

NOTICE OF INTENT

Department of Insurance Office of the Commissioner

REGULATION 46 – Long-Term Care Insurance (LAC 37:XIII.Chapter 19)

The Department of Insurance, pursuant to the authority of the Louisiana Insurance Code, R.S. 22:1 et seq., and in accordance with the Administrative Procedure Act, R.S. 49:950, et seq., hereby gives notice of its intent to amend Regulation 46 – Long-Term Care Insurance.

The purpose of the amendments to Regulation 46 is as follows:

1) to adopt changes made to date to the National Association of Insurance Commissioners' Long-Term Care Insurance Model Regulation ("Model Regulation"), to adopt Model Regulation definitions, and to make necessary technical amendments and redesignations to existing sections of Regulation 46 to accommodate the Model Regulation.

2) to amend §1937.B for clarity, consistent with the drafting notes of the Model Regulation.

3) to update cross-references to redesignated sections of Title 22 of the Louisiana Revised Statutes, which were redesignated pursuant to Act 415 of the 2008 Regular Session.

4) to amend §1907.A consistent with Act 811 of the 2014 Regular Session, revising terminology referring to persons with disabilities and other persons with exceptionalities.

The following table shows new placement for some of the current Sections being amended:

Proposed Placement	Current Placement
§1939. Premium Rate Schedule Increases for Policies Subject to Loss Ratio Limits Related to Original Filings (new)	-
§1941. Filing Requirement	§1939
§1943. Filing Requirements for Advertising	§1941
§1945. Standards for Marketing	§1943
§1947. Suitability	§1945
§1949. Prohibition Against Pre-Existing Conditions and Probationary Periods in Replacement Policies or Certificates	§1947
§1951. Availability of New Services or Providers (new)	-
§1953. Right to Reduce Coverage and Lower Premiums (new)	-

§1955. Nonforfeiture Benefit Requirement	§1949
§1957. Standards for Benefit Triggers	§1951
§1959. Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts	§1953
§1961. Appealing an Insurer’s Determination that the Benefit Trigger Is Not Met (new)	-
§1963. Standard Format Outline of Coverage	§1955
§1965. Requirement to Deliver Shopper’s Guide	§1957
§1967. Penalties	§1959
§1969. Appendices	§1961

Title 37
INSURANCE
PART XIII. Regulations
Chapter 19. Regulation 46 – Long-Term Care Insurance

§1901. Purpose

A. The purpose of this regulation is to implement R.S. ~~22:1731-1741~~ 22:1181-1191, Long-Term Care Insurance 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.

AUTHORITY NOTE: Promulgated in accordance with ~~R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:462 (February 2005)-, repromulgated LR

§1903. Applicability and Scope

A. – B.3. ...

AUTHORITY NOTE: Promulgated in accordance with ~~R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:462 (February 2005)-, repromulgated LR

§1905. Definitions

A. For the purpose of this regulation, the terms Applicant, Certificate, Commissioner, Group Long-Term Care Insurance, Long-Term Care Insurance, Policy, and Qualified Long-Term Care Insurance shall have the meanings set forth in R.S. ~~22:1734~~ 22:1184. In addition, the following definitions will apply.

Benefit Trigger - for the purposes of independent review, a contractual provision in the insured's policy of long-term care insurance conditioning the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. For purposes of a tax-qualified long-term care insurance contract, as defined in Section 7702B of the Internal Revenue Code of 1986, as amended, "benefit trigger" shall include a determination by a licensed health care practitioner that an insured is a chronically ill individual.

* * *

Independent review organization – an organization that conducts independent reviews of long-term care benefit trigger decisions.

Licensed health care professional – an individual qualified by education and experience in an appropriate field, to determine, by record review, an insured's actual functional or cognitive impairment.

* * *

Similar Policy Forms - all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in R.S. ~~22:1734~~ 22:1184(4)(a) are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

AUTHORITY NOTE: Promulgated in accordance with R.S. ~~22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:462 (February 2005); LR

§1907. Policy Definitions

A. ...

* * *

Adult Day Care—a program for six or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting ~~frail, impaired elderly or other disabled adults~~ adults who are frail, impaired and elderly, or have other disabilities and who can benefit from care in a group setting outside the home.

* * *

Home Health Care Services—medical and nonmedical services provided in their residences to ill, disabled, or infirmed persons ~~persons who are ill, have a disability, or have an infirmity in their~~

residences. Such services may include homemaker services, assistance with activities of daily living, and respite care services.

* * *

Skilled Nursing Care, ~~Intermediate Care~~, Personal Care, Home Care, Specialized Care, Assisted Living Care, and other services—shall be defined in relation to the level of skill required, the nature of the care, and the setting in which care must be delivered.

* * *

All providers of services including, but not limited to, *Skilled Nursing Facility, Extended Care Facility, ~~Intermediate Care Facility~~, Convalescent Nursing Home, Personal Care Facility, Specialized Care Providers, Assisted Living Facility, and Home Care Agency*—shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration, or degree status of those providing or supervising the services. ~~The definition may require that the provider be appropriately licensed or certified. When the definition requires that the provider be appropriately licensed, certified, or registered, it shall also state what requirements a provider must meet in lieu of licensure, certification, or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified, registered, or when the state licenses, certifies, or registers the provider of services under another name.~~

AUTHORITY NOTE: Promulgated in accordance with ~~R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:976 (August 1997)-, LR

§1909. Policy Practices and Provisions

A. - B.7. ...

B.8.a. Subsection 1909.B is not intended to prohibit exclusions and limitations by type of provider. However, no long-term care issuer may deny a claim because services are provided in a state other than the state of policy issued under the following conditions:

i. when the state other than the state of policy issue does not have the provider licensing, certification, or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification, or registration; or

ii. when the state other than the state of policy issue licenses, certifies, or registers the provider under another name.

b. For purposes of §1909.B.8, “state of policy issue” means the state in which the individual policy or certificate was originally issued.

9. Subsection 1909.B is not intended to prohibit territorial limitations.

C. - F.1. ...

F.2. The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under ~~§1949 1955~~, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

3. A reduction in benefits shall not be considered a premium change, but for purposes of the calculation required under ~~§1949~~ 1955, the initial annual premium shall be based on the reduced benefits.

G. Electronic Enrollment for Group Policies

1. In the case of a group defined in R.S. ~~22:1734~~ 22:1184(4)(a), any requirement that a signature of an insured be obtained by a producer or insurer shall be deemed satisfied if:

G.1.a. – 2. ...

AUTHORITY NOTE: Promulgated in accordance with ~~R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:462 (February 2005), repromulgated LR

§1911. Unintentional Lapse

A. – B. ...

AUTHORITY NOTE: Promulgated in accordance with ~~R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:978 (August 1997), LR 31:464 (February 2005), repromulgated LR

§1913. Required Disclosure Provisions

A. – G. ...

H. A qualified long-term care insurance contract shall include a disclosure statement in the policy, and in the outline of coverage as contained in ~~§1955~~ 1963.F.3 that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

I. A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in ~~§1955~~ 1963.F.3 that the policy is not intended to be a qualified long-term care insurance contract.

AUTHORITY NOTE: Promulgated in accordance with ~~R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:978 (August 1997), LR 31:465 (February 2005), repromulgated LR

§1915. Required Disclosure of Rating Practices to Consumers

A - A.1. ...

A.2. For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in R.S. ~~22:1734~~ 22:1184(4), which policy was in force at the time this amended regulation became effective, the provisions of §1915 shall apply on the policy anniversary following February 19, 2006.

B. – E. ...

AUTHORITY NOTE: Promulgated in accordance with ~~R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:465 (February 2005)-, repromulgated LR

§1917. Initial Filing Requirements

A. This Section applies to any long-term care policy issued in this state on or after August 19, 2005, except that §1917.B.2.d and §1917.B.3 apply to any long-term care policy issued in this state on or after [the date that is six months after the amendment of Regulation 46].

B. – B.2.c. ...

B.2.d. ~~a complete description of the basis for contract reserves that are anticipated to be held under the form, to include: a statement that the premiums contain at least the minimum margin for moderately adverse experience defined in §1917.B.2.d.i or the specification of and justification for a lower margin as required by §1917.B.2.d.ii.~~

i. ~~sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; a composite margin shall not be less than 10 percent of lifetime claims.~~

ii. ~~a statement that the assumptions used for reserves contain reasonable margins for adverse experience; a composite margin that is less than 10 percent may be justified in uncommon circumstances. The proposed amount, full justification of the proposed amount, and methods to monitor developing experience that would be the basis for withdrawal of approval for such lower margins must be submitted.~~

iii. ~~a statement that the net valuation premium for renewal years does not increase (except for attained age rating where permitted); and a composite margin lower than otherwise considered appropriate for the stand-alone long-term care policy may be justified for long-term care benefits provided through a life policy or an annuity contract. Such lower composite margin, if utilized, shall be justified by appropriate actuarial demonstration addressing margins and volatility when considering the entirety of the product.~~

iv. ~~a statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur; a greater margin may be appropriate in circumstances where the company has less credible experience to support its assumptions used to determine the premium rates.~~

(a). ~~an aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;~~

(b). ~~if the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under §1917.C based on a standard age distribution; and~~

B.2.e.i. – B.2.e. ii. ...

B.2.f. a statement that reserve requirements have been reviewed and considered. Support for this statement shall include:

i. sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; and

ii. a statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship.

3. An actuarial memorandum prepared, dated, and signed by a member of the Academy of Actuaries shall be included and shall address and support each specific item required as part of the actuarial certification and provide at least the following information:

a. an explanation of the review performed by the actuary prior to marking the statements in §1917.B.2.b and §1917.B.2.c.

b. a complete description of pricing assumptions; and

c. sources and levels of margins incorporated into the gross premiums that are the basis for the statement in §1917.B.2.a of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. Deviations in margins between ages, sexes, plans, or states shall be clearly described. Deviations in margins required to be described are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating gross premium scales.

d. a demonstration that the gross premiums include the minimum composite margin specified in §1917.B.2.d.

~~C.1. The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both. In any review of the actuarial certification and actuarial memorandum, the commissioner may request review by an actuary with experience in long-term care pricing who is independent of the company. In the event the commissioner asks for additional information as a result of any review, the period in §1917.B does not include the period during which the insurer is preparing the requested information.~~

~~2. In the event the commissioner asks for additional information under this provision, the period in §1917.B does not include the period during which the insurer is preparing the requested information.~~

AUTHORITY NOTE: Promulgated in accordance with ~~R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:466 (February 2005)-, LR

§1919. Requirements to Offer Inflation Protection

A. – A.3. ...

B. Where the policy is issued to a group, the required offer in §1919.A shall be made to the group policyholder; except, if the policy is issued to a group defined in R.S. ~~22:1734~~ 22:1184(4)(d), other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

C. – G.2. ...

AUTHORITY NOTE: Promulgated in accordance with ~~R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1156 (September 1993), amended LR 23:975 (August 1997), LR 31:467 (February 2005); repromulgated LR

§1921. Prohibition against Post-Claim Underwriting (former §1915)

A. – D. ...

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 in ~~§1964~~ 1969, Appendix A.

AUTHORITY NOTE: Promulgated in accordance with ~~R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:467 (February 2005); repromulgated LR

§1923. Minimum Standards for Home Health and Community Care Benefits in Long-Term Care Insurance Policies (former §1917)

A. – C. ...

AUTHORITY NOTE: Promulgated in accordance with ~~R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1158 (September 1993), amended LR 23:982 (August 1997), repromulgated LR 31:467 (February 2005); repromulgated LR

§1925. Requirements for Application Forms and Replacement Coverage (former §1921)

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the

applicant and producer, except where the coverage is sold without a producer, containing such questions may be used. With regard to a replacement policy issued to a group defined by R.S. ~~22:1734~~ 22:1184(4)(a), the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement:

A.1. – F. ...

AUTHORITY NOTE: Promulgated in accordance with ~~R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:468 (February 2005), repromulgated LR

§1927. Reporting Requirements (former §1923)

A. ...

B. Each insurer shall report annually, by June 30, the 10 percent of its producers with the greatest percentages of lapses and replacements, as measured by §1927.A (~~§1964~~ 1969, Appendix G).

C. ...

D. Every insurer shall report annually, by June 30, the number of lapsed policies as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the end of the preceding calendar year (~~§1964~~ 1969, Appendix G).

E. Every insurer shall report annually, by June 30, the number of replacement policies sold as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the preceding calendar year (~~§1964~~ 1969, Appendix G).

F. Every insurer shall report annually, by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied (~~§1964~~ 1969, Appendix E).

G. – H. ...

I. Annual rate certification requirements

1. Section 1927.I applies to any long-term care policy issued in this state on or after [the date that is six months after the amendment of Regulation 46].

2. The following annual submission requirements apply subsequent to initial rate filings for individual long-term care insurance policies made under §1927:

a. an actuarial certification prepared, dated, and signed by a member of the American Academy of Actuaries who provides the information shall be included and shall provide at least the following information:

i. a statement of the sufficiency of the current premium rate schedule including:

(a). for the rate schedules currently marketed.

(i). the premium rate schedule continues to be sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated; or

(ii).if the above statement cannot be made, a statement that margins for moderately adverse experience may no longer be sufficient. In this situation, the insurer shall provide to the commissioner, within 60 days of the date the actuarial certification is submitted to the commissioner, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience so that the ultimate premium rate schedule would be reasonably expected to be sustainable over the future life of the form with no future premium increases anticipated. Failure to submit a plan of action to the commissioner within 60 days or to comply with the time frame stated in the plan of action constitutes grounds for the commissioner to withdraw or modify approval of the form for future sales pursuant to R.S. 22:972.

(b). for the rate schedules that are no longer marketed.

(i). that premium rate schedule continues to be sufficient to cover anticipated costs under best estimate assumptions; or

(ii). that the premium rate schedule may no longer be sufficient. In this situation the insurer shall provide to the commissioner, within 60 days of the date the actuarial certification is submitted to the commissioner, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience.

ii. a description of the review performed that led to the statement.

b. an actuarial memorandum dated and signed by a member of the American Academy of Actuaries who prepares the information shall be prepared to support the actuarial certification and provide at least the following information:

i. a detailed explanation of the data sources and review performed by the actuary prior to making the statement in §1927.I.2.a.

ii. a complete description of experience assumptions and their relationship to the initial pricing assumptions.

iii. a description of the credibility of the experience data.

iv. an explanation of the analysis and testing performed in determining the current presence of margins.

c. the actuarial certification required pursuant to §1927.I.2.a must be based on calendar year data and submitted annually no later than May 1st of each year starting in the second year following the year in which the initial rate schedules are first used. The actuarial memorandum required pursuant to §1927.I.2.b must be submitted at least once every three years with the certification.

AUTHORITY NOTE: Promulgated in accordance with ~~R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:469 (February 2005), LR

§1929. Licensing (former §1925)

A. A producer is not authorized to market, sell, solicit, or negotiate with respect to long-term care except as authorized by R.S. ~~22:1133~~ 22:1543 and R.S. ~~22:1137~~ 22:1547(A)(1) and (2).

AUTHORITY NOTE: Promulgated in accordance with ~~R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:470 (February 2005), repromulgated LR

§1931. Discretionary Powers of Commissioner (former §1927)

A. – A.3.c. ...

AUTHORITY NOTE: Promulgated in accordance with ~~R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:470 (February 2005), repromulgated LR

§1933. Reserve Standards (former §1929)

A. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with R.S. ~~22:162~~ 22:751, R.S. ~~22:162.1~~ 22:752, and R.S. ~~22:163~~ 22:753. Claim reserves shall also be established in the case when the policy or rider is in claim status.

B. – D. ...

AUTHORITY NOTE: Promulgated in accordance with ~~R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:470 (February 2005), repromulgated LR

§1935. Loss Ratio (former §1931)

A. This Section shall apply to all long-term care insurance policies or certificates except those covered under §1917, ~~and §1937,~~ and §1939.

B. - C.1. ...

2. the portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of R.S. ~~22:168~~ 22:936;

3. the policy meets the disclosure requirements of R.S. ~~22:1736~~ 22:1186(H), (I) and (J);

C.4. – C.5.h. ...

AUTHORITY NOTE: Promulgated in accordance with ~~R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:470 (February 2005), LR

§ 1937. Premium Rate Schedule Increases

A. This Section shall apply as follows:

1. Except as provided in §1937.A.2, §1937 applies to any long-term care policy or certificate issued in this state on or after August 19, 2005 and prior to [the date that is six months after the amendment of Regulation 46].

2. For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in R.S. ~~22:1734~~ 22:1184(4)(a), which policy was in force at the time this amended regulation became effective, the provisions of § 1937 shall apply on the policy anniversary following February 19, 2006.

B. An insurer shall ~~provide notice~~ request approval of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least 45 days prior to the notice to the policyholders and shall include:

B.1. – B.2.b. ...

c. The insurer may request a premium rate schedule increase less than what is required under §1937, and the commissioner may approve such premium rate schedule increase, without submissions of the certification in §1937.B.2.a., if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required under §1937.B.2.a., the premium rate schedule increase filing satisfies all other requirements of §1937, and is, in the opinion of the commissioner, in the best interest of policyholders.

B.3. - B.3.a.iv.(a). ...

(b). in the event the commissioner determines as provided in §1905-A.4 that offsets may exist, the insurer shall use appropriate net projected experience;

B.3.b. – B.3.c. ...

d. a statement that policy design, underwriting and claims adjudication practices have been taken into consideration; ~~and~~

e. in the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates; and

f. a demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin specified in §1917.B.2.d. is projected to be exhausted.

B.4. – C.3. ...

4. all present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as defined annually under R.S. ~~22:163~~ 22:753. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

D. – I.2. ...

J. Section 1937.A through I shall not apply to policies for which the long-term care benefits provided by the policy are *incidental*, as defined in §1905.B, if the policy complies with all of the following provisions:

J.1. ...

2. the portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

- a. R.S. ~~22:168~~ 22:936;
- b. R.S. ~~22:173.1~~, 22:952; and
- c. R.S. ~~22:1500~~ 22:914;

3. the policy meets the disclosure requirements of R.S. ~~22:1736~~ 22:1186(H), (I), and (J);

J.4. – J.5.h ...

K. Sections 1937.F and 1937.H shall not apply to group insurance policies as defined in R.S. ~~22:1734~~ 22:1184(4)(a) where:

K.1. – K.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. ~~22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:471 (February 2005)-, amended LR

§1939. Premium Rate Schedule Increases for Policies Subject to Loss Ratio Limits Related to Original Filings

A. Section 1939 shall apply as follows:

1. Except as provided in §1939.A.2, §1939 applies to any long-term care policy or certificate issued in this state on or after [the date that is six months after the amendment of Regulation 46].

2. For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in R.S. 22:1184(4)(a), which policy was in force at the time this amended regulation became effective, the provisions of §1939 shall apply on the policy anniversary following [the date that is six months after the amendment of Regulation 46].

B. An insurer shall request approval of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least 45 days prior to the notice to the policyholders and shall include:

1. information required by §1915;

2. certification by a qualified actuary that:

a. if the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

b. the premium rate filing is in compliance with the provisions of §1939;

c. the insurer may request a premium rate schedule increase less than what is required under §1939 and the commissioner may approve such premium rate schedule increase, without submissions of the certification in §1939.B.2.a., if the actuarial memorandum discloses the

premium rate schedule increase necessary to make the certification required under §1939.B.2.a., the premium rate schedule increase filing satisfies all other requirements of §1939, and is, in the opinion of the commissioner, in the best interest of policyholders.

3. an actuarial memorandum justifying the rate schedule change request that includes:

a. lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

i. annual values for the five years preceding and the three years following the valuation date shall be provided separately;

ii. the projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

iii. the projections shall demonstrate compliance with §1939.C; and

iv. for exceptional increases:

(a).the projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(b).in the event the commissioner determines as provided in §1905 that offsets may exist, the insurer shall use appropriate net projected experience;

b. disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

c. disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

d. a statement that policy design, underwriting, and claims adjudication practices have been taken into consideration;

e. in the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates; and

f. a demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin specified in §1917.B.2.d. is projected to be exhausted.

4. a statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

5. sufficient information for review and approval of the premium rate schedule increase by the commissioner.

C. All premium rate schedule increases shall be determined in accordance with the following requirements:

1. exceptional increases shall provide that 70 percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

2. premium rate schedule increases shall be calculated such that the sum of the lesser of the accumulated value of incurred claims, without the inclusion of active life reserves, or the

accumulated value of historic expected claims, without the inclusion of active life reserves, plus the present value of the future expected incurred claims, projected without the inclusion of active life reserves, will not be less than the sum of the following:

a. the accumulated value of the initial earned premium times the greater of 58 percent and the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience;

b. 85 percent of the accumulated value of prior premium rate schedule increases on an earned basis;

c. the present value of future projected initial earned premiums times the greater of 58 percent and the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience; and

d. 85 percent of the present value of future projected premiums not in §1939.C.2.c. on an earned basis;

3. expected claims shall be calculated based on the original filing assumptions assumed until new assumptions are filed as part of a rate increase. New assumptions shall be used for all periods beyond each requested effective date of a rate increase. Expected claims are calculated for each calendar year based on the in-force at the beginning of the calendar year. Expected claims shall include margins for moderately adverse experience; either amounts included in the claims that were used to determine the lifetime loss ratio consistent with the original filing or as modified in any rate increase filing;

4. in the event that a policy form has both exceptional and other increases, the values in §1939.C.2.b. and d. will also include 70 percent for exceptional rate increase amounts; and

5. all present and accumulated values used to determine rate increases, including the lifetime loss ratio consistent with the original filing reflecting margins for moderately adverse experience, shall use the maximum valuation interest rate for contract reserves as defined annually under R.S. 22:753. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

D. For each rate increase that is implemented, the insurer shall file for approval by the commissioner updated projections, as defined in §1939.B.3.a., annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in §1939.K, the projections required by §1939.D shall be provided to the policyholder in lieu of filing with the commissioner.

E. If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in §1939.B.3.a., shall be filed for approval by the commissioner every five years following the end of the required period in §1939.D. For group insurance policies that meet the conditions in §1939.K, the projections required by §1939.E shall be provided to the policyholder in lieu of filing with the commissioner.

F.1. If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in §1939.C, the commissioner may require the insurer to implement any of the following:

- a. premium rate schedule adjustments; or
- b. other measures to reduce the difference between the projected and actual experience.

2. In determining whether the actual experience adequately matches the projected experience, consideration should be given to §1939.B.3.e., if applicable.

G. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file a plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in §1939.H.

H.1. For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

- a. the rate increase is not the first rate increase requested for the specific policy form or forms;
- b. the rate increase is not an exceptional increase; and
- c. the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

2. In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

- a. The offer shall:
 - i. be subject to the approval of the commissioner;
 - ii. be based on actuarially sound principles, but not be based on attained age; and
 - iii. provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

b. The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

- i. the maximum rate increase determined based on the combined experience; and
- ii. the maximum rate increase determined based only on the experience of the insureds originally issued the form plus 10 percent.

I. If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of §1939.H, prohibit the insurer from either of the following:

- 1. filing and marketing comparable coverage for a period of up to five years; or

2. offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

J. Section 1939.A through I shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in §1905, if the policy complies with all of the following provisions:

1. the interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

2. the portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

a. R.S. 22:936;

b. R.S. 22:952; and

c. R.S. 22:914;

3. the policy meets the disclosure requirements of R.S. 22:1186(H), (I), and (J);

4. the portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

a. policy illustrations as required by Regulation 55;

b. disclosure requirements in Regulation 28;

5. an actuarial memorandum is filed with the insurance department that includes:

a. a description of the basis on which the long-term care rates were determined;

b. a description of the basis for the reserves;

c. a summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

d. a description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

e. a description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

f. the estimated average annual premium per policy and the average issue age;

g. a statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

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

K. Section 1939.F and H shall not apply to group insurance policies as defined in R.S. 22:1184(4)(a) where:

1. the policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

2. the policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than 20 percent of the total premium for the group in the calendar year prior to the year a rate increase is filed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR

§~~1939~~ 1941. Filing Requirement (former §~~1933~~ 1939)

A. Prior to a long-term care insurer or other similar organization offering group long-term care insurance to a resident of this state, pursuant to R.S. ~~22:1735~~ 22:1185, it shall file with the commissioner evidence that the group meets the requirements of R.S. ~~22:1734~~ 22:1184(4)(d); and such insurers shall file for approval any group policy or certificate to be offered to residents of this state, regardless of from where it was issued or delivered.

AUTHORITY NOTE: Promulgated in accordance with R.S. ~~22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:473 (February 2005);, repromulgated LR

§~~1941~~ 1943. Filing Requirements for Advertising (former §~~1935~~ 1941)

A. – B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. ~~22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), repromulgated LR 31:473 (February 2005);, repromulgated LR

§~~1943~~ 1945. Standards for Marketing (former §~~1937~~ 1943)

A. – A.2. ...

3. provide copies of the disclosure forms required in §1915.~~C~~ D (Appendices B and F) to the applicant;

A.4. - A.7. ...

8. provide an explanation of contingent benefit upon lapse provided in §~~1949~~. 1955.D.3 and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in §1955.D.4.

B. In addition to the practices prohibited in R.S. ~~22:1211~~ 22:1961 et seq., the following acts and practices are prohibited:;

Cold Lead Advertising—making use directly, or indirectly, of any method of marketing which fails to disclose, in a conspicuous manner, that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.

High Pressure Tactics—employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

Misrepresentation—misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

Twisting—knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

C.1. With respect to the obligations set forth in ~~§1943~~ 1945.C.1, the primary responsibility of an association, as defined in R.S. ~~22:1734~~ 22:1184(4)(b), when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues, in general, so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

C.2. – C.6.a.iii. ...

C.6.b. Section ~~1943~~ 1945.C.6.a.i.-iii shall not apply to qualified long-term care insurance contracts.

7. No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the state insurance department the information required in ~~§1943~~ 1945.C.

8. The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in ~~§1943~~ 1945.C.

9. Failure to comply with the filing and certification requirements of ~~§1943~~ constitutes an unfair trade practice in violation of R.S. ~~22:1211~~ 22:1961 et seq.

AUTHORITY NOTE: Promulgated in accordance with ~~R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:473 (February 2005)-, repromulgated LR

§1945 1947. Suitability (former §1939-1945)

A. Section ~~1945~~ 1947 shall not apply to life insurance policies that accelerate benefits for long-term care.

B. – C.1.c. ...

C.2. The issuer, and where a producer is involved, the producer shall make reasonable efforts to obtain the information set out in ~~§1945~~ 1947.C.1. The efforts shall include presentation to the applicant at, or prior to, application the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix B, in not less than 12-point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the commissioner.

C.3. ...

C.4. The sale or dissemination outside the company or agency by the issuer or producer of information obtained through the personal worksheet in ~~§1961~~ 1969, Appendix B, is prohibited.

D. The issuer shall use the suitability standards it has developed, pursuant to ~~§1945~~ 1947, in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

E. ...

F. At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in ~~§1961~~ 1969, Appendix C, in not less than 12-point type.

G. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to ~~§1961~~ 1969, Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

H. ...

AUTHORITY NOTE: Promulgated in accordance with ~~R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:475 (February 2005); repromulgated LR

§1947 1949. Prohibition against Pre-Existing Conditions and Probationary Periods in Replacement Policies or Certificates (former §1941-1947)

A. ...

AUTHORITY NOTE: Promulgated in accordance with ~~R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), repromulgated LR 31:475 (February 2005); repromulgated LR

§1949. Nonforfeiture Benefit Requirement (former §1943)

§1951. Availability of New Services or Providers

A. An insurer shall notify policyholders of the availability of a new long-term care policy series that provides coverage for new long-term care services or providers material in nature and not previously available through the insurer to the general public. The notice shall be provided within 12 months of the date that the new policy series is made available for sale in this state.

B. Notwithstanding §1951.A above, notification is not required for any policy issued prior to the effective date of §1951 or to any policyholder or certificateholder who is currently eligible for benefits, within an elimination period or on a claim, or who previously had been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

C. The insurer shall make the new coverage available in one of the following ways:

1. By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age;

2. By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits shall be based on premiums paid or reserves held for the prior policy or certificate.

3. By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or

4. By an alternative program developed by the insurer that meets the intent of §1951 if the program is filed with and approved by the commissioner.

D. An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of §1951.D, "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders that purchased such a new proprietary policy shall be notified when a new long-term care policy series that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel.

E. Policies issued pursuant to §1951 shall be considered exchanges and not replacements. These exchanges shall not be subject to §1925 and §1947 and the reporting requirements of §1927.A through E.

F. Where the policy is offered through an employer, labor organization, professional, trade, or occupational association, the required notification in §1951.A above shall be made to the offering entity. However, if the policy is issued to a group defined in R.S. 22:1184(4)(d), the notification shall be made to each certificateholder.

G. Nothing in §1951 shall prohibit an insurer from offering any policy, rider, certificate, or coverage change to any policyholder or certificateholder. However, upon request, any policyholder may apply for currently available coverage that includes the new services or providers. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

H. Section 1951 does not apply to life insurance policies or riders containing accelerated long-term care benefits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR

§1951. Standards for Benefit Triggers (former §1945)

§1953. Right to Reduce Coverage and Lower Premiums

A.1. Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:

- a. Reducing the maximum benefits; or
- b. Reducing the daily, weekly or monthly benefit amount.

2. The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier's administrative processes.

3. In the event the reduction in coverage involves the reduction or elimination of the inflation protection provision, the insurer shall allow the policyholder or certificateholder to continue the benefit amount in effect at the time of the reduction.

B. The provision shall include a description of the process for requesting and implementing a reduction in coverage.

C. The premium for the reduced coverage shall:

1. Be based on the same age and underwriting class used to determine the premium for the coverage currently in force; and
2. Be consistent with the approved rate table.

D. The insurer may limit any reduction in coverage to plans or options available for that policy form or certificate and to those for which benefits will be available after consideration of claims paid or payable.

E. If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by §1911.A.1.d.

F. Section 1953 does not apply to life insurance policies or riders containing accelerated long-term care benefits.

G. The requirements of §1953.A through F shall apply to any long-term care policy issued in this state on or after [the date that is six months after the amendment of Regulation 46].

H. A premium increase notice required by §1915.E shall include:

1. An offer to reduce policy benefits provided by the current coverage consistent with the requirements of §1953;
2. A disclosure stating that all options available to the policyholder or certificateholder may not be of equal value; and

3. In the case of a partnership policy or certificate, a disclosure that some benefit reduction options may result in a loss in partnership status that may reduce policyholder or certificateholder protections.

I. The requirements of §1953.H shall apply to any rate increase implemented in this state on or after [the date that is six months after the amendment of Regulation 46].

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR

§1953. Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts (former §1947)

§1955. Nonforfeiture Benefit Requirement (former §1949)

A. Section ~~1949~~ 1955 does not apply to life insurance policies or riders containing accelerated long-term care benefits.

B. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of R.S. ~~22:1738~~ 22:1188:

B.1. a policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in ~~§1949~~ 1955.E; and

B.2. ...

C. If the offer required to be made under R.S. ~~22:1738~~ 22:1188 is rejected, the insurer shall provide the contingent benefit upon lapse described in ~~§1949~~ 1955. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in §1955.D.4 shall still apply.

D.1. After rejection of the offer required under R.S. ~~22:1738~~ 22:1188, for individual and group policies without nonforfeiture benefits issued after the effective date of ~~§1949~~ 1955, the insurer shall provide a contingent benefit upon lapse.

D.2. ...

D.3. ~~The A~~ A contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least 45 days prior to the due date of the premium reflecting the rate increase.

...

4. a. A contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio in §1955.D.6.b

is 40 percent or more. Unless otherwise required, policyholders shall be notified at least 45 days prior to the due date of the premium reflecting the rate increase.

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

b. This provision shall be in addition to the contingent benefit provided by §1955.D.3 above and, where both are triggered, the benefit provided shall be at the option of the insured.

5. On or before the effective date of a substantial premium increase as defined in §1949 1955.D.3, the insurer shall:

a. offer to reduce policy benefits provided by the current coverage ~~without the requirement of additional underwriting~~ consistent with the requirements of §1953 so that required premium payments are not increased;

b. offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of §1949 1955.E. This option may be elected at any time during the 120-day period referenced in §1949 1955.D.3; and

c. notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in §1949 1955.D.3 shall be deemed to be the election of the offer to convert in §1949.D.4.b 1955.D.5.b above unless the automatic option in §1955.D.6.c applies.

6. On or before the effective date of a substantial premium increase as defined in §1955.D.4 above, the insurer shall:

a. offer to reduce policy benefits provided by the current coverage consistent with the requirements of §1953 so that required premium payments are not increased;

b. offer to convert the coverage to a paid-up status where the amount payable for each benefit is 90 percent of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period reference in §1955.D.4; and

c. notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in §1955.D.4 shall be deemed to be the election of the offer to convert in §1955.D.6.b above if the ratio is 40 percent or more.

7. For any long-term care policy issued in this state on or after [the date that is six months after the amendment of Regulation 46].

a. In the event the policy or certificate was issued at least 20 years prior to the effective date of the increase, a value of zero percent shall be used in place of all values in the above table; and

b. Values above 100 percent in the table in §1955.D.3 above shall be reduced to 100 percent.

E. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with §1955.D.3. but not §1955.D.4, are described in §1949 1955.E.

1. For purposes of ~~§1949~~ 1955.E, *attained age rating* is defined as a schedule of premiums, starting from the issue date, which increases with increasing age at least 1 percent per year prior to age 50, and at least 3 percent per year beyond age 50.

2. For purposes of ~~§1949~~ 1955.E, the nonforfeiture benefit shall be a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in ~~§1949~~ 1955.E.3.

3. The standard nonforfeiture credit will be equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of ~~§1949~~ 1955.F.

E.4.a. ...

b. Notwithstanding ~~§1949~~ 1955.E.4.a, for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

E.4.b.i. – F. ...

G. There shall be no difference in the minimum nonforfeiture benefits, as required under ~~§1949~~ 1955, for group and individual policies.

H. The requirements set forth in ~~§1949~~ 1955 shall be effective January 1, 1999 and shall apply as follows:-

1. Except as provided in ~~§1949~~ 1955.H.2 and §1955.H.3 below, the provisions of ~~§1949~~ 1955 apply to any long-term care policy issued in this state on or after the effective date of this amended regulation.

2. For certificates issued on or after the effective date of ~~§1949~~ 1955, under a group long-term care insurance policy, as defined in R.S. ~~22:1734~~ 22:1184(4)(a), which policy was in force at the time this amended regulation became effective, the provisions of ~~§1949~~ 1955 shall not apply.

3. The last sentence in §1955.C and §1955.D.4 and §1955.D.6 shall apply to any long-term care insurance policy or certificate issued in this state after [the date that is six months after the amendment of Regulation 46], except new certificates on a group policy as defined in R.S. 22:1184(4)(a) after [the date that is one year after the amendment of Regulation 46].

I. Premiums charged for a policy or certificate containing nonforfeiture benefits or a ~~continuing contingent~~ benefit on lapse shall be subject to the loss ratio requirements of §1935, §1937, or §1939, whichever is applicable, treating the policy as a whole.

J. To determine whether contingent nonforfeiture upon lapse provisions are triggered under ~~§1949~~ 1955.D.3 or §1955.D.4, a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

K. – K.3.d ...

AUTHORITY NOTE: Promulgated in accordance with ~~R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:475 (February 2005); LR

§1955. Standard Format Outline of Coverage (former §1949)

§1957. Standards for Benefit Triggers (former §1951)

A. – B.1. ...

2. Insurers may use activities of daily living to trigger covered benefits in addition to those contained in ~~§1951.B.1~~ §1957.B.1, as long as they are defined in the policy.

C. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in ~~§1951.A-B~~ §1957.A - B.

D. For purposes of ~~§1951~~ §1957, the determination of a deficiency shall not be more restrictive than:

D.1. – F. ...

G. The requirements set forth in ~~§1951~~ §1957 shall be effective January 1, 1999 and shall apply as follows.

1. Except as provided in ~~§1951.G.2~~ §1957.G.2, the provisions of ~~§1951~~ §1957 apply to a long-term care policy issued in this state on or after the effective date of the amended regulation.

2. For certificates issued on or after the effective date of ~~§1951~~ §1957, under a group long-term care insurance policy, as defined in R.S. ~~22:1734~~ 22:1184(4)(a) that was in force at the time this amended regulation became effective, the provisions of ~~§1951~~ §1957 shall not apply.

AUTHORITY NOTE: Promulgated in accordance with ~~R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), repromulgated LR 31:477 (February 2005); repromulgated LR

§1957. Requirement to Deliver Shopper's Guide (former §1951)

§1959. Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts (former §1953)

A. – C. ...

D. Certifications regarding activities of daily living and cognitive impairment required pursuant to ~~§1953.C~~ §1959.C shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the secretary of the treasury.

E. Certifications required pursuant to ~~§1953.C~~ §1959.C may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the 90-day period.

F. ...

AUTHORITY NOTE: Promulgated in accordance with ~~R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:477 (February 2005), repromulgated LR

§1959. Penalties (former § 1953)

§1961. Appealing An Insurer's Determination That the Benefit Trigger is Not Met

A. For purposes of this §1961, "authorized representative" is authorized to act as the covered person's personal representative within the meaning of 45 CFR 164.502(g) promulgated by the Secretary of the U.S. Department of Health and Human Services under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act and means the following:

1. A person to whom a covered person has given express written consent to represent the covered person in an external review;
2. A person authorized by law to provide substituted consent for a covered person; or
3. A family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent.

B. If an insurer determines that the benefit trigger of a long-term care insurance policy has not been met, it shall provide a clear, written notice to the insured and the insured's authorized representation, if applicable, of all of the following;

1. The reason that the insurer determined that the insured's benefit trigger has not been met;
2. The insured's right to internal appeal in accordance with §1961.C, and the right to submit new or additional information relating to the benefit trigger denial with the appeal request; and
3. The insured's right, after exhaustion of the insurer's internal appeal process, to have the benefit trigger determination reviewed under the independent review process in accordance with §1961.D.

C. Internal Appeal. The insured or the insured's authorized representative may appeal the insurer's adverse benefit trigger determination by sending a written request to the insurer, along with any additional supporting information, within 120 calendar days after the insured and the insured's authorized representative, if applicable, receives the insurer's benefit determination notice. The internal appeal shall be considered by an individual or group of individuals designated by the insurer, provided that the individual or individuals making the internal appeal decision may not be the same individual or individuals who made the initial benefit determination. The internal appeal shall be completed and written notice of the internal appeal decision shall be sent to the

insured and the insured's authorized representative, if applicable, within 30 calendar days of the insurer's receipt of all necessary information upon which a final determination can be made.

1. If the insurer's original determination is upheld upon internal appeal, the notice of the internal appeal decision shall describe any additional internal appeal rights offered by the insurer. Nothing herein shall require the insurer to offer any internal appeal rights other than those described in §1961.C.

2. If the insurer's original determination is upheld after the internal appeal process has been exhausted, and new or additional information has not been provided to the insurer, the insurer shall provide a written description of the insured's right to request an independent review of the benefit determination as described in §1961.D to the insured and the insured's authorized representative, if applicable.

3. As part of the written description of the insured's right to request an independent review, an insurer shall include the following, or substantially equivalent, language: "We have determined that the benefit eligibility criteria ("benefit trigger") of your [policy] [certificate] has not been met. You may have the right to an independent review of our decision conducted by long-term care professionals who are not associated with us. Please send a written request for independent review to us at [address]. You must inform us, in writing, of your election to have this decision reviewed within 120 days of receipt of this letter. Listed below are the names and contact information of the independent review organizations approved by your state insurance commissioner's office to conduct long-term care insurance benefit eligibility reviews. If you wish to request an independent review, please choose one of the listed organizations and include its name with your request for independent review. If you elect independent review but do not choose an independent review organization with your request, we will choose one of the independent review organizations for you and refer the request for independent review to it."

4. If the insurer does not believe the benefit trigger decision is eligible for independent review, the insurer shall inform the insured and the insured's authorized representative, if applicable, and include in the notice the reasons for its determination of independent review ineligibility.

5. The appeal process described in §1961.C is not deemed to be a "new service or provider" as referenced in §1951, Availability of New Services or Providers, and therefore does not trigger the notice requirements of §1951.

D. Independent Review of Benefit Trigger Determination.

1. Request. The insured or the insured's authorized representative may request an independent review of the insured's benefit trigger determination after the internal appeal process outlined in §1961.C has been exhausted. A written request for independent review may be made by the insured or the insured's authorized representative to the insurer within 120 calendar days after the insurer's written notice of the final internal appeal decision is received by the insured and the insured's authorized representative, if applicable.

2. Cost. The cost of the independent review shall be borne by the insurer.

3. Independent Review Process.

a. Within five business days of reviewing a written request for independent review, the insurer shall refer the request to the independent review organization that the insured or the insured's authorized representative has chosen from the list of approved organizations the insurer has provided to the insured. If the insured or the insured's authorized representative does not choose an approved independent review organization to perform the review, the insurer shall choose an

independent review organization approved by the state. The insurer shall vary its selection of authorized independent review organizations on a rotating basis.

b. The insurer shall refer the request for independent review of a benefit trigger determination to an independent review organization subject to the following:

i. The independent review organization shall be on a list of approved independent review organizations that satisfy the requirements of a qualified long-term care insurance independent review organization contained in §1961;

ii. The independent review organization shall not have any conflicts of interest with the insured, the insured's authorized representative, if applicable, or the insurer; and

iii. Such review shall be limited to the information or documentation provided to and considered by the insurer in making its determination, including any information or documentation considered as part of the internal appeal process.

c. If the insured or the insured's authorized representative has new or additional information not previously provided to the insurer, whether submitted to the insurer or the independent review organization, such information shall first be considered in the internal review process, as set forth in §1961.C.

i. While this information is being reviewed by the insurer, the independent review organization shall suspend its review and the time period for review is suspended until the insurer completes its review.

ii. The insurer shall complete its review of the information and provide written notice of the results of the review to the insured and the insured's authorized representative, if applicable, and the independent review organization within five business days of the insurer's receipt of such new or additional information.

iii. If the insurer maintains its denial after such review, the independent review organization shall continue its review and render its decision within the time period specified in §1961.D.3.i below. If the insurer overturns its decision following its review, the independent review request shall be considered withdrawn.

d. The insurer shall acknowledge in writing to the insured and the insured's authorized representative, if applicable, that the request for independent review has been received, accepted, and forwarded to an independent review organization for review. Such notice will include the name and address of the independent review organization.

e. Within five business days of receipt of the request for independent review, the independent review organization assigned pursuant to §1961.D.3 shall notify the insured and the insured's authorized representative, if applicable, and the insurer that it has accepted the independent review request and identify the type of licensed health care professional assigned to the review. The assigned independent review organization shall include in the notice a statement that the insured or the insured's authorized representative may submit in writing to the independent review organization within seven days following the date of receipt of the notice of additional information and supporting documentation that the independent review organization should consider when conducting its review.

f. The independent review organization shall review all of the information and documents received pursuant to §1961.D.3.e that has been provided to the independent review organization. The independent review organization shall provide copies of any documentation or information provided by the insured or the insured's authorized representative to the insurer for its review, if

it is not part of the information or documentation submitted by the insurer to the independent review organization. The insurer shall review the information and provide its analysis of the new information in accordance with the §1961.D.3.h.

g. The insured or the insured's authorized representative may submit, at any time, new or additional information not previously provided to the insurer but pertinent to the benefit trigger denial. The insurer shall consider such information and affirm or overturn its benefit trigger determination. If the insurer affirms its benefit trigger determination, the insurer shall promptly provide such new or additional information to the independent review organization for its review, along with the insurer's analysis of such information.

h. If the insurer overturns its benefit trigger determination:

i. The insurer shall provide notice to the independent review organization and the insured and the insured's authorized representative, if applicable, of its decision; and

ii. The independent review process shall immediately cease.

i. The independent review organization shall provide to the insured and the insured's authorized representative, if applicable, and the insurer written notice of its decision, within 30 calendar days from receipt of the referral referenced in §1961.D.3.b. If the independent review organization overturns the insurer's decision, it shall:

i. Establish the precise date within the specific period of time under review that the benefit trigger was deemed to have been met;

ii. Specify the specific period of time under review for which the insurer declined eligibility but during which the independent review organization deemed the benefit trigger to have been met; and

iii. For tax-qualified long-term care insurance contracts, provide a certification (made only by a licensed health care practitioner as defined in Section 7702B(c)(4) of the Internal Revenue Code) that the insured is a chronically ill individual.

j. The decision of the independent review organization with respect to whether the insured met the benefit trigger will be final and binding on the insurer.

k. The independent review organization's determination shall be used solely to establish liability for benefit trigger decisions and is intended to be admissible in any proceeding only to the extent it establishes the eligibility of benefits payable.

l. Nothing in §1961 shall restrict the insured's right to submit a new request for benefit trigger determination after the independent review decision, should the independent review organization uphold the insurer's decision.

m. The insurance department shall utilize the criteria set forth in §1969, Appendix H, Guidelines for Long-Term Care Independent Review Entities, in certifying or approving entities to review long-term care insurance benefit trigger decisions.

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

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

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

2. Neither it nor any of its licensed health care professionals may, in any manner, be related to or affiliated with an entity that previously provided medical care to the insured.

3. Utilize a licensed health care professional who is not an employee of the insurer or related in any manner to the insured.

4. Neither it nor its licensed health care professional who conducts the reviews may receive compensation of any type that is dependent on the outcome of the review.

5. Be state approved to conduct such reviews if the state requires such approvals.

6. Provide a description of the fees to be charged by it for independent reviews of a long-term care insurance benefit trigger decision. Such fees shall be reasonable and customary for the type of long-term care insurance benefit trigger decision under review.

7. Provide the name of the medical director or health care professional responsible for the supervision and oversight of the independent review procedure.

8. Have on staff, or contract with, a licensed health care practitioner, as defined by Section 7702B(c)(4) of the Internal Revenue Code of 1986, as amended, who is qualified to certify that an individual is chronically ill for purposes of a qualified long-term care insurance contract.

F. Maintenance of Records and Reporting Obligations by Independent Review Organizations. Each approved independent review organization shall comply with the following:

1. Maintain written documentation establishing the date it receives a request for independent review, the date each review is conducted, the resolution, the date such resolution was communicated to the insurer and the insured, the name and professional status of the reviewer conducting such review in an easily accessible and retrievable format for the year in which it received the information, plus two calendar years.

2. Be able to document measures taken to appropriately safeguard the confidentiality of such records and prevent unauthorized use and disclosures in accordance with applicable federal and state law.

3. Report annually to the commissioner, by June 30, in the aggregate and for each long-term care insurer all of the following:

a. The total number of requests received for independent review of long-term care benefit trigger decisions;

b. The total number of reviews conducted and the resolution of such reviews (i.e., the number of reviews which upheld or overturned the long-term care insurer's determination that the benefit trigger was not met);

c. The number of reviews withdrawn prior to review;

d. The percentage of reviews conducted within the prescribed timeframe set forth in §1961.D.3.i; and

e. Such other information the commissioner may require.

4. Report immediately to the commissioner any change in its status which would cause it to cease meeting any of the qualifications required of an independent review organization performing independent reviews of long-term care benefit trigger decisions.

G. Additional Rights. Nothing contained in this Section shall limit the ability of an insurer to assert any rights an insurer may have under the policy related to:

1. An insured's misrepresentation;
2. Changes in the insured's benefit eligibility; and
3. Terms, conditions, and exclusions of the policy, other than failure to meet the benefit trigger.

H. Applicability. The requirements of §1961 apply to a benefit trigger request made under a long-term care insurance policy on or after [the date that is 12 months after the amendment of Regulation 46].

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR

§1961. Appendices (former § 1955)

§1963. Standard Format Outline of Coverage (former §1955)

A. Section ~~1955~~ 1963 of the regulation implements, interprets, and makes specific the provisions of R.S. ~~22:1736~~ 22:1186(G) in prescribing a standard format and the content of an outline of coverage.

B. – F. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. ~~22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:478 (February 2005), LR

§1965. Requirement to Deliver Shopper's Guide (former §1957)

A. ...

B. Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under R.S. ~~22:1736~~ 22:1186(I).

AUTHORITY NOTE: Promulgated in accordance with R.S. ~~22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:480 (February 2005), repromulgated LR

§1967. Penalties (former §1959)

A. ...

AUTHORITY NOTE: Promulgated in accordance with ~~R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740~~ R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:480 (February 2005), repromulgated LR

§1969. Appendices (former 1961)

A. ...

B. Appendix B

LONG-TERM CARE INSURANCE
PERSONAL WORKSHEET

...

Questions Related to Your Income

...

Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

...

C. Appendix C

THINGS YOU SHOULD KNOW BEFORE YOU BUY LONG-TERM CARE INSURANCE

...

Facilities

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

D. ...

E. Appendix E

CLAIMS DENIAL REPORTING FORM
LONG-TERM CARE INSURANCE

...

Instructions

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

Per claimant – counts each individual who makes one or a series of claim requests.

Per transaction – counts each claim payment request.

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

Inforce Data

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

Claims & Denial Data

...

F. Appendix F

...

[The following contingent nonforfeiture disclosure need only be included for those limited pay policies to which §1955.D.4 and §1955.D.6 are applicable.

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

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

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

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

2. You stop paying your premiums within 120 days of when the premium increase took effect; AND

3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

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

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

b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

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

Example:

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

G. ...

H. Appendix H

GUIDELINE FOR LONG-TERM CARE INDEPENDENT REVIEW ENTITIES

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

a. The independent review organization shall ensure that all health care professionals on its staff and with whom it contracts to provide benefit trigger determination reviews hold a current unrestricted license or certification to practice a health care profession in the United States.

b. The independent review organization shall ensure that any health care professional on its staff with whom it contracts to provide benefit trigger determination reviews who is a physician holds a current certification by a recognized American medical specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

c. The independent review organization shall ensure that any health care professional on its staff with whom it contracts to provide benefit trigger determination reviews who is not a physician holds a current certification in the specialty in which that person is licensed, by a recognized American specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

d. The independent review organization shall ensure that all health care professionals on its staff and with whom it contracts to provide benefit trigger determination reviews have no history of disciplinary actions or sanctions including, but not limited to, the loss of staff privileges or any participation restriction taken or pending by any hospital or state or federal government regulatory agency.

e. The independent review organization shall ensure that neither it, nor any of its employees, agents, or licensed health care professionals utilized for benefit trigger determination reviews receives compensation of any type that is dependent on the outcome of the review.

f. The independent review organization shall ensure that neither it, nor any of its employees, agents, or licensed health care professionals it utilized for benefit trigger determination reviews are in any manner related to, employed by, or affiliated with the insurer, insured, or with a person who previously provided medical care or long-term care services to the insured.

g. The independent review organization shall provide a description of the qualifications of the reviewers retained to conduct independent review of long-term care insurance benefit trigger decisions, including the reviewer's current and past employment history, practice affiliations, and a description of past experience with decisions relating to long-term care, functional capacity, dependency in activities of daily living, or in assessing cognitive impairment. Specifically, with regard to reviews of tax qualified long-term care insurance contracts, it must demonstrate the ability to assess the severity of cognitive impairment requiring substantial supervision to protect the individual from harm or with assessing deficits in the ability to perform without substantial assistance from another person at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity.

h. This independent review organization shall provide a description of the procedures employed to ensure that reviewers conducting independent reviews are appropriately licensed or registered; trained in the principles, procedures, and standards of the independent review organization; and knowledgeable about the functional or cognitive impairments associated with the diagnosis and disease staging processes, including expected duration of such impairment, which is the subject of the independent review.

i. The independent review organization shall provide the number of reviewers retained by the independent review organization and a description of the areas of expertise available from such reviewers and the types of cases such reviewers are qualified to review (e.g. assessment of cognitive impairment or inability to perform activities of daily living due to a loss of functional capacity).

j. The independent review organizations shall provide a description of the policies and procedures employed to protect confidentiality of protected health information, in accordance with federal and state law.

k. The independent review organization shall provide a description of its quality assurance program.

l. The independent review organization shall provide the names of all corporations and organizations owned or controlled by the independent review organization or which own or control the organization, and the nature and extent of any such ownership or control. The independent review organization shall ensure that neither it, nor any of its employees, agents, or licensed health care professionals utilized are not a subsidiary of, or owned or controlled by, an insurer or by a trade association of insurers of which the insured is a member.

m. The independent review organization shall provide the names and résumés of all directors, officers, and executives of the independent review organization.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR