

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**STATE REGULATION
OF LONG-TERM CARE INSURANCE**



**Richard P. Kusserow
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Department of Health and Human Services

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EXECUTIVE SUMMARY

PURPOSE

The purpose of this inspection was to obtain current information on consumer problems and State regulation of private long-term care (LTC) insurance.

BACKGROUND

This inspection was requested by Congressman Ron Wyden, Chairman of the House Small Business Subcommittee on Regulation, Business Opportunities, and Energy.

Long-term care insurance policies provide "coverage for not less than 12 consecutive months...for one or more necessary...diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital." ¹ Long-term care insurance has grown significantly only recently. The number of LTC policies has increased from 125,000 in 1986 to more than 1.6 million in 1990.

In 1986, the National Association of Insurance Commissioners (NAIC) developed the first Long-Term Care Insurance Model Act in collaboration with the Department of Health and Human Services (HHS) and insurance industry representatives. The following year, it issued its first model regulation. The model act and regulation provide States with minimum standards to use in crafting LTC insurance laws and regulations. The NAIC modifies the model act and regulation frequently to improve policyholder coverage and strengthen consumer protection. Both were revised most recently in December 1990. A lag exists before States adopt model changes, and new State standards usually do not apply to policies already in effect.

While States have primary responsibility for regulating private insurance, the Federal government has played a role in regulating Medicare supplemental insurance, commonly known as Medigap insurance. In 1980, Congress enacted the Baucus amendment to the Social Security Act. The amendment defines minimum standards that policies must meet before they can be marketed as certified Medigap policies. Congress enacted further Medigap controls in the Omnibus Budget Reconciliation Act of 1990. Currently, no Federal laws govern LTC insurance.

¹As defined in section 4A of the NAIC Long-Term Care Insurance Model Act.

METHODOLOGY

In order to answer Congressman Wyden's questions about State LTC insurance regulation, we (1) analyzed all 50 States' LTC insurance laws and regulations, (2) requested complaint and enforcement data from all State insurance commissioners, and (3) conducted telephone interviews with State insurance regulators and counselors in 8 States. We also conducted telephone interviews with NAIC officials, two industry representatives, and representatives of five national and three State consumer advocate organizations.

FINDINGS

Only 17 States substantially meet both the model act and model regulation standards.

We considered a State to "substantially meet" the model act and regulation if its provisions conform with all applicable sections of the model act or regulation even though the State language varies. We considered a State to "partially meet" the standards if its provisions conform with only a portion of the model act or regulation.

Although all 50 States have LTC insurance laws, only 17 States substantially meet both the model act and the model regulation minimum standards. Specifically,

- ▶ 25 States substantially meet and 20 States partially meet the model act minimum standards, and
- ▶ 18 States substantially meet and 10 States partially meet the model regulation minimum standards.

State totals reflect State laws and regulations that had been adopted through March 1991. Of all 50 States, 8 States are considering stronger LTC insurance laws, and 14 are considering stronger regulations.

Long-term care insurance complaint data are incomplete and inconclusive.

Twenty-one States reported receiving a total of 840 complaints in 1990. The major categories of complaints are: (1) claims handling delays, (2) premium and refund disputes, and (3) agent misrepresentation. Seventeen States were unable to provide complaint data because (1) they do not keep separate LTC insurance information, or (2) the data were not readily accessible. Twelve States did not respond to our request for complaint data.

States report little enforcement action against LTC insurance companies and agents.

Only 10 of the 30 States that responded to our request were able to provide data on the number of administrative and enforcement actions they had taken against LTC insurance companies and agents. Four States reported 26 actions in 1990, and 6 States said they had taken no action. Penalties included monetary fines, license suspensions and revocations, and cease and desist orders. Twenty States do not maintain readily available enforcement data for LTC insurance.

Almost all of the insurance counselors, consumer advocates, and industry representatives believe that State enforcement and monitoring need to be strengthened. Insurance regulators in four of the eight sample States volunteered that resource constraints prevent them from adequately enforcing their LTC insurance laws and regulations.

MATTERS FOR CONGRESSIONAL CONSIDERATION

If Congress decides to impose minimum Federal standards for LTC insurance, it should consider that:

- ▶ strong laws and regulations will have limited effectiveness if they are not adequately monitored and enforced,
- ▶ minimum standards may improve consumer protection in some States,
- ▶ opinion is divided on whether the NAIC model act and regulation provide adequate consumer protection,
- ▶ mandating more stringent consumer protection may increase premiums, and
- ▶ minimum standards should allow insurers flexibility to develop innovative products that could benefit consumers.

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INTRODUCTION

OBJECTIVES

We conducted this inspection at the request of Congressman Ron Wyden, Chairman of the House Small Business Subcommittee on Regulation, Business Opportunities, and Energy. In January 1991, he asked the Office of Inspector General (OIG) to obtain current information on consumer problems and State regulation of private long-term care (LTC) insurance. Specifically, he asked the OIG to:

- ▶ assess the extent to which States have adopted the National Association of Insurance Commissioners (NAIC) Long-Term Care Insurance Model Act and Model Regulation or other significant laws or regulations;
- ▶ document the nature and range of consumer complaints about LTC insurance;
- ▶ determine how States monitor compliance with and enforce their LTC insurance laws and regulations; and
- ▶ obtain the views of selected regulatory officials, insurance counselors, consumer advocates, and industry representatives regarding (1) the major problems consumers are experiencing with LTC insurance, (2) the adequacy of State regulation, and (3) the need for reform.

BACKGROUND

Long-term care insurance policies provide "coverage for not less than 12 consecutive months...for one or more necessary...diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital."¹ These policies vary in terms of (1) the services they cover, (2) the amounts they pay per day, (3) the duration of coverage, and (4) coverage conditions or other restrictions.

The need for long-term care is growing. During the past decade, life expectancies have increased and hospitals have discharged patients earlier to contain costs. While an individual's need for long-term care may be temporary, consumers purchase insurance to guard against financial ruin.

Long-term care insurance has grown significantly only recently. According to a 1989 General Accounting Office (GAO) report, only a few companies offered policies

¹As defined in section 4A of the NAIC Long-Term Care Insurance Model Act.

before 1986 when approximately 125,000 policies were in effect.² As of July 1990, more than 100 companies underwrote more than 1.6 million LTC insurance policies.³

State Regulation and the NAIC Model Act and Regulation

States have primary responsibility for regulating the insurance industry. The NAIC provides a forum for State insurance officials to discuss common problems, standardize the annual reporting of financial information by insurance companies, and develop model legislative acts for adoption by the States.

In 1986, NAIC developed its first model act which provides States with minimum standards to use in crafting LTC insurance laws and regulations. The model act's goals are to (1) protect policy applicants from unfair or deceptive sales or enrollment practices, (2) facilitate public understanding and the comparison of policies, and (3) encourage flexible and innovative policy coverage. In 1987, NAIC issued its first LTC insurance model regulation, which provides requirements specifically for implementing the model act.

State insurance regulators, industry representatives, consumer advocates, and officials from the Department of Health and Human Services (HHS) participated in drafting the model act and regulation. The NAIC modifies the model act and regulation frequently to improve policyholder coverage and strengthen consumer protection. Both were last revised in December 1990. A lag exists before States adopt model act and regulation changes, and new State standards usually do not apply to policies already in effect. Neither the NAIC nor States know what percentage of policies, currently in effect, meet NAIC standards.

Federal Regulation

While States have primary responsibility for regulating the private insurance market, the Federal government has played a role in regulating Medicare supplemental insurance, commonly known as Medigap insurance. In 1980, Congress enacted the Baucus Amendment of the Social Security Act establishing minimum standards that policies must meet before they can be marketed as certified Medigap policies. Congress enacted additional Medigap controls in the Omnibus Budget Reconciliation Act of 1990. Currently, no Federal laws govern LTC insurance.

²Long-Term Care Insurance: State Regulatory Requirements Provide Inconsistent Consumer Protection, General Accounting Office, April 1989

³The Federal Role in Consumer Protection and Regulation of Long Term Care Insurance, Departmental Work Group on Consumer Protection and Long Term Care Insurance, U. S. Department of Health and Human Services, January 1991, p. 1

Previous Studies of LTC Insurance Regulation and Consumer Complaints

During the past 3 years, Congress and others have undertaken several studies concerning long-term care:

- ▶ **House Aging Subcommittee on Health and Long-Term Care Report on Private LTC Insurance**

In May 1989, the House Aging Subcommittee on Health and Long-Term Care, chaired by Congressman Claude Pepper, issued a report entitled "Private Long-Term Care Insurance: Unfit for Sale?" The Subcommittee found that, in 1987, 70 percent of the States had no LTC insurance laws or regulations and only 14 percent had any professional staff specifically assigned to LTC insurance issues.

- ▶ **GAO Studies on State Regulatory Requirements for LTC Insurance**

An April 1989 GAO survey of all 50 States found that (1) about half the States had adopted LTC insurance legislation, (2) legislation varied in the extent to which it met the NAIC's standards, and (3) few States maintained statistics on LTC insurance complaints. The GAO currently is studying eight States to update its information.

- ▶ **House Energy and Commerce Subcommittee on Oversight and Investigations Survey of LTC Complaints**

The House Energy and Commerce Subcommittee on Oversight and Investigations, chaired by Congressman John Dingell, surveyed States to identify LTC insurance complaints and State responses. In a 1990 hearing, Congressman Dingell expressed concern that (1) States did not identify complaints by type of policy, and (2) State regulation continues to be inadequate. Other Subcommittee concerns include duplicate coverage, inappropriate movement of consumers from one policy to another, lack of clearly defined policy benefits, and lack of sanctions against agents and insurers who mislead consumers.

- ▶ **American Association of Retired People/Project Hope Study of State Regulation of LTC Insurance**

The American Association of Retired People has hired Project Hope to (1) survey all 50 States to evaluate conformity of State laws with NAIC's model act and regulation and (2) assess the adequacy of State regulatory activity.

► **House Joint Survey of State Insurance Regulatory Agencies**

The House Aging Subcommittee on Health and Long-Term Care, chaired by Congressman Edward R. Roybal, and the House Small Business Subcommittee on Regulation, Business Opportunities, and Energy, chaired by Congressman Ron Wyden, are conducting a direct survey of State insurance departments to obtain information about their regulation of LTC insurance policies. In March 1991, Congressmen Wyden and Roybal jointly requested information on issues including budget levels, complaint data, agent regulation, and loss ratios.

METHODOLOGY

Congressman Wyden asked the OIG to answer a series of questions about each State's LTC insurance laws and regulations. Although NAIC's model act and regulation were amended most recently in December 1990, we based our analysis primarily on the January 1990 model language because States have not yet had sufficient time to adopt the December amendments. Congressman Wyden's questions cover most key issues pertaining to individual LTC insurance policies included in the model act and regulation. We did not review provisions dealing with group policies.

Since some applicable laws and regulations are found in other sections of State insurance codes, we sent each State a copy of our analysis which was based on the LTC laws and regulations on file with NAIC. We asked the State to verify our analysis and identify any other relevant provisions in the insurance codes. Three States (Alaska, New Jersey, and Nevada) did not respond. Two States (North Dakota and New Mexico) responded too late for their verification to be included in this report. Where necessary, we conducted telephone interviews to clarify the States' responses.

We conducted detailed telephone interviews with eight State insurance regulators in eight sample States. We selected the States based on (1) the extent to which they have adopted strict LTC insurance laws and regulations and (2) the prevalence of LTC insurance counseling programs. The States with strong laws and regulations are Massachusetts, Minnesota, New York, and Wisconsin. The States with weak laws and regulations are Kentucky, Maryland, Texas, and Utah. The States with counseling programs are Maryland, Massachusetts, Texas, and Wisconsin.

We conducted additional telephone interviews with NAIC officials, six state insurance counselors, two industry representatives, and representatives of five national and three State consumer advocate organizations. Whenever possible, we coordinated with GAO and other agencies that are studying LTC insurance regulation. In selecting our sample of eight States for detailed interviews, we did not duplicate the eight States in GAO's current survey.

FINDINGS

Only 17 States substantially meet both the model act and model regulation standards.

The model act contains some provisions, such as a prohibition against requiring prior hospitalization that are not incorporated in the model regulation. On the other hand, some important provisions, such as inflation protection and post-claims underwriting, are included only in the model regulation. Thus, some States may comply with the act but not the regulation and vice versa.

Although all 50 States have LTC insurance laws, only 17 States substantially meet both the model act and model regulation minimum standards.⁴

STATE COMPLIANCE WITH MODEL ACT AND REGULATION

<u>Requirement</u>	<u>Number of States in Compliance</u>	
	<u>Act</u>	<u>Regulation</u>
Substantially meet	25	18
Partially meet	20	10
Generally do not meet	5	22

These totals reflect laws and regulations that States had adopted through March 1991. Of all 50 States, 8 are considering stronger LTC insurance laws, and 14 are considering stronger regulations. It is possible that more States would meet model act and regulation standards if pending proposals are adopted. Appendix A details the extent to which States have implemented specific provisions.

Long-term care insurance complaint data are incomplete and inconclusive.

Only 21 States provided complaint data. They received a total of 840 complaints in 1990, a 78 percent increase from 1988.

STATE COMPLAINT DATA ARE INCOMPLETE

	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>TOTAL</u>
States reporting	10	15	21	n/a
Number of complaints	471	756	840	2067

⁴We considered a State to "substantially meet" the model act and regulation if its provisions conform with all applicable sections of the model act or regulation even though the State language varies. We considered a State to "partially meet" a standard if its provisions conform with only a portion of the model act and regulation.

COMPLAINTS REPORTED TO STATES IN 1990

<u>Common complaints</u>	<u>Number</u>
Claim delays	104
Premium and refund disputes	73
Agent misrepresentation/misconduct	61
Marketing and sales practices	59
Claim denials	52
Poor policyholder service	44
Unsatisfactory settlements	14
Recisions	12
Refusals to insure	9
Other	24
Noncategorized complaints	<u>388</u>
Total	840

Seventeen States were unable to provide complaint data because they do not keep separate LTC insurance information or could not readily access the data. Twelve States did not respond to our request for complaint data.

The NAIC is developing a pilot project to track complaints in the "senior market" (i.e., both LTC and Medigap). It is requesting that all States use a standardized complaint form to ensure systematic collection of comparable data and to allow for automation.

Three of the State insurance commission staff and three of the consumer advocates attributed the small number of reported complaints to the fact that LTC insurance policies have become more common only recently. They believe problems may not surface in significant numbers until current purchasers begin filing claims many years from now. Two insurance commission staff attributed the small number of complaints to their States' strict LTC insurance laws and regulations.

States report little enforcement action against LTC insurance companies and agents.

Of the 30 States that responded to our request for enforcement data, only 10 were able to provide the number of administrative and enforcement actions they had taken against LTC insurance companies and agents. Four States reported 26 actions in 1990, and 6 States said they had taken no action. Penalties included monetary fines, license suspensions and revocations, and cease and desist orders. Twenty States said they do not maintain readily available enforcement data for LTC insurance.

Almost all of the insurance counselors, consumer advocates, and industry representatives believe that State enforcement and monitoring need to be strengthened. Insurance regulators in four of the eight sample States volunteered that resource constraints prevent them from adequately enforcing their LTC insurance laws and regulations.

MATTERS FOR CONGRESSIONAL CONSIDERATION

If Congress decides to impose minimum Federal standards for LTC insurance, it should consider the following:

- ▶ Strong laws and regulations will have limited effectiveness if they are not adequately monitored and enforced. Almost all the industry representatives, consumer advocates, and insurance counselors believe that State monitoring and enforcement of LTC insurance needs to be strengthened. A typical comment came from a Health Insurance Association of America official: "What we need is not new laws, but enforcement of existing laws."
 - ▶ Minimum standards may improve consumer protection in some States.
 - ▶ Opinion is divided on whether NAIC's model act and regulation provide adequate consumer protection. Industry representatives believe that NAIC's model act and regulation generally are a good basis for LTC insurance regulation. Most of the insurance counselors, consumer advocates, and State regulators believe that the model act and regulation are a good starting point. Some consumer advocates believe the model act and regulation are too weak.
 - ▶ Mandating more stringent consumer protection may increase premiums. All of the insurance counselors and consumer advocates as well as five of the eight State insurance regulators identified the high cost of premiums as a major problem. Previous studies have estimated that only 10 to 40 percent of seniors can afford private LTC insurance.⁵
- Industry representatives and State regulators also caution that overregulation could reduce the number of companies willing to offer LTC insurance. Insurance regulators in three States (Massachusetts, Minnesota, and New York) said that fewer companies are willing to sell LTC insurance in their States because of their strict requirements.
- ▶ Minimum standards should allow flexibility and innovation. The LTC insurance market is still evolving, and flexibility that allows insurers to develop innovative new products could benefit consumers.

⁵The Federal Role in Consumer Protection and Regulation of Long-Term Care Insurance, draft discussion paper, The Department Work Group on Consumer Protection and Long-Term Care Insurance, U.S. Department of Health and Human Services, January 1991, p. 1; and The Unaffordability of Nursing Home Insurance, Families USA Foundation, January 1990.

APPENDIX A

SUMMARY OF STATE LONG-TERM CARE INSURANCE PROVISIONS

This section summarizes our analysis of Congressman Wyden's specific questions. We will provide a detailed State-by-State analysis in a separate report.

Twenty-eight States require policies to be guaranteed renewable.

Section 6A of the model regulation requires individual policies to be guaranteed renewable. This means that the insurer may not (1) unilaterally change any policy provision, (2) decline to renew a policy, except for nonpayment of premiums, and (3) revise premium rates, except on a class basis.

Twenty-eight States substantially meet this model requirement. Although three States require guaranteed renewability, their definition does not meet all model regulation criteria. Three other States do not require guaranteed renewability, but insurers must meet model regulation criteria if they use the term. We found no provision in 12 States' LTC insurance laws or regulations and were unable to determine requirements for 4 States.

Section 6B of the model act contains a more limited renewability requirement which prohibits insurers from cancelling or not renewing an individual's LTC insurance policy based on age or health deterioration. All but four States substantially meet this requirement.

No State requires policies to be noncancellable.

Although neither the model act nor the model regulation requires policies to be noncancellable, section 6A of the regulation establishes a standard definition that a policy must meet if the term "noncancellable" is used: (1) the policy may not be cancelled, except for nonpayment of premiums, and (2) the insurer may not make any unilateral changes in the policy provisions or premium rate.

Although no State requires policies to be noncancellable, 23 States require policies to meet the model regulation's standard definition if the term "noncancellable" is used. Five States use a standard definition partially based on the model, and one has a stricter definition. We found no provision in 17 States and were unable to determine the requirements in 4 States.

Twenty-seven States have no post-claims underwriting provisions.

Post-claims underwriting refers to the practice of medically underwriting a policy when a claim is filed rather than at the time of application. If the insurer discovers

any "incorrect or untrue answer" in the application, the insurer may void the policy or deny the claim. The model regulation requires insurers to (1) ascertain the applicant's health condition and (2) provide disclaimers informing the consumer of the insurer's right to rescind the policy if further underwriting uncovers an untrue or incorrect statement. For applicants over the age of 80, additional medical information is required prior to the issuance of a policy.

Only 12 States have adopted the model regulation limiting post-claims underwriting. One State has a provision partially based on the model, 4 have other requirements, and 27 have no provision. We were unable to determine coverage for six States.

States conform with or exceed the NAIC contestable period standard.

The contestable period is the time during which an insurer may deny a claim or void a policy because of a misstatement that the insured made in an application.⁶ The contestable period usually appears in the general section of a State's insurance code and typically applies to all lines of life and health insurance, including LTC insurance. The NAIC's Uniform Individual Accident and Sickness Policy Provision Model Law provides for a maximum 3-year contestable period for individual policies.⁷ All the States for which information was available conform with or exceed this standard, i.e., have shorter contestable periods.

CONTESTABLE PERIOD STANDARD

<u>Requirement</u>	<u>Number of States</u>
6-month contestable period	1
2-year contestable period	20
3-year individual/2-year group	2
3-year contestable period	9
Information unavailable	18

Seventeen States require inflation protection as an optional provision.

Although the model regulation does not require that policies include inflation protection, it does require that insurers offer consumers optional protection. If offered, the inflation protection must be at least as favorable as one of the following options: (1) compounded annual increases, (2) the right to periodically increase benefit levels without requiring evidence of health status, or (3) a percentage of actual charges. The December 1990 amendments to the model regulations added the requirement that the increases be compounded annually at a rate not less than 5 percent, but did not specify an index on which to base the rate.

⁶ These time limitations generally do not apply in the case of fraudulent misstatements.

⁷ The NAIC has not established a contestable period for group policies.

Although no States require that all policies include inflation protection, 17 States require inflation protection as an optional provision. We found no provision in 28 States and were unable to determine if there was a provision in 5 States. Of the 17 States that require inflation protection as an option, 14 require compound rate increases; the other 3 require simple rate increases. Five of the 17 States specify the Consumer Price Index (CPI), the CPI for Urban Areas, or the Medical CPI as the basis for calculating interest. The other 12 States do not specify an index.

Although 20 States define skilled and intermediate care, only 4 define custodial care.

Many long-term care insurance policies contain definitions of terms such as skilled, intermediate, and custodial care. Insurers may condition eligibility and set benefit levels based on these definitions. Section 5 of the model regulation defines home health care, skilled nursing care, intermediate nursing care, personal care, and home care "in relation to the level of skill required, the nature of the care, and the setting in which care must be delivered." It also defines providers in relation to services and facilities required and the licensure or degree status of the provider. It does not define custodial care.

We found that 20 States substantially adopted the model definitions. Four States had their own specific definitions for skilled, intermediate, and custodial care. Eight States defined the terms based on State facility licensing laws or other definitions. We found no provision in 14 States' laws and regulations and were unable to determine the definitions in 4 States.

Most States prohibit prior institutionalization requirements for home care benefits.

State requirements regarding home care benefits vary greatly. Both NAIC and the States have evolved gradually--from allowing insurers to require a 3-day prior hospitalization to the current model regulation that prohibits requiring prior institutionalization for any benefits, including home care.

With exceptions, Section 6D of the model act prohibits companies from conditioning eligibility for any benefits on (1) prior hospitalization or (2) the receipt of a higher level of institutional care. Most States have adopted a provision that meets or exceeds the model act prohibition. The following table summarizes the State laws and regulations.

PROHIBITION AGAINST REQUIRING PRIOR CONFINEMENT

<u>Requirement</u>	<u>Number of States</u>
Conforms with or exceeds the model act prohibition	29
Prohibits prior hospitalization only	9
Allows prior hospitalization or institutionalization if an identical policy is offered that prohibits prior hospitalization or institutionalization	4
No provision found	7
Unable to determine	1

Most States prohibit the sale of LTC insurance policies that limit coverage to skilled nursing care only or offer more generous coverage for skilled than nonskilled care.

Section 6B(3) of the model act states that "no LTC insurance policy shall provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care." It does not define or specify a measurement for "more coverage."

Several States require that coverage be measured by the number of days of care. We found that 44 States have prohibited policies that limit coverage to skilled nursing care only. We found no provision in five States and were unable to determine coverage in one State.

Thirty-eight States also have provisions prohibiting policies that provide significantly more coverage for skilled care in a facility than coverage for lower levels of care. One State allows significantly greater coverage. Another State has no provision but would reject a policy if the benefits were unreasonable. Nine states have no provisions. We were unable to determine the provision in one State.

While all States have maximum preexisting condition exclusion periods, 23 do not meet current NAIC standards.

Section 6C of the model act requires that individual policies use a definition of "preexisting condition" no more restrictive than: "... a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services, within six (6) months preceding the effective date of coverage on an insured person." The act further prohibits policies from excluding coverage for a preexisting condition unless loss or confinement begins within 6 months following the effective date of coverage of an insured person.

Although all 50 States limit preexisting condition exclusions, 23 States do not conform with NAIC's model act. For example, previous versions of the model act defined preexisting conditions as the presence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care, or treatment. Although this definition has been eliminated, nine States still include it. Another 14 States have provisions which do not conform with the model act because they contain prior coverage restrictions which depend on the policyholder's age or some other variation.

Most States require coverage for Alzheimer's disease and related dementia.

Model regulation sections 6B(2) and 16E10 specifically require coverage for Alzheimer's disease and related degenerative and dementing illnesses. Most States require coverage for these conditions.

ALZHEIMER'S AND DEMENTIA COVERAGE

<u>Requirement</u>	<u>Number of States</u>	
	<u>Alzheimer's</u>	<u>Dementia</u>
Specific coverage required	36	30
State indicates it requires coverage based on other laws/regulations	5	2
No specific coverage requirement	8	13
Unable to determine	1	5

Although most States require insurers to cover Alzheimer's disease and related dementia, insurers may use other allowed policy restrictions (e.g., medical necessity, preexisting conditions) to deny claims. An industry representative identified this as an important loophole that should be closed.

Although 48 States require standard outlines of coverage, only 11 substantially meet all model act and regulation requirements.

Section 6G of the model act requires that insurers furnish applicants a standard outline of coverage before a sale is made. Section 16 of the model regulation prescribes a standard format for the outline of coverage.

REQUIRE STANDARD OUTLINE OF COVERAGE PRIOR TO SALE

<u>Requirement</u>	<u>Number of States</u>
Substantially meet model act and regulation	11
Partially meet model act and regulation	33

Require standard outline, but do not specify when it must be provided	2
Require standard outline, but allow it to be delivered after sale (at time policy is delivered)	2
No outline requirement found	2

Nineteen States require that life insurance policies providing long-term care benefits conform to the model act and regulation.

The model act (section 4A) defines LTC insurance as including LTC coverage or supplemental coverage that is provided as a benefit in a life insurance policy. For a State to substantially conform with the model act and regulation, its definition of LTC insurance must include life insurance policies that provide or supplement long-term care insurance.

REGULATION OF LIFE INSURANCE POLICIES THAT PROVIDE LONG-TERM CARE BENEFITS

<u>Requirement</u>	<u>Number of States</u>
Provision substantially based on model	14
No provision found, but State reports life insurance policies are covered by LTC laws/regulations	5
Other provision in laws not based on model	5
No provision found	19
Unable to determine	7

Only 11 States specifically require policy summaries for life insurance policies that provide LTC benefits.

Section 6I of the model act requires that, if a life insurance policy provides LTC benefits, a policy summary must be provided to the applicant at the time the life insurance policy is delivered. The policy summary is similar to the required outline of coverage in intent, but it also includes a detailed explanation of how long-term care benefits interact with the rest of the life insurance policy. Some States believe that the policy summary requirement duplicates the requirement for an outline of coverage.

Only 11 States specifically require policy summaries. Seven more require delivery of some sort of outline or summary with a life insurance policy. We did not find a provision in 25 States and were unable to determine coverage in 7 states.

Seven States mandate standard or minimum LTC benefit packages.

Three States mandate standard benefit packages for all LTC insurance. Minnesota establishes two long-term care insurance policy categories and sets minimum standards and minimum coverage for each. New York mandates specific coverage and payment amounts, and Wisconsin mandates a detailed list of coverage agreements and payment amounts. Four States have mandated minimum benefit packages, and three States have mandated partial benefit packages for home care services. Thirty-four States have not mandated a standard benefit package. We were unable to determine coverage in six States.

Industry and consumer representatives disagree on the value of mandating benefit packages. According to industry representatives, such a mandate may drive some insurers from the market. They argue that no one policy is best for everyone because people's needs vary based on their financial and family resources, health, and other circumstances. On the other hand, national consumer advocates urge greater standardization.

Thirty-one States have minimum loss ratio requirements that meet model regulation standards.

Section 6E of the model act authorizes the State insurance commissioner to establish loss ratio (i.e., benefits paid out divided by premiums earned) standards for long-term care insurance policies. Section 14 of the model regulation requires the expected loss ratio for individual policies to be at least 60 percent.

Approximately half of the individuals we interviewed volunteered an opinion that States should not currently emphasize loss ratio regulation because LTC insurance is too new to calculate loss ratios precisely. Because of the substantial lag time between purchase and use, neither companies nor regulators can project anticipated claims or premiums. An industry representative stated that with the declining average age of individuals purchasing LTC insurance policies, "actual loss ratio experience will take a minimum of 10 years to develop." A State insurance commission representative noted, "...we want the companies to be around to pay benefits, and if we are too tough in loss ratio requirements in the early years by making companies sell only to high-risk people at first, then the companies may go under."

Thirty-one States have loss ratio requirements set at least as high as the model regulation's suggested 60 percent. Seven States have established loss ratios at less than 60 percent. Four of these base their loss ratios on the different terms of renewability; for example, 50 percent for optional renewability, 55 percent for guaranteed renewability, and 60 percent for noncancellable policies. Eight States

have the authority to establish loss ratios but have not done so. We found no provision in two States and were unable to determine requirements in two States.

Eleven States reported specific procedures for loss ratio enforcement.

Although the model act and regulation do not provide specific procedures for enforcing LTC insurance loss ratios, general provisions in most State insurance codes cover enforcement. No States reported taking any actions concerning loss ratio enforcement, although 11 have specific enforcement procedures. Oklahoma and Wisconsin indicated that they annually review loss ratios. Most other States review them only upon initial rate filing and when insurers seek rate increases. If the loss ratio is not met, States usually require rate reductions. They also can impose penalties.

Thirty States consider expected premiums and claims when evaluating loss ratios.

Calculation of LTC insurance loss ratios is a complex task. Since policies usually are bought years before a claim is filed and since LTC insurance policies are so new, quantitative descriptions of expected premiums earned and benefits paid out may not be accurate. At present, 30 States use expected premiums and claims to measure loss ratios. Four States consider both actual and expected claims and benefits, and three consider only actual. We found no provisions in eight States and were unable to determine coverage in five States.

Nine States mandate refunds to policyholders when loss ratios are not met.

The model act and regulation do not require that States mandate refunds to policyholders if loss ratios are not met. However, nine States have adopted such a requirement. The refund usually is granted in one of three forms--premium reduction, cash refund, or extra benefits. Three of the nine States have specific regulations calling for refunds. The remaining six States have laws but no implementing regulations. We found no provisions in 33 States and were unable to determine coverage in 8 States.

Sixteen States have strict prior rate approval requirements.

Under a prior rate approval system, policy rates are reviewed and approved by the State before a LTC insurance policy can be issued. Under a "file-and-use" system, an insurer submits the rate to the State and, if the rate is not specifically disapproved, proceeds to issue LTC insurance policies. Most States specify a period (usually 30 to 60 days) within which the regulatory agency must act on a company's request.

The model act and regulation do not address the issue of prior rate approval for LTC insurance. According to NAIC, most States require rate approval in the general insurance codes. We were able to identify only one State (Rhode Island) that specifically requires rate approval as part of its LTC insurance provisions.

PRIOR RATE APPROVAL/FILE-AND-USE REQUIREMENTS

<u>Requirement</u>	<u>Number of States</u>
State has a strict prior rate approval requirement	16
Prior approval in practice, but State technically allows file-and-use	9
State allows file-and-use	5
Dual option--prior approval or file-and-use depending upon whether insurer has met specified criteria	2
State does not approve rates	2
Unable to determine	16

While all States have fiscal solvency requirements, none has specific provisions for long-term care insurance.

According to NAIC, all States have fiscal solvency requirements that apply to all lines of insurance. No States have fiscal solvency requirements that are specific to LTC insurance.

Regulation of solvency is complex and detailed, involving legal criteria, surveillance, and enforcement. The most important criteria are dollar requirements to fund initial and on-going capital assets and surplus reserves to meet future claims. The NAIC issues standard instructions and examiners handbooks specifically designed for surveillance of fiscal solvency. The NAIC coordinates the auditing of some companies using teams of examiners from the company's home State and other States in which the company does business. State agencies take informal action or issue formal orders to remedy fiscal solvency problems.

Three State insurance regulators and two consumer advocates expressed concerns about the future fiscal solvency of LTC insurance companies. They are concerned because the market is new and policyholders may not start filing claims in large numbers for many years. Insurance companies may not be pricing policies appropriately. By the time they recognize insolvency, it may be too late to take corrective action. The NAIC is developing fiscal solvency accreditation guidelines.

Twenty-three States reported minimum specific dollar requirements for capital and surplus funds.

FISCAL SOLVENCY REQUIREMENTS

<u>Aggregate of Minimum Capital Assets and Surplus Requirements</u>	<u>Number of States</u>
\$100,000 to \$500,000	2
> \$500,000 to \$1 million	9
> \$1 million to \$2 million	6
> \$2 million	6
No specific dollar amount	13
Unable to determine	14

States have broad authority to impose penalties against both agents and insurers.

All States have authority in the general section of their insurance codes to impose penalties against agents and insurers who violate State insurance laws or regulations, including those that apply to LTC insurance. The penalties usually include fines, license suspensions, revocations or nonrenewals, and cease and desist orders. If certain conditions are present, penalties also may include restitution, jail sentences, or referrals for felony prosecution.

According to NAIC, all States have adopted at least a modified version of the NAIC Unfair Trade Practices Model Act. This model act authorizes penalties against both agents and insurers for a wide range of prohibited practices, including misrepresentations. Monetary penalties are set at \$1,000 for most violations and \$25,000 for either flagrant violations or violations of cease and desist orders. Because each individual act or practice (each policy sale) constitutes a separate violation, the total fines can escalate rapidly. The act caps aggregate penalties at \$100,000 for most violations and \$250,000 for flagrant violations or violations of cease and desist orders.

The NAIC did not establish specific penalties for LTC insurance violations until December 1990. Section 24 of the model regulation now prescribes penalties against companies and agents for violations of any LTC insurance laws or regulations, including prohibited marketing practices. The regulation calls for fines of up to three times the amount of the commissions paid for each policy involved in the violation or up to \$10,000, whichever is greater. These fines are in addition to any other penalties authorized by State law. At least six States have penalty provisions in their LTC insurance laws or regulations.

Few States currently limit commission differentials for the sale of new and renewal policies.

Although NAIC did not have any agent compensation standards for LTC insurance until December 1990, four States had adopted them by March 1991. The agent compensation standards currently are the only optional provision in the model act or regulation.

The drafting language that accompanies the December amendments cites two competing considerations to explain why the provision is optional. On the one hand, it acknowledges that the senior market "has been identified as being susceptible to abusive marketing practices." On the other hand, it notes that "not all policy replacements are improper" because "LTC insurance and LTC insurance regulations are continually changing."

The NAIC's optional provision restricts first year commission per policy to no more than 200 percent of second year commission. It also requires that (1) the commission received in subsequent years be equal to the amount received in the second year and (2) the commission be provided for a "reasonable number of years" (the model language does not define what constitutes a reasonable number of years).

Industry representatives believe it is inappropriate to limit commission differentials for the sale of new and renewal policies and oppose the NAIC optional provision. They maintain that differential commissions should be permitted because long-term care is a complex product and initial sales require significantly more agent time than renewals.

No State specifically prohibits the sale of multiple or duplicative long-term care insurance policies.

Although no State has a specific prohibition against the sale of multiple or duplicative LTC insurance policies, all States have the authority to regulate their sale. The regulatory authority is based on the NAIC Model Unfair Trade Practices Act that all States have adopted. Furthermore, section 20 of the December 1990 LTC model regulation amendments requires that "in recommending the purchase or replacement of any LTC insurance policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement." Although this provision could be used to regulate sales of inappropriate multiple or duplicative policies, few States have adopted it since it is so new. Nine States specifically identified this act or other provision as a basis for regulating the sale of multiple policies, and 13 States identified provisions regarding the sale of duplicative policies.

APPENDIX B

ORGANIZATIONS INTERVIEWED BY THE OIG

Insurance Commissioners' Offices:

Kentucky
Maryland
Massachusetts
Minnesota
New York
Texas
Utah
Wisconsin

Consumer Advocate Organizations:

Consumer Health Advocates, Boston, Massachusetts
Texas Citizen Action, Austin, Texas
American Association of Retired Persons, Washington D.C.
Consumers Union, Washington D.C.
Families USA, Washington D.C.
Older Women's League, Washington D.C.
United Seniors Health Cooperative, Washington D.C.
Center for Public Representation, Madison, Wisconsin

Counseling Programs:

Seniors Health Insurance Counseling and Advocacy Program, Baltimore,
Maryland
Serving Health Information Needs of Elders, Boston, Massachusetts
Ombudsman Program, State Department of Aging, St. Paul, Minnesota
Senior Federation, St. Paul, Minnesota
Insurance Board, Senior Concerns and Issues Section, Austin, Texas
Wisconsin Bureau on Aging, Madison, Wisconsin

Industry Representatives:

Health Insurance Association of America, Washington D.C.
LTC Incorporated, Kirkland, Washington

LONG-TERM CARE INSURANCE MODEL ACT

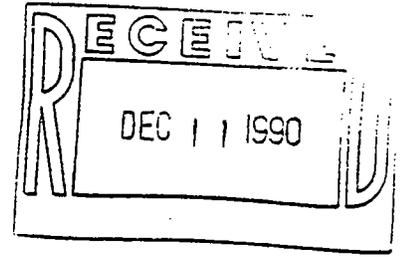


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Section 1. Purpose

The purpose of this Act is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

Comment: The purpose clause evidences legislative intent to protect the public while recognizing the need to permit flexibility and innovation with respect to long-term care insurance coverage.

Comment: The Task Force recognizes the viability of a long-term care product funded through a life insurance vehicle, and this Act is not intended to prohibit approval of this product. Section 4 now specifically addresses this product. However, states must examine their existing statutes to determine whether amendments to other code sections such as the definition of life insurance and accident and health reserve standards and further revisions are necessary to authorize approval of the product.

Section 2. Scope

The requirements of this Act shall apply to policies delivered or issued for delivery in this state on or after the effective date of this Act. This Act is not intended to supersede the obligations of entities subject to this Act to comply with the substance of other applicable insurance laws insofar as they do not conflict with this Act, except that laws and regulations designed and intended to apply to Medicare supplement insurance policies shall not be applied to long-term care insurance.

Note: See Section 6I.

Comment: This section makes clear that entities subject to the Act must continue to comply with other applicable insurance legislation not in conflict with this Act.

Section 3. Short Title

This Act may be known and cited as the "Long-Term Care Insurance Act."

Section 4. Definitions

Unless the context requires otherwise, the definitions in this section apply throughout this Act.

- A. "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit

of a hospital. Such term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

B. "Applicant" means:

- (1) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits, and
- (2) In the case of a group long-term care insurance policy, the proposed certificate holder.

C. "Certificate" means, for the purposes of this Act, any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

D. "Commissioner" means the Insurance Commissioner of this state.

Drafting Note: Where the word "Commissioner" appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted.

E. "Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this state and issued to:

- (1) One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations; or
- (2) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:
 - (a) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and
 - (b) Has been maintained in good faith for purposes other than obtaining insurance; or
- (3) An association or a trust or the trustee(s) of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the Commissioner that the association or associations have at the outset a minimum of 100 persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance, have been in active existence for at least one year, and have a constitution and bylaws which provide that:

- (a) The association or associations hold regular meetings not less than annually to further purposes of the members;
- (b) Except for credit unions, the association or associations collect dues or solicit contributions from members; and
- (c) The members have voting privileges and representation on the governing board and committees.

Thirty (30) days after such filing the association or associations will be deemed to satisfy such organizational requirements, unless the Commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

- (4) A group other than as described in Subsections E(1), E(2) and E(3), subject to a finding by the Commissioner that:
 - (a) The issuance of the group policy is not contrary to the best interest of the public;
 - (b) The issuance of the group policy would result in economies of acquisition or administration; and
 - (c) The benefits are reasonable in relation to the premiums charged.

F. "Policy" means, for the purposes of this Act, any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this state by an insurer, fraternal benefit society; nonprofit health, hospital, or medical service corporation; prepaid health plan; health maintenance organization or any similar organization.

Drafting Note: This Act is intended to apply to the specified group and individual policies, contracts, and certificates whether issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization. In order to include such organizations, each state should identify them in accordance with its statutory terminology or by specific statutory citation. Depending upon state law, insurance department jurisdiction and other factors, separate legislation may be required. In any event, the legislation should provide that the particular terminology used by these plans and organizations may be substituted for, or added to, the corresponding terms used in this Act. The term "regulations" should be replaced by the terms "rules and regulations" or "rules" as may be appropriate under state law.

The definition of "long-term care insurance" under this Act is designed to allow maximum flexibility in benefit scope, intensity and level, while assuring that the purchaser's reasonable expectations for a long-term care insurance policy are met. The Act is intended to permit long-term care insurance policies to cover either diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, or any combination thereof, and not to mandate coverage for each of these types of services. Pursuant to the definition, long-term care insurance may be either a group or individual insurance policy or a rider to such a policy, e.g., life or accident and sickness. The language in the definition concerning "other than an acute care unit of a hospital" is intended to allow payment of benefits when a portion of a hospital has been designated for, and duly licensed or certified as a long-term care provider or swing bed.

Section 5. Extraterritorial Jurisdiction - Group Long-Term Care Insurance

No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in Section 4E(4), unless this state or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met.

Drafting Note: By limiting extraterritorial jurisdiction to "discretionary groups," it is not the drafters' intention that jurisdiction over other health policies should be limited in this manner.

Section 6. Disclosure and Performance Standards for Long-Term Care Insurance

- A. The Commissioner may adopt regulations that include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, non-duplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions and definitions of terms.

Comment: This subsection permits the adoption of regulations establishing disclosure standards, renewability and eligibility terms and conditions, and other performance requirements for long-term care insurance. Regulations under this subsection should recognize the developing and unique nature of long-term care insurance and the distinction between group and individual long-term care insurance policies.

B. No long-term care insurance policy may:

- (1) Be cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder; or
- (2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or
- (3) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

C. Preexisting condition:

- (1) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4E(1) shall use a definition of "preexisting condition" which is more restrictive than the following: Preexisting condition means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six (6) months preceding the effective date of coverage of an insured person.
- (2) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4E(1) may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six (6) months following the effective date of coverage of an insured person.
- (3) The Commissioner may extend the limitation periods set forth in Sections 6C(1) and (2) above as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.
- (4) The definition of "preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in Section 6C(2) expires. No long-term care insurance policy or certificate may exclude or use waivers or

riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in Section 6C(2).

D. Prior hospitalization/institutionalization:

- (1) No long-term care insurance policy may be delivered or issued for delivery in this state if such policy:
 - (a) Conditions eligibility for any benefits on a prior hospitalization requirement;
 - (b) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or
 - (c) Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.
- (2) (a) A long-term care insurance policy containing post-confinement, post-acute care or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits" such limitations or conditions, including any required number of days of confinement.
- (b) A long-term care insurance policy or rider which conditions eligibility of non-institutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty (30) days.

Drafting Note: The amendment to the section is primarily intended to require immediate and clear disclosure where a long-term care insurance policy or rider conditions eligibility for non-institutional benefits on prior receipt of institutional care.

- (3) No long-term care insurance policy or rider which provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related conditions within a period of less than thirty (30) days after discharge from the institution.

Drafting Note: The Dec. 1988 amendment to this section eliminated the three-day prior hospitalization screen for new long-term care insurance policies. Some states may wish to consider a "dual-option" alternative to the total prohibition against the prior hospitalization screen, based on the state's particular demographic, geographic and market characteristics. If so, the following provision is such an alternative: "No long-term care insurance policy which conditions the eligibility of benefits on prior hospitalization may be delivered or issued for delivery in this State unless the insurer or other entity offering that policy also offers a long-term care insurance policy which does not condition eligibility of benefits on such a requirement."

Editors Note: Section 6D(3) is language from the original model act which did not prohibit prior institutionalization. The drafters intended that Section 6D(2) would be eliminated after adoption of the amendments to this section which prohibit prior institutionalization. States should examine their Section 6 carefully during the process of adoption or amendment of this Act.

- E. The Commissioner may adopt regulations establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the regulation.

F. Right to return - free look:

Long-term care insurance applicants shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page

or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in Section 4E(1) of this Act, the applicant is not satisfied for any reason.

- G. (1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.
- (a) The Commissioner shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.
 - (b) In the case of agent solicitations, an agent must deliver the outline of coverage prior to the presentation of an application or enrollment form.
 - (c) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.
- (2) The outline of coverage shall include:
- (a) A description of the principal benefits and coverage provided in the policy;
 - (b) A statement of the principal exclusions, reductions, and limitations contained in the policy;
 - (c) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;
 - (d) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;
 - (e) A description of the terms under which the policy or certificate may be returned and premium refunded; and
 - (f) A brief description of the relationship of cost of care and benefits.
- H. A certificate issued pursuant to a group long-term care insurance policy which policy is delivered or issued for delivery in this state shall include:
- (1) A description of the principal benefits and coverage provided in the policy;
 - (2) A statement of the principal exclusions, reductions and limitations contained in the policy; and
 - (3) A statement that the group master policy determines governing contractual provisions.
- Comment:** The above provisions are deemed appropriate due to the particular nature of long-term care insurance, and are consistent with group insurance laws. Specific standards would be contained in regulations implementing this Act.
- I. At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In

the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

- (1) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;
 - (2) An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;
 - (3) Any exclusions, reductions and limitations on benefits of long-term care; and
 - (4) If applicable to the policy type, the summary shall also include:
 - (a) A disclosure of the effects of exercising other rights under the policy;
 - (b) A disclosure of guarantees related to long-term care costs of insurance charges, and
 - (c) Current and projected maximum lifetime benefits.
- J. Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. Such report shall include:
- (1) Any long-term care benefits paid out during the month;
 - (2) An explanation of any changes in the policy, e.g. death benefits or cash values, due to long-term care benefits being paid out; and
 - (3) The amount of long-term care benefits existing or remaining.
- K. Any policy or rider advertised, marketed or offered as long-term care or nursing home insurance shall comply with the provisions of this Act.

Section 7. Administrative Procedures

Regulations adopted pursuant to this Act shall be in accordance with the provisions of [cite section of state insurance code relating to the adoption and promulgation of rules and regulations or cite the state's administrative procedures act, if applicable].

Section 8. Severability

If any provision of this Act or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 9. Effective Date

This Act shall be effective [insert date].

Long-Term Care Insurance Model Act

Legislative History (all references are to the Proceedings of the NAIC).

- 1987 Proc. I 11, 19, 655, 677-680, 700 (adopted).*
- 1987 Proc. II 15, 23, 632-633, 727, 730-734 (amended and reprinted).*
- 1988 Proc. I 9, 20-21, 629-630, 652, 661-665 (amended and reprinted).*
- 1989 Proc. I 9, 24-25, 703, 754-755, 789-793 (amended).*
- 1989 Proc. II 13, 23-24, 468, 476-477, 479-484 (amended and reprinted).*
- 1990 Proc. I 6, 27-28, 477, 541-542, 556-561 (amended and reprinted).*

LONG-TERM CARE INSURANCE MODEL REGULATION

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Section 1. Purpose

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

Section 2. Authority

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

Section 3. Applicability and Scope

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

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

Section 4. Definitions

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

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

Section 5. Policy Definitions

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

- A. "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.
- B. "Home health care services" means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.
- C. "Medicare" shall be defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.
- D. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.
- E. "Skilled nursing care," "intermediate care," "personal care," "home care," and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.
- F. All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal care facility," and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

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

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

Section 6. Policy Practices and Provisions

- A. Renewability. The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 7 of this regulation.

- (1) No such policy issued to an individual shall contain renewal provisions less favorable to the insured than "guaranteed renewable." However, the Commissioner may authorize nonrenewal on a statewide basis, on terms and conditions deemed necessary by the Commissioner, to best protect the interests of the insureds, if the insurer demonstrates:
 - (a) That renewal will jeopardize the insurer's solvency; or
 - (b) That:
 - (i) The actual paid claims and expenses have substantially exceeded the premium and investment income associated with the policies; and
 - (ii) The policies will continue to experience substantial and unexpected losses over their lifetime; and
 - (iii) The projected loss experience of the policies cannot be significantly improved or mitigated through reasonable rate adjustments or other reasonable methods; and
 - (iv) The insurer has made repeated and good faith attempts to stabilize loss experience of the policies, including the timely filing for rate adjustments.
 - (2) The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.
 - (3) The term "noncancellable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.
- B. Limitations and Exclusions. No policy may be delivered or issued for delivery in this state as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:
- (1) Preexisting conditions or diseases;
 - (2) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;
 - (3) Alcoholism and drug addiction;
 - (4) Illness, treatment or medical condition arising out of:
 - (a) War or act of war (whether declared or undeclared);
 - (b) Participation in a felony, riot or insurrection;
 - (c) Service in the armed forces or units auxiliary thereto;
 - (d) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or
 - (e) Aviation (this exclusion applies only to non-fare-paying passengers).

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- (5) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.
- (6) This Subsection B is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

Drafting Note: Paragraph (6) is intended to permit (a) exclusions and limitations for payment for services provided outside the United States and (b) legitimate variations in benefit levels to reflect differences in provider rates.

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

D. Continuation or Conversion.

- (1) Group long-term care insurance issued in this state on or after the effective date of this section shall provide covered individuals with a basis for continuation or conversion of coverage.
- (2) For the purposes of this section, "a basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies which restrict provision of benefits and services to, or contain incentives to use certain providers and/or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The Commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.
- (3) For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.
- (4) For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers and/or facilities, the Commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences

between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

- (5) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.
- (6) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.
- (7) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:
 - (a) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or
 - (b) The terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage:
 - (i) Providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and
 - (ii) The premium for which is calculated in a manner consistent with the requirements of Paragraph (6) of this section.
- (8) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.
- (9) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.
- (10) Notwithstanding any other provision of this section, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

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

Section 7. Required Disclosure Provisions

- A. **Renewability.** Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. This provision shall not apply to policies which do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

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

- B. **Riders and Endorsements.** Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.
- C. **Payment of Benefits.** A long-term care insurance policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.
- D. **Limitations.** If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."
- E. **Other Limitations or Conditions on Eligibility for Benefits.** A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in [insert citation to state law corresponding to Section 6D(2) of the Long-Term Care Insurance Model Act] shall set forth a description of such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

Section 8. Prohibition Against Post-Claims Underwriting

- A. All applications for long-term care insurance policies or certificates except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.
- B. (1) If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

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

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

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

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

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

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

- (3) Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the insurer shall obtain one of the following:

- (a) A report of a physical examination;
- (b) An assessment of functional capacity;
- (c) An attending physician's statement; or
- (d) Copies of medical records.

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

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

Section 9. Minimum Standards for Home Health Care Benefits in Long-Term Care Insurance Policies

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

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

- (2) By requiring that the insured/claimant first or simultaneously receive nursing and/or therapeutic services in a home or community setting before home health care services are covered;
 - (3) By limiting eligible services to services provided by registered nurses or licensed practical nurses;
 - (4) By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification.
 - (5) By requiring that the insured/claimant have an acute condition before home health care services are covered;
 - (6) By limiting benefits to services provided by Medicare-certified agencies or providers.
- B. Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

Drafting Note: Subsection B permits the home health care benefits to be counted toward the maximum length of long-term care coverage under the policy. The subsection is not intended to restrict home health care to a period of time which would make the benefit illusory. It is suggested that fewer than 40 visits amount to an illusory home health care benefit.

Section 10. Requirement to Offer Inflation Protection

- A. No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:
- (1) Increases benefit levels annually, [in a manner so that the increases are compounded annually];
 - (2) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined; or
 - (3) Covers a specified percentage of actual or reasonable charges.
- B. Where the policy is issued to a group, the required offer in Subsection A above shall be made to the group policyholder; except, if the policy is issued to a group defined in [Section 4E(4) of the Act] other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.
- C. The offer in Subsection A above shall not be required of:
- (1) Life insurance policies or riders containing accelerated long-term care benefits, nor
 - (2) Expense incurred long-term care insurance policies.

D. Insurers shall include the following information in or with the outline of coverage:

- (1) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period.
- (2) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases.

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

Drafting Note: It is intended that meaningful inflation protection be provided. It is suggested that a minimum of five percent (5%) (compounded) annual cost increase be used as a base for determining future costs and premiums. Meaningful benefit minimums or durations could include providing increases to attained age, or for a period such as at least 20 years, or for some multiple of the policy's maximum benefit, or throughout the period of coverage.

Section 11. Requirements for Replacement

- A. **Question Concerning Replacement.** Individual and direct response solicited long-term care insurance application forms shall include a question designed to elicit information as to whether the proposed insurance policy is intended to replace any other accident and sickness or long-term care insurance policy presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.
- B. **Solicitations Other than Direct Response.** Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its agent, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

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

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

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

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

The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

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

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

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

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

Section 12. Discretionary Powers of Commissioner

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

- A. The modification or suspension would be in the best interest of the insureds; and
- B. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and
- C. (1) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or
(2) The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or
(3) The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

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

Section 13. Reserve Standards

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

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

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

- (1) Definition of insured events;
- (2) Covered long-term care facilities;
- (3) Existence of home convalescence care coverage;
- (4) Definition of facilities;

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

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

- B. When long-term care benefits are provided other than as in Subsection A above, reserves shall be determined in accordance with [cite law referring to minimum health insurance reserves, the NAIC version of which requires reserves "using a table established for reserve purposes by a qualified actuary and acceptable to the commissioner"].

Section 14. Loss Ratio

Benefits under individual long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

- A. Statistical credibility of incurred claims experience and earned premiums;
- B. The period for which rates are computed to provide coverage;
- C. Experienced and projected trends;
- D. Concentration of experience within early policy duration;
- E. Expected claim fluctuation;

- F. Experience refunds, adjustments or dividends;
- G. Renewability features;
- H. All appropriate expense factors;
- I. Interest;
- J. Experimental nature of the coverage;
- K. Policy reserves;
- L. Mix of business by risk classification; and
- M. Product features such as long elimination periods, high deductibles and high maximum limits.

Drafting Note: The enumeration of the thirteen items includes factors traditionally not allowed in calculating rates. Because of the desire to foster development of the long-term care product, the drafters' intention is that the consideration of these factors will provide sufficient latitude to achieve the sixty percent loss ratio.

Section 15. Filing Requirement

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

Section 16. Standard Format Outline of Coverage

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

- A. The outline of coverage shall be a free-standing document, using no smaller than ten point type.
- B. The outline of coverage shall contain no material of an advertising nature.
- C. Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.
- D. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.
- E. Format for outline of coverage:

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

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

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

1. This policy is [an individual policy of insurance]([a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).
2. **PURPOSE OF OUTLINE OF COVERAGE.** This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!**
3. **TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.**
 - (a) [Provide a brief description of the right to return — "free look" provision of the policy.]
 - (b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]
4. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.** If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.
 - (a) [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.
 - (b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.
5. **LONG-TERM CARE COVERAGE.** Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

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

6. BENEFITS PROVIDED BY THIS POLICY.

- (a) [Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.]
- (b) [Institutional benefits, by skill level.]
- (c) [Non-institutional benefits, by skill level.]

[Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.]

7. LIMITATIONS AND EXCLUSIONS.

[Describe:

- (a) Preexisting conditions;
- (b) Non-eligible facilities/provider;
- (c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);
- (d) Exclusions/exceptions;
- (e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in (6) above.]

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

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

- (a) That the benefit level will not increase over time;
- (b) Any automatic benefit adjustment provisions;
- (c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;
- (d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;
- (e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

9. TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.

- [(a) Describe the policy renewability provisions;
- (b) For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;
- (c) Describe waiver of premium provisions or state that there are not such provisions;
- (d) State whether or not the company has a right to change premium, and if such a right exists, describe clearly and concisely each circumstance under which premium may change.]

10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

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

11. PREMIUM.

- [(a) State the total annual premium for the policy;
- (b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

12. ADDITIONAL FEATURES.

- [(a) Indicate if medical underwriting is used;
- (b) Describe other important features.]

Legislative History (all references are to the Proceedings of the NAIC).

1988 Proc. I 9, 20-21, 629-630, 652, 656-661 (adopted).

1989 Proc. I 9, 24-25, 703, 754-755, 791-794 (amended).

1989 Proc. II 13, 23-24, 468, 476-477, 484-493 (amended and reprinted).

1990 Proc. I (amended and reprinted).