of their nursing home costs. You may have to use up most of your assets on your health care before
Medicaid is able to help. Some assets and income can be protected for a spouse who remains at home. In addition, some of your assets may be protected if you have long-term care insurance approved under one of the state long-term care insurance partnership programs. (See section on partnership programs on page 11.)

State laws differ about how much money and assets you can keep and be eligible for Medicaid. (Some assets, such as your home, may not count when deciding if you are eligible for Medicaid.) However, federal law requires your state to recover from your estate the costs of the Medicaid-paid benefits you receive. Contact your state Medicaid office, office on aging or department of social services to learn about the rules in your state. The insurance counseling program in your state also may have some Medicaid information. (Please see the list of offices on aging and counseling programs starting on page 56.)

**Long-Term Care Insurance**

Long-term care insurance is one other way you may pay for long-term care. This type of insurance will pay or reimburse you for some or all of your long-term care. It was introduced in the 1980s as nursing home insurance but has changed a lot and now covers much more than nursing home care. The rest of this Shopper’s Guide will give you information on long-term care insurance.

You should know that a federal law, the **Health Insurance Portability and Accountability Act** of 1996, or HIPAA, gives some federal income tax advantages to people who buy certain long-term care insurance policies. These policies are called Tax-Qualified Long-Term Care Insurance Contracts, or simply Qualified Contracts. The tax advantages of these policies are outlined on page 15. There may be other tax advantages in your state. You should check with your state insurance department or insurance counseling program for information about tax-qualified policies. (See the list of state insurance departments and counseling programs starting on page 56.) Check with your tax advisor to find out if the tax advantages make sense for you.

**Who May Need Long-Term Care?**

The need for long-term care may begin gradually as you find that you need more and more help with activities of daily living, such as bathing and dressing or independent activities of daily living (IADLs) such as household chores, meal preparation, or managing money. Or you may suddenly need long-term care after a major illness, such as a stroke or a heart attack. If you do need care, you may need nursing home or home health care for only a short time. Or, you may need these services for many months, years or the rest of your life.
It is hard to know if and when you will need long-term care, but there are some statistics that may help. For example:

- Life expectancy after age 65 has now increased to 17.9 years. In 1940, life expectancy after 65 was only 13 extra years. The longer people live, the greater the chances they will need assistance due to chronic conditions.\(^9\)
- About 12.8 million Americans of all ages require long-term care, but only 2.4 million live in nursing homes.\(^10\)
- About 44\% of people reaching age 65 are expected to enter a nursing home at least once in their lifetime.\(^11\) Of those who do enter a nursing home, about 53\% will stay for one year or more.\(^12\)
- Most persons needing long-term care are elderly. Approximately 63\% are persons aged 65 and older (6.3 million). The remaining 37\% are 64 years of age or younger (3.7 million).\(^13\)
- The lifetime probability of becoming disabled in at least two activities of daily living or being cognitively impaired is 68\% for people age 65 and older.\(^14\)
- By 2050, the number of individuals using paid long-term care services or skilled nursing facilities will likely double from 13 million to 27 million. This estimate is influenced by growth in the population of older people in need of care.\(^15\)

Do You Need Long-Term Care Insurance?

Whether you should buy a long-term care insurance policy will depend on your age, health status, overall retirement goals, income and assets. For instance, if your only source of income is a Social Security benefit or Supplemental Security Income (SSI), you probably shouldn’t buy long-term care insurance, as you may not be able to afford the premium.

On the other hand, if you have a large amount of assets but don’t want to use them to pay for long-term care, you may want to buy a long-term care insurance policy. Many people buy a policy because they want to stay independent of government aid or the help of family. They don’t want to burden anyone with having to care for them. However, you should not buy a policy if you cannot afford the premium or aren’t sure you can pay the premium for the rest of your life.

If you already have health problems that are likely to mean you will need long-term care (for example, Alzheimer’s or Parkinson’s disease), you probably won’t be able to buy a policy. Insurance companies have medical underwriting standards to keep the cost of long-term care insurance affordable. Without such standards, most people would not buy coverage until they needed long-term care services.

Some states have a regulation requiring the insurance company and the agent to go through a worksheet with you to decide if long-term care insurance is right for you. The worksheet describes the premium for the policy you’re thinking about buying and asks you questions about the source and amount of your income and the amount of...
### Is Long-Term Care Insurance Right For You?

<table>
<thead>
<tr>
<th>You should NOT buy Long-Term Care Insurance if:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• You cannot afford the premiums.</td>
</tr>
<tr>
<td>• You have limited assets.</td>
</tr>
<tr>
<td>• Your only source of income is a Social Security benefit or Supplemental Security Income (SSI).</td>
</tr>
<tr>
<td>• You often have trouble paying for utilities, food, medicine, or other important needs.</td>
</tr>
<tr>
<td>• You are on Medicaid.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>You should CONSIDER buying Long-Term Care Insurance if:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• You have significant assets and income.</td>
</tr>
<tr>
<td>• You want to protect some of your assets and income.</td>
</tr>
<tr>
<td>• You can pay premiums, including possible premium increases, without financial difficulty.</td>
</tr>
<tr>
<td>• You want to stay independent of the support of others.</td>
</tr>
<tr>
<td>• You want to have the flexibility of choosing care in the setting you prefer or will be most comfortable in.</td>
</tr>
</tbody>
</table>

Remember, not everyone should buy a long-term care insurance policy. For some, a policy is affordable and worth the cost. For others, the cost is too great, or the policy they can afford doesn’t offer enough benefits to make it worthwhile. You should not buy long-term care insurance if the only way you can afford to pay for it is by not paying other important bills. Look closely at your needs and resources, and discuss it with a family member to decide if long-term care insurance is right for you. (There are several worksheets at the back of this book that will help you as you think about whether you should buy long-term care insurance.)

For further determination of whether you should or should not consider buying long-term care insurance, please refer to the Personal Worksheet found in the back of this Shopper’s Guide. In addition to the personal worksheet, consumer worksheets #1 through #4 should be used to help you decide.

If, after careful consideration, you decide that long-term care insurance is right for you, check out the company and the agent, if one is involved, before you buy a policy. Insurance companies and agents must be licensed in your state to sell long-term care insurance. **If you’re not sure, contact your state insurance department.** (Please see the list of state insurance departments starting on page 56.)
How Can You Buy Long-Term Care Insurance?

Private insurance companies sell long-term care insurance policies. You can buy an individual policy from an agent or through the mail. Or, you can buy coverage under a group policy through an employer or through membership in an association. The federal government and several state governments offer long-term care insurance coverage to their employees, retirees and their families. This program is voluntary, and premiums are paid by participants. You can also get long-term care benefits through a life insurance policy.

Individual Policies

Today, most long-term care insurance policies are sold to individuals. Insurance agents sell many of these policies, but companies also sell policies through the mail or by telephone. You will find that individual policies can be very different from one company to the next. Each company may also offer policies with different combinations of benefits. Be sure to shop among policies, companies and agents to get the coverage that best fits your needs.

Policies From Your Employer

Your employer may offer a group long-term care insurance plan or offer individual policies at a group discount. An increasing number of employers offer this benefit, especially since the passage of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA allows employers the same type of federal tax benefit when they pay for their employees’ long-term care insurance as when they pay for their health insurance (except for Section 125 cafeteria plans).

The employer-group plan may be similar to what you could buy in an individual policy. If you are an active employee, one advantage of an employer-group plan is you may not have to meet any medical requirements to get a policy or there may be a relaxed screening process for active employees. Many employers also let retirees, spouses, parents and parents-in-law apply for this coverage. Relatives must usually pass the company’s medical screening to qualify for coverage and must pay the premium.

Generally, insurance companies must let you keep your coverage after your employment ends or your employer cancels the group plan. In most cases, you will be able to continue your coverage or convert it to another long-term care insurance policy. Your premiums and benefits may change, however.

If an employer offers long-term care insurance, be sure to think about it carefully. An employer-group policy may offer you options you cannot find if you buy a policy on your own.
Federal Government
Federal and U.S. Postal Service employees and annuitants, members and retired members of the uniformed services, and qualified relatives of any of these are eligible to apply for long-term care insurance coverage under the Federal Long Term Care Insurance Program. Private insurance companies underwrite the insurance, and the federal government does not pay any of the premiums. The group rates under this program may or may not be lower than individual rates, and the benefits may also be different.17

State Government
If you or a member of your family is a state or public employee or retiree, you may be able to buy long-term care insurance under a state government program.

Association Policies
Many associations let insurance companies and agents offer long-term care insurance to their members. These policies are like other types of long-term care insurance and typically require medical underwriting. Like employer-group policies, association policies usually give their members a choice of benefit options. In most cases, policies sold through associations must let members keep or convert their coverage after leaving the association. Be careful about joining an association just to buy any insurance coverage. Review your rights if the policy is terminated or canceled.

Policies Sponsored by Continuing Care Retirement Communities
Many Continuing Care Retirement Communities (CCRC) offer or require you to buy long-term care insurance. A CCRC is a retirement complex that offers a broad range of services and levels of care. You must be a resident or on the waiting list of a CCRC and meet the insurance company’s medical requirements to buy its long-term care insurance policy. The coverage will be similar to other group or individual policies.

Life Insurance Policies
Some companies let you use your life insurance death benefit to pay for specific conditions such as terminal illness or for qualified long-term care expenses such as home health care, assisted living or nursing home care. A life insurance death benefit you use while you are alive is known as an accelerated death benefit. A life insurance policy that uses an accelerated death benefit to pay for long-term care expenses may also be known as a “life/long-term care” policy. It may be an individual or a group life insurance policy. The company pays you the actual charges for care when you receive long-term care services, but no more than a certain percent of the policy’s death
benefit per day or per month. Policies may pay part or all of the death benefit for qualified long-term care expenses. Some companies let you buy more long-term care coverage than the amount of your death benefit in the form of a **rider**.

Some policies may allow you to withdraw the cash value of your policy to pay for specific conditions and expenses. It is important to remember that if you use money from your life insurance policy to pay for long-term care, it will reduce the death benefit the beneficiary will get. For example, if you buy a policy with a $100,000 death benefit, using $60,000 for long-term care will cut the death benefit of your policy to $40,000. It may also affect the cash value of your policy. Ask your agent how this may affect other aspects of your life insurance policy. If you bought life insurance to meet a specific need after your death, your survivors may not be able to meet that need if you use your policy to pay for long-term care. If you never use the long-term care benefit, the policy will pay the full death benefit to your beneficiary.

**Long-Term Care Insurance Partnership Plans**

Some states have long-term care insurance **partnership programs** designed to help people with the financial impact of spending down to meet Medicaid eligibility standards. Under these partnership programs, when you buy a specially approved insurance policy, you will receive protection against the normal Medicaid requirement to spend down your assets to become eligible.

The long-term care partnership program is a creation of federal law allowing states to alter their Medicaid program to allow assets to be disregarded based upon claims paid by qualified long-term care insurance policies. Most states allow a dollar-for-dollar asset disregard for claims paid on qualified partnership policies and will not require you to exhaust the benefits offered under the partnership policy in order to qualify for Medicaid. Under the partnership program, if you need additional coverage beyond what is provided by your qualified partnership policy, you can access Medicaid without depleting all your assets.

**Benefits of the Partnership Program**

- Partnership policies are tax-qualified plans under federal law, must contain certain consumer protections and must provide inflation protection benefits for purchasers so that benefits keep up with the cost of inflation over time.
- The long-term care partnership program provides an alternative to spending down or transferring assets by forming a partnership between Medicaid and private long-term care insurers.
- Once private insurance benefits are used, special Medicaid eligibility rules are applied if additional coverage is necessary.
Key Features of Long-Term Care Partnership Policies

- The policies must be tax-qualified plans.
- Policies must provide inflation protection:
  - Those under age 61 at date of purchase must have compound annual inflation protection.
  - Those at least 61 years of age but under the age of 76 must have some level of inflation protection.
  - Those over the age of 76 may have but are not required to have inflation protection.

How Will I Know I Have Purchased a Partnership Policy?

- If the policy you purchased is a partnership plan, you will receive written notice from the insurance company. Depending upon the state, it will be in one of the following ways:
  - Your policy or certificate will be identified as a partnership policy in the policy itself either on the front page or on the schedule page of the policy.
  - You will receive a letter from your insurance company advising you that you have purchased a partnership policy. If this is the only notification you receive, it is extremely important to keep this letter.

Please keep in mind that these programs have specific requirements in each state in which they are offered. **Check with your state insurance department or counseling program to see if these policies are available in your state.** Many states with long-term care partnership programs have information about them on their Web sites. To locate your state’s insurance department Web site, visit [www.naic.org/state_web_map.htm](http://www.naic.org/state_web_map.htm). Also, the U.S. Department of Health and Human Services maintains a Web site with information on long-term care insurance and the partnership program at [www.longtermcare.gov](http://www.longtermcare.gov).

What Types of Policies Can I Buy?

You may be asked to choose between a “tax-qualified” long-term care insurance policy and one that is “non-tax-qualified.” There are important differences between the two types of policies. These differences were created by the Health Insurance Portability and Accountability Act (HIPAA). A federally tax-qualified long-term care insurance policy, or a qualified policy, offers certain federal income tax advantages. If you have a qualified long-term care policy and you itemize your deductions, you may be able to deduct part or all of the premium you pay for the policy. You may be able to add the premium to your other deductible medical expenses. You may then be able to deduct the amount that is more than 7.5% of your adjusted gross income on your federal income tax return. The amount depends on your age, as shown in the following table.
Regardless of which policy you choose, make sure that you understand how the benefits and triggers will work and that they are acceptable to you. For example, benefits paid by a qualified long-term care insurance policy are generally not taxable as income. Benefits from a long-term care insurance policy that is not qualified may be taxable as income.

If you bought a long-term care insurance policy before January 1, 1997, that policy is probably qualified. HIPAA allowed these policies to be “grandfathered,” or considered qualified, even though they may not meet all of the standards that new policies must meet to be qualified. The tax advantages are the same whether the policy was sold before or after 1997. You should carefully examine the advantages and disadvantages of trading a grandfathered policy for a new policy. In most cases, it will be to your advantage to keep your old policy.

Long-term care insurance policies that are sold on or after January 1, 1997, as tax-qualified must meet certain federal standards. To be qualified, policies must be labeled as tax-qualified, be guaranteed renewable, include a number of consumer protection provisions, cover only qualified long-term care services, and generally can provide only limited cash surrender values. (See Benefit Triggers, page 19.)

Qualified long-term care services are those generally given by long-term care providers. These services must be required by chronically ill individuals and must be given according to a plan of care prescribed by a licensed health care practitioner. You are considered chronically ill if you are expected to be unable to do at least two activities of daily living without substantial assistance from another person for at least 90 days. Another way you may be considered to be chronically ill is if you need substantial supervision to protect your health and safety because you have a cognitive impairment. A policy issued to you before January 1, 1997, doesn’t have to define chronically ill this way. (See Benefit Triggers, page 19.)

2009 figures. These amounts will increase annually based on the Medical Consumer Price Index.

<table>
<thead>
<tr>
<th>YOUR AGE</th>
<th>MAXIMUM AMOUNT THAT YOU CAN CLAIM</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 years old or younger</td>
<td>$320</td>
</tr>
<tr>
<td>More than 40 but not more than 50</td>
<td>$600</td>
</tr>
<tr>
<td>More than 50 but not more than 60</td>
<td>$1,190</td>
</tr>
<tr>
<td>More than 60 but not more than 70</td>
<td>$3,180</td>
</tr>
<tr>
<td>More than 70</td>
<td>$3,980</td>
</tr>
</tbody>
</table>
Some life insurance policies with long-term care benefits may be tax-qualified. You may be able to deduct the premium you pay for the long-term care benefits that a life insurance policy provides. However, be sure to check with your personal tax advisor to learn how much of the premium can be deducted as a medical expense.

The long-term care benefits paid from a tax-qualified life insurance policy with long-term care benefits are generally not taxable as income. Tax-qualified life insurance policies with long-term care benefits must meet the same federal standards as other tax-qualified policies, including the requirement that you must be chronically ill to receive benefits.

**How Do Long-Term Care Insurance Policies Work?**

Long-term care insurance policies are not standardized like Medicare supplement insurance. Companies sell policies that combine benefits and coverage in different ways.

**How Benefits Are Paid**

Insurance companies that sell long-term care insurance generally pay benefits using one of three different methods: the expense-incurred method, the indemnity method, or the disability method. It is important to read the literature that accompanies your policy (or certificate for group policies) and to compare the benefits and premiums.

When the expense-incurred method is used, the insurance company must decide if you are eligible for benefits and if your claim is for eligible services. Your policy or certificate will pay benefits only when you receive eligible services. Once you have incurred an expense for an eligible service, benefits are paid either to you or your provider. The coverage will pay for the lesser of the expense you incurred or the dollar limit of your policy. Most policies bought today pay benefits using the expense-incurred method.

When the indemnity method is used, the benefit is a set dollar amount. The benefit is not based on the specific services received or on the expenses incurred. The insurance company only needs to decide if you are eligible for benefits and if the services you are receiving are covered by the policy. Once the company decides you are eligible and you are receiving eligible long-term care services, the insurance company will pay that set amount directly to you up to the limit of the policy.

When the disability method is used, you are only required to meet the benefit eligibility criteria. Once you do, you receive your full daily benefit, even if you are not receiving any long-term care services.
### FEDERALLY TAX-QUALIFIED POLICIES

| 1. | Premiums can be included with other annual uncompensated medical expenses for deductions from your income in excess of 7.5% of adjusted gross income up to a maximum amount adjusted for inflation. |
| 2. | Benefits that you receive and use to pay for long-term care services generally will not be counted as income. For policies that pay benefits using the expense incurred method, benefits that you receive in excess of the costs of long term care services may be taxable. For policies that pay benefits using the indemnity or disability methods, all benefit payments up to the federally approved per diem (daily) rate are tax-free even if they exceed your expenses. |
| 3. | To trigger the benefits under your policy, the federal law requires you to be unable to do two ADLs without **substantial assistance**. |
| 4. | “Medical necessity” cannot be used as a trigger for benefits |
| 5. | Chronic illness or disability must be expected to last for at least 90 days. |
| 6. | For cognitive impairment to be covered, a person must require “substantial supervision.” |

### FEDERALLY NON-TAX-QUALIFIED POLICIES

| 1. | You may or may not be able to deduct any part of your annual premiums. Congress and the U.S. Department of the Treasury have not clarified this area of the law. |
| 2. | Benefits that you receive may or may not count as income. Congress and the U.S. Department of the Treasury have not clarified this area of the law. |
| 3. | Policies can offer a different combination of benefit triggers. Benefit triggers are not restricted to two ADLs. |
| 4. | “Medical necessity” and/or other measures of disability can be offered as benefit triggers. |
| 5. | Policies don’t have to require that the disability be expected to last for at least 90 days. |
| 6. | Policies don’t have to require “substantial supervision” to trigger benefits for cognitive impairments. |

Whether you are considering buying a tax-qualified or a non-tax-qualified policy, consult with your tax consultant or legal advisor regarding the tax consequences in your situation.
Pooled Benefits and Joint Policies

You may be able to buy a long-term care insurance policy that covers more than just one person, or more than one kind of long-term care service. The benefits provided by these policies are often called “pooled benefits.”

One type of pooled benefit covers more than one person, such as a husband and wife, or two partners, or two or more related adults. This type of benefit is sometimes called a “joint policy” or a “joint benefit.” This pooled benefit usually has a total benefit that applies to all of the individuals covered by the policy. If one of the covered individuals collects benefits, that amount is subtracted from the total policy benefit. For example, if a husband and wife have a policy that provides $150,000 in total long-term care benefits, and the husband uses $25,000 in benefits from the policy, $125,000 would be left to pay benefits for either the husband or the wife, or both.

Another kind of “pooled benefit” provides a total dollar amount that can be used for various long-term care services. These policies pay a daily, weekly, or monthly dollar limit for one or more covered services. You can combine benefits in ways that best meet your needs. This gives you more control over how your benefits are spent. For example, you may choose to combine the benefit for home care with the benefit for community-based care instead of using the nursing home benefit.

Some policies provide both types of pooled benefits. Other policies provide one or the other.

What Services Are Covered

It is important that you understand what services your long-term care insurance policy covers and how it covers the many types of long-term care services you might need to use. Policies may cover the following:

- Nursing home care
- Home health care
- Respite care
- Hospice care
- Personal care in your home
- Services in assisted living facilities
- Services in adult day care centers
- Services in other community facilities
There are several ways policies may cover home health care. Some long-term care insurance policies only pay for care in your home from licensed home health agencies. Some also will pay for care from licensed health care providers not from a licensed agency. These include licensed practical nurses; occupational, speech, or physical therapists; or licensed home health care aides. Other policies may pay for services from home health care aides who may not be licensed or are not from licensed agencies. Home health care aides help with personal care. You may find a policy that pays for homemaker or chore worker services. This type of benefit, though not available in all policies, would pay for someone to come to your home to cook meals and run errands. Generally, adding home care benefits to a policy also adds to the cost of the policy.

**NOTE:** Some policies pay benefits to family members who give care in the home.

**Where Services Are Covered**

You should know what types of facilities are covered by your long-term care insurance policy. If you’re not in the right type of facility, the insurance company can refuse to pay for eligible services. New kinds of facilities may be developed in the future, and it is important to know whether your policy will cover them.

Some policies may pay for care in any state-licensed facility. Others only pay for care in some state-licensed facilities, such as a licensed nursing facility. Still others list the types of facilities where services will not be covered, which may include state-licensed facilities. (For example, some places that care for elderly people are referred to as homes for the aged, rest homes or personal care homes, and are often not covered by long-term care policies). Some policies may list specific points about the kinds of facilities they will cover. Some will say the facilities must care for a certain number of patients or give a certain kind of care. When shopping for a long-term care policy, check these points carefully and compare the types of services and facilities covered in the policy. Also, be aware that many states, companies and policies define assisted living facilities differently. Policies that cover assisted living facilities in one state may not cover services provided in an assisted living facility in another state. Before you move or retire to another state, ask if your policy covers the types of services and facilities available in your new state. Also, if your policy lists kinds of facilities, be sure to check if your policy requires the facility to have a license or certification from a government agency.

**NOTE:** If you do NOT reside in the kind of facility specified by your policy, the insurance company may not pay for the services you require.
What Services Are Not Covered (Exclusions and Limitations)

Most long-term care insurance policies usually do not pay benefits for:

- A mental or nervous disorder or disease, other than Alzheimer’s disease or other dementia.
- Alcohol or drug addiction.
- Illness or injury caused by an act of war.
- Treatment the government has provided in a government facility or already paid for.
- Attempted suicide or intentionally self-inflicted injuries.

NOTE: In most states, regulations require insurance companies to pay for covered services for Alzheimer’s disease that may develop after a policy is issued. Ask your state insurance department if this applies in your state. Nearly all policies specifically say they will cover Alzheimer’s disease. Read about Alzheimer’s disease and eligibility for benefits in the section on benefit triggers on page 19.

NOTE: Many policies exclude or limit coverage for care outside of the United States.

How Much Coverage You Will Have

The policy or certificate may state the amount of coverage in one of several ways. A policy may pay different amounts for different types of long-term care services. Be sure you understand how much coverage you will have and how it will cover long-term care services you receive.

Maximum Benefit Limit. Most policies limit the total benefit they will pay over the life of the policy, but a few don’t. Some policies state the maximum benefit limit in years (one, two, three or more, or even lifetime). Others write the policy maximum benefit limit as a total dollar amount. Policies often use words like “total lifetime benefit,” “maximum lifetime benefit,” or “total plan benefit” to describe their maximum benefit limit. When you look at a policy or certificate, be sure to check the total amount of coverage. In most states, the minimum benefit period is one year. Most nursing home stays are short, but illnesses that go on for several years could mean long nursing home stays. You will have to decide if you want protection for very long stays. Policies with longer maximum benefit periods cost more. Read your long-term care insurance policy carefully to learn what the benefit period is.

Daily/Weekly/Monthly Benefit Limit. Policies normally pay benefits by the day, week or month. For example, in an expense-incurred plan, a policy might pay a daily nursing home benefit of up to $200 per day or $6,000 per month, and a weekly home care benefit of up to $1,400 per week. Some policies will pay one time for single events, such as installing a home medical alert system.

When you buy a policy, insurance companies let you choose a benefit amount (usually $50 to $350 a day, $350 to $2,450 a week, or $1,500 to $10,500 a month) for
care in a nursing home. If a policy covers home care, the benefit is usually a portion of the benefit for nursing home care (e.g., 50% or 75%), although a growing number of policies pay the same benefit amounts for care at home as in a facility. Often, you can select the home care benefit amount that you prefer. It is important to know how much skilled nursing homes, assisted living facilities, and home health care agencies charge for their services BEFORE you choose the benefit amounts in your long-term care insurance policy. Check the facilities in the area where you think you may be receiving care, whether they are local, near a grown child, or in a new place where you may retire. The worksheet on page 42 can help you track these costs.

**When You Are Eligible for Benefits (Benefit Triggers)**

The term usually used to describe the way insurance companies decide when to pay benefits is “benefit triggers.” This term refers to the criteria and the methods that the insurance company uses to evaluate when you are eligible for benefits, and the conditions you must meet to receive benefits. This is an important part of a long-term care insurance policy. Look at it carefully as you shop. The policy and the outline of coverage usually describe the benefit triggers. Look for a section called “Eligibility for the Payment of Benefits” or simply “Eligibility for Benefits.” Different policies may have different benefit triggers. Some states require certain benefit triggers, and the benefit triggers for tax-qualified contracts are also fairly standardized across insurance policies. Check with your state insurance department to find out what your state requires.

**NOTE:** Companies may use different benefit triggers for home health care coverage than for nursing home care, although most do not do so. If they do, they generally have a more restrictive benefit trigger for nursing home care than for home care.

**Types of Benefit Triggers**

**Activities of Daily Living.** The inability to do activities of daily living, or ADLs, is the most common way insurance companies decide when you are eligible for benefits. The ADLs most companies use are bathing, continence, dressing, eating, toileting and transferring. Typically, a policy pays benefits when you cannot do a certain number of the ADLs, such as two of the six or three of the six. The more ADLs you must be unable to do, the harder it will be for you to become eligible for benefits. Federally tax-qualified policies are required to use the inability to do certain ADLs as a benefit trigger. A qualified policy requires that a person be unable to perform at least two of their ADLs to collect benefits. The ADLs that trigger benefits in a tax-qualified policy must come from the list above. These triggers are specified in your policy.
If the policy you’re thinking of buying pays benefits when you cannot do certain ADLs, be sure you understand what that means. Some policies spell out very clearly what it means to be unable to feed or bathe oneself. Some policies say that you must have someone actually help you do the activities. That’s known as hands-on assistance. Specifying hands-on assistance will make it harder to qualify for benefits than if only stand-by assistance is required. The more clearly a policy describes its requirements, the less confusion you or your family will have when you need to file a claim.

**NOTE:** The six activities of daily living (ADLs) have been developed through years of research. This research also has shown that bathing is usually the first ADL that a person cannot do. While most policies use all six ADLs as benefit triggers, qualifying for benefits from a policy that uses five ADLs may be more difficult if bathing isn’t one of the five.

**Cognitive Impairment.** Most long-term care insurance policies also pay benefits for “cognitive impairment.” The policy usually pays benefits if you cannot pass certain tests of cognitive function.

Coverage of cognitive impairment is especially important if you develop Alzheimer’s disease or other dementia. If being unable to do ADLs is the only benefit trigger your policy uses, it may not pay benefits if you have Alzheimer’s disease but can still do most of the ADLs on your own. But if your policy also uses a test of your cognitive ability as a benefit trigger, it is more likely to pay benefits if you have Alzheimer’s disease. Most states do not allow policies to limit benefits solely because you have Alzheimer’s disease.

**Doctor Certification of Medical Necessity.** Some long-term care insurance policies will pay benefits if your doctor orders or certifies that the care is medically necessary. However, tax-qualified policies cannot use this benefit trigger.

**Prior Hospitalization.** Long-term care insurance policies sold in the past required a hospital stay of at least three days before paying benefits. Most companies no longer sell policies that require a hospital stay.

**NOTE:** Medicare still requires a three-day hospital stay to be eligible for Medicare payment of skilled nursing facility benefits.

**When Benefits Start (Elimination Period)**

With many policies, your benefits won’t start the first day you go to a nursing home or start using home care. Most policies have an **elimination period** (sometimes called a deductible or a waiting period). That means benefits can start zero, 20, 30, 60, 90, or 100 days after you start using long-term care or become disabled. Elimination
periods for nursing home and home health care may be different, or there may be a single elimination period that applies to any covered service. How many days you have to wait for benefits to start will depend on the elimination period you pick when you buy your policy. You might be able to choose a policy with a zero-day elimination period, but expect it to cost more.

Some policies calculate the elimination period using calendar days, while other policies count only the days on which you receive a covered service. Under the calendar days method, every day of the week would count in determining the elimination period regardless of whether you received any services on those days. Under the days of service method, only days when you receive services will count toward the elimination period. This means if you only receive services three days a week, it will take longer for your benefits to start, and it could mean that you have more out-of-pocket expenses before your benefits begin. Also, some policies have an elimination period that you only need to satisfy once in your lifetime, while other policies require that you satisfy the elimination period with each “episode of care.” Some policies allow you to accumulate non-consecutive days toward satisfying the elimination period, and some policies require consecutive days. Make sure you know how the policy defines the elimination period.

During an elimination period, the policy will not pay the cost of long-term care services. You may owe the cost of your care during the elimination period. You may choose to pay a higher premium for a shorter elimination period. If you choose a longer elimination period, you’ll pay a lower premium but must pay the cost of your care during the elimination period.

For example, if a nursing home in your area costs $150 a day and your policy has a 30-day elimination period, you’d have to pay $4,500 before your policy starts to pay benefits. A policy with a 60-day elimination period would mean you’d have to pay $9,000 of your own money, while a policy with a 90-day elimination period would mean you’d have to pay $13,500 of your own money.

If you only need care for a short time and your policy has a long elimination period, your policy may not pay any benefits. If, for example, your policy had a 100-day elimination period, and you received long-term care services for only 60 days, you would not receive any benefits from your policy.

On the other hand, if you can afford to pay for long-term care services for a short time, a longer elimination period might be right for you. It would protect you if you need extended care and also keep the cost of your insurance down.

You may also want to think about how the policy pays if you have a repeat stay in a nursing home. Some policies count the second stay as part of the first one as long as you leave and then go back within 30, 90 or 180 days. Find out if the insurance company requires another elimination period for a second stay. Some policies only require you to meet the elimination period once per lifetime.
What Happens When Long-Term Care Costs Rise (Inflation Protection)?

Inflation protection can be one of the most important additions you can make to a long-term care insurance policy. Inflation protection increases the premium. However, unless your benefits increase over time, years from now you may find that they haven’t kept up with the rising cost of long-term care. The cost of nursing home care has been rising at an annual rate of 5% for the past several years. This means that a nursing home that cost $150 a day in 2000 will cost $398 a day in 20 years, if inflation is 5% a year. Obviously, the younger you are when you buy a policy, the more important it is for you to think about adding inflation protection.

You can usually buy inflation protection in one of two ways: automatically or by special offer.

Automatic Inflation Protection. The first way automatically increases your benefits each year. Generally, there would be no increase in premium when the benefit is automatically increased. Policies that increase benefits for inflation automatically may use simple or compound rates. Either way, the daily benefit increases each year by a fixed percentage, usually 5%, for the life of the policy or for a certain period, usually 10 or 20 years.

The dollar amount of the increase depends on whether the inflation adjustment is “simple” or “compound.” If the inflation increase is simple, the benefit increases by the same dollar amount each year. If the increase is compounded, the dollar amount of the benefit increase goes up each year. For example, a $100 daily benefit that increases by a simple 5% a year will go up $5 a year and will be $265 a day in 20 years. If the increase is compounded, the annual increase will be higher each year and the $100 daily benefit will be $265 a day in 20 years.

<table>
<thead>
<tr>
<th>Rate of Inflation</th>
<th>2000</th>
<th>2005</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
<td>$150</td>
<td>$191</td>
<td>$244</td>
<td>$312</td>
<td>$398</td>
</tr>
<tr>
<td>6%</td>
<td>$150</td>
<td>$201</td>
<td>$269</td>
<td>$359</td>
<td>$481</td>
</tr>
<tr>
<td>7%</td>
<td>$150</td>
<td>$210</td>
<td>$295</td>
<td>$414</td>
<td>$580</td>
</tr>
<tr>
<td>8%</td>
<td>$150</td>
<td>$220</td>
<td>$324</td>
<td>$476</td>
<td>$699</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate of Inflation</th>
<th>2000</th>
<th>2005</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
<td>$150</td>
<td>$188</td>
<td>$225</td>
<td>$263</td>
<td>$300</td>
</tr>
<tr>
<td>6%</td>
<td>$150</td>
<td>$195</td>
<td>$240</td>
<td>$285</td>
<td>$330</td>
</tr>
<tr>
<td>7%</td>
<td>$150</td>
<td>$203</td>
<td>$255</td>
<td>$308</td>
<td>$360</td>
</tr>
<tr>
<td>8%</td>
<td>$150</td>
<td>$210</td>
<td>$270</td>
<td>$330</td>
<td>$390</td>
</tr>
</tbody>
</table>

The chart is for demonstration purposes only. It shows simple inflation increases over a 20-year period.
Automatic inflation increases that are compounded are a good idea, but not all policies offer them. Some states now require policies to offer compound inflation increases. Check with your state insurance department to find out if this applies in your state. All individual and some group tax-qualified policies must offer compound inflation increases as an option. Compounding can make a big difference in the size of your benefit.

**Special Offer or Non-Automatic Inflation Protection.** The second way to buy inflation protection lets you choose to increase your benefits periodically, such as every two or three years. With a periodic increase option, you usually don’t have to show proof of good health, if you regularly use the option. Your premium will increase if you increase your benefits. How much it increases depends on your age at the time and on the amount of additional benefit you want to buy. Buying more benefits every few years may help you afford the cost of the additional coverage. If you turn down the option to increase your benefit one year, you may not get the chance again. If you get the chance later, you may have to prove good health, or it may cost you more money. If you don’t accept the offer, you need to check your policy to see how it will affect future offers. Some policies continue the inflation offers while you are receiving benefits, but most do not. So check your policy carefully before you buy.

The above charts and graphs illustrate the effects of inflation in two formats.

**NOTE:** Most states have adopted regulations that require companies to offer inflation protection. It’s up to you to decide whether to buy the coverage. If you decide not to take the protection, you may be asked to sign a statement saying you didn’t want it. Be sure you know what you’re signing.
**Additional Benefits**

**Third Party Notice.** This benefit lets you name someone whom the insurance company would contact if your coverage is about to end because you forgot to pay the premium. Sometimes people with cognitive impairments forget to pay the premium and lose their coverage when they need it the most.

You can choose a relative, friend or a professional (e.g., a lawyer or accountant) as your third party. After the company contacts the person you choose, he or she would have some time to arrange for payment of the overdue premium. You can usually name a contact person without paying extra. Some states require insurance companies to give you the chance to name a contact and to update your list of contacts from time to time. You may be required to sign a waiver if you choose not to name anyone to be contacted if the policy is about to lapse.

**Other Long-Term Care Insurance Policy Options You Might Choose**

You can probably choose other policy features, but keep in mind that not all insurers offer all of the policy options. Each may add to the cost of your policy. Ask your insurer what features increase your policy’s cost.

**Waiver of Premium.** Many policies automatically include this feature, but some may only offer it as an additional optional benefit. Premium waiver lets you stop paying the premium once you are eligible for benefits and the insurance company has started to pay benefits. Some companies waive the premium as soon as they make the first benefit payment. Others wait until you have received benefits for 60 to 90 days.

**Restoration of Benefits.** This option gives you a way to keep the maximum amount of your original benefit even after your policy has paid you benefits. With this option, if you fully recover after a prior disability and go for a stated period without needing or receiving more long-term care services, your benefit goes back to the amount you first bought. For example, assume your policy paid you $5,000 in long-term care benefits out of a policy maximum of $75,000. You would have $70,000 in benefits left. With a restoration of benefits option, if you fully recovered and didn’t need or use any long-term care services for a specified time (usually 6 months), your maximum benefit would go back to the original $75,000. Premium Refund At Death. This benefit pays to your estate any premiums you paid minus any benefits the company paid. To get a refund at death, you must have paid premiums for a certain number of years. Some companies refund premiums only if the policyholder dies before a certain age, usually 65 or 75. The premium refund option may also add to the cost of a policy.

**Downgrades.** While it may not always appear in the contract, most insurers let policyholders reduce their coverage if they have trouble paying the premium. When you downgrade to a less comprehensive policy, you will pay a lower premium, usually based on your age at the time you purchased your original policy. This may allow you to keep the policy in force instead of dropping it.
What Happens If You Cannot Afford the Premiums Anymore?

Nonforfeiture Benefits. If, for whatever reason, you drop your coverage and you have a nonforfeiture benefit in your policy, you will receive some benefit value for the money you’ve paid into the policy. Without this type of benefit, you get nothing, even if you’ve paid premiums for 10 or 20 years before dropping the policy.

Some states may require insurance companies to offer long-term care insurance policies with a written offer of nonforfeiture benefit. In this case, you may be given benefit options with different premium costs, including reduced paid-up policies, shortened benefit period policies and extended term policies. Under these benefit options, when you stop paying your premiums, the company gives you a paid-up policy. Depending on the option you chose, your paid-up policy either will have the same benefit period but with a lower daily benefit (reduced paid-up policy) or will have the same daily benefit but with a shorter benefit period (shortened benefit period policy or extended term policy). Under all of these options, the level of benefits you will receive depends on how long you paid premiums and the amount of premiums you have paid. Since it’s paid-up, you won’t owe any more premiums.

Other insurers may offer a “return of premium” nonforfeiture benefit. They pay back to you all or part of the premiums that you paid in if you drop your policy after a certain number of years. This is generally the most expensive type of nonforfeiture benefit. A nonforfeiture benefit can add roughly 10% to 100% (and sometimes more) to a policy’s cost. How much it adds depends on such things as your age at the time you bought the policy, the type of nonforfeiture benefit, and whether the policy has inflation protection.

You have the option to add a nonforfeiture benefit if you’re buying a tax-qualified policy. The “return of premium” nonforfeiture benefit, the “reduced paid-up policy” and the “shortened benefit period policy” may be available options under a tax-qualified policy if you drop the policy. You should consult a tax advisor to see if adding a nonforfeiture benefit would be good for you.

Contingent Nonforfeiture. In some states, if you don’t accept the offer of a nonforfeiture benefit, a company is required to provide a “contingent benefit upon lapse.” This means that when your premiums increase to a certain level (based on a table of increases), the “contingent benefit upon lapse” will take effect. For example, if you bought the policy at age 70 and did not accept the insurance company’s offer of a nonforfeiture benefit, if the premium rises to 40% more than the original premium, you will be offered the opportunity to accept one of the “contingent benefits upon lapse.” The benefits offered are: 1) a reduction in the benefits provided by the current policy so that premium costs stay the same; or 2) a conversion of the policy to paid-up status with a shorter benefit period. You may also choose to keep your policy and continue to pay the higher premium.
Will Your Health Affect Your Ability to Buy a Policy?

Companies that sell long-term care insurance medically “underwrite” their coverage. They look at your health and health history before they decide to issue a policy. You may be able to buy coverage through an employer or another type of group without any health underwriting or with more relaxed underwriting. Insurance companies’ underwriting practices affect the premiums they charge you now and in the future. Some companies do what is known as “short-form” underwriting. They ask you to answer a few questions on the insurance application about your health. For example, they may want to know if you have been in a nursing home or received care at home in the last 12 months.

Sometimes companies don’t check your medical record until you file a claim. Then they may try to refuse to pay you benefits because of information found in your medical record after you file your claim. This practice is called “post-claims underwriting.” It is illegal in many states. Companies that thoroughly check your health before selling you a policy aren’t as likely to do post-claims underwriting.

Some companies do more underwriting. They may ask more questions, look at your current medical records, and ask your doctor for a statement about your health. These companies may insure fewer people with health problems. If you have certain conditions that are likely to mean you’ll soon need long-term care (Parkinson’s disease, for example), you probably cannot buy coverage from these companies.

No matter how the company underwrites, you must answer certain questions that the company uses to decide if it will insure you. When you fill out your application, be sure to answer all questions correctly and completely. A company depends on the information you put on your application. If the information is wrong, an insurance company may decide to rescind your policy and return the premiums you have paid. It can usually do this within two years after you buy the policy. Most states require the insurance company to give you a copy of your application when it delivers the policy. At this time, you can review your answers again. You should keep this copy of the application with your insurance papers.

What Happens If You Have Pre-Existing Conditions?

A long-term care insurance policy usually defines a pre-existing condition as one for which you received medical advice or treatment or had symptoms of within a certain period before you applied for the policy. Some companies look further back in time than others. That may be important to you if you have a pre-existing condition. A company that learns you didn’t tell it about a pre-existing condition on your
application might not pay for treatment related to that condition and might even cancel your coverage. A company can usually do this within two years after you buy the policy, or in some cases later, if you intentionally mislead the insurer.

Many companies will sell a policy to someone with a pre-existing condition. However, the company may not pay benefits for long-term care related to that condition for a period after the policy goes into effect, usually six months. Some companies have longer pre-existing condition periods; others have none.

Can You Renew Your Long-Term Care Insurance Policy?

In most states, long-term care insurance policies sold today must be **guaranteed renewable**. When a policy is guaranteed renewable, it means that the insurance company guarantees you a chance to renew the policy. It does not mean that it guarantees you a chance to renew at the same premium. Your premium may go up over time as your company pays more claims and more expensive claims.

Insurance companies can raise the premiums on their policies, but only if they increase the premiums on all policies that are the same in that state. **No individual can be singled out for a rate increase**, no matter how many claims have been filed. In some states, the premium cannot increase just because you are older. If you bought a policy in a group setting and you leave the group, you may be able to keep your group coverage or convert it to an individual policy, but you may pay more. **You can ask your state insurance department if your state requires this option.**

How Much Do Long-Term Care Insurance Policies Cost?

A long-term care insurance policy can be expensive. Be sure you can pay the premiums and still afford your other health insurance and other expenses.

Premiums will vary based on a variety of factors. These factors include your age and health when you buy a policy and the level of coverage, benefits and options you select for your policy. If you buy a policy with a large daily benefit, a longer maximum benefit period, or a home health care benefit, it will cost you more. Inflation protection and nonforfeiture benefits can increase premiums for long-term care substantially.

Inflation protection can add 25% to 40% to the premium. Non-forfeiture benefits can add 10% to 100% to the premium, as noted on page 25. In fact, either of these options can easily double your premium, depending on your age when you buy a policy. The older you are when you buy long-term care insurance, the higher your premiums will be, as it’s more likely you will need long-term care services. (See “Who May Need Long-Term Care” on page 6.) If you buy at a younger age, your premiums will be lower, but you will pay premiums for a longer period of time. Recent studies have found the average age of purchasers was age 65 in the individual market and age 43 in the employer-sponsored market.20
Here is an example of how much premiums can fluctuate based on your age and your coverage options:\(^{21}\)

- The average annual premiums for basic long-term care insurance ($100 daily benefit amount, four years of coverage, and a 20-day elimination period) that do not include a 5% compound inflation protection option or a nonforfeiture benefits option were:
  - $300 for a 40-year-old.
  - $409 for a 50-year-old.
  - $1,002 for a 65-year-old.
  - $4,166 for a 79-year-old.

- The average annual premiums for the same policy with the 5% compound inflation protection option but no nonforfeiture benefit option were:
  - $649 for a 40-year-old.
  - $881 for a 50-year-old.
  - $1,802 for a 65-year-old.
  - $5,895 for a 79-year-old.

- The average annual premiums for the same policy with the nonforfeiture benefits option but no inflation protection were:
  - $382 for a 40-year-old.
  - $506 for a 50-year-old.
  - $1,196 for a 65-year-old.
  - $5,067 for a 79-year-old.

- The average annual premiums for the same policy with both the 5% compound inflation protection option and the nonforfeiture benefits option were:
  - $798 for a 40-year-old.
  - $1,087 for a 50-year-old.
  - $2,130 for a 65-year-old.
  - $7,000 for a 79-year-old.

Remember, your actual premium may be very different if it's based on other factors.

Another issue to keep in mind is that long-term care insurance policies may not cover the entire cost of your care. For example, your policy may cover $110 per day in a nursing home, but the total cost of care may be $150 per day. You must pay the difference. Remember, medications and therapies will increase your total daily costs for care. The costs of long-term care in your state should influence the amount of coverage you buy and the premiums you will pay. (See “How Much Does Long-Term Care Cost?” on page 4.)

When you buy a long-term care policy, think about how much your income is and how much you could afford to spend on a long-term care insurance policy now. Also
try to think about what your future income and living expenses are likely to be and how much premium you can pay then. If you don’t expect your income to increase, it probably isn’t a good idea to buy a policy if you can barely afford the premium now.

You also need to think about whether you could afford a rate increase on your policy some time in the future. Remember, while a company cannot raise your rates based on your age or health, the company can raise the rates for an entire class of policies. Some states have laws that limit rate increases. **Check with your insurance department to learn how your state regulates rate increases.** A directory of state insurance departments begins on page 56. Again, it probably isn’t a good idea to buy a policy if you can barely afford the premium now.

**NOTE:** Don’t be misled by the term “level premium.” You may be told that your long-term care insurance premium is “level.” That doesn’t mean that it will never increase. Except for whole life insurance policies and noncancellable policies or riders, companies cannot guarantee premiums will never increase. Many states have adopted regulations that don’t let insurance companies use the word “level” to sell guaranteed renewable policies. Companies must tell consumers that premiums may go up. Look for that information on the outline of coverage and the policy’s face page when you shop.

**What Options Do I Have to Pay the Premiums on the Policy?**

If you decide you can afford to buy a long-term care insurance policy, there are two main ways in which you may be able to pay your premiums—the **continuous payment option** and the **limited payment option**.

Under the continuous payment option, you would pay the premiums on your policy until you trigger your benefits, traditionally on a monthly, quarterly, semi-annual or annual basis. The policy is not cancelable except in the event of nonpayment of premiums; however, the insurance company can increase premiums on an entire class of policies. Premiums are usually the lowest available under this payment option.

In addition to the continuous payment option, you may be able to pay your premiums under a limited payment option. Under this option, you would pay premiums for a set time period using one of the following ways:

- **Single pay.** This allows you to make one lump-sum payment.
- **10-pay and 20-pay.** This allows you to complete payment of your premiums in 10 or 20 years, depending on the option you choose. You might choose this option if your income will be lower in 10 or 20 years.
- **Pay-to-65.** You pay higher-than-usual premiums, but payments end when you reach age 65.
After the last premium payment, neither you nor the company can cancel the policy. Policies with the limited payment option are more expensive than continuous payment policies, because your premium is set at a higher rate than it would have been had you paid over a longer period of time. In addition, unless the contract fixes your premium for the pay period, it could increase. However, the guaranteed fixed payment and the no-cancel features make limited payment premiums attractive to some clients. You should consult your tax advisor for information on the tax treatment of accelerated premium payments.

It is important to note that not all of these payment options are offered by all companies or are available in all states. Check with the insurance company to see what payment options it offers. Also check with your state insurance department to find out what options your state allows. A directory of state insurance departments begins on page 56.

If You Already Own a Policy, Should You Switch Plans or Upgrade the Coverage You Have Now?

Before you switch to a new long-term care insurance policy, make sure it is better than the one you already have. Even if your agent now works for another company, think carefully before making any changes. First check to see if you can upgrade the coverage on your current policy. If not, you may replace your current policy with a different one that gives you more benefits, or even choose a second policy. Be sure to discuss any change in your coverage with your financial advisor.

If you decide to switch to a new long-term care insurance policy, make sure the new company has accepted your application and issued the new policy before you cancel the old one. When you cancel a policy in the middle of its term, many companies will not give back any premiums you have paid. If you switch policies, new restrictions on pre-existing conditions may apply. You may not have coverage for some conditions for a certain period.

Switching may be right for you if your old policy requires you to stay in the hospital or to receive other types of care before it pays benefits. Before you decide to change, though, make sure you are in good health and can qualify for another policy. If you bought a policy when you were younger, you might ask the insurance company if you can improve it. For example, you might add inflation protection or take off the requirement that you stay in the hospital. It might cost less to improve a policy you have now than to buy a new one.
What Shopping Tips Should You Keep in Mind?

Here are some points to keep in mind as you shop.

**Ask questions.**

If you have questions about the agent, the insurance company or the policy, contact your state insurance department or insurance counseling program. (A directory starts on page 56.) Make sure the company is reputable and is licensed to sell long-term care insurance policies in your state.

**Check with several companies and agents.**

Contacting several companies (and agents) before you buy is wise. Be sure to compare benefits, the types of facilities you have to be in to get coverage, the limits on your coverage, what’s excluded, and, of course, the premium. (Policies that have the same coverage and benefits may not cost the same.)

**Check out the companies’ rate increase histories.**

Ask companies about their rate increase histories and whether they have increased the rates on the long-term care insurance policies that they sell. Ask to see a company’s personal worksheet that includes this information.

Some state insurance commissioners annually prepare a consumer rate guide for long-term care insurance. These guides may include an overview of long-term care insurance, a list of companies selling long-term care insurance in your state, the types of benefits and policies you can buy (both as an individual and as a member of a group), and a rate history of each company that sells long-term care insurance in your state. Some guides even include examples of different coverage types and combinations and provide rates to assist consumers in comparing policies. Contact your state insurance department or insurance counseling program for this information. A list of insurance departments and counseling programs starts on page 56.

**Take your time and compare outlines of coverage.**

Never let anyone pressure or scare you into making a quick decision. Don’t buy a policy the first time you see an agent. Ask for an outline of coverage. It outlines the policy’s benefits and points out important features. Compare outlines of coverage for several policies, and make sure the outlines are similar (if not the same) when comparing premiums. In most states the agent must leave an outline of coverage when he or she first contacts you.
Understand the policies.

Make sure you know what the policy covers and what it doesn’t. If you have any questions, call the insurance company before you buy.

If you receive any information that confuses you or is different from the information in the company literature, don’t hesitate to call or write the company to ask your questions. Don’t trust any sales presentation or literature that claims you have only one chance to buy a policy.

Some companies sell their policies through agents, and others may sell their policies through the mail, skipping agents entirely. No matter how you buy your policy, check with the company if you don’t understand how the policy works.

Talk about the policy with a friend or relative. You may also want to contact your state insurance department or insurance counseling program. A list of insurance departments and counseling programs starts on page 56.

Don’t be misled by advertising.

Most celebrity endorsers are professional actors paid to advertise. They are not insurance experts. Medicare does not endorse or sell long-term care insurance policies. Be wary of any advertising that suggests Medicare is involved.

Don’t trust cards you get in the mail that look like official government documents until you check with the government agency identified on the card. Insurance companies or agents trying to find buyers may have sent them. Be careful if anyone asks you questions over the telephone about Medicare or your insurance. They may sell any information you give to long-term care insurance marketers, who might call you, come to your home or try to sell you insurance by mail.

Don’t buy more coverage than you need.

You don’t have to buy more than one policy to get enough coverage. One good policy is enough. Also, don’t buy more insurance than you need. For example, buying a policy with a $500 daily benefit in order to prepare for inflation is not necessary. You should choose the daily benefit that matches the cost of long-term care. For more information, reread the section “If You Already Own a Policy, Should You Switch Plans or Upgrade the Coverage You Have Now?” on page 30. Be sure to discuss any change in your coverage with your financial advisor.
Be sure you accurately complete your application.

Don’t be misled by long-term care insurance marketers who say your medical history isn’t important—it is! Give correct information. If an agent fills out the application for you, don’t sign it until you have read it. Make sure that all of the medical information is accurate and complete. If it isn’t and the company used that information to decide whether to insure you, it can refuse to pay your claims and can even cancel your policy.

Never pay in cash.

Use a check or an electronic bank draft made payable to the insurance company.

Be sure to get the name, address, and telephone number of the agent and the company.

Get a local or toll-free number for both the agent and the company.

If you don’t get your policy within 60 days, contact the company or agent.

You have a right to expect prompt delivery of your policy. When you get it, keep it somewhere you can easily find it. Tell a trusted friend or relative where it is.

Be sure you look at your policy during the free-look period.

If you decide you don’t want the policy soon after you bought it, you can cancel it and get your money back. You must tell the company you don’t want the policy within a certain number of days after you get it. How many days you have depends on the “free-look” period. In some states the insurance company must tell you about the free-look period on the cover page of the policy. In most states you have 30 days to cancel, but in some you have less time. Check with your state insurance department to find out how long the free-look period is in your state.

If you want to cancel:

- Keep the envelope the policy was mailed in. Or ask the agent for a signed delivery receipt when he or she hands you the policy.
- Send the policy to the insurance company along with a short letter asking for a refund.
- Send both the policy and the letter by certified mail. Keep the mailing receipt.
- Keep a copy of all letters.

It usually takes four to six weeks to get your refund.
Read the policy again and make sure it gives you the coverage you want.

Check the policy to see if the benefits and the premiums are what you expected. If you have any questions, call the agent or company right away. Also, reread the application you signed. It is part of the policy. If it’s not filled out correctly, contact the agent or company right away. You may want to fill out Worksheet 3 on page 49.

Think about having the premium automatically taken out of your bank account.

Automatic withdrawal may mean that you won’t lose your coverage if an illness makes you forget to pay your premium. If you decide not to renew your policy, be sure you tell the bank to stop the automatic withdrawals.

Check on the financial stability of the company you’re thinking about buying from.

Several insurer rating services analyze the financial strength of insurance companies. The ratings can show you how some analysts see the financial health of individual insurance companies. Different rating services use different rating scales. Be sure to find out how the agency labels its highest ratings and the meaning of the ratings for the companies you are considering.

You can get ratings from some insurer rating services for free at most public libraries. Or you can call the services directly at the numbers listed below. (Note that calls to a “900” number will mean an extra charge on your telephone bill.) And now you can get information from these services on the Internet.

Rating Agencies

• A.M. Best Company
  (900) 439-2200 (billed to telephone) or (800) 424-BEST (charged to credit card)
  or on the Internet at www.ambest.com

• Fitch IBCA, Duff & Phelps, Inc.
  (212) 908-0800 or on the Internet at www.fitchrating.com

• Moody’s Investor Service, Inc.
  (212) 553-0377 or on the Internet at www.moodys.com

• Standard & Poor’s Insurance Rating Services
  (212) 438-2400 or on the Internet at www.standardandpoors.com

• Weiss Ratings, Inc.
  (800) 289-9222 or on the Internet at www.WeissRatings.com
References

8. Omnibus Budget Reconciliation Act of 1993 (OBRA). OBRA requires each state to have an “Estate Recovery Program,” which is designed to recover the costs of Medicaid-paid benefits from that person’s estate or the estate of his or her spouse. If you are age 55 or over and receive Medicaid benefits for nursing home care and related services, OBRA requires that states recover the paid benefits in an amount equal to the total of the assistance provided from your estate. This could include your home and any other property that otherwise would be passed to your heirs.
16. Health Insurance Association of America Survey. “Research Findings: Long-Term Care Insurance in 1998-1999,” February 2002, pages 3, 5, 13, 17, 27. The employer-sponsored market contributed 25% of the sales in 1999. By the end of 1999, more than 1 million policies had been sold through more than 3,200 employers. This represents 35% average growth rate. There were more than 770 employer-sponsored plans introduced in 1999 alone.
17. Members of the federal family can obtain information on this program from the United States Office of Personnel Management by calling the toll-free number 1-800-582-3337 or by accessing the Web site http://www.opm.gov/insure/lte/.
GLOSSARY

**Accelerated Death Benefit** – A feature of a life insurance policy that lets you use some of the policy’s death benefit prior to death.

**Activities of Daily Living (ADLs)** – Everyday functions and activities individuals usually do without help. ADL functions include bathing, continence, dressing, eating, toileting and transferring. Many policies use the inability to do a certain number of ADLs (such as two of six) to decide when to pay benefits.

**Adult Day Care** – Care provided during the day at a community-based center for adults who need assistance or supervision during the day, including help with personal care, but who do not need round-the-clock care.

**Alzheimer’s Disease** – A progressive, degenerative form of dementia that causes severe intellectual deterioration.

**Assisted Living Facility** – A residential living arrangement that provides individualized personal care and health services for people who require assistance with activities of daily living. The types and sizes of facilities vary; they can range from a small home to a large apartment-style complex. They also vary in the levels of care and services that can be provided. Assisted living facilities offer a way to keep a relatively independent lifestyle for people who don’t need the level of care provided by nursing homes.

**Bathing** – Washing oneself by sponge bath, in either a tub or shower. This activity includes the task of getting into or out of the tub or shower.

**Benefit Triggers (Triggers)** – Term used by insurance companies to describe the criteria and methods they use to determine when you are eligible to receive benefits.

**Benefits** – Monetary sum paid or payable to a recipient for which the insurance company has received the premiums.

**Care Management Services** – A service in which a professional, typically a nurse or social worker, may arrange, monitor or coordinate long-term care services (also referred to as care coordination services).

**Cash Surrender Value** – The amount of money you may be entitled to receive from the insurance company when you terminate a life insurance or annuity policy. The amount of cash value will be determined as stated in the policy.

**Chronic Illness** – An illness with one or more of the following characteristics: permanency, residual disability, requires rehabilitation training, or requires a long period of supervision, observation or care.

**Chronically Ill** – A term used in a tax-qualified long-term care contract to describe a person who needs long-term care either because of an inability to do everyday activities of daily living (ADLs) without help or because of a severe cognitive impairment.
Cognitive Impairment – 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.

Community-Based Services – Services designed to help older people stay independent and in their own homes.

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

Continuing Care Retirement Communities (CCRC) – A retirement complex that offers a broad range of services and levels of care.

Continuous Payment Option – A premium payment option that requires you to pay premiums until you trigger your benefits. Premiums are usually paid on a monthly, quarterly, semi-annual or annual basis. The policy is not cancelable except when premiums aren’t paid; however, the insurance company can increase premiums on an entire class of policies. Premiums are usually the lowest available.

Custodial Care (Personal Care) – Care to help individuals meet personal needs such as bathing, dressing and eating. Someone without professional training may provide care.

Daily Benefit – The amount of insurance benefit in dollars a person chooses to buy for long-term care expenses.

Dementia – Deterioration of intellectual faculties due to a disorder of the brain.

Disability Method – Method of paying benefits that only requires you to meet the benefit eligibility criteria. Once you do, you receive your full daily benefit.

Dressing – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

Eating – 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.

Elimination Period – A type of deductible; the length of time the individual must pay for covered services before the insurance company will begin to make payments. The longer the elimination period in a policy, the lower the premium. Sometimes also called a “waiting period.”

Expense-Incurred Method – Method of paying benefits where the insurance company must decide if you are eligible for benefits and if your claim is for eligible services. Your policy or certificate will pay benefits only when you receive eligible services. Once you have incurred an expense for an eligible service, benefits are paid either to you or your provider. The coverage will pay for the lesser of the expense you incurred or the dollar limit of your policy. Most policies bought today pay benefits using the expense-incurred method.
Extended Term Benefits – Full benefits for a reduced time period, applicable for use during a certain period of time. If not used in a set number of years after the lapse, then you lose it. Once the period has expired, the contract terminates.

Guaranteed Renewable – When a policy cannot be cancelled by an insurance company and must be renewed when it expires unless benefits have been exhausted. The company cannot change the coverage or refuse to renew the coverage for other than nonpayment of premiums (including health conditions and/or marital or employment status). In a guaranteed renewable policy, the insurance company may increase premiums, but only on an entire class of policies, not just on your policy.

Hands-On Assistance – Physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activities of daily living.

Health Insurance Portability and Accountability Act (HIPAA) – Federal health insurance legislation passed in 1996 that allows, under specified conditions, long term care insurance policies to be qualified for certain tax benefits.

Home Health Care – Services for nursing care or occupational, physical, respiratory or speech therapy. Also included are medical, social worker, home health aide, and homemaker services.

Homemaker Services – Household services done by someone other than yourself because you’re unable to do them.

Home for the Aged – A general term for a facility that cares for elderly people. It is often not covered under a long-term care policy.

Hospice Care – Continuous care provided at home or in a facility with a home-like setting for a terminally ill person. A terminally ill person has a life expectancy of six months or less.

Indemnity Method – Method of paying benefits where the benefit is a set dollar amount and is not based on the specific service received or on the expenses incurred. The insurance company only needs to decide if you are eligible for benefits. Once the company determines you are eligible and you are receiving eligible long-term care services, the insurance company will pay that set amount directly to you up to the limit of the policy.

Inflation Protection – A policy option that provides for increases in benefit levels to help pay for expected increases in the costs of long-term care services.

Lapse – Termination of a policy when a renewal premium is not paid.

Limited Payment Option – A premium payment option in which the person pays premiums for a set time period. After the last premium payment, neither the company nor the person can cancel the policy. These plans are more expensive than continuous payment policies; however, their guaranteed fixed payment and no-cancel features make them attractive to some people.
Medicaid – A joint federal/state program that pays for health care services for those with low incomes or very high medical bills relative to income and assets.

Medicare – The federal program providing hospital and medical insurance to people aged 65 or older and to certain ill or disabled persons. Benefits for nursing home and home health services are limited.

Medicare Supplement Insurance – A private insurance policy that covers many of the gaps in Medicare coverage (also called Medigap insurance coverage).

National Association of Insurance Commissioners (NAIC) – Membership organization of state insurance commissioners. One of its goals is to promote uniformity of state regulation and legislation related to insurance.

Noncancelable Policies – Insurance contracts that cannot be cancelled by the insurance company and the rates cannot be changed by the insurance company.

Nonforfeiture Benefits – A policy feature that returns at least part of the premiums to you if you cancel your policy or let it lapse.

Nursing Home – A licensed facility that provides general nursing care to those who are chronically ill or unable to take care of daily living needs. May also be referred to as a Long-Term Care Facility.

Paid-up Policy – When you prematurely stop paying your premiums, your insurance policy is deemed to be paid-in-full. You do not pay any more premiums, but the benefits you receive under this policy will be determined based on the amount of premiums you have already paid, not on the level of benefits that you originally purchased.

Partnership Policy – A type of policy that allows you to protect (keep) some of your assets if you apply for Medicaid after using your policy’s benefits. Not all states have these policies.

Personal Care (Custodial care) – Care to help individuals meet personal needs such as bathing, dressing and eating. Someone without professional training may provide care.

Personal Care Home – A general term for a facility that cares for elderly people. It is often not covered under a long-term care policy.

Pre-existing Condition – Illnesses or disability for which you were treated or advised within a time period before applying for a life or health insurance policy.

Reduced Paid-up Benefits – A nonforfeiture option that reduces your daily benefit but retains the full benefit period on your policy until death. For example, you buy a policy for three years of coverage with a $150 daily benefit. Then if you let the policy lapse, the daily benefit will be reduced to $100. The exact amount of the reduction depends upon how much premium you have paid on the policy. The benefit period on your policy continues to be three years. Unlike extended term benefits, which must be used in a certain amount of time after the lapse, you can use reduced paid-up benefits at any time after you lapse (until death).
**Rescind** – When the insurance company voids (cancels) a policy.

**Respite Care** – Care provided by a third party that relieves family caregivers for a few hours to several days and gives them an occasional break from daily caregiving responsibilities.

**Rest Home** – A general term for a facility that cares for elderly people. It is often not covered under a long-term care policy.

**Rider** – Addition to an insurance policy that changes the provisions of the policy.

**Shortened Benefit Period** – A nonforfeiture option that reduces the benefit period but retains the full daily maximums applicable until death. The period of time for which benefits are paid will be shorter. For example, you buy a policy for three years of coverage with a $150 daily benefit, but if you let the policy lapse, the benefit period is reduced to one year, with full daily benefits paid. The exact amount of the reduction depends upon how much premium you have paid on the policy. Unlike extended term benefits, which must be used in a certain amount of time after the lapse, you can use shortened benefits at any time after you let the premium lapse (until death).

**Skilled Care** – Daily nursing and rehabilitative care that can be performed only by, or under the supervision of, skilled medical personnel. This care is usually needed 24 hours a day, must be ordered by a physician, and must follow a plan of care. Individuals usually get skilled care in a nursing home but may also receive it in other places.

**Spend Down** – A requirement that an individual use up most of his or her income and assets to meet Medicaid eligibility requirements.

**Stand-by Assistance** – Caregiver stays close to the individual to watch over the individual and to provide physical assistance if necessary.

**State Health Insurance Program** – Federally funded program to train volunteers to provide counseling on the insurance needs of senior citizens. See pages 54-62 for a list of State Health Insurance Programs.

**Substantial Assistance** – Hands-on or stand-by help required to do ADLs.

**Substantial Supervision** – The presence of a person directing and watching over another who has a cognitive impairment.

**Tax-Qualified Long-Term Care Insurance Policy** – A policy that conforms to certain standards in federal law and offers certain federal tax advantages.

**Term Life Insurance** – Covers a person for a period of one or more years. It pays a death benefit only if you die during that term. It generally does not build a cash value.

**Third Party Notice** – A benefit that lets you name someone whom the insurance company would notify if your coverage is about to end because the premium hasn’t been paid. This can be a relative, friend or professional such as a lawyer or accountant.
Toileting – Getting to and from the toilet, getting on and off the toilet and performing associated personal hygiene.

Transferring – Moving into and out of a bed, chair or wheelchair.

Triggers (Benefit Triggers) – Term used by insurance companies to describe when to pay benefits.

Underwriting – The process of examining, accepting or rejecting insurance risks, and classifying those selected, to charge the proper premium for each.

Universal Life Insurance – A kind of flexible policy that lets you vary your premium payments and adjust the face amount of your coverage.

Waiver of Premium – A provision in an insurance policy that relieves the insured of paying the premiums while receiving benefits.

Whole Life Insurance – Policies that build cash value and cover a person for as long as he or she lives if premiums continue to be paid.
**WORKSHEET 1**

**Information About the Availability and Cost of Long-Term Care in Your Area**

Find out what facilities and services provide long-term care in your area (or in the area where you would be most likely to receive care) and what the costs are for these services. List the information below.

---

<table>
<thead>
<tr>
<th>Home Health Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of one Home Health Agency you might use</td>
</tr>
<tr>
<td>Name of another Home Health Agency you might use</td>
</tr>
<tr>
<td>Address ...........................................</td>
</tr>
<tr>
<td>Address ...........................................</td>
</tr>
<tr>
<td>Phone Number ..................</td>
</tr>
<tr>
<td>Phone Number ..................</td>
</tr>
<tr>
<td>Contact Person ...............</td>
</tr>
<tr>
<td>Contact Person ...............</td>
</tr>
</tbody>
</table>

---

**Check which types of care are available and list the cost**

- [ ] Skilled Nursing Care  
  Cost/Visit $ ________________

- [ ] Home Health Care  
  Cost/Visit $ ________________

- [ ] Personal/Custodial Care  
  Cost/Visit $ ________________

- [ ] Homemaker Services  
  Cost/Visit $ ________________

- [ ] Skilled Nursing Care  
  Cost/Visit $ ________________

- [ ] Home Health Care  
  Cost/Visit $ ________________

- [ ] Personal/Custodial Care  
  Cost/Visit $ ________________

- [ ] Homemaker Services  
  Cost/Visit $ ________________
### Nursing Facility

<table>
<thead>
<tr>
<th>Name of one Nursing Facility you might use</th>
<th>Name of another Nursing Facility you might use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Address</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone Number</td>
<td>Phone Number</td>
</tr>
<tr>
<td>Contact Person</td>
<td>Contact Person</td>
</tr>
</tbody>
</table>

#### Check which types of care are available and list the cost

- [ ] Skilled Nursing Care
  - Cost/Visit $ 
- [ ] Personal/Custodial Care
  - Cost/Visit $ 

#### Other Facility

<table>
<thead>
<tr>
<th>Other Facility or Service you might use (e.g., adult day care center, assisted living, etc.)</th>
<th>Other Facility or Service you might use (e.g., adult day care center, assisted living, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Address</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone Number</td>
<td>Phone Number</td>
</tr>
<tr>
<td>Contact Person</td>
<td>Contact Person</td>
</tr>
<tr>
<td>What services are available?</td>
<td>What services are available?</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>What are the costs for those services?</td>
<td>What are the costs for those services?</td>
</tr>
</tbody>
</table>
# WORKSHEET 2

## How to Compare Long-Term Care Insurance Policies

Fill in the information below so that you can compare long-term care insurance policies. Most of the information you need is in the outline of coverage provided in the policies you are comparing. Even so, you will need to calculate some information and talk to the agent or a company representative to get the rest.

### Insurance Company Information

1. Name of the insurance company’s agent.

2. Is the company licensed in your state?

3. Insurance rating service and rating.  
   (Refer to Page 33)

### What levels of care are covered by this policy?  (Refer to page 16)

4. Does the policy provide benefits for these levels of care?  
   - Skilled nursing care?  
   - Personal / Custodial Care?  
   (In many states, both levels of care are required)

5. Does the policy pay for any nursing home stay, no matter what level of care you receive?  
   - If not, what levels aren’t covered?

### Where can you receive care covered under the policy?  (Refer to page 17)

6. Does the policy pay for care in any licensed facility?  
   - If not, what doesn’t it pay for?

7. Does the policy provide home care benefits for:  
   - Skilled nursing care?  
   - Personal care given by home health aides?  
   - Homemaker services?  
   - Other ___________________________?

8. Does the policy pay for care received in:  
   - Adult day care centers?  
   - Assisted living facilities?  
   - Other settings? (list)
A Shopper’s Guide to Long-Term Care Insurance

How long are benefits paid and what amounts are covered?* (Refer to page 18)

9. How much will the policy pay per day for:
   • nursing home care?
   • assisted living facility care?
   • home care?

<table>
<thead>
<tr>
<th>Policy 1</th>
<th>Policy 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

10. Are there limits on the number of days or visits per year for which benefits will be paid? If yes, what are the limits for:
   • nursing home care?
   • assisted living facility care?
   • home care? (days or visits?)

<table>
<thead>
<tr>
<th></th>
<th>yes/no</th>
<th>yes/no</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>days</td>
<td>days</td>
</tr>
</tbody>
</table>

11. What is the length of the benefit period that you are considering?

<table>
<thead>
<tr>
<th></th>
<th>yrs</th>
<th>yrs</th>
</tr>
</thead>
</table>

12. Are there limits on the amounts the policy will pay during your lifetime?
   If yes, what are the limits for:
   • nursing home care?
   • assisted living facility care?
   • home care? (days or visits?)
   • total lifetime limit

<table>
<thead>
<tr>
<th></th>
<th>yes/no</th>
<th>yes/no</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

How does the policy decide when you are eligible for benefits? (Refer to page 19)

13. Which of the “benefit triggers” does the policy use to decide your eligibility for benefits? (It may have more than one)
   • unable to do activities of daily living (ADLs)
   • cognitive impairment (older policies may discriminate against Alzheimer’s; newer ones don’t)
   • doctor certification of medical necessity
   • prior hospital stay
   • bathing is one of the ADLs

<table>
<thead>
<tr>
<th></th>
<th>yes/no</th>
<th>yes/no</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>yes/no</td>
<td>yes/no</td>
</tr>
<tr>
<td></td>
<td>yes/no</td>
<td>yes/no</td>
</tr>
<tr>
<td></td>
<td>yes/no</td>
<td>yes/no</td>
</tr>
<tr>
<td></td>
<td>yes/no</td>
<td>yes/no</td>
</tr>
</tbody>
</table>

When do benefits start? (Refer to page 20)

14. How long is the waiting period before benefits begin for:
   • nursing home care?
   • assisted living care?

<table>
<thead>
<tr>
<th></th>
<th>days</th>
<th>days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>days</td>
<td>days</td>
</tr>
</tbody>
</table>

* You may be considering a policy that pays benefits on a different basis, so you may have to do some calculations to determine comparable amounts.
A Shopper’s Guide to Long-Term Care Insurance

<table>
<thead>
<tr>
<th>Question</th>
<th>Policy 1</th>
<th>Policy 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>home health care?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>waiting period - service days or calendar days?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Are the waiting periods for home care cumulative or consecutive?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. How long will it be before you are covered for a pre-existing condition? (Usually 6 months)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. How long will the company look back on your medical history to determine a pre-existing condition? (Usually 6 months)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the policy have inflation protection? (Refer to page 22)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Are the benefits adjusted for inflation?</td>
<td>yes/no</td>
<td>yes/no</td>
</tr>
<tr>
<td>19. Are you allowed to buy more coverage?</td>
<td>yes/no</td>
<td>yes/no</td>
</tr>
<tr>
<td>If yes,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• When can you buy more coverage?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• How much can you buy?</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>• When can you no longer buy more coverage?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Do the benefits increase automatically?</td>
<td>yes/no</td>
<td>yes/no</td>
</tr>
<tr>
<td>If yes,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What is the rate of increase?</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>• Is it a simple or compound increase?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• When do automatic increases stop?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. If you buy inflation coverage, what daily benefit would you receive for Nursing home care:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 5 years from now?</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>• 10 years from now?</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Assisted living facility care:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 5 years from now?</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>• 10 years from now?</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Home health care:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 5 years from now?</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>• 10 years from now?</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>22. If you buy inflation coverage, what will your premium be:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 5 years from now?</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>• 10 years from now?</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>• 15 years from now?</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>
What other benefits are covered under the policy?

23. Is there a waiver of premium benefit?  
(Refer to Page 24)
   If yes,  
   • How long do you have to be in a nursing home before it begins?  
   • Does the waiver apply when you receive home care?  

<table>
<thead>
<tr>
<th>Policy 1</th>
<th>Policy 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes/no</td>
<td>yes/no</td>
</tr>
</tbody>
</table>

24. Does the policy have a nonforfeiture benefit?  
(Refer to Page 25)

<table>
<thead>
<tr>
<th>Policy 1</th>
<th>Policy 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes/no</td>
<td>yes/no</td>
</tr>
</tbody>
</table>

25. Does the policy have a return of premium benefit?  
(Refer to Page 25)

<table>
<thead>
<tr>
<th>Policy 1</th>
<th>Policy 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes/no</td>
<td>yes/no</td>
</tr>
</tbody>
</table>

26. Does the policy have a death benefit?  
(Refer to Page 24)
   If yes, are there any restrictions before the benefit is paid?  

<table>
<thead>
<tr>
<th>Policy 1</th>
<th>Policy 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes/no</td>
<td>yes/no</td>
</tr>
</tbody>
</table>

27. Will the policy cover one person or two?

<table>
<thead>
<tr>
<th>Policy 1</th>
<th>Policy 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>one/two</td>
<td>one/two</td>
</tr>
</tbody>
</table>

Tax-qualified status

28. Is the policy tax-qualified?  
(Refer to Page 12)

<table>
<thead>
<tr>
<th>Policy 1</th>
<th>Policy 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes/no</td>
<td>yes/no</td>
</tr>
</tbody>
</table>

What does the policy cost?  
(Refer to page 12)

29. What is the premium excluding all riders?  
   • monthly  
   • yearly

<table>
<thead>
<tr>
<th>Policy 1</th>
<th>Policy 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

30. What is the premium if home care is covered?  
   • monthly  
   • yearly

<table>
<thead>
<tr>
<th>Policy 1</th>
<th>Policy 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

31. What is the premium if assisted living is covered?  
   • monthly  
   • yearly

<table>
<thead>
<tr>
<th>Policy 1</th>
<th>Policy 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

32. What is the premium if you include an inflation rider?  
   • monthly  
   • yearly

<table>
<thead>
<tr>
<th>Policy 1</th>
<th>Policy 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

33. What is the premium if you include a nonforfeiture benefit?  
   • monthly  
   • yearly

<table>
<thead>
<tr>
<th>Policy 1</th>
<th>Policy 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>
34. Is there any discount if you and your spouse both buy policies?
   • If yes, what is the amount of the discount?
   • Do you lose the discount when one spouse dies?

35. What is the total annual premium including all riders and discounts?
   • total monthly premium
   • total annual premium

36. When looking at the results of Questions 29 through 35, how much do you think you are willing to pay in premiums?
WORKSHEET 3

Facts About Your Long-Term Care Insurance Policy

For use after you buy a long-term care policy. Fill out this form and put it with your important papers. You may want to make a copy for a friend or a relative.

1. **Insurance Policy Date**
   - Policy Number ____________________________
   - Date Purchased ____________________________
   - Annual Premium $ ____________________________

2. **Insurance Company Information**
   - Name of Company ____________________________
   - Address ____________________________________
   - Phone Number _______________________________

3. **Agent Information**
   - Agent’s Name ________________________________
   - Address ____________________________________
   - Phone Number _______________________________

4. **Type of Long-Term Care Policy**
   - ___ Nursing home only
   - ___ Facilities only
   - ___ Home care only
   - ___ Comprehensive (nursing home, assisted living, home and community care)
   - ___ Other
   - ___ Tax-qualified

5. **How long is the waiting period before benefits begin?**

6. **How do I file a claim?** (Check all that apply)
   - ___ I need prior approval
   - ___ Contact the company
   - ___ Fill out a claim form
   - ___ Submit a plan of care
   - ___ Doctor notifies the company
   - ___ Assessment by company
   - ___ Assessment by care manager

7. **How often do I pay premiums:** ___ Annually ___ Semi-annually ___ Other
   - Specify Other: _______________________________________

8. **The person to be notified if I forget to pay the premium**
   - Name _________________________________________
   - Address _______________________________________
   - Phone number _________________________________
9. Are my premiums deducted from my bank account?  ____Yes  ____No
   Name of my bank ________________________________
   Address ________________________________
   Phone Number ________________________________
   Bank account number ________________________________

10. Where do I keep this long-term care policy? ________________________________
    Other information ________________________________

11. Friend or relative who knows where my policy is:
    Name ________________________________
    Address ________________________________
    Phone number ________________________________
WORKSHEET 4
Long-Term Care Riders To Life Insurance Policies

The purpose of this worksheet is to help you to evaluate one or more life long-term care insurance policies. Fill out the form so you can compare your options. In addition, you will want to fill out Worksheet 2 regarding the long-term care benefits provided by the policy.

Life Insurance Company Information
1. Name of the insurance company’s agent
2. Is the company licensed in your state?
3. Insurance rating service and rating
   (Refer to Page 34)

Policy Information
4. What kind of life insurance policy is it?
   - Whole life insurance
   - Universal life insurance
   - Term life insurance

5. What is the policy’s premium?

6. How often is the premium paid?
   - One time / single premium
   - Annually for life
   - Annually for 10 years only
   - Annually for 20 years only
   - Other

7. Is there a separate premium for the long-term care benefit provided by the life insurance policy?
   If not, how is the premium paid?
   • Included in life insurance premium?
   • Deducted from the cash value of the life insurance policy?

8. How many people will the policy cover?
9. Will the payment of long-term care benefits decrease the death benefit and cash value of the policy?

10. Will an outstanding loan affect the long-term care benefits?

11. Did you receive an illustration of guaranteed values?
   If yes, do the policy values equal zero at some age on a guaranteed or midpoint basis?
   If so, at what age?

<table>
<thead>
<tr>
<th>Policy 1</th>
<th>Policy 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes/no</td>
<td>yes/no</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy 1</th>
<th>Policy 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes/no</td>
<td>yes/no</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy 1</th>
<th>Policy 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes/no</td>
<td>yes/no</td>
</tr>
</tbody>
</table>
People buy long-term care insurance for many reasons. Some don’t want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don’t want their family to have to pay for care or don’t want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

**Premium Information**

Policy Form Numbers ________________

The premium for the coverage you are considering will be [$_________ per month, or $_______ per year,] [a one-time single premium of $___________.]

**Type of Policy** (noncancellable/guaranteed renewable): ________________________________

**The Company’s Right to Increase Premiums:** ________________________________

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

**Rate Increase History**

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.]

_Drafting Note:_ A company may use the first bracketed sentence above only if it has never increased rates under any prior policy forms in this state or any other state. The issuer shall list each premium increase it has instituted on this or similar policy forms in this state or any other state during the last 10 years. The list shall provide the policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.
A Shopper's Guide to Long-Term Care Insurance

Questions Related to Your Income

How will you pay each year’s premium?
- [ ] From my Income
- [ ] From my Savings/Investments
- [ ] My Family will Pay

Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

Drafting Note: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.

What is your annual income? (check one)
- [ ] Under $10,000
- [ ] $10,000-$20,000
- [ ] $20,000-$30,000
- [ ] $30,000-$50,000
- [ ] Over $50,000

Drafting Note: The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)
- [ ] No change
- [ ] Increase
- [ ] Decrease

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 if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one)
- [ ] Yes
- [ ] No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?
- [ ] From my Income
- [ ] From my Savings/Investments
- [ ] My Family will Pay

The national average annual cost of 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. In the above statement, the second figure equals 163% of the first figure.

What elimination period are you considering?
Number of days: _______ Approximate cost: $__________ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)
- [ ] From my Income
- [ ] From my Savings/Investments
- [ ] My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)
- [ ] Under $20,000
- [ ] $20,000-$30,000
- [ ] $30,000-$50,000
- [ ] Over $50,000

How do you expect your assets to change over the next ten years? (check one)
- [ ] Stay about the same
- [ ] Increase
- [ ] Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.
## Disclosure Statement

- The answers to the questions above describe my financial situation.
- OR
- I choose not to complete this information.

I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures.

- I understand that the rates for this policy may increase in the future.

Signed: ___________________________ (Applicant) ___________________________ (Date)

[ I explained to the applicant the importance of completing this information.

Signed: ___________________________ (Agent) ___________________________ (Date)

Agent’s Printed Name: ___________________________ ]

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

[ My agent has advised me that this policy 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.

_The company may contact you to verify your answers._

_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.
List of State Insurance Departments, Agencies on Aging and State Health Insurance Assistance Programs

Each state has its own laws and regulations governing all types of insurance. The insurance departments, which are listed in the left column, are responsible for enforcing these laws, as well as providing the public with information about insurance. The agencies on aging, listed in the right column, are responsible for coordinating services for older Americans. Centered below each state listing is the telephone number for the insurance counseling programs. Please note that calls to 800 numbers listed here can only be made from within the respective state.

<table>
<thead>
<tr>
<th>INSURANCE DEPARTMENTS</th>
<th>STATE HEALTH INSURANCE ASSISTANCE PROGRAMS</th>
<th>AGENCIES ON AGING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama Department of Insurance 201 Monroe Street, Suite 1700 Montgomery, AL 36104 (334) 269-3550 Fax: (334) 241-4192 <a href="http://www.aldoi.org">www.aldoi.org</a></td>
<td>ALABAMA 1-800-243-5463 (334) 242-5743 Fax: (334) 242-5594 TDD (334) 242-0995</td>
<td>Department of Senior Services P.O. Box 301851 770 Washington Avenue, Suite 470 Montgomery, AL 36130-1851 1-800-243-5463 (334) 242-5743 Fax: (334) 242-5788</td>
</tr>
<tr>
<td>Alaska Division of Insurance PO Box 110805 3601 C Street, Suite 1324 Anchorage, AK 99811-0805 (907) 269-7900 Fax: (907) 269-7910 <a href="http://www.commerce.state.ak.us/insurance">www.commerce.state.ak.us/insurance</a></td>
<td>ALASKA 1-800-478-6065 In State Only (907) 269-3680 Fax: (907) 269-3690 TDD (907) 269-3691</td>
<td>Alaska Commission on Aging Dept. of Health and Social Services P.O. Box 110693 Juneau, AK 99811-0693 (907) 465-4879 Fax: (907) 465-4716</td>
</tr>
<tr>
<td>Arizona Department of Insurance 2910 North 44th Street, Suite 210 Phoenix, AZ 85018-7269 (602) 364-3100 Fax: (602) 364-3470 <a href="http://www.id.state.az.us">www.id.state.az.us</a></td>
<td>ARIZONA 1-800-432-4040 TDD (602) 542-6366 Fax: (602) 542-6575</td>
<td>Division of Aging and Adult Services 1789 W Jefferson - No. 950A Phoenix, AZ 85007 (602) 542-4446 Fax: (602) 542-6575</td>
</tr>
<tr>
<td>Arkansas Department of Insurance 1200 West 3rd Street Little Rock, AR 72201-1904 (501) 371-2600 Fax: (501) 371-2618 <a href="http://www.insurance.arkansas.gov">www.insurance.arkansas.gov</a></td>
<td>ARKANSAS 1-800-282-9134 (501) 371-2600 Fax (501) 371-2618 TDD 501-371-2718 1-501-682-3000</td>
<td>Division of Aging &amp; Adult Services Arkansas Dept of Human Services P.O. Box 1437, S530 700 Main Street Little Rock, AR 72203-1437 (501) 682-2441 Fax: (501) 682-8155</td>
</tr>
<tr>
<td>California Dept. of Insurance 300 Capitol Mall, Suite 1700 Sacramento, CA 95814 (916) 492-3500 Fax: (916) 445-5280 <a href="http://www.insurance.ca.gov">www.insurance.ca.gov</a></td>
<td>CALIFORNIA 1-800-434-0222 (916) 323-6525 Fax: (916) 327-2081</td>
<td>California Department of Aging 1300 National Drive, Suite 200 Sacramento, CA 95834 (916) 419-7500 Fax: (916) 928-2500</td>
</tr>
<tr>
<td>INSURANCE DEPARTMENTS</td>
<td>STATE HEALTH INSURANCE ASSISTANCE PROGRAMS</td>
<td>AGENCIES ON AGING</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------------------------</td>
<td>------------------</td>
</tr>
</tbody>
</table>
| **COLORADO**           | COLORADO Division of Aging and Adult Services  
1-800-544-9181 or 1-888-696-7213  
(303) 894-7553  
TDD (303) 894-7880  
(303) 894-7455  
www.dora.state.co.us/insurance | Colorado Division of Aging and Adult Services  
Department of Human Services  
1575 Sherman Street, Tenth Floor  
Denver, CO 80203-1714  
(303) 866-2800  
Fax: (303) 866-2696 |
| **COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS** | Mariana Islands CNMI Office on Aging  
Commonwealth of the Northern Mariana Islands  
P.O. Box 502178  
Saipan, MP 96950-2178  
011 (671) 734-4361  
Fax: 011 (670) 233-1327 |
| **CONNECTICUT**        | Connecticut Aging Services Div.  
Department of Social Services  
25 Sigourney St.  
Hartford, CT 06106  
(860) 424-5277  
Fax: (860) 424-4866 |
| **DELAWARE**           | Div. of Services for Aging & Adults w/ Physical Disabilities  
Dept. of Health & Social Services  
1901 North DuPont Highway  
New Castle, DE 19720  
(302) 255-9390  
Fax: (302) 255-4445 |
| **DISTRICT OF COLUMBIA** | District of Columbia Office on Aging  
One Judiciary Square  
441 4th St., N.W., 9th Floor  
Washington, DC 20001  
(202) 724-9797 |
| **FEDERATED STATES OF MICRONESIA** | State Agency on Aging Office of Health Services  
Federated States of Micronesia  
Ponape, E.C.I. 96941 |
| **FLORIDA**            | Florida Department of Elder Affairs  
Building B - Suite 152  
4040 Esplanade Way  
Tallahassee, FL 32399  
(850) 414-2000  
Fax: (850) 414-2004 |
| **COLORADO**           | Colorado Division of Aging and Adult Services  
Department of Human Services  
1575 Sherman Street, Tenth Floor  
Denver, CO 80203-1714  
(303) 866-2800  
Fax: (303) 866-2696 |
| **COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS** | Mariana Islands CNMI Office on Aging  
Commonwealth of the Northern Mariana Islands  
P.O. Box 502178  
Saipan, MP 96950-2178  
011 (671) 734-4361  
Fax: 011 (670) 233-1327 |
| **CONNECTICUT**        | Connecticut Aging Services Div.  
Department of Social Services  
25 Sigourney St.  
Hartford, CT 06106  
(860) 424-5277  
Fax: (860) 424-4866 |
| **DELAWARE**           | Div. of Services for Aging & Adults w/ Physical Disabilities  
Dept. of Health & Social Services  
1901 North DuPont Highway  
New Castle, DE 19720  
(302) 255-9390  
Fax: (302) 255-4445 |
| **DISTRICT OF COLUMBIA** | District of Columbia Office on Aging  
One Judiciary Square  
441 4th St., N.W., 9th Floor  
Washington, DC 20001  
(202) 724-9797 |
| **FEDERATED STATES OF MICRONESIA** | State Agency on Aging Office of Health Services  
Federated States of Micronesia  
Ponape, E.C.I. 96941 |
| **FLORIDA**            | Florida Department of Elder Affairs  
Building B - Suite 152  
4040 Esplanade Way  
Tallahassee, FL 32399  
(850) 414-2000  
Fax: (850) 414-2004 |
<table>
<thead>
<tr>
<th>INSURANCE DEPARTMENTS</th>
<th>STATE HEALTH INSURANCE ASSISTANCE PROGRAMS</th>
<th>AGENCIES ON AGING</th>
</tr>
</thead>
</table>
| **Georgia Department of Insurance**  
2 Martin Luther King, Jr. Drive  
Floyd Memorial Bldg., 704 West Tower  
Atlanta, GA 30334  
(404) 656-2056  
Fax: (404) 657-8542  
www.gainsurance.org | **GEORGIA**  
1-800-669-8387  
(404) 657-5347  
Fax: (404) 657-5285 | **Georgia Division for Aging Services**  
2 Peachtree St. N.W. 9th Floor  
Atlanta, GA 30303  
(404) 657-5258  
Fax: (404) 657-5285 |
| **Dept. of Revenue and Taxation**  
Banking Insurance Commissioner  
PO Box 23607  
GMF, Barrigada, Guam 96921  
(1240 Route 16, Barrigada, Guam, 96913)  
(671) 475-1843 through -1846  
Fax: (671) 633-2643  
www.guamtax.com | **GUAM**  
N/A | **Regulatory Programs Administrator**  
Dept. of Revenue and Taxation  
P O Box 23607 GMF, Barrigada, Guam 96921  
1240 Route 16, Barrigada, Guam 96913 (use street address only if using US Express Mail, DHL, FedEx or UPS)  
Email: jqcarlos@revtax.gov.gu  
(671) 635-1846 |
| **Hawaii Insurance Division**  
PO Box 3614  
335 Merchant Street, Room 2113  
Honolulu, HI 96811  
(808) 586-2790  
Fax: (808) 587-6714  
www.hawaii.gov/dcca/ins | **HAWAII**  
1-888-875-9229  
(808) 586-7300  
Fax: (808) 586-0185 | **Hawaii Executive Office on Aging**  
No. 1 Capitol District  
250 South Hotel St., Ste 406  
Honolulu, HI 96813-2831  
(808) 586-0100  
Fax: (808) 586-0185 |
| **Idaho Department of Insurance**  
700 West State Street, 3rd Floor  
Boise, ID 83720-0043  
(208) 334-4250  
Fax: (208) 334-4398  
www.doi.idaho.gov | **IDAHO**  
1-800-247-4422  
(208) 334-4350  
TDD 1-800-377-3529  
Fax: (208) 334-4389 | **Idaho Commission on Aging**  
3380 Americana Terrace, Suite 120  
P.O. Box 83720  
Boise, ID 83720-0007  
(208) 334-3833  
Fax: (208) 334-3033 |
| **Illinois Division of Insurance**  
320 West Washington St., 4th Floor  
Springfield, IL 62767-0001  
(217) 782-4515  
Fax: (217) 782-5020  
www.idfpr.com/DOI/default2.asp | **ILLINOIS**  
1-800-548-9034  
(217) 782-0004  
TDD (217) 524-4872  
In State Only  
Fax: (217) 782-4105 | **Illinois Department on Aging**  
421 East Capitol Ave., Suite 100  
Springfield, IL 62701-1789  
(217) 785-3356  
Fax: (217) 785-4477 |
| **Indiana Department of Insurance**  
311 W. Washington St., Suite 300  
Indianapolis, IN 46204-2787  
(317) 232-2385  
Fax: (317) 232-5251  
www.in.gov/doi | **INDIANA**  
1-800-452-4800  
In State Only  
(765) 608-2318  
Fax: (765) 608-2322 | **Family and Services Administration**  
Division of Aging  
402 W. Washington St.  
P.O. Box 7083  
Indianapolis, IN 46207-7083  
(317) 232-7123  
Fax: (317) 232-7867 |
<table>
<thead>
<tr>
<th>INSURANCE DEPARTMENTS</th>
<th>STATE HEALTH INSURANCE ASSISTANCE PROGRAMS</th>
<th>AGENCIES ON AGING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division of Insurance</td>
<td>IOWA</td>
<td>Iowa Department of Elder Affairs</td>
</tr>
<tr>
<td>State of Iowa</td>
<td></td>
<td>Jessie M. Parker Bldg.</td>
</tr>
<tr>
<td>330 E. Maple Street</td>
<td>1-800-351-4664 In State Only</td>
<td>510 East 12th St., Suite 2</td>
</tr>
<tr>
<td>Des Moines, IA 50319</td>
<td>TTY 1-800-735-2942</td>
<td>Des Moines, IA 50319-9025</td>
</tr>
<tr>
<td>(515) 281-5705</td>
<td>(515) 281-6867</td>
<td>(515) 242-3333</td>
</tr>
<tr>
<td>Fax: (515) 281-3059</td>
<td></td>
<td>Fax: (515) 725-3300</td>
</tr>
<tr>
<td><a href="http://www.iid.state.ia.us">www.iid.state.ia.us</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kansas Department of</td>
<td>KANSAS</td>
<td>Kansas Department on Aging</td>
</tr>
<tr>
<td>Insurance</td>
<td></td>
<td>New England Building</td>
</tr>
<tr>
<td>420 S.W. 9th Street</td>
<td>1-800-860-5260</td>
<td>503 South Kansas Avenue</td>
</tr>
<tr>
<td>Topeka, KS 66612-1678</td>
<td>(316) 337-7386</td>
<td>Topeka, KS 66603-3404</td>
</tr>
<tr>
<td>(785) 296-3071</td>
<td>TDD 1-877-235-3151</td>
<td>(785) 296-4986</td>
</tr>
<tr>
<td>Fax: (785) 296-7805</td>
<td>Fax: (316) 337-6018</td>
<td>1-800 432-3535</td>
</tr>
<tr>
<td><a href="http://www.ksinsurance.org">www.ksinsurance.org</a></td>
<td></td>
<td>Fax: (785) 296-0256</td>
</tr>
<tr>
<td>Kentucky Dept. of</td>
<td>KENTUCKY</td>
<td>Kentucky Office of Aging Services</td>
</tr>
<tr>
<td>Insurance</td>
<td></td>
<td>Cabinet for Health Services</td>
</tr>
<tr>
<td>P.O. Box 517</td>
<td>1-877-293-7447</td>
<td>275 East Main Street, 3W-F</td>
</tr>
<tr>
<td>215 West Main Street</td>
<td>(502) 564-7372</td>
<td>Frankfort, KY 40621</td>
</tr>
<tr>
<td>Frankfort, KY 40602-0517</td>
<td>TTY 1-888-642-1137</td>
<td>(502) 564-6930</td>
</tr>
<tr>
<td>(502) 564-6027</td>
<td>Fax: (502) 564-4595</td>
<td>Fax: (502) 564-4595</td>
</tr>
<tr>
<td>Fax: (502) 564-1453</td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="http://www.doi.state.ky.us/kentucky">www.doi.state.ky.us/kentucky</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Louisiana Dept. of</td>
<td>LOUISIANA</td>
<td>Governor’s Office of Elderly Affairs</td>
</tr>
<tr>
<td>Insurance</td>
<td></td>
<td>PO Box 61</td>
</tr>
<tr>
<td>1702 N. 3rd Street</td>
<td>Both In State Only</td>
<td>412 N 4th St.</td>
</tr>
<tr>
<td>Baton Rouge, LA 70802</td>
<td>1-800-259-5301</td>
<td>Baton Rouge, LA 70821</td>
</tr>
<tr>
<td>(225) 342-5423</td>
<td>(225) 342-5301</td>
<td>(225) 342-7100</td>
</tr>
<tr>
<td>Fax: (225) 342-8622</td>
<td>Fax: (225) 342-7401</td>
<td>Fax: (225) 342-7133</td>
</tr>
<tr>
<td><a href="http://www.ldi.la.gov">www.ldi.la.gov</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maine Bureau of Insurance</td>
<td></td>
<td>Maine Bureau of Elder &amp; Adult Services</td>
</tr>
<tr>
<td>Dept. of Professional &amp; Financial Reg.</td>
<td></td>
<td>442 Civic Center Drive</td>
</tr>
<tr>
<td>State Office Building, Station 34</td>
<td>In State Only</td>
<td>11 State House Station</td>
</tr>
<tr>
<td>Augusta, ME 04333-0034</td>
<td>1-877-353-3771</td>
<td>Augusta, ME 04333-0011</td>
</tr>
<tr>
<td>(207) 624-8475</td>
<td>Fax: (207) 624-5361</td>
<td>(207) 287-9200</td>
</tr>
<tr>
<td>Fax: (207) 624-8599</td>
<td></td>
<td>Fax: (207) 287-9229</td>
</tr>
<tr>
<td><a href="http://www.maine.gov/insurance">www.maine.gov/insurance</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maryland Insurance Administration</td>
<td>Both In State Only</td>
<td>Maryland Department of Aging</td>
</tr>
<tr>
<td>525 St. Paul Place</td>
<td>1-800-243-3425</td>
<td>State Office Building, Room 1007</td>
</tr>
<tr>
<td>Baltimore, MD 21202-2272</td>
<td>(410) 767-1109</td>
<td>301 West Preston Street</td>
</tr>
<tr>
<td>(410) 468-2090</td>
<td>(410) 333-7943</td>
<td>Baltimore, MD 21201</td>
</tr>
<tr>
<td>Fax: (410) 468-2020</td>
<td></td>
<td>(410) 767-1100</td>
</tr>
<tr>
<td><a href="http://www.mdinsurance.state.md.us">www.mdinsurance.state.md.us</a></td>
<td></td>
<td>Fax: (410) 333-7943</td>
</tr>
<tr>
<td>Division of Insurance</td>
<td>MARYLAND</td>
<td>Massachusetts Executive Office of Elder Affairs</td>
</tr>
<tr>
<td>Commonwealth of</td>
<td>Both In State Only</td>
<td>One Ashburton Place, 5th Floor</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>1-800-AGE-INFO</td>
<td>Boston, MA 02108</td>
</tr>
<tr>
<td>One South Station, 5th Floor</td>
<td>(617) 727-7750</td>
<td>(617) 727-7750</td>
</tr>
<tr>
<td>Boston, MA 02110</td>
<td>(617) 727-9368</td>
<td>(617) 727-9368</td>
</tr>
<tr>
<td>(617) 521-7794</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax: (617) 521-7575</td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="http://www.mass.gov/doi">www.mass.gov/doi</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INSURANCE DEPARTMENTS</td>
<td>STATE HEALTH INSURANCE ASSISTANCE PROGRAMS</td>
<td>AGENCIES ON AGING</td>
</tr>
<tr>
<td>------------------------</td>
<td>--------------------------------------------</td>
<td>-------------------</td>
</tr>
</tbody>
</table>
| Office of Financial and Insurance Services  
State of Michigan  
611 W. Ottawa St., 3rd Floor North  
Lansing, MI 48933-1020  
(517) 335-3167  
Fax: (517) 335-4978  
www.michigan.gov/ofis | MICHIGAN  
1-800-803-7174  
(517) 886-0899  
Fax: (517) 886-1305 | Michigan Office of Services to the Aging  
P.O. Box 30676  
7109 W. Saginaw, First Floor  
Lansing, MI 48909  
(517) 373-8230  
Fax: (517) 373-4092  
(FedEx Zip: 48917) |
| Minnesota Dept. of Commerce  
85 7th Place East, Suite 500  
St. Paul, MN 55101-2198  
(651) 296-6025  
Fax: (651) 282-2568  
www.commerce.state.mn.us | MINNESOTA  
1-800-333-2433  
Fax: (651) 641-8614 | Minnesota Board on Aging  
Aging and Adult Services Division  
540 Cedar Street  
St. Paul, MN 55101  
(651) 431-2600  
Fax: (651) 297-7855 |
| Mississippi Insurance Dept.  
501 N. West Street  
Woollah State Office Bldg., 10th Fl.  
Jackson, MS 39201  
(601) 359-3569  
Fax: (601) 359-1077  
www.doi.state.ms.us | MISSISSIPPI  
In State Only  
1-800-948-3090  
(601) 359-4929  
Fax: (601) 359-9664 | Mississippi Council on Aging  
Division of Aging & Adult Services  
750 N. State Street  
Jackson, MS 39202  
(601) 359-4925  
Fax: (601) 359-4370 |
| Missouri Department of Insurance  
301 West High Street, Suite 530  
Jefferson City, MO 65101  
(573) 751-4126  
Fax: (573) 751-1165  
www.insurance.mo.gov | MISSOURI  
(573) 817-8300  
In State Only  
1-800-390-3330  
Fax: (573) 817-8341 | Missouri Department of Health and Senior Services  
Division of Senior Services and Regulations  
343 Constitution Court Suite E  
Jefferson City, MO 65109-0570  
(573) 817-8300  
Fax: (573) 522-1473 |
| Montana Department of Insurance  
840 Helena Avenue  
Helena, MT 59601  
(406) 444-2040  
Fax: (406) 444-3497  
www.sao.mt.gov | MONTANA  
1-800-551-3191  
In State Only  
1-800-332-2272  
Fax: (406) 444-7743 | Montana Office on Aging  
Senior Long Term Care Division  
Department of Public Health and Human Services  
111 Sanders Street  
P.O. Box 4210  
Helena, MT 59604  
(406) 444-7788  
Fax: (406) 444-7743 |
| Nebraska Department of Insurance  
Terminal Building, Suite 400  
941 ‘O’ Street  
Lincoln, NE 68508  
(402) 471-2201  
Fax: (402) 471-4610  
www.doi.ne.gov | NEBRASKA  
(402) 471-4506  
In State Only  
1-800-234-7119 or  
1-800-833-7352  
Fax: (402) 471-6559 | Nebraska Division of Aging and Disability Services  
P.O. Box 95026  
301 Centennial Mall-South  
Lincoln, NE 68509  
(402) 471-2307  
Fax: (402) 471-4619 |
<table>
<thead>
<tr>
<th>INSURANCE DEPARTMENTS</th>
<th>STATE HEALTH INSURANCE ASSISTANCE PROGRAMS</th>
<th>AGENCIES ON AGING</th>
</tr>
</thead>
</table>
| Nevada Division of Insurance  
788 Fairview Drive, Suite 300  
Carson City, NV 89701-5753  
(775) 687-4270  
Fax: (775) 687-3937  
www.doi.state.nv.us | NEVADA  
1-800-307-4444  
(702) 486-3478  
Fax: (702) 486-0865 | Nevada Division For Aging Services  
Department of Human Resources  
3416 Goni Road, Building D-132  
Carson City, NV 89706  
(775) 687-4210  
Fax: (775) 687-4264 |
| New Hampshire Department of Insurance  
21 South Fruit Street, Suite 14  
Concord, NH 03301  
(603) 271-2261  
Fax: (603) 271-1406  
www.nh.gov/insurance | NEW HAMPSHIRE  
1-800-852-3388 In State Only  
(603) 271-3944  
Fax: (603) 271-4643 | New Hampshire Division of Elderly & Adult Services  
State Office Park South  
Brown Building - 129 Pleasant St.  
Concord, NH 03301-3857  
(603) 271-4394  
Fax: (603) 271-4643 |
| New Jersey Dept. of Insurance  
20 West State Street CN325  
Trenton, NJ 08625  
(609) 292-5360  
Fax: (609) 984-5273  
www.njdobi.org | NEW JERSEY  
1-800-792-8820  
Fax: (609) 943-4033 | New Jersey Aging & Community Services  
Dept. of Health and Senior Services  
P.O. Box 807  
Trenton, NJ 08625-0807  
(609) 943-3345  
Fax: (609) 943-3343 |
| New Mexico Dept. of Insurance  
P.O. Drawer 1269  
Santa Fe, NM 87504-1269  
(505) 827-6401  
Fax: (505) 476-0326  
www.nmprc.state.nm.us/id.htm | NEW MEXICO  
(505) 827-7640  
In State Only  
1-800-432-2080  
Fax: (505) 476-4836 | New Mexico Aging & LTC Services Department  
2550 Cerrillos Road  
Santa Fe, NM 87505  
(505) 476-4799  
Fax: (505) 476-4836 |
| New York Dept. of Insurance  
25 Beaver Street  
New York, NY 10004-2319  
(212) 480-2292  
Fax: (212) 480-2310  
www.ins.state.ny.us | NEW YORK  
1-800-333-4114  
Fax: (518) 486-2225 | New York Office for the Aging  
Two Empire State Plaza  
Albany, NY 12223-1251  
(518) 474-7012  
Fax: (518) 474-1398 |
| North Carolina Dept. of Insurance  
1201 Mail Service Center  
Raleigh, NC 27699-1201  
(919) 733-3058  
Fax: (919) 733-6495  
www.ncdoi.com | NORTH CAROLINA  
1-800-443-9354  
Fax: (919) 733-3682 | North Carolina Division of Aging  
2101 Mail Service Center  
Raleigh, NC 27699  
(919) 733-3983  
Fax: (919) 733-0433  
Office Address (FedEx): 693 Palmer Drive  
Raleigh, NC 27699-2101 |
| North Dakota Dept. of Insurance  
600 E. Boulevard  
Bismarck, ND 58505-0320  
(701) 328-2440  
Fax: (701) 328-4880  
www.nd.gov/ndins | NORTH DAKOTA  
1-800-247-0560  
TDD 1-800-366-6888  
Fax: (701) 328-4880 | North Dakota Aging Services Division  
Department of Human Services  
1237 West Divide Ave, Suite 6  
Bismarck, ND 58501-0208  
(701) 328-4601  
Fax: (701) 328-8744 |
## Directories

**A Shopper’s Guide to Long-Term Care Insurance**

<table>
<thead>
<tr>
<th>INSURANCE DEPARTMENTS</th>
<th>STATE HEALTH INSURANCE ASSISTANCE PROGRAMS</th>
<th>AGENCIES ON AGING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ohio Department of Insurance</strong>&lt;br&gt;2100 Stella Court&lt;br&gt;Columbus, OH 43215-1067&lt;br&gt;(614) 644-2658&lt;br&gt;Fax: (614) 644-3743&lt;br&gt;www.ohioinsurance.gov</td>
<td><strong>OHIO</strong>&lt;br&gt;1-800-686-1578&lt;br&gt;(614) 644-3399&lt;br&gt;TDD (614) 644-3745&lt;br&gt;Fax: (614) 752-0740</td>
<td><strong>Ohio Department of Aging</strong>&lt;br&gt;50 West Broad Street, 9th Fl.&lt;br&gt;Columbus, OH 43215-5928&lt;br&gt;(614) 466-5500&lt;br&gt;Fax: (614) 995-1049</td>
</tr>
<tr>
<td><strong>Oklahoma Dept. of Insurance</strong>&lt;br&gt;2401 NW 23rd St., Suite 28&lt;br&gt;Oklahoma City, OK 73107&lt;br&gt;(405) 521-2828&lt;br&gt;Fax: (405) 521-6635&lt;br&gt;www.oid.state.ok.us</td>
<td><strong>OKLAHOMA</strong>&lt;br&gt;(405) 521-6628&lt;br&gt;In State Only&lt;br&gt;1-800-763-2828&lt;br&gt;Fax: (405) 522-4492</td>
<td><strong>Oklahoma Dept. of Human Services Aging Services Division</strong>&lt;br&gt;P.O. Box 25352&lt;br&gt;2401 N.W., 23rd St., Suite 40&lt;br&gt;Oklahoma City, OK 73107-2422&lt;br&gt;(405) 521-2327&lt;br&gt;Fax: (405) 521-2086</td>
</tr>
<tr>
<td><strong>Oregon Insurance Division</strong>&lt;br&gt;350 Winter Street NE, Room 440&lt;br&gt;Salem, OR 97301-3838&lt;br&gt;(503) 947-7980&lt;br&gt;Fax: (503) 378-4351&lt;br&gt;www.insurance.oregon.gov</td>
<td><strong>OREGON</strong>&lt;br&gt;(503) 947-7263&lt;br&gt;In State Only&lt;br&gt;1-800-722-4134&lt;br&gt;Fax: (503) 378-4351</td>
<td><strong>Oregon Senior &amp; Disabled Services Division</strong>&lt;br&gt;500 Summer St., N.E., E02&lt;br&gt;Salem, OR 97301-1073&lt;br&gt;(503) 945-5811&lt;br&gt;Fax: (503) 373-7823</td>
</tr>
<tr>
<td><strong>Palau</strong>&lt;br&gt;State Agency on Aging&lt;br&gt;Department of Social Services&lt;br&gt;Republic of Palau&lt;br&gt;P.O. Box 100&lt;br&gt;Koror, Palau 96940</td>
<td><strong>PALAU</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Pennsylvania Insurance Dept.</strong>&lt;br&gt;1326 Strawberry Square, 13th Floor&lt;br&gt;Harrisburg, PA 17120&lt;br&gt;(717) 783-0442&lt;br&gt;Fax: (717) 772-1969&lt;br&gt;www.ins.state.pa.us</td>
<td><strong>PENNSYLVANIA</strong>&lt;br&gt;1-800-783-7067&lt;br&gt;Must call SHIP number to obtain proper fax number depending on location in state</td>
<td><strong>Pennsylvania Department of Aging</strong>&lt;br&gt;555 Walnut Street, 5th Fl.&lt;br&gt;Harrisburg, PA 17101-1919&lt;br&gt;(717) 783-1550&lt;br&gt;Fax: (717) 772-3382</td>
</tr>
<tr>
<td><strong>Puerto Rico Dept. of Insurance</strong>&lt;br&gt;B5 Calle Tabonuco Suite 216&lt;br&gt;PMB 356&lt;br&gt;Guaynabo, PR 00968-3029&lt;br&gt;(787) 722-8686&lt;br&gt;Fax: (787) 723-6082&lt;br&gt;www.ocs.gobierno.pr</td>
<td><strong>PUERTO RICO</strong>&lt;br&gt;1-877-725-4300&lt;br&gt;(787) 721-8590&lt;br&gt;Fax: (787) 721-6510</td>
<td><strong>Governors Office For Elderly Affairs</strong>&lt;br&gt;P.O. Box 191179&lt;br&gt;San Juan, PR 00919-1179&lt;br&gt;(787) 721-6121&lt;br&gt;Fax: (787) 721-6510</td>
</tr>
<tr>
<td><strong>REPUBLIC OF THE MARSHALL ISLANDS</strong>&lt;br&gt;State Agency on Aging&lt;br&gt;Department of Social Services&lt;br&gt;Republic of the Marshall Islands&lt;br&gt;Marjuro, Marshall Islands 96960</td>
<td><strong>REPUBLIC OF THE MARSHALL ISLANDS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Rhode Island Insurance Division</strong>&lt;br&gt;233 Richmond Street, Suite 233&lt;br&gt;Providence, RI 02903-4233&lt;br&gt;(401) 222-2223&lt;br&gt;Fax: (401) 222-5475&lt;br&gt;www.dbr.state.ri.us</td>
<td><strong>RHODE ISLAND</strong>&lt;br&gt;(401) 222-2130</td>
<td><strong>Department of Elderly Affairs</strong>&lt;br&gt;35 Howard Avenue&lt;br&gt;Benjamin Rush Bldg 55&lt;br&gt;Cranston, RI 02920&lt;br&gt;(401) 462-3000&lt;br&gt;Fax: (401) 462-0503</td>
</tr>
<tr>
<td>INSURANCE DEPARTMENTS</td>
<td>STATE HEALTH INSURANCE ASSISTANCE PROGRAMS</td>
<td>AGENCIES ON AGING</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>South Carolina Dept. of Insurance Capitol Center 1201 Maine Street, Suite 1000 Columbia, SC 29201 (803) 737-6160 Fax: (803) 737-6229 <a href="http://www.doi.sc.gov">http://www.doi.sc.gov</a></td>
<td>SOUTH CAROLINA 1-800-868-9095 (803) 898-2850 Fax: (803) 734-9886</td>
<td>Dept. of Health &amp; Human Services Bureau of Senior Services P.O. Box 8206 1801 Main St. Columbia, SC 29202-8206 (803) 734-9900 Fax: (803) 898-4515</td>
</tr>
<tr>
<td>South Dakota Division of Insurance Dept. of Commerce &amp; Regulation 445 East Capitol Avenue, 1st Floor Pierre, SD 57501-3185 (605) 773-3563 Fax: (605) 773-5369 <a href="http://www.sd.2000/insurance">www.sd.2000/insurance</a></td>
<td>SOUTH DAKOTA 1-800-536-8197 (605) 773-3656 TDD 1-800-642-6410 Fax: (605) 336-7471</td>
<td>South Dakota Office of Adult Services &amp; Aging Department of Social Services 700 Governors Drive Pierre, SD 57501 (605) 773-3656 Fax: (605) 773-6834</td>
</tr>
<tr>
<td>Tennessee Dept. of Commerce &amp; Ins. Davy Crockett Tower, Fifth Floor 500 James Robertson Parkway Nashville, TN 37243-0565 (615) 741-2241 Fax: (615) 532-6934 <a href="http://www.ten.state.us/insurance">www.ten.state.us/insurance</a></td>
<td>TENNESSEE 1-877-801-0044 (615) 242-0438 TDD (615) 532-3893 Fax: (731) 587-6744</td>
<td>Tennessee Commission on Aging and Disability Andrew Jackson Building 500 Deaderick Street, No. 825 Nashville, TN 37243-0860 (615) 741-2056 Fax: (615) 741-3309</td>
</tr>
<tr>
<td>Texas Department of Insurance 333 Guadalupe Street Austin, TX 78701 1-800-252-3439 Consumer Help Line (512) 463-6464 Fax: (512) 475-2005 <a href="http://www.tdi.state.tx.us">www.tdi.state.tx.us</a></td>
<td>TEXAS 1-800-252-9240 TDD 1-800-735-2989 Fax: (512) 305-7463</td>
<td>Texas Department of Aging &amp; Disability Services P.O. Box 149030 (W-619) Austin, TX 78714-9030 1-800-252-9240 (512) 438-3030 Fax: (512) 438-4220</td>
</tr>
<tr>
<td>Utah Department of Insurance 3110 State Office Building Salt Lake City, UT 84114-1201 (801) 538-3800 Fax: (801) 538-3829 <a href="http://www.insurance.utah.gov">www.insurance.utah.gov</a></td>
<td>UTAH 1-800-541-7735 (801) 538-3910 Fax: (801) 538-4395</td>
<td>Utah Division of Aging &amp; Adult Services Department of Human Services 120 North 200 West, Room 325 Salt Lake City, UT 84103 (801) 538-3910 Fax: (801) 538-4395</td>
</tr>
<tr>
<td>Vermont Division of Insurance Dept. of Banking, Ins. &amp; Securities 89 Main Street, Drawer 20 Montpelier, VT 05620-3101 (802) 828-3301 Fax: (802) 828-3306 <a href="http://www.bishca.state.vt.us">www.bishca.state.vt.us</a></td>
<td>VERMONT 1-800-639-1873 (802)-748-5182 Fax: (802) 748-6622</td>
<td>Vermont Department of Aging and Disabilities 103 South Main Street Waterbury, VT 05671-1601 (802) 241-2196 Fax: (802) 241-4224</td>
</tr>
<tr>
<td>Attn.: Marileen Thomas #18 Kongens Gade St. Thomas, Virgin Islands 00802 (340) 774-7166 Fax: (340) 774-9458 or (340) 774-6953</td>
<td>VIRGIN ISLANDS (340) 778-6311 x2338 Fax: (340) 778-5500</td>
<td>Senior Citizen Affairs Department of Human Services #19 Estate Diamond Fredericksted St. Croix, VI 00840 (340) 692-5950 Fax: (340) 692-2062</td>
</tr>
<tr>
<td>INSURANCE DEPARTMENTS</td>
<td>STATE HEALTH INSURANCE ASSISTANCE PROGRAMS</td>
<td>AGENCIES ON AGING</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>State Corporation Commission Bureau of Insurance Commonwealth of Virginia P.O. Box 1157 Richmond, VA 23218 (804) 371-9694 Fax: (804) 371-9873 <a href="http://www.scc.virginia.gov/division/boi">www.scc.virginia.gov/division/boi</a></td>
<td>VIRGINIA 1-800-552-3402 (804) 662-7048 Fax: (804) 662-9354</td>
<td>Virginia Department For The Aging 1610 Forest Avenue Preston Building, Suite 100 Richmond, VA 23229 (804) 662-9333 Fax: (804) 662-9354</td>
</tr>
<tr>
<td>Washington Office of the Insurance Commissioner 302 Sid Snyder Avenue SW Insurance Room 200 Olympia, WA 98504-0255 (360) 725-7100 Fax: (360) 586-3535 <a href="http://www.insurance.wa.gov">www.insurance.wa.gov</a></td>
<td>WASHINGTON 1-800-397-4422 TDD (360) 664-3154 (206) 654-1833 Fax: (206) 389-2745</td>
<td>Washington Aging &amp; Disability Services Dept. of Social &amp; Health Services PO Box 45050 14th and Jefferson Olympia, WA 98504-5050 (360) 902-7797 Fax: (360) 902-7848</td>
</tr>
<tr>
<td>West Virginia Dept. of Insurance P.O. Box 50540 Charleston, WV 25305-0540 (304) 558-3354 Fax: (304) 558-0412 <a href="http://www.wvinsurance.gov">www.wvinsurance.gov</a></td>
<td>WEST VIRGINIA 1-877-987-4463 (304) 558-3317 Fax: (304) 558-5609</td>
<td>West Virginia Bureau of Senior Services 1900 Kanawha Blvd, East State Capitol Charleston, WV 25305-0160 (304) 558-3317 Fax: (304) 558-5609</td>
</tr>
<tr>
<td>Office of the Commissioner of Ins. State of Wisconsin PO Box 7873 125 South Webster Street GEF III – 2nd floor Madison, WI 53707-7873 (608) 267-1233 Fax: (608) 261-8579 <a href="http://www.oci.wi.gov">www.oci.wi.gov</a></td>
<td>WISCONSIN 1-800-242-1060</td>
<td>Wisconsin Bureau of Aging &amp; LTC Resources Dept. of Health and Family Services PO Box 7851 One West Wilson St., Room 450 Madison, WI 53707-7851 (608) 266-2536 Fax: (608) 267-3203</td>
</tr>
<tr>
<td></td>
<td>WYOMING 1-800-856-4398 (307) 856-6880 Fax: (307) 856-4466</td>
<td>Wyoming Aging Division Department of Health 6101 Yellow Stone Road, Room 259B Cheyenne, WY 82002 (307) 777-7986 or 1-800-442-2766 Fax: (307) 777-5340</td>
</tr>
</tbody>
</table>
APPENDIX 7. ADDITIONAL LTCI PROVISIONS

In recent years, many companies selling LTCI have developed and offered many other varied riders and additional benefits to the base LTCI plan. Below is a description of some of these offerings not explained in the Shopper’s Guide.

1. **Adult Day Care Programs**

Like home health care, policies may provide reduced coverage for services received in an adult day care facility. Adult day care programs provide care on a daily basis to individuals who do not require confinement in a nursing home. Typical adult day care benefits include: nursing care; therapeutic, social, and educational activities; and constant supervision because of Alzheimer’s or a similar disease.

2. **Dependent Spouse Home Care**

The Dependent Spouse Home Care provision will allow the policyholder’s spouse to concurrently receive home health care coverage during the same visit by the same provider, if such home health care is being provided for the policyholder. Under this benefit, the dependent spouse is named as a secondary insured under the policy and is therefore eligible to receive benefits that would be payable under the policy. If this is a tax-qualified policy, the spouse (secondary insured) must meet HIPAA’s benefit trigger requirements (i.e., ADL or cognitive impairment trigger, plan of care and licensed health care practitioner certification). Coverage is extended to the dependent spouse if:

   (a) The reason the dependent spouse receives care is primarily for the policyholder’s benefit;
   (b) The care is provided during the same visit; and
   (c) The care is provided by the same provider.

The purpose of this benefit is to protect the financial interests of the married couple. In the case of this benefit, home care provided to the dependent spouse, which would not be otherwise covered, can be paid through private insurance; thus reducing the out-of-pocket expenses of the policyholder.

3. **Weekly Home Health Care**

The Weekly Home Health Care provision changes the daily benefit for home health care services to a weekly benefit. It provides the policyholder with access to seven times their home health daily benefit with no restriction of a daily cap. Quite often, an individual receives intensive nursing services, the cost of which exceeds the daily benefit amount. Here, the individual would have access to the entire weekly amount to pay for such services or visits. Any excess would remain in the policy limit.

4. **Flex Fund**

This provision allows the policyholder to use their Flex Fund Benefit Amount for a variety of long-term care expenses that are not otherwise covered under the policy while he or she is living at home. Some of the benefits payable under this provision may be covered charges under the policy, such as covered care and services used to satisfy the elimination period. Additionally, charges incurred in excess of the home health care daily benefit could be reimbursed.

5. **Enhanced Elimination Period**

The Enhanced Elimination Period provision liberalizes how days are credited toward the elimination period. Rather than require the satisfaction of possible multiple elimination periods (if separated by periods of care), this provision would provide that each date of service would satisfy the elimination period regardless of whether it was accumulated under separate claims.
6. **Spousal Survivorship/Waiver**

The Spousal Survivorship/Waiver provision waives the policyholder’s premium in the event that his or her spouse dies or goes on claim after a defined period (e.g., 10 years) without any claims. The main conditions for benefits under this provision are as follows:

(a) Both spouses must have had their policies in force for a defined period of time (e.g., 10 years) during which no benefits were paid.

(b) If such is the case, then in the event of the death of one’s spouse, no further premiums are due under the survivor’s policy.

(c) Furthermore, in the event that one spouse goes on claim after satisfying the elimination period, no further premium is due for either the non-claiming spouse or the spouse on claim for the duration of the spouse’s claim.

The purpose of this benefit is to protect the financial interests of the married couple. Under this benefit, when one spouse goes on claim or dies, the healthy or surviving spouse has additional financial concerns that must be addressed. This benefit would alleviate a significant cost for this spouse via the waiver provision.

7. **Limited Payment Plans**

(a) **Single Premium**

The single premium payment endorsement revises the renewability section of the policy. The insured person pays a one-time premium and the insurer may not charge further premium, regardless of insurer experience.

(b) **Specified Number of Years**

Another endorsement revises the renewability section of the policy so that premiums are paid for a specified number of years (e.g., 10 years). This allows participants to pay their premiums in full in the specified number of years. During the premium paying period, the policy will be noncancelable as long as premiums are paid when due or within the grace period. At the end of the specified time period, if each required renewal premium has been paid, the policy will be automatically renewed for life with no further premium payments required.

(c) **Paid-Up at 65**

The paid-up at 65 endorsement revises the renewability section of the policy to allow applicants to pay their premiums in full by age 65. Often, premium rates are guaranteed to not increase during an initial period (e.g., 5 years) from the effective date of coverage. The policy will be automatically renewed for life with no further premium payments required if each required renewal premium has been paid up to the anniversary of the effective date of coverage on or after the insured’s 65th birthday.
Table of Contents

Section 1. Purpose
Section 2. Scope
Section 3. Short Title
Section 4. Definitions
Section 5. Extraterritorial Jurisdiction—Group Long-Term Care Insurance
Section 6. Disclosure and Performance Standards for Long-Term Care Insurance
Section 7. Incontestability Period
Section 8. Nonforfeiture Benefits
Section 9. Producer Training Requirements
Section 10. Authority to Promulgate Regulations
Section 11. Administrative Procedures
Section 12. Severability
Section 13. Penalties
Section 14. Effective Date

Section 1. Purpose

The purpose of this Act is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

Drafting Note: The purpose clause evidences legislative intent to protect the public while recognizing the need to permit flexibility and innovation with respect to long-term care insurance coverage.

Drafting Note: The Task Force recognizes the viability of a long-term care product funded through a life insurance vehicle, and this Act is not intended to prohibit approval of this product. Section 4 now specifically addresses this product. However, states must examine their existing statutes to determine whether amendments to other code sections such as the definition of life insurance and accident and health reserve standards and further revisions are necessary to authorize approval of the product.

Section 2. Scope

The requirements of this Act shall apply to policies delivered or issued for delivery in this state on or after the effective date of this Act. This Act is not intended to supersede the obligations of entities subject to this Act to comply with the substance of other applicable insurance laws insofar as they do not conflict with this Act, except that laws and regulations designed and intended to apply to Medicare supplement insurance policies shall not be applied to long-term care insurance.

Note: See Section 6J.

Drafting Note: This section makes clear that entities subject to the Act must continue to comply with other applicable insurance legislation not in conflict with this Act.
Section 3. Short Title

This Act may be known and cited as the “Long-Term Care Insurance Act.”

Section 4. Definitions

Unless the context requires otherwise, the definitions in this section apply throughout this Act.

A. “Long-term care insurance” means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; 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. The term includes group and individual annuities and life insurance policies or riders that provide directly or supplement long-term care insurance. The term also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term shall also include qualified long-term care insurance contracts. Long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With regard to life insurance, this term does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision of this Act, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this Act.

B. “Applicant” means:

(1) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and

(2) In the case of a group long-term care insurance policy, the proposed certificate holder.

C. “Certificate” means, for the purposes of this Act, any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

D. “Commissioner” means the Insurance Commissioner of this state.

Drafting Note: Where the word “commissioner” appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted.

E. “Group long-term care insurance” means a long-term care insurance policy that is delivered or issued for delivery in this state and issued to:

(1) One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof,
for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations; or

(2) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if the association:
   
   (a) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and
   
   (b) Has been maintained in good faith for purposes other than obtaining insurance; or

(3) An association or a trust or the trustees of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering the policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the commissioner that the association or associations have at the outset a minimum of 100 persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws that provide that:
   
   (a) The association or associations hold regular meetings not less than annually to further purposes of the members;
   
   (b) Except for credit unions, the association or associations collect dues or solicit contributions from members; and
   
   (c) The members have voting privileges and representation on the governing board and committees.

Thirty (30) days after the filing the association or associations will be deemed to satisfy the organizational requirements, unless the commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

(4) A group other than as described in Subsections E(1), E(2) and E(3), subject to a finding by the commissioner that:
   
   (a) The issuance of the group policy is not contrary to the best interest of the public;
   
   (b) The issuance of the group policy would result in economies of acquisition or administration; and
   
   (c) The benefits are reasonable in relation to the premiums charged.

F. “Policy” means, for the purposes of this Act, any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this state by an insurer; fraternal benefit society; nonprofit health, hospital, or medical service corporation; prepaid health plan; health maintenance organization or any similar organization.

Drafting Note: This Act is intended to apply to the specified group and individual policies, contracts, and certificates whether issued by insurers; fraternal benefit societies; nonprofit health, hospital, or medical service corporations; prepaid health plans; health maintenance organizations or any similar organization. In order to include such organizations, each state should identify them in accordance with its statutory terminology or by specific statutory citation. Depending upon state law, insurance department jurisdiction and other factors, separate legislation may be required. In any event, the legislation should provide that the particular terminology used by
these plans and organizations may be substituted for, or added to, the corresponding terms used in this Act. The term “regulations” should be replaced by the terms “rules and regulations” or “rules” as may be appropriate under state law.

The definition of “long-term care insurance” under this Act is designed to allow maximum flexibility in benefit scope, intensity and level, while assuring that the purchaser’s reasonable expectations for a long-term care insurance policy are met. The Act is intended to permit long-term care insurance policies to cover either diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, or any combination thereof, and not to mandate coverage for each of these types of services. Pursuant to the definition, long-term care insurance may be either a group or individual insurance policy or a rider to such a policy, e.g., life or accident and sickness. The language in the definition concerning “other than an acute care unit of a hospital” is intended to allow payment of benefits when a portion of a hospital has been designated for, and duly licensed or certified as a long-term care provider or swing bed.

G. (1) “Qualified long-term care insurance contract” or “federally tax-qualified long-term care insurance contract” means an individual or group insurance contract that meets the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as amended, as follows:

(a) The only insurance protection provided under the contract is coverage of qualified long-term care services. A contract shall not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

(b) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act, as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this subparagraph do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payor. A contract shall not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

(c) The contract is guaranteed renewable, within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended;

(d) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in [insert reference to state law equivalent to Section 4G(1)(e) of the Long-Term Care Insurance Model Act];

(e) All refunds of premiums, and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract; and

(f) The contract meets the consumer protection provisions set forth in Section 7702B(g) of the Internal Revenue Code of 1986, as amended.
“Qualified long-term care insurance contract” or “federally tax-qualified long term care insurance contract” also means the portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of Sections 7702B(b) and (e) of the Internal Revenue Code of 1986, as amended.

**Drafting Note:** The definition of “qualified long-term care insurance contract” has been added to assist states in regulating long-term care insurance policies that are federally tax-qualified. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Section 7702B of the Internal Revenue Code, as amended, provide a definition of this term and clarify federal income tax treatment of premiums and benefits. Treasury Regulations 1.7702B-1 and 1.7702B-2, and Notice 97-31 issued by the Internal Revenue Service, further address these issues.

### Section 5. Extraterritorial Jurisdiction—Group Long-Term Care Insurance

No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in Section 4E(4), unless this state or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met.

**Drafting Note:** By limiting extraterritorial jurisdiction to “discretionary groups,” it is not the drafters’ intention that jurisdiction over other health policies should be limited in this manner.

### Section 6. Disclosure and Performance Standards for Long-Term Care Insurance

**A.** The commissioner may adopt regulations that include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, non-duplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions and definitions of terms.

**Drafting Note:** This subsection permits the adoption of regulations establishing disclosure standards, renewability and eligibility terms and conditions, and other performance requirements for long-term care insurance. Regulations under this subsection should recognize the developing and unique nature of long-term care insurance and the distinction between group and individual long-term care insurance policies.

**B.** No long-term care insurance policy may:

1. Be cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder; or

2. Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

3. Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

**C.** Preexisting condition.
(1) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4E(1) shall use a definition of “preexisting condition” that is more restrictive than the following: Preexisting condition means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six (6) months preceding the effective date of coverage of an insured person.

(2) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4E(1) may exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within six (6) months following the effective date of coverage of an insured person.

(3) The commissioner may extend the limitation periods set forth in Sections 6C(1) and (2) above as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(4) The definition of “preexisting condition” does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer’s established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in Section 6C(2) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in Section 6C(2).

D. Prior hospitalization/institutionalization.

(1) No long-term care insurance policy may be delivered or issued for delivery in this state if the policy:

   (a) Conditions eligibility for any benefits on a prior hospitalization requirement;

   (b) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

   (c) Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.

(2) (a) A long-term care insurance policy containing post-confinement, post-acute care or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled “Limitations or Conditions on Eligibility for Benefits” such limitations or conditions, including any required number of days of confinement.

   (b) A long-term care insurance policy or rider that conditions eligibility of non-institutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty (30) days.

Drafting Note: The amendment to the section is primarily intended to require immediate and clear disclosure where a long-term care insurance policy or rider conditions eligibility for non-institutional benefits on prior receipt of institutional care.
(3) No long-term care insurance policy or rider that provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related conditions within a period of less than thirty (30) days after discharge from the institution.

**Drafting Note:** Section 6D(3) is language from the original model act which did not prohibit prior institutionalization. The drafters intended that Section 6D(3) would be eliminated after adoption of the amendments to this section which prohibit prior institutionalization. States should examine their Section 6 carefully during the process of adoption or amendment of this Act.

E. The commissioner may adopt regulations establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the regulation.

F. Right to return—free look. Long-term care insurance applicants shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in Section 4E(1) of this Act, the applicant is not satisfied for any reason. This subsection shall also apply to denials of applications and any refund must be made within thirty (30) days of the return or denial.

G. (1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose.

(a) The commissioner shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.

(b) In the case of agent solicitations, an agent shall deliver the outline of coverage prior to the presentation of an application or enrollment form.

(c) In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form.

(d) In the case of a policy issued to a group defined in Section 4E(1) of this Act, an outline of coverage shall not be required to be delivered, provided that the information described in Section 6G(2)(a) through (f) is contained in other materials relating to enrollment. Upon request, these other materials shall be made available to the commissioner.

**Drafting Note:** States may wish to review specific filing requirements as they pertain to the outline of coverage and these other materials.

(2) The outline of coverage shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions and limitations contained in the policy;
(c) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;

(d) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(e) A description of the terms under which the policy or certificate may be returned and premium refunded;

(f) A brief description of the relationship of cost of care and benefits; and

(g) A statement that discloses to the policyholder or certificateholder whether the policy is intended to be a federally tax-qualified long-term care insurance contract under 7702B(b) of the Internal Revenue Code of 1986, as amended.

H. A certificate issued pursuant to a group long-term care insurance policy that policy is delivered or issued for delivery in this state shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the principal exclusions, reductions and limitations contained in the policy; and

(3) A statement that the group master policy determines governing contractual provisions.

Drafting Note: The above provisions are deemed appropriate due to the particular nature of long-term care insurance, and are consistent with group insurance laws. Specific standards would be contained in regulations implementing this Act.

I. If an application for a long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than thirty (30) days after the date of approval.

J. At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy that provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant’s request, but regardless of request shall make delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

(1) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(2) An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;

(3) Any exclusions, reductions and limitations on benefits of long-term care;

(4) A statement that any long-term care inflation protection option required by [cite to state’s inflation protection option requirement comparable to Section 11 of the Long-Term Care Insurance Model Regulation] is not available under this policy;
If applicable to the policy type, the summary shall also include:

(a) A disclosure of the effects of exercising other rights under the policy;

(b) A disclosure of guarantees related to long-term care costs of insurance charges; and

(c) Current and projected maximum lifetime benefits; and

The provisions of the policy summary listed above may be incorporated into a basic illustration required to be delivered in accordance with [cite to state’s basic illustration requirement comparable to Sections 6 and 7 of the Life Insurance Illustrations Model Regulation] or into the life insurance policy summary which is required to be delivered in accordance with [cite to state’s life insurance policy summary requirement comparable to Section 5 of the Life Insurance Disclosure Model Regulation].

Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include:

(1) Any long-term care benefits paid out during the month;

(2) An explanation of any changes in the policy, e.g. death benefits or cash values, due to long-term care benefits being paid out; and

(3) The amount of long-term care benefits existing or remaining.

If a claim under a long-term care insurance contract is denied, the issuer shall, within sixty (60) days of the date of a written request by the policyholder or certificateholder, or a representative thereof:

(1) Provide a written explanation of the reasons for the denial; and

(2) Make available all information directly related to the denial.

Any policy or rider advertised, marketed or offered as long-term care or nursing home insurance shall comply with the provisions of this Act.

Section 7. Incontestability Period

A. For a policy or certificate that has been in force for less than six (6) months an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.

B. For a policy or certificate that has been in force for at least six (6) months but less than two (2) years an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.
C. After a policy or certificate has been in force for two (2) years it is not contestable upon the grounds of misrepresentation alone; such policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured’s health.

D. (1) A long-term care insurance policy or certificate may be field issued if the compensation to the field issuer is not based on the number of policies or certificates issued.

(2) For purposes of this section, “field issued” means a policy or certificate issued by a producer or a third-party administrator pursuant to the underwriting authority granted to the producer or third party administrator by an insurer and using the insurer’s underwriting guidelines.

E. If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

F. In the event of the death of the insured, this section shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies shall be governed by [cite to state’s life insurance incontestability clause]. In all other situations, this section shall apply to life insurance policies that accelerate benefits for long-term care.

Section 8. Nonforfeiture Benefits

A. Except as provided in Subsection B, a long-term care insurance policy may not be delivered or issued for delivery in this state unless the policyholder or certificateholder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. In the event the policyholder or certificateholder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates.

B. When a group long-term care insurance policy is issued, the offer required in Subsection A shall be made to the group policyholder. However, if the policy is issued as group long-term care insurance as defined in Section 4E(4), other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificateholder.

C. The commissioner shall promulgate regulations specifying the type or types of nonforfeiture benefits to be offered as part of long-term care insurance policies and certificates, the standards for nonforfeiture benefits, and the rules regarding contingent benefit upon lapse, including a determination of the specified period of time during which a contingent benefit upon lapse will be available and the substantial premium rate increase that triggers a contingent benefit upon lapse as described in Subsection A.

Section 9. Producer Training Requirements

A. (1) An individual may not sell, solicit or negotiate long-term care insurance unless the individual is licensed as an insurance producer for accident and health or sickness or life [include other lines of authority as applicable] and has completed a one-time training course. The training shall meet the requirements set forth in Subsection B.
(2) An individual already licensed and selling, soliciting or negotiating long-term care insurance on the effective date of this Act may not continue to sell, solicit or negotiate long term care insurance unless the individual has completed a one-time training course as set forth in Subsection B, within one year from [insert effective date of this legislation].

(3) In addition to the one-time training course required in Paragraphs (1) and (2) above, an individual who sells, solicits or negotiates long-term care insurance shall complete ongoing training as set forth in Subsection B.

(4) The training requirements of Subsection B may be approved as continuing education courses under [insert reference to applicable state law or regulation].

B. (1) The one-time training required by this Section shall be no less than eight (8) hours and the ongoing training required by this Section shall be no less than four (4) hours every 24 months.

(2) The training required under Paragraph (1) shall consist of topics related to long-term care insurance, long-term care services and, if applicable, qualified state long-term care insurance Partnership programs, including, but not limited to:

(a) State and federal regulations and requirements and the relationship between qualified state long-term care insurance Partnership programs and other public and private coverage of long-term care services, including Medicaid;

(b) Available long-term services and providers;

(c) Changes or improvements in long-term care services or providers;

(d) Alternatives to the purchase of private long-term care insurance;

(e) The effect of inflation on benefits and the importance of inflation protection; and

(f) Consumer suitability standards and guidelines.

(3) The training required by this Section shall not include training that is insurer or company product specific or that includes any sales or marketing information, materials, or training, other than those required by state or federal law.

C. (1) Insurers subject to this Act shall obtain verification that a producer receives training required by Subsection A before a producer is permitted to sell, solicit or negotiate the insurer’s long-term care insurance products, maintain records subject to the state’s record retention requirements, and make that verification available to the commissioner upon request.

(2) Insurers subject to this Act shall maintain records with respect to the training of its producers concerning the distribution of its Partnership policies that will allow the state insurance department to provide assurance to the state Medicaid agency that producers have received the training contained in Subsection B(2)(a) as required by Subsection A and that producers have demonstrated an understanding of the Partnership policies and their relationship to public and private coverage of long-term care, including Medicaid, in this state. These records shall be maintained in accordance with the state’s record retention requirements and shall be made available to the commissioner upon request.
D. The satisfaction of these training requirements in any state shall be deemed to satisfy the training requirements in this state.

**Drafting Note:** Guidance on the implementation of the Deficit Reduction Act of 2005 (DRA), Pub. L. 109-171, provided by the Centers for Medicare & Medicaid Services in the July 27, 2006 State Medicaid Director Letter (SMDL #06-019) states that “[t]he State insurance department must provide assurance to the State Medicaid agency that anyone who sells a policy under the Partnership receives training and demonstrates an understanding of Partnership policies and their relationship to public and private coverage of [long term care].” There is no guidance as to how the State insurance department is to accomplish this requirement. This drafting note provides information to the State insurance departments with respect to achieving the aforementioned requirements.

Section 9C of the NAIC Long-Term Care Insurance Model Act requires insurers to obtain and maintain records verifying that producers who sell, solicit or negotiate long-term care insurance products on their behalf have received the training required in this Section and to make such records available to the State insurance department. In addition, Section 9C(2) requires insurers to obtain and maintain records concerning the training of their agents for Partnership policies. Insurers are to maintain records that verify its producers have received the training required for Partnership policies and that they demonstrate an understanding of the policies and their relationship to public and private long-term care coverage.

State insurance departments, in order to meet the standards contained in the DRA concerning producer training should consider developing a process to communicate with the State Medicaid agency on how the DRA requirements will be met. They should develop a process to verify insurance company compliance with these requirements including, as an audit step, the verification of compliance with the above requirements as part of a market conduct examination. In addition, State insurance departments should consider performing annual, random verifications of insurance company compliance. Finally, consideration may be given to deeming those training programs, specifically approved by the State for Partnership policy training that qualify for Continuing Education, as meeting the requirements contained in Section 9C(2).

**Section 10. Authority to Promulgate Regulations**

The commissioner shall issue reasonable regulations to promote premium adequacy and to protect the policyholder in the event of substantial rate increases, and to establish minimum standards for producer education, marketing practices, producer compensation, producer testing, penalties and reporting practices for long-term care insurance.

**Drafting Note:** Each state should examine its statutory authority to promulgate regulations and revise this section accordingly so that sufficient rulemaking authority is present and that unnecessary duplication of unfair practice provisions does not occur.

**Section 11. Administrative Procedures**

Regulations adopted pursuant to this Act shall be in accordance with the provisions of [cite section of state insurance code relating to the adoption and promulgation of rules and regulations or cite the state’s administrative procedures act, if applicable].

**Section 12. Severability**

If any provision of this Act or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.
Section 13. Penalties

In addition to any other penalties provided by the laws of this state, any insurer and any producer 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 intention of this section is to authorize separate fines for both the insurer and the producer in the amounts suggested above.

Section 14. Effective Date

This Act shall be effective [insert date].

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

1999 Proc. 4th Quarter 18, 929, 969, 972-978 (amended).
2007 Proc. 3rd Quarter (amended).
Table of Contents

Section 1. Purpose
Section 2. Authority
Section 3. Applicability and Scope
Section 4. Definitions
Section 5. Policy Definitions
Section 7. Unintentional Lapse
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 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. (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 Section 20, 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.

B. “Incidental,” as used in Section 20J, 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.

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

D. “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.


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 9 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.
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. 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
When the state other than the state of policy issue licenses, certifies or registers the provider under another name.

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.

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 purposes 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 31E(3) 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 31E(3) 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) (a) Information regarding each premium rate increase on this policy form or similar policy forms over the past ten (10) years for this state or any other state that, at a minimum, identifies:

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

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

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

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

(c) An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the 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 additional, 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].

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 complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

(i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(ii) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(iii) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and
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;

**Drafting Note:** When the difference between the gross premium and the renewal net valuation premiums is not sufficient to cover expected renewal expenses, the description provided could demonstrate the type and level of change in the reserve assumptions that would be necessary for the difference to be sufficient.

(I) An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;

(II) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under Subsection C based on a standard age distribution; and

(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:** 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.

C. (1) The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

(2) In the event the commissioner asks for additional information under this provision, the period in Subsection B does not include the period during which the insurer is preparing the requested information.

**Drafting Note:** The commissioner may wish to have the actuarial demonstration reviewed by an independent actuary in those instances where the demonstration does not address fully the questions that triggered the request for the actuarial demonstration.

**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.
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%);
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

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 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 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:

**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 you 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)

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:
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.

[Company Name]

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.

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.
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 most recent version of the NAIC Minimum Reserve Standards for Individual and Group Health Insurance Contracts].

**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 and 20.
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

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. 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;

(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; and

(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;
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

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 © 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 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 4B, 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
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.
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;
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;

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

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.
The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier’s administrative processes.

B. The provision shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

C. The age to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force.

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 this Section shall apply to any long-term care policy issued in this state on or after [insert date that is 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.
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.

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.

<table>
<thead>
<tr>
<th>Issue Age</th>
<th>Percent Increase Over Initial Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>29 and under</td>
<td>200%</td>
</tr>
<tr>
<td>30-34</td>
<td>190%</td>
</tr>
<tr>
<td>35-39</td>
<td>170%</td>
</tr>
<tr>
<td>40-44</td>
<td>150%</td>
</tr>
<tr>
<td>45-49</td>
<td>130%</td>
</tr>
<tr>
<td>50-54</td>
<td>110%</td>
</tr>
<tr>
<td>55-59</td>
<td>90%</td>
</tr>
<tr>
<td>60</td>
<td>70%</td>
</tr>
<tr>
<td>61</td>
<td>66%</td>
</tr>
<tr>
<td>62</td>
<td>62%</td>
</tr>
<tr>
<td>63</td>
<td>58%</td>
</tr>
<tr>
<td>64</td>
<td>54%</td>
</tr>
<tr>
<td>65</td>
<td>50%</td>
</tr>
<tr>
<td>66</td>
<td>48%</td>
</tr>
<tr>
<td>67</td>
<td>46%</td>
</tr>
<tr>
<td>68</td>
<td>44%</td>
</tr>
<tr>
<td>69</td>
<td>42%</td>
</tr>
<tr>
<td>70</td>
<td>40%</td>
</tr>
<tr>
<td>71</td>
<td>38%</td>
</tr>
<tr>
<td>72</td>
<td>36%</td>
</tr>
<tr>
<td>73</td>
<td>34%</td>
</tr>
<tr>
<td>74</td>
<td>32%</td>
</tr>
<tr>
<td>75</td>
<td>30%</td>
</tr>
<tr>
<td>76</td>
<td>28%</td>
</tr>
<tr>
<td>77</td>
<td>26%</td>
</tr>
<tr>
<td>78</td>
<td>24%</td>
</tr>
<tr>
<td>79</td>
<td>22%</td>
</tr>
<tr>
<td>80</td>
<td>20%</td>
</tr>
<tr>
<td>81</td>
<td>19%</td>
</tr>
<tr>
<td>82</td>
<td>18%</td>
</tr>
<tr>
<td>83</td>
<td>17%</td>
</tr>
<tr>
<td>84</td>
<td>16%</td>
</tr>
<tr>
<td>85</td>
<td>15%</td>
</tr>
<tr>
<td>86</td>
<td>14%</td>
</tr>
<tr>
<td>87</td>
<td>13%</td>
</tr>
<tr>
<td>88</td>
<td>12%</td>
</tr>
<tr>
<td>89</td>
<td>11%</td>
</tr>
<tr>
<td>90 and over</td>
<td>10%</td>
</tr>
</tbody>
</table>
(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.

<table>
<thead>
<tr>
<th>Issue Age</th>
<th>Percent Increase Over Initial Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65</td>
<td>50%</td>
</tr>
<tr>
<td>65-80</td>
<td>30%</td>
</tr>
<tr>
<td>Over 80</td>
<td>10%</td>
</tr>
</tbody>
</table>

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 without the requirement of additional underwriting 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 without the requirement of additional underwriting 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.
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.

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 Subsection 4E(1) 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 or Section 20, 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. 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] 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 32. 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 33. 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.

<table>
<thead>
<tr>
<th>Policy Form #</th>
<th>Policy and Certificate #</th>
<th>Name of Insured</th>
<th>Date of Policy Issuance</th>
<th>Date/s Claim/s Submitted</th>
<th>Date of Rescission</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Detailed reason for rescission: ____________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

__________________________________  
Signature

__________________________________  
Name and Title (please type)

__________________________________  
Date
People buy long-term care insurance for many reasons. Some don’t want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don’t want their family to have to pay for care or don’t want to go on Medicaid. But long term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

**Premium Information**

Policy Form Numbers ________________________________

The premium for the coverage you are considering will be [$_________ per month, or $_______ per year.] [a one-time single premium of $____________.]

**Type of Policy** (noncancellable/guaranteed renewable): ________________________________

**The Company's Right to Increase Premiums:** ________________________________

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

**Rate Increase History**

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.]

**Drafting Note:** A company may use the first bracketed sentence above only if it has never increased rates under any prior policy forms in this state or any other state. The issuer shall list each premium increase it has instituted on this or similar policy forms in this state or any other state during the last 10 years. The list shall provide the policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.
Questions Related to Your Income

How will you pay each year’s premium?
☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

[ ☐ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?]

Drafting Note: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.

What is your annual income? (check one) ☐ Under $10,000 ☐ $10,000-$20,000 ☐ $20,000-$30,000 ☐ $30,000-$50,000 ☐ Over $50,000

Drafting Note: The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)
☐ No change ☐ Increase ☐ Decrease

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 if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ☐ Yes ☐ No
If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?
☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

The national average annual cost of 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. In the above statement, the second figure equals 163% of the first figure.

What elimination period are you considering? Number of days _______ Approximate cost $_________ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)
☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)
☐ Under $20,000 ☐ $20,000-$30,000 ☐ $30,000-$50,000 ☐ Over $50,000

How do you expect your assets to change over the next ten years? (check one)
☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing 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 acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. I understand that the rates for this policy may increase in the future. (This box must be checked).

Signed:_______________________________________  ______________________________

(Applicant) (Date)

☐ I explained to the applicant the importance of completing this information.

Signed:_______________________________________  ______________________________

(Agent) (Date)

Agent’s Printed Name:__________________________________________________________

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

[My agent has advised me that this policy 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.

The company may contact you to verify your answers.

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.
### 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.
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. “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.

<table>
<thead>
<tr>
<th></th>
<th>State Data</th>
<th>Nationwide Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Total Number of Long-Term Care Claims Reported</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Total Number of Long-Term Care Claims Denied/Not Paid</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Number of Claims Not Paid due to Preexisting Condition Exclusion</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Number of Claims Not Paid due to Waiting (Elimination) Period Not Met</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Number of Long-Term Care Claim Denied due to:</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>• Long-Term Care Services Not Covered under the Policy</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>• Provider/Facility Not Qualified under the Policy</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>• Benefit Eligibility Criteria Not Met</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>• Other</td>
<td></td>
</tr>
</tbody>
</table>

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:

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Insurers shall provide all of the following information to the applicant:

Long Term Care Insurance
Potential Rate Increase Disclosure Form

1. Premium Rate| Premium Rate Schedules: [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [filed][approved] for an increase [is][are] [on the application][$_____]}

Drafting Note: Use “approved” in states requiring prior approval of rates.

2. The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.

3. Rate Schedule Adjustments:

   The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): __________________.

4. Potential Rate Revisions:

   This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

   If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

   - Pay the increased premium and continue your policy in force as is.
   - Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
   - Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
   - Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

   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*
Contingent Nonforfeiture
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.)

<table>
<thead>
<tr>
<th>Issue Age</th>
<th>Percent Increase Over Initial Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>29 and under</td>
<td>200%</td>
</tr>
<tr>
<td>30-34</td>
<td>190%</td>
</tr>
<tr>
<td>35-39</td>
<td>170%</td>
</tr>
<tr>
<td>40-44</td>
<td>150%</td>
</tr>
<tr>
<td>45-49</td>
<td>130%</td>
</tr>
<tr>
<td>50-54</td>
<td>110%</td>
</tr>
<tr>
<td>55-59</td>
<td>90%</td>
</tr>
<tr>
<td>60</td>
<td>70%</td>
</tr>
<tr>
<td>61</td>
<td>66%</td>
</tr>
<tr>
<td>62</td>
<td>62%</td>
</tr>
<tr>
<td>63</td>
<td>58%</td>
</tr>
<tr>
<td>64</td>
<td>54%</td>
</tr>
<tr>
<td>65</td>
<td>50%</td>
</tr>
<tr>
<td>66</td>
<td>48%</td>
</tr>
<tr>
<td>67</td>
<td>46%</td>
</tr>
<tr>
<td>68</td>
<td>44%</td>
</tr>
<tr>
<td>69</td>
<td>42%</td>
</tr>
<tr>
<td>70</td>
<td>40%</td>
</tr>
<tr>
<td>71</td>
<td>38%</td>
</tr>
<tr>
<td>72</td>
<td>36%</td>
</tr>
<tr>
<td>73</td>
<td>34%</td>
</tr>
<tr>
<td>74</td>
<td>32%</td>
</tr>
<tr>
<td>75</td>
<td>30%</td>
</tr>
<tr>
<td>76</td>
<td>28%</td>
</tr>
<tr>
<td>77</td>
<td>26%</td>
</tr>
<tr>
<td>78</td>
<td>24%</td>
</tr>
<tr>
<td>79</td>
<td>22%</td>
</tr>
<tr>
<td>80</td>
<td>20%</td>
</tr>
<tr>
<td>81</td>
<td>19%</td>
</tr>
<tr>
<td>82</td>
<td>18%</td>
</tr>
<tr>
<td>83</td>
<td>17%</td>
</tr>
<tr>
<td>84</td>
<td>16%</td>
</tr>
<tr>
<td>85</td>
<td>15%</td>
</tr>
<tr>
<td>86</td>
<td>14%</td>
</tr>
<tr>
<td>87</td>
<td>13%</td>
</tr>
<tr>
<td>88</td>
<td>12%</td>
</tr>
<tr>
<td>89</td>
<td>11%</td>
</tr>
<tr>
<td>90 and over</td>
<td>10%</td>
</tr>
</tbody>
</table>
[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;

<table>
<thead>
<tr>
<th>Issue Age</th>
<th>Percent Increase Over Initial Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65</td>
<td>50%</td>
</tr>
<tr>
<td>65-80</td>
<td>30%</td>
</tr>
<tr>
<td>Over 80</td>
<td>10%</td>
</tr>
</tbody>
</table>

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

Long-Term Care Insurance
Replacement and Lapse Reporting Form

For the State of _________________________                  For the Reporting Year of ________________

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

Instructions

The purpose of this form is to report on a statewide basis information regarding 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

<table>
<thead>
<tr>
<th>Agent’s Name</th>
<th>Number of Policies Sold By This Agent</th>
<th>Number of Policies Replaced By This Agent</th>
<th>Number of Replacements As % of Number Sold By This Agent</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Agent’s Name</th>
<th>Number of Policies Sold By This Agent</th>
<th>Number of Policies Lapsed By This Agent</th>
<th>Number of Lapses As % of Number Sold By This Agent</th>
</tr>
</thead>
</table>

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

1997 Proc. 2nd Quarter 25-26, 676 (amendments on personal worksheet adopted).
1999 Proc. 4th Quarter 18, 929, 969, 972, 978-991 (amended).
Formed in 1871, the National Association of Insurance Commissioners (NAIC) is a voluntary organization of the chief insurance regulatory officials of the 50 states, the District of Columbia and five U.S. territories. The NAIC has three offices: Executive Office, Washington, D.C.; Central Office, Kansas City, Mo.; and Securities Valuation Office, New York City.

The NAIC serves the needs of consumers and the industry, with an overriding objective of supporting state insurance regulators as they protect consumers and maintain the financial stability of the insurance marketplace.

For more information, visit www.naic.org.