

APPENDIX A

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

Company Name: _____

Address: _____

Phone Number: _____

Due: March 1 annually

Instructions:

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

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

Detailed reason for rescission: _____

Signature

Name and Title (please type)

Date

APPENDIX B

Long-Term Care Insurance
Personal Worksheet

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 \$[10-20,000] \$[20-30,000] \$[30-50,000] 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

<input type="checkbox"/> The answers to the questions above describe my financial situation. Or <input type="checkbox"/> I choose not to complete this information. (Check one.)
<input type="checkbox"/> 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.

APPENDIX C

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

- Long-Term Care Insurance**
- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
 - [You should not buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]
- Drafting Note:** For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.
- Medicare**
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
- Medicaid**
- Medicare does not pay for most long-term care.
 - Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.
 - Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
 - When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
 - Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.
- Shopper's Guide**
- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.
- Counseling**
- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.
- Facilities**
- Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

APPENDIX D

Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

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

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

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

Drafting Note: Choose the paragraph that applies.

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

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

Please check one box and return in the enclosed envelope.

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

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

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

APPLICANT'S SIGNATURE

DATE

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

APPENDIX E

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

For the State of _____
For the Reporting Year of _____

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

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

Line of Business: Individual Group

Instructions

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

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

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

Inforce Data

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

Long-Term Care Insurance Model Regulation

Claims & Denial Data

		State Data	Nationwide Data ¹
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Long-Term Care Claim Denied due to:		
8	• Long-Term Care Services Not Covered under the Policy ²		
9	• Provider/Facility Not Qualified under the Policy ³		
10	• Benefit Eligibility Criteria Not Met ⁴		
11	• Other		

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

APPENDIX F

Instructions:

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.)	
Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

Long-Term Care Insurance Model Regulation

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

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

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

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

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

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

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

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

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

Example:

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy benefits are .46 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy.

Appendix G

Replacement and Lapse Reporting Form

For the State of _____

For the Reporting Year of _____

Company Name: _____

Due: June 30 annually

Company Address: _____

Company NAIC Number: _____

Contact Person: _____
() _____

Phone Number: _____

Instructions

The purpose of this form is to report on 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

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

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

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

Company Totals

Percentage of Replacement Policies Sold to Total Annual Sales ____%

Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year) ____%

Percentage of Lapsed Policies to Total Annual Sales ____%

Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) ____%

Appendix H.

Guidelines for Long-Term Care Independent Review Entities

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

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

- h. The independent review organization shall provide a description of the procedures employed to ensure that reviewers conducting independent reviews are appropriately licensed, registered or certified; trained in the principles, procedures and standards of the independent review organization; and knowledgeable about the functional or cognitive impairments associated with the diagnosis and disease staging processes, including expected duration of such impairment, which is the subject of the independent review.
- i. The independent review organization shall provide the number of reviewers retained by the independent review organization and a description of the areas of expertise available from such reviewers and the types of cases such reviewers are qualified to review (e.g., assessment of cognitive impairment or inability to perform activities of daily living due to a loss of functional capacity).
- j. The independent review organization shall provide a description of the policies and procedures employed to protect confidentiality of protected health information, in accordance with federal and state law.
- k. The independent review organization shall provide a description of its quality assurance program.
- l. The independent review organization shall provide the names of all corporations and organizations owned or controlled by the independent review organization or which own or control the organization, and the nature and extent of any such ownership or control. The independent review organization shall ensure that neither it, nor any of its employees, agents, or licensed health care professionals utilized are not a subsidiary of, or owned or controlled by, an insurer or by a trade association of insurers of which the insured is a member.
- m. The independent review organization shall provide the names and resumes of all directors, officers and executives of the independent review organization.

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

1988 Proc. I 9, 20-21, 629-630, 652, 656-661 (adopted).
1989 Proc. I 9, 24-25, 703, 754-755, 791-794 (amended).
1989 Proc. II 13, 23-24, 463, 476-477, 484-493 (amended and reprinted).
1990 Proc. I 6, 27-28, 477, 541-542, 545-556 (amended and reprinted).
1990 Proc. II 7, 16, 600, 617, 649 (amended).
1991 Proc. I 9, 17-18, 609-610, 662, 672-687 (amended and reprinted).
1992 Proc. I 86, 95, 914, 954, 963, 967-982, 987 (amended and reprinted).
1992 Proc. II 9, 11, 672, 687, 696 (amended).
1993 Proc. I 8, 136, 819, 843-844, 846-848 (amended).
1993 Proc. Ist Quarter 3, 34, 267, 274, 276 (amended).
1994 Proc. Ist Quarter 4, 39, 446-447, 451, 457-459 (amended).
1994 Proc. Ist Quarter 17, 26, 713-714, 722, 731, 737, 739-761 (amended and reprinted).
1995 Proc. 2nd Quarter 2, 36, 533, 651, 653-659 (amended).
1996 Proc. 2nd Quarter 10, 33, 731, 812, 825 (amended).
1997 Proc. Ist Quarter 54, 55, 56, 57, 700, 704-714 (amendments on life/long-term care).
1997 Proc. Ist Quarter 759, 771-772 (discussed amendments on personal worksheet).
1997 Proc. 2nd Quarter 25-26, 676 (amendments on personal worksheet adopted).
1998 Proc. Ist Quarter 15, 17, 769, 800, 894 (amended).
1999 Proc. Ist Quarter 18, 929, 969, 972, 978-991 (amended).
2000 Proc. 2nd Quarter 21-22, 162, 292-309 (amended).
2001 Proc. Ist Quarter 6, 14, 208, 285, 304-306 (amended).
2006 Proc. Ist Quarter 44, 61-122 (amended).
2009 Proc. 3rd Quarter (amended).
2014 Summer National Meeting (amended).

Long-Term Care Insurance Model Regulation

This page is intentionally left blank

LONG-TERM CARE INSURANCE MODEL REGULATION

These charts are intended to provide the readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings which are related to the NAIC model. Such guidance provides the reader with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has made an interpretation of adoption or related state activity based on the definitions listed below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

This state page does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist the reader in targeting useful information. For further details, the laws cited should be consulted. The NAIC attempts to provide current information; however, due to the timing of our publication production, the information provided may not reflect the most up to date status. Therefore, readers should consult state law for additional adoptions and subsequent bill status.

LONG-TERM CARE INSURANCE MODEL REGULATION

This page is intentionally left blank

LONG-TERM CARE INSURANCE MODEL REGULATION

KEY:

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

RELATED STATE ACTIVITY: States that have citations identified in this column have not adopted the most recent version of the NAIC model in a substantially similar manner. Examples of Related State Activity include but are not limited to: An older version of the NAIC model, legislation or regulation derived from other sources such as Bulletins and Administrative Rulings.

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

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama		ALA. ADMIN. CODE r. 482-1-091-.32 to 482-1-091-.36 (1990/2009) (previous version of model).
Alaska	NO CURRENT ACTIVITY	
American Samoa	NO CURRENT ACTIVITY	
Arizona		ARIZ. ADMIN. CODE §§ 20-6-1001 to 20-6-1024 (1992/2005) (previous version of model); BULLETIN 2009-5 (2009).
Arkansas		ARK. CODE R. § 13 (1990/2008) (previous version of model).
California		CAL. INS. CODE §§ 10230 to 10237.6 (1988/2013) (previous version of model).
Colorado		3 COLO. CODE REGS. § 702-4:4-4-1 (1997/2011); COLO. CODE REGS. § 702-4:4-4-4 (2010/2013) (LTC partnership program); BULLETIN B-1-20 (2007); BULLETIN B-4.27 (2010/2012); BULLETIN B-4.30 (2012).

LONG-TERM CARE INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Connecticut		CONN. AGENCIES REGS. §§ 38a-501-8 to 38a-501-24 (1994/2013) (Individual); §§ 38a-528-1 to 38a-528-17 (1994/2013) (Group) (previous version of model).
Delaware		18 DEL. CODE REGS. § 1404 (1990/2010) (portions of previous version of model). BULLETIN 23 (2006).
District of Columbia		D.C. MUN. REGS. tit. 26, § 2600.1 (2006/2008).
Florida		FLA. ADMIN. CODE ANN. r. 690-157.001 to 690-157.023 (1989/2012) (previous version of model); §§ 690-157.101 to 690-157.122 (2003/2013) (previous version of model).
Georgia		GA. COMP. R. & REGS. 120-2-16-.01 to 120-2-16-.34 (1989/2009) (previous version of model).
Guam	NO CURRENT ACTIVITY	
Hawaii		HAW. REV. STAT. §§ 431:10H-201 to 431:10H-402 (2000/2014) (previous version of model).
Idaho		IDAHO ADMIN. CODE r. 60.18.01.60 (1990/2007) (previous version of model); BULLETIN 2007-7.
Illinois		ILL. ADMIN. CODE tit. 50, §§ 2012.10 to 2012.150 (1990/2014) (previous version of model).
Indiana		760 IND. ADMIN. CODE 2-1-1 to 2-20-42 (2007) (previous version of model).

LONG-TERM CARE INSURANCE MODEL REGULATION

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

LONG-TERM CARE INSURANCE MODEL REGULATION

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

LONG-TERM CARE INSURANCE MODEL REGULATION

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

LONG-TERM CARE INSURANCE MODEL REGULATION

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 1. Purpose

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

Section 2. Authority

Section 3. Applicability and Scope

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

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

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 3 (cont.)

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

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

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

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

Section 4. Definitions

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

Section 5. Policy Definitions

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 5 (cont.)

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

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

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

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

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

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

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

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

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

Section 6. Policy Practices and Provisions

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 6A (cont.)

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

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

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

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

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

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

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

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

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

The existing section was superseded by an entirely new Section 6D in December of 1988. The section now mandates provision for continuation or conversion. The regulation provides a right to continuation by whatever means and reasonably approximates a guaranteed renewable individual policy. One other significant provision of the section is that an individual will be able to continue coverage at entrance age and the benefits will be identical to or determined by the commissioner to

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 6D (cont.)

be substantially equivalent. There was discussion on whether language should be included in the model to require a secondary carrier to reserve prior to its responsibility for continuing coverage. This is an item that the insurer should resolve, according to members of the working group. It was suggested that a future modification would be language requiring the insurer to notify certificate holders of their right to continuation or conversion of their policy at the time of termination. 1989 Proc. I 761-762.

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

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

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 6F (cont.)

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

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 6F (cont.)

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 6F (cont.)

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 6F (cont.)

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 6F (cont.)

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

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

The task force chair pointed out that no state had yet adopted the rate stability provisions in the model and he stated the model may have gone too far and created too large an impact on premiums. Several regulators agreed that discussion needed to be reopened on this issue. 1997 Proc. 1st Quarter 761.

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 6F (cont.)

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 6F (cont.)

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

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 6G (cont.)

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

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

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

Section 7. Unintentional Lapse

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 7 (cont.)

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

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

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

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

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

Consumer representatives and insurance industry representatives met to draft compromise language that removed the responsibility of proving cognitive impairment from the insured. The language presented to the task force was satisfactory to both groups and was then adopted by the task force. 1997 Proc. 1st Quarter 775.

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 8. Required Disclosure Provisions

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

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

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

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

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

Section 9. Required Disclosure of Rating Practices to Consumer

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 9 (cont.)

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

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 9 (cont.)

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 9 (cont.)

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

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

Section 10. Initial Filing Requirements

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

Section 11. Prohibition Against Post Claims Underwriting

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 11C (cont.)

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

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations

Cited to the Proceedings of the NAIC

Section 12 (cont.)

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

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

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

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

Section 13. Requirement to Offer Inflation Protection

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 13 (cont.)

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

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 13G (cont.)

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

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

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

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

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

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

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

Section 14. Requirements for Application Forms and Replacement Coverage

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 14 (cont.)

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

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

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

Section 15. Reporting Requirements

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 16. Licensing

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

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

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

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

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

Section 17. Discretionary Powers of Commissioner

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 18. Reserve Standards

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

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

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

Section 19. Loss Ratio

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 19 (cont.)

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

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 19 (cont.)

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

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

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

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

Section 20. Premium Rate Schedule Increases

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 20 (cont.)

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

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

Section 21. Filing Requirement

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

Section 22. Filing Requirement for Advertising

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

Section 23. Standards for Marketing

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 23 (cont.)

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

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

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

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 23 (cont.)

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

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

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

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

Section 24. Suitability

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 24 (cont.)

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 24 (cont.)

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 24 (cont.)

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 24B (cont.)

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

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

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

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

The chair said the working group had several options: (1) no exemption for the group market; (2) exempt the entire group market; (3) exempt active employees; (4) exempt active employees and their spouses; (5) exempt employer groups; or (6) exempt guaranteed issue policies. He said he was comfortable with exempting the group market from a requirement to use the personal worksheet, but he felt they should get the disclosure form.

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 24B (cont.)

Another regulator saw a need for parents and relatives to get the information. One attendee suggested exempting individuals who were below a certain age from the personal worksheet requirements whether they were in the individual or group market. One company representative opined that it was a violation of age discrimination laws to treat older employed persons differently than younger employed persons. Another person suggested that exempting active employees and their spouses would alleviate the problem and another suggested exempting persons who were actively at work, even if they were in the individual market. The working group agreed to exempt long-term care insurance policies sold through an employer group to active employees and their spouses from a requirement to obtain a personal worksheet from each applicant. The worksheet would be provided to people of all ages. 1994 Proc. 3rd Quarter 620.

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 26. Nonforfeiture Benefit Requirement

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

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 26B (cont.)

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

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

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

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 26B (cont.)

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

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

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

D. The provisions of the new Subsection D adopted in 1998 contained brackets for premium changes at younger ages and then changed every year to age 90. The task force noted it was trying to protect the older population from significant rate increases that could result in lapse with no benefits for premiums previously paid. 1997 Proc. 1st Quarter 776.

E. When originally developing nonforfeiture benefits, there was a strong preference of the task force that only one scale of nonforfeiture values be used. There were two choices theoretically possible: (1) as a percent of the benefit period (so that the actual benefit would vary according to the duration of benefit provided), or (2) as a fixed benefit period (so that all insured would receive the same nonforfeiture benefit, regardless of the actual duration of the benefits that would have been available during the premium-paying period).

Given that the nonforfeiture benefits purchased by asset shares increase for all attained ages as the underlying benefit period increases, it seemed most appropriate to express the nonforfeiture benefit as a percentage of the benefit period. 1993 2nd Quarter 753.

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 26E (cont.)

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 26E (cont.)

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

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 26E (cont.)

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations

Cited to the Proceedings of the NAIC

Section 26E (cont.)

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

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

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

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

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

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

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

G. One of the principles agreed upon by the working group was that there should be no difference in the nonforfeiture benefits mandated for group and individual policies. One regulator expressed concern that the inclusion of high nonforfeiture values in group policies would discourage employer group products with a significant employer contribution. Another regulator pointed out that the current tax law is a significant deterrent for policies with employer contributions and that until the tax code is changed, employers are not likely to pay premiums on behalf of employees.

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 26G (cont.)

She expressed concern about the applicability of nonforfeiture values for a certificateholder that converts from a group policy. An insurer representative said that the conversion could be based on the original purchase date of the group coverage. 1994 Proc. 1st Quarter 463.

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

Section 27. Standards for Benefit Triggers

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

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 27 (cont.)

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

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

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

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

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

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

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

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

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

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

Later there was discussion regarding whether a carrier had the ability to require that certifications of inability to perform ADLs had to be performed by health care professionals hired by the insurer. A consumer advocate said it was dangerous to force people to use carrier providers that are paid by the insurer. She stated that tax-qualified plans are indemnity products, not managed care products.

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 28E (cont.)

She believed it was a conflict of interest for the carrier that is liable to pay benefits to have control of the process regarding whether the benefits can be accessed. 1999 Proc. 2nd Quarter 662.

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

Section 29. Standard Format Outline of Coverage

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

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 29 (cont.)

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

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

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

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

Section 30. Requirement to Deliver Shopper's Guide

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 31. Penalties

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

Section []. [Optional] Permitted Compensation Arrangements

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

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

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

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

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

Appendix A

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Appendix B

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Appendix B (cont.)

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Appendix B (cont.)

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Appendix B (cont.)

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

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Appendix B (cont.)

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

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

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

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

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

Appendix C

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Appendix C (cont.)

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

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

Appendix D

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

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

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

Appendix E

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Appendix E (cont.)

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

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

Appendix F

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

Appendix G

A consumer advocate submitted a letter to the task force regarding reporting requirements for long-term care insurance companies. She expressed concern that the NAIC Long-Term Care Insurance Model Regulation required annual reporting of replacement, lapse, denied claims and agent replacement activity, but contained only one reporting form that was specific to denied claims. The chair stated that Section 15 of the model regulation required the reporting of the specific data. He asked the NAIC staff to reconcile the requirements in the model and in the current reporting form to determine what data was actually captured and to offer recommendations as to how the states could accurately capture this information. 2001 Proc. 1st Quarter 183.

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Chronological Summary of Actions

December 1987: Model regulation adopted.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations
Cited to the Proceedings of the NAIC

Chronological Summary (cont.)

December 1997: Amended personal worksheet (Appendix B).

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

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

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

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

LONG-TERM CARE INSURANCE MODEL REGULATION

Proceedings Citations
Cited to the Proceedings of the NAIC

This page is intentionally left blank