

RULES AND REGULATIONS

Title 31—INSURANCE

INSURANCE DEPARTMENT

[31 PA. CODE CHS. 89 AND 89a]

Long-Term Care Insurance

The Insurance Department (Department) deletes Chapter 89, Subchapter M and adds Chapter 89a (relating to long-term care insurance model regulation) to read as set forth in Annex A. Chapter 89a sets forth the requirements for the content and filing of long-term care insurance form and rate filings.

Statutory Authority

The rulemaking is adopted under the authority contained in sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412) and sections 1101—1115 of The Insurance Company Law of 1921 (act) (40 P. S. §§ 991.1101—991.1115).

Comments and Response

Notice of proposed rulemaking was published at 31 Pa.B. 5553 (October 6, 2001) with a 30-day comment period. During the 30-day comment period, comments were received from Independence Blue Cross (IBC), the Insurance Federation of Pennsylvania, Inc. (IFP), the Independent Insurance Agents of Pennsylvania, the Pennsylvania Association of Insurance and Financial Advisors and the Pennsylvania Association of Health Underwriters (AGENTS).

On December 6, 2001, as part of its regulatory review, the Independent Regulatory Review Commission (IRRC) submitted comments to the Department. The following is a response to those comments.

Rather than listing the sections of the regulations where commentators expressed their full support, the Department would like to express its sincere thanks to those commentators for supporting the regulations.

Section 89a.103. Definitions.

The AGENTS noted that the terms “producer,” “agent” or “broker” are all used throughout various sections in the regulations. It was recommended that the term “producer” be used throughout the regulations. The AGENTS further noted that the term “producer” should be redefined as, “a licensee that solicits, sells or negotiates an insurance product.”

IRRC noted that the term “producer” was defined, yet the regulations contained reference to the terms “agent” and “broker.” Therefore, the term “producer” needs to be used consistently throughout the regulations and the terms “agent” and “broker” should be replaced with “producer.”

The Department agrees and has made the change as requested to use the term “producer” consistently throughout the regulations. However, the Department has retained the current definition as it cites current statutory law.

Definitions of “exceptional increase”

The AGENTS commented that the wording was somewhat unclear and the criteria for approving premium schedule rate increases is not clearly spelled out in the regulation. They suggested the following substitution:

“Rate increases. Those increases in premiums for long-term care policies, which are either schedule rate increases or exceptional rate increases.

(a) Schedule rate increases are those premium increases approved by the Commissioner when . . . (list the conditions under which a schedule rate increase may occur.)

(b) Exceptional increases are those premium increases deemed by the Commissioner to be outside of the scope of schedule rate increases and based on justification that:

(i) Due to changes in laws and regulations . . .

(ii) Due to increased and unexpected utilization . . .

(iii) Except as substantiated by an actuarial review requested by the Commissioner.”

The Department has taken the language from the National Association of Insurance Commissioners (NAIC) Long-Term Care Insurance Model Regulation (Model) and believes that the language is sufficiently clear both in the definition and as well as in § 89a.118 (relating to premium rate schedule increases). No change was made.

Section 89a.104. Policy definitions.

Definition of “bathing”

The IFP stated that the various components of the activities of daily living are essential to triggering benefits under long-term care policies and any variation from state to state would cause administrative problems. Several IFP members noted that in the definition of “bathing” in § 89a.104, the Department has added to the NAIC Model definition the phrase, “. . . or drawing the water for a sponge bath and getting the equipment to the person or the person to the equipment.”

The IFP believed that this is a complicating addition for several reasons. First, it implies that some element in this Commonwealth differs from the understanding of insurers around the country about this term. Presumably, getting to and from the bathing location and equipment is an integral part of being able to wash oneself. Second, the introduction of the capabilities of a second person who may be bringing the person to the equipment or the equipment to the person is simply confusing. Individuals cannot acquire an Activity of Daily Living (ADL) from a caregiver.

The IFP believed that unless there is some major need for this additional phrase, it should be deleted, staying with the NAIC Model’s definition.

IRRC also had concerns with the term “bathing.” They stated that the definition of this term begins with a reference to “oneself,” but concludes with the phrase “or drawing the water for a sponge bath and getting the equipment to the person or the person to the equipment.” It is IRRC’s understanding that the Department did not intend for the definition to encompass the services of a second person. Therefore, the definition should be revised to clarify this point. Further, IRRC requested the Department to provide an explanation for the deviation from the NAIC Model language.

This phrase is not included in the definition of “bathing” in the NAIC Model. Furthermore, the references to transporting equipment or the person imply that a second person is involved in the bathing process.

The Department agrees with all comments and has changed the definition to mirror the NAIC Model language.

Definition of "cognitive impairment"

The IBC expressed concerns about the definition of "cognitive impairment" and that the regulations define cognitive impairment without the ability of an insurer to qualify the level of impairment for purposes of benefit eligibility. Although the IBC recognizes that the proposed definition is the medical standard, the IBC believed that the term "deficiency," which is defined in the dictionary as "inadequacy," is not a sufficiently significant standard to trigger benefits for the type of cognitive impairment covered by long-term care insurance policies. Further, it appears that the draft regulations can be interpreted to prohibit an insurer from establishing an appropriate standard to determine the level of cognitive impairment subject to long-term care insurance benefits. While the IBC did not object to a definition requiring only one type of deficiency before a person would be determined cognitively impaired, it seems that the language of the draft regulations could allow benefits to be triggered for minimum cognitive impairment when a person is still capable of functioning independently. The IBC believed that the draft definition ultimately could lead to an inordinate number of claims for minimal cognitive impairment, and this could adversely affect premium rates for future policyholders.

In the alternative, the IBC suggested that the Department adopt a definition that allows the policyholder with moderate to severe cognitive impairment to appropriately claim benefits as well as the insurer to develop rates for long-term care insurance that are affordable by the consumer. In this regard, the IBC suggested the following definition:

"Cognitive impairment" means a [significant deficiency/deterioration] in a person's short-term or long-term memory, recognition as to person, place and time, deductive or abstract reasoning, or judgment [as it relates to safety awareness/that requires continual supervision to protect the individual covered under the policy].

An alternative would be to retain the draft definition but include in the regulations an express provision that allows insurers to determine at least a moderate level of cognitive impairment for a policyholder to claim benefits.

The Department does not agree and is retaining the definition as contained in the NAIC Model. Cognitive impairment should be determined by standardized testing therefore the change was not warranted.

Definition of "long-term care insurance"

The AGENTS stated that a restatement of section 1103 of the act (40 P. S. § 991.1103) would be useful in the regulations to show that it includes qualified and non-qualified products, which are then defined separately in the definition.

The Department does not believe that a reiteration of the statute would add any substantive clarification. Therefore no change has been made.

Definition of "mental or nervous disorder"

The AGENTS stated that the definition should be checked to see if it is compliant with the Healthcare Insurance Portability and Accountability Act (Pub. L. No. 104-191, 110 Stat. 1836) (HIPAA) and the act of December 21, 1998 (P. L. 1108, No. 150) (Act 150) regarding conditions covered under mental health parity. If there is

a group long-term care policy with over 50 lives, the definition may need to be compatible. In addition to the text of covered conditions, there should be proper legislative citation.

The Department disagrees as the HIPAA and Act 150 specifically exempt the long-term care policies from this requirement.

Definition of "home health care service"

The AGENTS raised the issue of whether this regulation complies with the act of December 20, 2000 (P. L. 967, No. 132) (Act 132) as it relates to home health care services.

The Department believes that the intent of section 4 of Act 132 (40 P. S. § 991.1103) was to include home health care service contracts under the definition of insurance rather than to define the actual services to be provided by home health care services. Any entity selling home health care service contracts that meets the revised definition in the Long-Term Care Act would be subject to these regulations. Therefore, no change was made.

Definition of "Medicare"

The IFP stated that in referring to the Federal legislation which constitutes this program, this definition omits the NAIC phrase "and any later amendments or substitutes thereof." Since the purpose of defining this term is presumably to treat benefits under that program as a whole, adding this phrase will prevent any inadvertent gaps from being created by changes in the Medicare program over time. They suggested the quoted phrase to contemplate future changes.

IRRC stated that this definition is similar to the corresponding definition in the NAIC Model. However, the NAIC Model definition of "Medicare" references "any later amendments or substitutes thereof." The Department should revise the definition to include the NAIC language. Otherwise, the definition will not encompass future amendments to the Medicare statutes.

The Department agrees and has made the requested changes.

§ 89a.104(b)

The IFP stated that identifying providers of services may depend on their appropriate licensure or certification, the Department has added the phrase "when the licensure or certification of the provider is required by the Commonwealth." The phrase, which varies from the NAIC Model, causes a problem by implying that appropriate licensure may not be required if another state does not have that requirement.

Since licensure or certification usually includes oversight, long-term care insurers would be hesitant to cover and somewhat lost to underwrite care provided at facilities not subject to that oversight. The IFP proposes that this phrase be deleted.

IRRC had concerns with subsection (b) which addresses the definitions of various service providers. The last sentence states, "The definition may require that the provider be appropriately licensed or certified when the licensure or certification of the provider is required by the Commonwealth." IRRC believed that this sentence was confusing and that the intent of this provision should be clarified in the final-form regulations.

The Department is concerned that long-term care insurers could require providers of services who are not subject to Commonwealth licensure or certification to be licensed or certified in order to cover their services. The section

has been modified to clarify that an insurer can require licensure or certification "only" if the "state in which the provider is located" requires licensure or certification of that provider.

Section 89a.105. Policy practices and provisions.

Definition of "level premium"

The IBC believed the proposed definition of "level premium" should be clarified by the addition of the phrase "for an individual person" after the phrase "change the premium." Otherwise, the absence of the term "level premium" may incorrectly lead the consumer to believe that the policy premium can change due to individual circumstances, such as attained age, health status, etc.

The Department is following the NAIC Model language and believes that the intent of this strict language is to not permit the use of the term "level premium" in any circumstance where the insurer has the ability to change the premium. The NAIC Model language was retained and no change was made.

Mental or nervous disorders

The IFP stated that § 89a.105(b)(1)(ii) prohibits the exclusion or limitation of benefits based on someone having "Alzheimer's Disease or other related degenerative or dementing illnesses." In that these diseases are not clearly defined, the IFP suggested that the Department use the language within the § 89a.126(e)(12) (relating to standard format outline of coverage) prohibiting exclusion for "insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses."

The IFP believed that while this would not operate as a complete definition, it would guarantee a clinical diagnosis of Alzheimer's or a related condition.

IRRC commented that the reference to "other related degenerative or dementing illnesses" in § 89a.105(b)(1)(ii) is vague and is not in the NAIC Model. IRRC further suggested that these terms should be clarified or deleted.

The Department agrees with the comments and has made the clarifying change as suggested by the IFP and IRRC. The Department added the additional language to be consistent with the language contained in the standard format Outline of Coverage in § 89a.126(e)(12). The standard format Outline of Coverage is consistent with the current regulation in § 89.919(5)(10) (relating to standard format for outline of coverage).

Premium rate increase

The AGENTS noted that in § 89a.105(f)(2), a reduction in benefits is not considered a premium change, and questioned whether the insurer should issue a retro credit or premium rollback to the initial annual premium date or whether the initial premium rate remains with reduced benefits.

The Department would like to clarify that § 89a.105(f)(2) and (3) are specifically related to the nonforfeiture benefit requirement in § 89a.123 (relating to nonforfeiture of benefit requirement). These two paragraphs define how initial premium levels are determined when changes in coverage levels have occurred that may trigger the nonforfeiture benefit. These paragraphs do not require insurers to issue retro credits or premium rollbacks. Therefore, the Department does not believe any further clarification or changes are necessary.

Privileged Information

IRRC mentioned that § 89a.105(g)(1)(iii) requires that telephonic or electronic enrollment include safeguards that assure the confidentiality of "individually identifiable information." This provision in the NAIC Model includes the terms "individually identifiable information" and "privileged information." The NAIC Model also references a definition of "privileged information." The Department should explain why the term "privileged information" is not in this provision in the proposed rulemaking.

The Department did not incorporate this language because the NAIC Model references a definition that has not been adopted in the Commonwealth in either statute or regulation. Furthermore, privacy concerns have been addressed by Chapter 146a (relating to privacy of consumer financial information). In addition, the health information will be covered with the promulgation of Chapter 146b (relating to privacy of consumer health information). Thus, broad privacy protection will be accomplished by means of two different regulations.

Section 89a.106. Unintentional lapse.

The AGENTS stated that in § 89a.106(a)(3) the following should be inserted "The 30-day notice by the insurer to the insured of a lapse for nonpayment of premium should be preceded by a notice from the insurer to the insurance producer." The AGENTS believed that the goal is to keep people covered. A producer can follow up to see if the premium notice was overlooked or that the insured's medical condition changed so that the bill was not paid. The AGENTS felt it is good public policy to prevent unintentional lapses in coverage. Requiring notification to the individual producer as soon as the termination date occurs puts the person who has the greatest interest in policy retention into the front line of clarifying the cause for the unintentional lapse. Producer notification as soon as the due date passes gives the consumer a chance to preserve coverage.

The Department wants to clarify that this regulation allows the insured to designate one additional person to be notified upon the lapse or termination of the policy. The insured has the choice of that designation. The Department can appreciate the AGENTS concerns and therefore have no objection to having an insured name the producer as an alternate to receive notices, if that is what the insured desires. However, it would be unduly burdensome on insurers to mandate that they also send the producer a notice of lapse or termination. Furthermore, this would be a significant deviation from the NAIC Model. Nothing in the regulation prohibits an insurer from notifying the producer of a lapse or termination in addition to the insured and their designee.

Section 89a.108. Required disclosure of rating practices to consumers.

In general, the IBC agreed with the intent of the draft regulations to protect the consumer by establishing new regulatory standards on disclosure and development of premium rates. The IBC believed that certain insurers in the long-term care marketplace have engaged in predatory pricing practices from time to time to the detriment of the consumer. Predatory pricing can result in large rate increases often unaffordable for individual policyholders, who potentially would be left without coverage. This practice damages the industry's reputation as well. Long-term care insurance is a relatively immature product without a large experience base or standard policies. Therefore, a significant amount of actuarial judgment is involved in developing rates. Furthermore, unlike health

insurance, claims experience can take a long time to develop as well as be subject to short-term fluctuations. The practice of a 10-year "look back" period covers a period in which there were significant changes in the long-term care insurance marketplace. The IBC was concerned that a long period could result in irrelevant or potentially misleading information being presented to the consumer. Therefore, the IBC recommends a shorter "look back" period, such as 5 years.

The AGENTS stated that § 89a.108(b)(5) requiring 10 years' rate experience seemed like consumerism but it may be hard to achieve. Products change. The long-term care policies have evolved considerably over the past few years. Specific coverage being offered now may not have existed 10 years ago, as with qualified long-term care policies which did not come into existence until the HIPAA in 1996. The AGENTS recommended that subsection (b)(5) be deleted.

The AGENTS also stated that § 89a.108(c) requiring consumer signature attesting to the fact that he has read the cost of the product's evolution over 10 years may be meaningless because, as mentioned previously, the product is not the same. Besides, the consumer is more interested in what is being obtained now. That is a little like saying that a small group two-person health product costing \$722 per month now only cost \$200 10 years ago is relevant. It's not relevant to today's sale because the world has changed with new mandates, greater utilization, more uncompensated care and the resulting cost shifting to those with insurance, and the like.

The AGENTS stated that § 89a.108(e) requiring notice of a premium rate schedule increase to consumers 45 days prior to implementation date is prudent. They also wanted "Advance notice to producers should also be sent out by the insurer" added to this section. This helps the consumer in two ways: First, the producer can explain the basis for the change and preserve the account; or, second, if the rate increase is too steep, the producer will have some time to shop around to other insurers on the consumer's behalf.

IRRC believed that in § 89a.108(b)(5), insurers are required to provide premium rate increase information for a policy form or similar forms for the past 10 years. They stated that comparable policies, in many cases, did not exist 10 years ago and wanted the Department to amend the regulation to provide for flexibility when 10 years of data is not available.

The Department wants to note that the 10-year history requirement is NAIC Model language. It was developed with insurance industry input. The Department agrees that not all policies (or similar policies) existed 10 years ago; therefore the information is not available. As a result, the Department is inserting the following language "... over the past 10 years or *during the existence of the policy or similar policy up to a maximum of 10 years for this state . . .*" (new language italicized). This new language should allow flexibility when the 10-year history is not available, while still remaining consistent with the intent of the NAIC Model.

With respect to § 89a.108(c), the Department believes this requirement is an important consumer protection provision to ensure that consumers are provided with the consumer disclosure information required by the regulation. This section is consistent with the NAIC Model and no changes have been made to it.

With respect to § 89a.108(e), the Department believes that this proposed requirement would also be burdensome

to insurers and is not consistent with the NAIC Model. Nothing in the regulation would prohibit the insurer from providing this type of notification to producers.

Section 89a.109. Initial filing requirements.

IBC stated that § 89a.109(b)(2)(iv)(B) provides that an actuary must certify that he has taken into account moderately adverse experience, i.e., a contingency margin, and that the carrier is pricing with the expectation of no future rate increase. Overall, IBC believed that this provision is a positive addition to the regulatory scheme as it will protect the consumer from certain predatory pricing practices. However, the IBC believed that there is also a negative aspect to this requirement in cases when an actuary has followed the regulatory guidelines, including margin and pricing so that there is no anticipated rate increase, but the carrier still is forced to file a rate increase.

The Department wants to note that this requirement is consistent with the NAIC Model. The Department believes this requirement is important for providing rate stability and predictability, one of the main goals of these revised regulations. No changes have been made.

IRRC noted that § 89a.109 of the proposed rulemaking does not mention a specific time period, but does reference the Accident and Health Filing Reform Act (40 P. S. §§ 3801—3815). To be more specific, the regulation should reference the time periods in sections 3 and 4 of the Accident and Health Filing Reform Act (40 P. S. §§ 3803 and 3804). IRRC also noted that in the NAIC Model, the insurer is given 30 days to provide the required information to the Commissioner.

The Department has added the specific citations to the regulation. However, the Department does not believe it is necessary to add specific time periods. If the statute changes the time-frames allowed, this reference to the sections will be more appropriate than actually giving the number of days.

Sections 89a.111. Minimum standards.

The IFP believed that in § 89a.111(4), (6) and (7) removing "requiring" from the beginning of the phrase will follow the style of the other subsections which begin with "that."

The Department agrees that this style would be more appropriate and has made the change accordingly.

Section 89a.112. Inflation protection.

The AGENTS supported presenting the option of inflation protection to consumers. Unfortunately, the NAIC Model assumes a choice for inflation protection that may or may not be there unless the consumer specifically opts-out by rejecting this coverage. The NAIC and the Department clearly want to protect consumers from future expenses due to cost of living increases. The way the regulation is currently worded may result in higher-priced coverage than the consumer wanted in the event that the producer did not obtain the signature. This would lead to more consumer complaints to the Department and policy cancellations because they may feel that coverage was forced upon them even if the producer's error was unintentional. A simpler way is to require the signature form as part of the application.

The AGENTS recommend the following language as a substitute for subsection (g).

(g) Inflation protection in a long-term care insurance policy shall be offered by the producer and documented by a form signed by the consumer that

attests to the fact that inflation protection was offered and accepted or rejected. The form may be included within the application or on a separate form as the insurer chooses. An insurer shall not accept an application from a producer without this signed form.'

MThe text of this signed statement shall read, "I have reviewed the outline of coverage and graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed policies(s) _____, and I accept ___ reject ___ (check one) inflation protection."

The IFP believed that in describing in § 89a.112(g), the process by which an applicant may accept or reject inflation protection, the Department prescribes the language by which a rejection should be made. The language currently states that the applicant has "reviewed policy(ies), and . . ." rejects the inflation protection.

The IFP suggested that it would be more accurate in terms of what actually takes place in such a process to have that last sentence state, "Specifically, I have reviewed Plans _____, and I reject inflation protection."

The Department believes it is important to maintain the consumer protections by means of the mandatory offer of inflation protection in § 89a.112(g). This type and manner of offer is consistent with NAIC Model and is therefore not being revised. The Department is making the minor editorial change as suggested by the IFP. This change makes the section consistent with the NAIC Model.

Section 89a.113. Requirements for application forms and replacement coverage.

The IFP brought to the Department's attention that while it is legally more accurate, the substitution of "Commonwealth" for "state" in various standardized forms which must be delivered requires carriers to dispense with current materials, file forms for approval and print materials specific to Pennsylvania. It would save insurers money if this change were deleted from the proposal at least with respect to specified forms which must be delivered and the use of which insurers may already have adopted across their operations.

The IFP pointed out, for example, that in § 89a.113(c) that item 4 of the Statement to Applicant By Agent starts: "2. Commonwealth law provides . . ." This is a variation from the NAIC Model, which, while meaningless in terms of substance, is a cost item which is more than negligible.

IRRC looked at the sample application forms that are to be used by insurance companies and noted that the Department had changed NAIC Model language from "state" to "Commonwealth" in the proposed rulemaking. Commentators have suggested that by substituting "Commonwealth" for "state" in various standardized forms, carriers would be required to print costly materials specific only to Pennsylvania. IRRC wondered if there is a need for insurers to make application forms that are specific to Pennsylvania?

The Department realized that there could be additional and unnecessary costs associated with the changes as proposed and therefore has changed the term "Commonwealth" back to "state" in applications and other standard forms that do not have to be Pennsylvania specific.

Section 89a.114. Reporting requirements.

The AGENTS stated that § 89a.114(b) requiring insurers to report to the Department the top 10% of its producers with the greatest percentages of lapses and replacements appears to be adding to the Department workload without producing discernable benefit. For one thing, the Department's enforcement resources do not extend to launching an investigation of the top 10% unless there is a specific suspected pattern of abuse. If the intent is to have ready access to the data through a Market Conduct Examination, another approach would be to have insurers collect this data and have it readily available if the Department needs it. The other thing missing from this section is the understanding that all replacements are not the same. The Department is looking for abuses occurring when the original policy did not need to be replaced. It should not lump these abuses in with legitimate replacements occurring because of a policy enhancement.

Alternative wording should be:

(b) 'Insurers shall provide this data to the department in the event of a market conduct or enforcement investigation. For purposes of this section, the term replacement shall not include long-term care product improvements or enhancements of coverage as an endorsement to or in the context of an existing policy.'

The AGENTS stated that in § 89a.114(c) they agree with the statement in the regulation that reported replacement and lapse rates do not constitute a violation of insurance law. The AGENTS recommend that the word "alone" be deleted in this sentence. Including it leaves the implication that reported lapse and replacement rates might be a violation of insurance laws or necessarily imply wrongdoing. There may be legitimate reasons why policies lapse, for example if a company does not renew a group plan or if an area is hit by layoffs or by the economic downturn.

The sentence "The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance" should be deleted for the reason stated. If the Department requires the information for purposes of a market conduct exam or enforcement investigation, it is available on a case by case basis from the insurer.

The AGENTS stated that § 89a.114(f) requires reporting of qualified the long-term care contracts. They wondered "Why did the Department ask for this information re qualified and not unqualified policies as well?"

The Department believes that the information required in the reports in § 89a.114(b) are important monitoring and enforcement tools and has not changed the language. The Department is adding a new standardized reporting form as Appendix G (relating to long-term care insurance replacement and lapse reporting form). This new form is being adopted in the NAIC Model.

The Department agrees with the AGENTS regarding § 89a.114(c) that replacement and lapse rates alone should not constitute a violation of insurance laws or necessarily imply wrongdoing. However, they have misinterpreted this section. It affirms that these replacement and lapse rates alone would not be used as the sole evidence of a violation. The Department has not revised the NAIC Model language.

The requirement in § 89a.114(f) is necessary for Federally tax-qualified long-term care policies to meet Federal

IRS requirements. There are no similar requirements for nontax qualified long-term care policies. This is consistent with the NAIC Model and the Department has not made any changes to this section.

Section 89a.115. Licensing.

The AGENTS commented that too specific a reference to a section of the law that may be changed because of Model Producer Licensing Act enactment in the near future may force the Department to update this regulation shortly after it went into effect. Alternative wording might be:

'No one may sell, solicit or negotiate with respect to long-term care insurance unless licensed as a producer by the department.'

The Department wants to note that the statutory citations contained in the regulation are current to date. The Department believes it is appropriate to cite to current law and not take into account pending legislative language. If legislation is enacted, the new requirements would supersede all previous licensing requirements. Thus, no change has been made.

Section 89a.118 Premium rate schedule increases.

The IFP stated that projected lapse and past lapse rates are required for rate increase filings meeting certain criteria under this section. Following the wording of the NAIC Model, it appears that the last word in the first criteria subsection (h)(1) should be "form or forms" rather than "form."

The IBC stated that the required disclosure of all prior rate increases for similar policy forms, especially given the broad definition of "similar" policy forms in § 89a.108(b)(5), could make selling policies difficult after a rate increase. Because the relevant loss ratio calculations for determining rate increases are on a present value basis, and because of the previously-referenced disincentives for rate increases, a company with adverse experience might choose to wait and see if experience improves rather than file for a rate increase. If claims experience does not improve, however, the insurer could sustain a large financial loss that could result in a large premium increase later for the consumer.

The IBC stated that § 89a.118 allows for an 85% loss ratio on the premium increase and a 58% loss ratio on the initial premium in pricing a revised premium. Thus the loss ratio on the block of business over its lifetime is a weighted average (by premium dollars) of 58% and 85%. Under some circumstances, depending on claim and administrative expenses, an insurer ultimately could show a financial loss on the business. Too frequent and significant financial losses could result in the withdrawal of carriers from the marketplace.

The Department agrees with the minor editorial change the IFP suggested and has modified the section to add "or forms" which follows the NAIC Model.

The Department believes that the required loss ratios in § 89a.118 are appropriate. The loss ratios were developed by the NAIC with input from the insurance industry. Thus, the Department has not changed this section.

Section 89a.119, 89.123 and 89.124. Filing requirement; nonforfeiture benefit requirement; and standards for benefit triggers.

The IFP noted that one of its members called attention to the fact that statutory references in the proposed regulation in the captioned sections differ from citations in the current regulation. The IFP suspected that this is

not surprising in light of intervening changes, but suggested that they be reviewed for accuracy.

The Department has reviewed the statutory references and modified § 89a.119 as appropriate. The other referenced sections did not require any changes.

Section 89a.120. Standards for marketing.

The AGENTS stated in § 89a.120(c)(1) that association group marketing of long-term care insurance is a growing component of the market. Associations promoting the long-term care insurance policies do not sell insurance unless they are licensed to do so. Associations may endorse a product under an arrangement with bona fide producers. The word 'selling' should be deleted. The AGENTS suggested the addition of a sentence to read:

"Nothing in this section shall be construed as permitting the marketing, soliciting, selling, or negotiating of an association-sponsored long-term care insurance policy unless there is compliance with producer licensing laws of the Commonwealth."

The AGENTS stated in § 89a.120(c)(3) that the association is required in this section to reveal commissions received. Again, the point must be made that associations must be licensed before it can legally receive commissions. The other issue is the disclosure of the commission itself. Certainly, the association's Board and other decision-makers would have that information when the decision was made. Disclosing commissions received might encourage agent rebating. Members might exert pressure to "give back" some of the commission, something at odds with Act 205 and long-standing Department policy. This regulation should not place producers in a position to fend off association demands for a rebate. Insurance producers are not required to disclose commission income now for any type of insurance. This should not be the place to start.

The AGENTS stated in § 89a.120(c)(5) that the board of directors of an association should be required to approve of the sponsored plan and terms of compensation arrangements with the insurer. Add the words "or producer" since the association considers a sponsored policy through a licensed producer and not necessarily directly to the insurer. Again, the word 'selling' should be deleted as inconsistent with licensing law.

The AGENTS stated in § 89a.120(c)(6) that this section has an exemption for qualified long-term care insurance. The AGENTS requested clarification. Does this pose an added regulatory hurdle for nonqualified plans? This section also mandates that an association "engage the services of a person with expertise in long-term care insurance" to examine the proposed policy, and the like. The AGENTS question this requirement. Should the association always contract with a person having expertise in long-term care insurance before deciding? It may not always be in its best interest if the expert is, in fact, partial towards a competitor. An expert may recommend that the association not pursue a long-term care policy because the consumer may just happen to have a disability income policy that the consumer wants to place. This requirement will enhance predatory behavior in the marketplace. It may also add to the association's total cost of providing long-term care insurance because of the consultant's cost. In addition, if the association has a comfort level with an existing producer or product, why create another hoop to jump through? We understand where we think the Department is going on this provision but maintain that it will impede the growth of long-term care insurance. There is no harm in getting a second opinion

but a better approach would delete existing paragraph (6)(i) and use the following substitute language:

“Nothing shall prevent an association from engaging the services of a person with expertise in the long-term care insurance not affiliated with the insurer to conduct an examination of the policies . . .”

The Department has, after further examination and research, considered the comments made here and has retained language relating to associations from the NAIC Model. The AGENTS stated correctly that associations may only sell, solicit or negotiate insurance when licensed to do so. In such a case, compliance with licensing statutes and all other applicable statutes and regulations would apply accordingly. Further, the Department has added the phrase “or producer” in § 89a.120(c)(5) as suggested by the AGENTS.

Section 89a.123. Nonforfeiture benefit requirement.

Overall the IBC believed this provision is favorable because it prevents carriers from engaging in inappropriately low pricing. In certain instances, predatory pricing carriers would benefit from having received premiums, which later are raised significantly for policies that subsequently lapse after a rate increase. The reason this practice is favorable to the companies is that long-term care insurance is considered a “lapse supported product.” In considering profit or loss for a lapse supported product, an actuary takes into account those policies that lapse after covering issue and maintenance expenses but before claims are incurred.

Under the draft regulations, the policyholder had two choices. The policyholder can obtain either a reduced benefit, under certain circumstances, at the original premium or a reduced paid-up benefit with no further premium payments required in the event of a rate increase. The IBC believed that the addition of these options is a good alternative to the lapse of a policy after a consumer would have paid premiums for a number of years without receiving benefits.

The IBC was concerned, however, that in the event of a rate increase this provision, which potentially provides a nonforfeiture benefit depending on issue age and level of premium increase, imposed another additional cost to the insurer because long-term care insurance is a lapse supported product. The proposed rulemaking did mitigate this cost somewhat by the Department’s allowing the insurer (if the Department is convinced that a rising rate spiral exists) to replace existing coverage, without underwriting, with a comparable product being sold. This is essentially a pooling mechanism that allows individuals holding a troubled policy to switch to a more stable policy without underwriting. While this provision is preferable to merely letting the troubled policy spiral out of control, there are still restrictions on rate increases for the resulting combined block of policies that could prevent a carrier from effectively pricing its products to remain in the marketplace.

The Department believes these requirements are appropriate and were developed by the NAIC with input from the insurance industry. No changes have been made to this section.

Section 89a.124. Standards for benefit triggers.

The AGENTS stated in § 89a.124(b) that this section lists activities of daily living as ‘triggers’ for long-term care insurance. Although the Department uses the word “may,” there appears to be an inference that all must be triggered versus a number of these activities depending

on the specific policy and whether or not it is qualified or nonqualified. Although not explicitly stated, the regulation appears to be addressing nonqualified plans since § 89a.125 (relating to additional standards for benefit triggers for qualified long-term care insurance contracts) cites additional standards for qualified long-term care triggers.

The AGENTS further stated that in light of Act 13, home health care plans that are regulated as long-term care insurance may not have the same set of triggers. Consider substitute language:

‘(b) Insurers must conspicuously list the activities of daily living necessary to trigger benefits.’

The Department considered the use of “may” in § 89a.124(b). It should be noted that § 89a.124(a) requires: “Eligibility for the payment of benefits may not be more restrictive than requiring either a deficiency in the ability to perform not more three activities of daily living or the presence of cognitive impairment.” As stated earlier regarding home health polices in § 89a.104, the home health care insurance licensing requirements added by Act 132 did not address nor change the services provided under home health care insurance that would include benefit triggers. Furthermore, these requirements are consistent with the NAIC Model. The Department believes these requirements are clear and no changes have been made.

Section 89a.125. Additional standards for benefit triggers for qualified long-term care insurance contracts.

The Department has modified this section to put the defined terms in alphabetical order.

Section 89a.126. Standard format for coverage.

The AGENTS stated in § 89a.126(e)(15) that this part of the format directs the policyholder to contact the Department of Aging’s Senior Health Insurance Assistance Program (SHIP) (APPRISE (800) 783-7067) for general questions regarding the long-term care insurance and to the insurer for specific questions about the policy.

From the point of view of the three agents’ associations commenting on this regulation, the first point of contact should be the producer who sold the policy. The consumer has the professional credentials to discuss the long-term care insurance. The consumer also has the professional basis to want a good customer relationship to continue. The incentive is to answer both general and specific questions. The AGENTS strongly believe that the producer is the first recourse. Contacting the Senior Health Insurance Assistance Program or the insurer, or both, should be fallback options after the producer has tried to help resolve the question. The regulation’s language ignores the vital function of the insurance producer.

The AGENTS suggested substitute language should be: “For questions of either a general or specific nature regarding long-term care insurance, contact the licensed insurance producer who sold you the policy. Other resources are the State Senior Health Insurance Assistance Program for questions generally relating to long-term care insurance or the insurer (insert insurance company name and phone number) for questions specific to a particular long-term care policy.”

The Department generally agrees that the producer is an integral part of the communication process with insurance consumers, however it appears unnecessary to list them in this section. The Department, in consistency with IRRC comments on § 89a.113 regarding Nationally consistent forms, has revised this language to be consis-

tent with the NAIC Model by removing the specific reference to the APPRISE Program and using the generic reference to the "State Health Insurance Assistance Program listed in the brochure." The Department believes that APPRISE, which is part of the SHIP program, is the best source for impartial information and counseling on long-term care insurance and the SHIP should be identified as the primary contact for general long-term care insurance questions.

Section 89a.129. Permitted compensation arrangements.

The AGENTS stated in § 89a.129(a) and (b) that the sections listing permitted compensation should spell out exactly the legislative citation regarding new policies (50 %) and renewals (up to 10%) as well as the prohibition on receiving higher commissions on replacements.

Regarding § 89a.129(c), the AGENTS commented that they strongly disagree with the definition to include nonmonetary incentives such as trips. Given that a producer's bonus may include more than one type of insurance, it creates bookkeeping difficulty. If a producer sells several types of health insurance, incentives such as trips are usually bundled rather than being segmented by specific line. In addition, a bonus may have the real world impact of reducing producer financial compensation if there is an overall cap including nonmonetary gain. This amounts to an intrusion into the ways producers are compensated, a stretch from the traditional regulatory reach of the Department. Traditionally, the Department in areas such as Act 143 on the P/C side (agency termination law) has shied away from getting into the middle of agency-company commission issues.

The IFP very much appreciated the Department's willingness to take another look at the advisability of retaining the current regulation's restrictions on sales compensation. The IFP realized that the Department may have received some correspondence from insurers separate from the IFP's on this issue. Moreover, as the IFP discussed, this is noted as an optional piece in the NAIC Model. Frankly, member companies of the IFP have been living with the regulation for some time, so deleting this takes second seat to getting the overall regulation in place.

The IFP stated that there is little use in reiterating arguments for deleting this section which have been well articulated by companies which are experts in selling the product. However, the success of the effort to delete this section probably depends on the Department's view of what has happened in the marketplace and what protections are required.

The IFP also stated that the new regulation unarguably contains many standards intended to address the problem of inappropriate replacements. Further, the Department is aware that the proper sale of this product is contact intensive, so that, unless inappropriate sales behavior is a major problem, allowing ample selling inducements is essential to having both knowledgeable agents and sound sales practices. Consequently, unless there is widespread inappropriate replacement activity which these older restrictions really help discourage, the IFP believes the case for dropping this section is compelling.

IRRC questioned the retention of this section with the existing provisions, which place limits on compensation to an agent or broker for the sale of a long-term care insurance policy (see § 89.921 (relating to permitted compensation arrangements)). For example, the rule limits a commission or other compensation to a maximum of 50% of the first year premium of a long-term care policy.

However, the NAIC Model uses a maximum of 200%. Commentators question the need for the 50% limitation. IRRC wanted to know what is the Department's rationale for maintaining the 50% rule?

The Department noted that section 1112 of the Long-Term Care Act (40 P.S. § 991.1112) requires that: "The department shall promulgate reasonable regulations to establish minimum standards for marketing practices, agent compensation arrangements, agent testing, penalties and reporting practices for long-term care insurance." The Department established the permitted compensation arrangements in 1995 by means of an approved and promulgated regulation to address concerns about marketing and sales practices including churning of policies, which sometimes included physical intimidation of senior citizens. The number of churning cases has decreased since the Department originally promulgated this regulation. However, the Department is concerned that revising these requirements would cause an increase in abusive sales and marketing practices, including churning.

Regarding the NAIC Model language on permitted compensation arrangements, the NAIC Model states: "An insurer or other entity may provide commission or other compensation to an agent or other representative for the sale of a long-term care insurance policy or certificate only if the first year commission or other first year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period." The 200% commission in the NAIC Model is based upon the maximum allowable second year commission for the policy, not based upon the policy premiums, while Pennsylvania's permitted compensation arrangements are based on policy premiums. Therefore, the Department's current regulatory language allows for a higher initial year commission. The Department believes the permitted compensation arrangements are reasonable and has not changed this section.

Appendix B—Long-Term Care Personal Worksheet

The IFP noted that the Long-Term Care Personal Worksheet which is Appendix B follows the NAIC Model except for the addition on the second page under the question about buying inflation protection referring applicants to the Agency on Aging. That information is already provided in the Shopper's Guide and its repetition here would require a separate Pennsylvania form. As the IFP indicated, this is an additional cost to insurers which it appears unnecessary to incur in light of the redundancy.

The Department agrees and, in consistency with the IRRC comments on § 89a.113 regarding Nationally consistent forms, has modified the language to be consistent with the NAIC Model.

The NAIC, at its winter meeting in Chicago (December 2001), proposed that Appendix G be added to the NAIC Model regulation. As this was after the proposed regulation's public comment period, commentators did not have the opportunity to comment on this addition. However, this change was signed off by the industry and does not add any substantive changes to the NAIC Model regulation. In fact, it makes it easier for insurers to use the same format, therefore, the Department has added Appendix G with the appropriate references in § 89a.114.

Affected Parties

This final-form rulemaking applies to insurance companies doing the business of long-term care insurance in this Commonwealth.

Fiscal Impact

State Government

There will be no increase in cost to the Department due to the adoption of Chapter 89a.

General Public

There will be no fiscal impact to the public.

Political Subdivisions

The final-form rulemaking will not impose additional costs on political subdivisions.

Private Sector

This final-form rulemaking will not impose additional costs on insurance companies doing the business of long-term care insurance in this Commonwealth.

Paperwork

The adoption of the rulemaking will not impose additional paperwork on the Department or the insurance industry.

Effectiveness/Sunset Date

This final-form rulemaking becomes effective upon publication in the *Pennsylvania Bulletin*. No sunset date has been assigned.

Contact person

Questions regarding this final-form rulemaking, should be directed to Peter J. Salvatore, Regulatory Coordinator, Office of Special Projects, 1326 Strawberry Square, Harrisburg, PA 17120, (717) 787-4429. In addition, questions may be e-mailed to psalvatore@state.pa.us or faxed to (717) 772-1969.

Regulatory review

Under section 5(a) of the Regulatory Review Act, on January 23, 2002 (71 P.S. § 745.5(a)), the Department submitted a copy of this final-form rulemaking to IRRC and to the Chairpersons of the House Insurance Committee and the Senate Banking and Insurance Committee. In addition to the submitted final-form rulemaking, the Department has provided IRRC and the Committees with a copy of a detailed Regulatory Analysis Form prepared by the Department in compliance with Executive Order 1996-1, "Regulatory Review and Promulgation." A copy of that material is available to the public upon request.

In preparing this final-form rulemaking, the Department considered all comments received from IRRC, the Committees and the public. This final-form rulemaking was deemed approved by the House and Senate Committees on February 12, 2002. In accordance with section 5.1(d) of the Regulatory Review Act (71 P.S. § 745.5a(d)), IRRC met on February 21, 2002, and approved the final-form rulemaking in accordance with section 5.1(e) of the Regulatory Review Act.

Findings

The Department finds that:

(1) Public notice of intention to adopt this rulemaking as amended by this order has been given under sections 201 and 202 of the act of July 31, 1968 (P.L. 769, No. 240) (45 P.S. §§ 1201 and 1202) and the regulations thereunder, 1 Pa. Code §§ 7.1 and 7.2.

(2) The adoption of this rulemaking in the manner provided in this order is necessary and appropriate for the administration and enforcement of the authorizing statutes.

Order

The Department, acting under the authorizing statutes, orders that:

(a) The regulations of the Department, 31 Pa. Code, are amended by deleting §§ 89.901—89.921 and by adding §§ 89a.1—89a.129 and Appendices A—G, to read as set forth in Annex A.

(2) The Department shall submit this order and Annex A to the Office of General Counsel and Office of Attorney General for approval as to form and legality as required by law.

(3) The Department shall certify this order and Annex A and deposit them with the Legislative Reference Bureau as required by law.

(4) This final-form rulemaking shall take effect upon final publication in the *Pennsylvania Bulletin*.

M. DIANE KOKEN,
Insurance Commissioner

(Editor's Note: For the text of the order of the Independent Regulatory Review Commission, relating to this document, see 32 Pa.B. 1362 (March 9, 2002).)

Fiscal Note: Fiscal Note 11-208 remains valid for the final adoption of the subject regulations.

Annex A

TITLE 31. INSURANCE

PART IV. LIFE INSURANCE

CHAPTER 89. APPROVAL OF LIFE, ACCIDENT AND HEALTH INSURANCE

Subchapter M. (Reserved)

§§ 89.901—89.921. (Reserved).

CHAPTER 89a. LONG-TERM CARE INSURANCE MODEL REGULATION

- Sec.
- 89a.101. Purpose.
- 89a.102. Applicability and scope.
- 89a.103. Definitions.
- 89a.104. Policy definitions.
- 89a.105. Policy practices and provisions.
- 89a.106. Unintentional lapse.
- 89a.107. Required disclosure provisions.
- 89a.108. Required disclosure of rating practices to consumers.
- 89a.109. Initial filing requirements.
- 89a.110. Prohibition against postclaims underwriting.
- 89a.111. Minimum standards for home health and community care benefits in long-term care insurance policies.
- 89a.112. Requirement to offer inflation protection.
- 89a.113. Requirements for application forms and replacement coverage.
- 89a.114. Reporting requirements.
- 89a.115. Licensing.
- 89a.116. Reserve standards.
- 89a.117. Loss ratio.
- 89a.118. Premium rate schedule increases.
- 89a.119. Filing requirement.
- 89a.120. Standards for marketing.
- 89a.121. Suitability.
- 89a.122. Prohibition against preexisting conditions and probationary periods in replacement policies or certificates.
- 89a.123. Nonforfeiture benefit requirement.
- 89a.124. Standards for benefit triggers.
- 89a.125. Additional standards for benefit triggers for qualified long-term care insurance contracts.
- 89a.126. Standard format outline of coverage.
- 89a.127. Requirement to deliver shopper's guide.
- 89a.128. Penalties.
- 89a.129. Permitted compensation arrangements.

§ 89a.101. Purpose.

The purpose of this chapter is to implement sections 1101—1115 of the act (40 P.S. §§ 991.1101—991.1115), 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.

§ 89a.102. Applicability and scope.

Except as otherwise specifically provided, this chapter applies to all long-term care insurance policies, including qualified long-term care contracts delivered or issued for delivery in this Commonwealth on or after March 16, 2002, by insurers, fraternal benefit societies, nonprofit hospital plan and professional health services plan corporations, prepaid health plans, health maintenance organizations and all similar organizations. Certain provisions of this chapter apply only to qualified long-term care insurance contracts as noted.

§ 89a.103. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Act—The Insurance Company Law of 1921 (40 P. S. §§ 341—991.2361)

Applicant—The term as defined in section 1103 of the act (40 P. S. § 991.1103).

Certificate—The term as defined in section 1103 of the act.

Commissioner—The Insurance Commissioner of the Commonwealth.

Department—The Insurance Department of the Commonwealth.

Exceptional increase—Only those increases filed by an insurer as exceptional for which the Commissioner determines the need for the premium rate increase is justified.

(i) Increases due to changes in laws or regulations applicable to long-term care coverage in this Commonwealth or due to increased and unexpected utilization that affects the majority of insurers of similar products.

(ii) Except as provided in § 89a.118 (relating to premium rate schedule increases), exceptional increases are subject to the same requirements as other premium rate schedule increases.

(iii) The Commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.

(iv) The Commissioner, in determining that the necessary basis for an exceptional increase exists, will also determine potential offsets to higher claims costs.

Functionally necessary—The term as defined in section 1103 of the act.

Group long-term care insurance—The term as defined in section 1103 of the act.

Incidental—As used in § 89a.118(j), means that the value of the long-term care benefits provided is less than 10% of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

Long-term care insurance—The term as defined in section 1103 of the act.

Medically necessary—The term as defined in section 1103 of the act.

Policy—The term as defined in section 1103 of the act.

Producer—An agent as defined in section 601 of the act (40 P. S. § 231), or a broker as defined in section 621 of the act (40 P. S. § 251).

Qualified actuary—A member in good standing of the American Academy of Actuaries.

Qualified long-term care insurance contract or Federally tax-qualified long-term care insurance contract—

(i) An individual or group insurance contract that meets all of the following requirements of section 7702B(b) of the Internal Revenue Code of 1986 (IRC) (26 U.S.C.A. § 77026B(b)):

(A) The only insurance protection provided under the contract is coverage of qualified long-term care services. A contract may not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(B) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act (42 U.S.C.A. §§ 1395—1395ggg) or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this subparagraph do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payor. A contract may not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(C) The contract is guaranteed renewable, within the meaning of section 7702B(b)(1)(C) of the IRC.

(D) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed.

(E) All refunds of premiums and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract.

(F) The contract meets the consumer protection provisions in section 7702B(g) of the IRC.

(ii) The term also means the portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of section 7702B(b) and (e) of the IRC.

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 section 1103 of the act (40 P. S. § 991.1103) 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:

(i) Institutional long-term care benefits only.

(ii) Noninstitutional long-term care benefits only.

(iii) Comprehensive long-term care benefits.

§ 89a.104. Policy definitions.

(a) A long-term care insurance policy delivered or issued for delivery in this Commonwealth may not use the terms set forth as follows, unless the terms are defined in the policy and the definitions satisfy the following requirements:

Activities of daily living—Bathing, continence, dressing, eating, toileting and transferring.

Acute condition—The term means that the individual is medically unstable. This individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, to maintain the individual's health status.

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 who can benefit from care in a group setting outside the home.

Bathing—Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.

Cognitive impairment—A deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

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

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

Eating—Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

Hands-on assistance—Physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.

Home health care services—Medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. The services may include homemaker services, assistance with activities of daily living and respite care services.

Medicare—The program under the Health Insurance for the Aged Act in Title XVIII of the Social Security Amendments of 1965 (42 U.S.C.A. §§ 1395—1395ggg) and any later amendments or substitutes thereof.

Mental or nervous disorder—The term may not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

Personal care—The provision of supervisory or hands-on services to assist an individual with activities of daily living.

Skilled nursing care, intermediate care, personal care, home care and other services—These terms 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.

Toileting—Getting to and from the toilet, getting on and off the toilet and performing associated personal hygiene.

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

(b) All providers of services, including, but not limited to, skilled nursing facility, extended care facility, intermediate care facility, convalescent nursing home, personal care facility and home care agency shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified only when the licensure or certification of the provider is required by the state in which the provider is located.

§ 89a.105. Policy practices and provisions.

(a) *Renewability*. The terms "guaranteed renewable" and "noncancellable" may not be used in an individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of § 89a.108 (relating to required disclosure of rating practices to consumers).

(1) A policy issued to an individual may not contain renewal provisions other than "guaranteed renewable" or "noncancellable."

(2) The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make a change in a provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(3) The term "noncancellable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make a change in a provision of the insurance or in the premium rate.

(4) The term "level premium" may only be used when the insurer does not have the right to change the premium.

(5) In addition to the requirements of this subsection, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code of 1986 (26 U.S.C.A. § 7702B(b)(1)(C)).

(b) *Limitations and exclusions*.

(1) A policy may not be delivered or issued for delivery in this Commonwealth as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

(i) Preexisting conditions or diseases.

(ii) Mental or nervous disorders; however, this may not permit exclusion or limitation of benefits on the basis of clinically diagnosed Alzheimer's Disease or related degenerative or dementing illnesses.

(iii) Alcoholism and drug addiction.

(iv) Illness, treatment or medical condition arising out of any of the following:

(A) War or act of war (whether declared or undeclared).

(B) Participation in a felony, riot or insurrection.

(C) Service in the armed forces or units auxiliary thereto.

(D) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury.

(E) Aviation (this exclusion applies only to nonfare-paying passengers).

(v) Treatment provided in a government facility (unless a charge is made and the insured is legally obligated to pay), services for which benefits are available under Medicare or other governmental program except Medicaid, a state or Federal workers' compensation, employer's liability or occupational disease law or services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.

(vi) Expenses for services or items available or paid under another long-term care insurance or health insurance policy.

(vii) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act (Medicare) (42 U.S.C.A. §§ 1395—1395ggg) or would be so reimbursable but for the application of a deductible or coinsurance amount.

(2) This subsection is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

(3) Benefits otherwise payable under a long-term care policy shall be payable in excess of and not in duplication of valid and collectable first party benefits under a state motor vehicle responsibility law. See 75 Pa.C.S. §§ 1701—1798 (relating to Motor Vehicle Financial Responsibility Law).

(c) *Extension of benefits.* Termination of long-term care insurance shall be without prejudice to benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period or to payment of the maximum benefits and may be subject to a policy waiting period and other applicable provisions of the policy.

(d) *Continuation or conversion.*

(1) Group long-term care insurance issued in this Commonwealth on or after March 16, 2002, shall provide covered individuals with a basis for continuation or conversion of coverage.

(2) For the purposes of this section, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The Commissioner will make a determination as to the substantial equivalency of benefits, and in doing so, will take into consideration the differences between managed care and nonmanaged care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(3) For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would

otherwise terminate or has been terminated for a reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and a group policy which it replaced), for at least 6 months immediately prior to termination, will be entitled to the issuance of a converted policy by the insurer under whose group policy the individual is covered, without evidence of insurability.

(4) For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. When the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the Commissioner, in making a determination as to the substantial equivalency of benefits, will take into consideration the differences between managed care and nonmanaged care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(5) Written application for the converted policy shall be made and the first premium due, if applicable, shall be paid as directed by the insurer not later than 31 days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

(6) When an insured converts from a group policy with rates based on the issue age of the insured to a conversion policy, the premium for the conversion policy shall be calculated on the basis of the insured's age at inception of continuous coverage on the original group policy and any other group policy which replaced the original group policy. When an insured converts from a group policy with rates based on the attained age of the insured, the premium for the conversion policy shall be calculated on the insured's age as of the date of conversion.

(7) Continuation of coverage or issuance of a converted policy shall be mandatory, except when:

(i) Termination of group coverage resulted from an individual's failure to make the required payment of premium or contribution when due.

(ii) The terminating coverage is replaced not later than 31 days after termination, by group coverage effective on the day following the termination of coverage. Both of the following provisions apply:

(A) Providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage.

(B) The premium for which is calculated in a manner consistent with paragraph (6).

(8) Notwithstanding this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100% of incurred expenses. The provision shall only be included in the converted policy if the converted policy

also provides for a premium decrease or refund which reflects the reduction in benefits payable.

(9) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, may not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

(10) Notwithstanding this section, an insured individual whose eligibility for group long-term care coverage is based upon the individual's relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

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

(e) *Discontinuance and replacement.* If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy may not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced and may not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

(f) *Premium rate increase.*

(1) The premium charged to an insured may not increase due to either of the following:

(i) The increasing age of the insured at ages beyond 65.

(ii) The duration the insured has been covered under the policy.

(2) The purchase of additional coverage may not be considered a premium rate increase, but for purposes of the calculation required under § 89a.123 (relating to nonforfeiture benefit requirement), 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 may not be considered a premium change, but for purpose of the calculation required under § 89a.123, 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 section 1103 of the act (40 P. S. § 991.1103), a requirement that a signature of an insured be obtained by a producer or insurer shall be deemed satisfied if the following conditions are met:

(i) The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee.

(ii) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records.

(iii) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information is maintained.

(2) The insurer shall make available, upon request of the Commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

§ 89a.106. Unintentional lapse.

(a) Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following conditions:

(1) *Notice before lapse or termination.* An individual long-term care policy or certificate may not be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation may not constitute acceptance of liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect not to designate a person to receive this notice." The insured shall be able to change the written designation at any time. The insurer shall notify the insured of the right to change this written designation, at least once every 2 years.

(2) *Deduction plans.* When the policyholder or certificateholder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in paragraph (1) need not be met until 60 days after the policyholder or certificateholder is no longer on the payment plan. The application or enrollment form for those policies or certificates shall clearly indicate the payment plan selected by the applicant.

(3) *Lapse or termination for nonpayment of premium.* No individual long-term care policy or certificate may lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated under paragraph (1), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of 5 days after the date of mailing.

(b) *Reinstatement.* In addition to the requirement in subsection (a), a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within 5 months after termination

and shall allow for the collection of a past due premium, when appropriate. The standard of proof of cognitive impairment or loss of functional capacity may not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

§ 89a.107. Required disclosure provisions.

(a) *Renewability.* Individual long-term care insurance policies shall contain a renewability provision.

(1) The provision shall be appropriately captioned, shall appear on the first page of the policy and clearly state that the coverage is guaranteed renewable or noncancellable. This provision does not apply to policies that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

(2) A long-term care insurance policy or certificate, other than one in which the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

(b) *Riders and endorsements.* Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, a rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. When a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider or endorsement.

(c) *Payment of benefits.* A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of these terms and an explanation of the terms in its accompanying outline of coverage.

(d) *Limitations.* If a long-term care insurance policy or certificate contains limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."

(e) *Other limitations or conditions on eligibility for benefits.* A long-term care insurance policy or certificate containing limitations or conditions for eligibility other than those prohibited in sections 1105 and 1108 of the act (40 P. S. §§ 991.1105 and 991.1108) shall set forth a description of the limitations or conditions, including the required number of days of confinement, in a separate paragraph of the policy or certificate and shall label this paragraph "Limitations or Conditions on Eligibility for Benefits."

(f) *Benefit triggers.* Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." Additional benefit triggers shall also be explained in this section. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit

description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

(g) *Disclosure statement—qualified.* A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in § 89a.126(e)(3) (relating to standard format outline of coverage) 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 (26 U.S.C.A. § 7702B(b)).

(h) *Disclosure statement—nonqualified.* A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in § 89a.126(e)(3) that the policy is not intended to be a qualified long-term care insurance contract.

§ 89a.108. Required disclosure of rating practices to consumers.

(a) This section shall apply as follows:

(1) Except as provided in paragraph (2), this section applies to a long-term care policy or certificate issued in this Commonwealth on or after September 16, 2002.

(2) For certificates issued on or after March 16, 2002, under a group long-term care insurance policy as defined in section 1103 of the act (40 P. S. § 991.1103), which policy was in force on March 16, 2002, this section shall apply on the policy anniversary following March 17, 2003.

(b) Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subsection to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this section to the applicant no later than at the time of delivery of the policy or certificate.

(1) A statement that the policy may be subject to rate increases in the future.

(2) An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision.

(3) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase.

(4) A general explanation for applying premium rate or rate schedule adjustments that shall include both of the following:

(i) A description of when premium rate or rate schedule adjustments will be effective (for example, next anniversary date, next billing date).

(ii) The right to a revised premium rate or rate schedule as provided in paragraph (2) if the premium rate or rate schedule is changed.

(5) The following information:

(i) Information regarding each premium rate increase on this policy form or similar policy forms over the past 10 years or during the existence of the policy or similar policy up to a maximum of 10 years for this State or any other state that, at a minimum, identifies all of the following:

(A) The policy forms for which premium rates have been increased.

(B) The calendar years when the form was available for purchase.

(C) The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(ii) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

(iii) An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from nonaffiliated insurers or the long-term care policies acquired from nonaffiliated insurers when those increases occurred prior to the acquisition.

(iv) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of March 16, 2002, or the end of a 24-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with subparagraph (i).

(v) If the acquiring insurer in subparagraph (iv) files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in subparagraph (iv), the acquiring insurer shall make all disclosures required by this paragraph, including disclosure of the earlier rate increase referenced in subparagraph (iv).

(c) An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under subsection (b)(1) and (5). If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

(d) An insurer shall use the forms in Appendices B and F (relating to long-term care insurance personal worksheet; and rate information) to comply with the requirements of subsections (a) and (b).

(e) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer for the policyholder or certificateholder. The notice shall include the information required by subsection (b) when the rate increase is implemented.

§ 89a.109. Initial filing requirements.

(a) This section applies to a long-term care policy issued in this Commonwealth on or after September 16, 2002.

(b) An insurer shall provide the information listed in this subsection to the Commissioner prior to making a long-term care insurance form available for sale subject to sections 3 and 4 of the Accident and Health Filing Reform Act (40 P. S. §§ 3803 and 3804).

(1) A copy of the disclosure documents required in § 89a.108 (relating to required disclosure of rating practices to consumer).

(2) An actuarial certification consisting of at least the following:

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

(ii) A statement that the policy design and coverage provided have been reviewed and taken into consideration.

(iii) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration.

(iv) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include the following:

(A) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held.

(B) A statement that the assumptions used for reserves contain reasonable margins for adverse experience.

(C) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted).

(D) 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 this statement cannot be made, a complete description of the situations where this does not occur.

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

(II) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the Commissioner may request a demonstration under subsection (c) based on a standard age distribution.

(v) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits and a comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

(c) 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 premium or benefit differences; relevant and credible data from other studies, or both. In the event the Commissioner asks for additional information under this provision, the period in subsection (a) does not include the period during which the insurer is preparing the requested information.

§ 89a.110. Prohibition against postclaims underwriting.

(a) Applications for long-term care insurance policies or certificates except those that are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(b) If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed. If the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, the policy or certificate may not be rescinded for that condition.

(c) Except for policies or certificates which are guaranteed issue:

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

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

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

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

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

- (i) A report of a physical examination.
- (ii) An assessment of functional capacity.
- (iii) An attending physician's statement.
- (iv) Copies of medical records.

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

(e) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both State and countrywide, except those that the insured voluntarily effectuated and shall annually furnish this information to the Commissioner in the format prescribed by the National Association of Insurance Commissioners in Appendix A (relating to rescission reporting form for long-term care policies).

§ 89a.111. Minimum standards for home health and community care benefits in long-term care insurance policies.

(a) A long-term care insurance policy or certificate may not, if it provides benefits for home health care or community care services, limit or exclude benefits by requiring any of the following:

(1) That the insured or claimant would need care in a skilled nursing facility if home health or community care services were not provided.

(2) That the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before home health care services are covered.

(3) Limiting eligible services to services provided by registered nurses or licensed practical nurses.

(4) That a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or licensed or certified home care worker acting within the scope of the person licensure or certification.

(5) Excluding coverage for personal care services provided by a home health aide.

(6) That the provision of home health or community care services be at a level of certification or licensure greater than that required by the eligible service.

(7) That the insured or claimant have an acute condition before home health or community care services are covered.

(8) Limiting benefits to services provided by Medicare-certified agencies or providers.

(9) Excluding coverage for adult day care services.

(b) A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of 1 year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement does not apply to policies or certificates issued to residents of continuing care retirement communities.

(c) Home health or community care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

§ 89a.112. Requirement to offer inflation protection.

(a) An insurer may not offer a long-term care insurance policy unless the insurer also offers to the policyholder in addition to other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers shall offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(1) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate of at least 5%.

(2) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit may not be less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5% for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made.

(3) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(b) When the policy is issued to a group, the required offer in subsection (a) shall be made to the group policyholder; except, if the policy is issued to a group defined in section 1103 of the act (40 P. S. § 991.1103) other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

(c) The offer in subsection (a) is not required of life insurance policies or riders containing accelerated long-term care benefits.

(d) Insurers shall include all of the information listed in this subsection or with the outline of coverage. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure. The information is as follows:

(1) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20 year period.

(2) Expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(e) Inflation protection benefit increases under a policy which contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

(f) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(g) Inflation protection as provided in subsection (a)(1) shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection. The rejection may be either in the application or on a separate form. The rejection shall be considered a part of the application and shall state:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed plans _____, and I reject inflation protection.

§ 89a.113. Requirements for application forms and replacement coverage.

(a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace another accident and sickness or long-term care policy or certificate presently in force. A supplementary application or form to be signed by the applicant and producer, except when the coverage is sold without a producer, containing the questions may be used. With regard to a replacement policy issued to a group defined by section 1103 of the act (40 P. S. § 991.1103), the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement.

(1) Do you have another long-term care insurance policy or certificate in force (including health care service contract or health maintenance organization contract)?

(2) Did you have another long-term care insurance policy or certificate in force during the last 12 months?

(i) If so, with which company?

(ii) If that policy lapsed, when did it lapse?

(3) Are you covered by Medicaid? If you are eligible or covered by Medicaid, you may not need to purchase the policy since it may provide duplicate benefits.

(4) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

(b) Producers shall list health insurance policies they have sold to the applicant.

(1) List policies sold that are still in force.

(2) List policies sold in the past 5 years that are no longer in force.

(c) Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its producer, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

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

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU
IN THE FUTURE.

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

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY PRODUCER [OR
OTHER REPRESENTATIVE]:

(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

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

(Signature of Producer or Other Representative)

[Typed Name and Address of producer]

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

(Applicant's Signature)

(Date)

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

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

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU
IN THE FUTURE.

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

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial

or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within 30 days if any information is not correct and complete, or if any past medical history has been left out of the application.

[Company Name]

(e) Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, the name of the insured and policy number or address including zip code. Notice shall be made within 5 working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

(f) The insurer shall maintain records demonstrating delivery date of policies so that this date can be used to determine the commencement of the 30-day policy examination period. Delivery date shall be deemed the date the policy is received by the policyholder.

§ 89a.114. Reporting requirements.

(a) Every insurer shall maintain records for each producer of that producer's amount of replacement sales as a percent of the producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the producer as a percent of the producer's total annual sales.

(b) Every insurer shall report annually to the Department by June 30 the 10% of its producers with the greatest percentages of lapses and replacements as measured by subsection (a). (See Appendix G (relating to long-term care insurance replacement and lapse reporting form).)

(c) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely producer activities regarding the sale of long-term care insurance.

(d) Every insurer shall report annually to the Department by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year. (See Appendix G.).

(e) Every insurer shall report annually to the Department by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year. (See Appendix G.)

(f) Every insurer shall report annually to the Department 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. (See Appendix E (relating to claims denial reporting form long term care insurance).)

(g) For purposes of this section:

(1) "Policy" means only long-term care insurance.

(2) Subject to paragraph (3), "claim" means a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or terms or conditions of the policy have been met.

(3) "Denied" means the insurer refuses to pay a claim for reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

(4) "Report" means on a Statewide basis.

(h) Reports required under this section shall be filed with the Commissioner.

§ 89a.115. Licensing.

A producer is not authorized to sell, solicit or negotiate with respect to long-term care insurance except as authorized by sections 601 and 621 of the act (40 P. S. §§ 231 and 251).

§ 89a.116. Reserve standards.

When long-term care benefits are provided, reserves shall be determined in accordance with sections 301.1 and 311.1 of the act (40 P. S. §§ 71.1 and 93) and Chapter 84a (relating to minimum reserve standards for individual and group health and accident insurance contracts).

§ 89a.117. Loss ratio.

(a) This section shall apply to all long-term care insurance policies or certificates except those covered under §§ 89a.109 and 89.118 (relating to initial filing requirements; and premium rate schedule increases).

(b) Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least 60%, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including the following:

- (1) Statistical credibility of incurred claims experience and earned premiums.
- (2) The period for which rates are computed to provide coverage.
- (3) Experienced and projected trends.
- (4) Concentration of experience within early policy duration.
- (5) Expected claim fluctuation.
- (6) Experience refunds, adjustments or dividends.
- (7) Renewability features.
- (8) All appropriate expense factors.
- (9) Interest.
- (10) Experimental nature of the coverage.

(11) Policy reserves.

(12) Mix of business by risk classification.

(13) Product features such as long elimination periods, high deductibles and high maximum limits.

§ 89a.118. Premium rate schedule increases.

(a) This section shall apply as follows:

(1) Except as provided in paragraph (2), this section applies to a long-term care policy or certificate issued in this Commonwealth on or after September 16, 2002.

(2) For certificates issued on or after March 16, 2002, under a group long-term care insurance policy as defined in section 1103 of the act (40 P. S. § 991.1103), which policy was in force on March 16, 2002, this section shall apply on the policy anniversary following March 17, 2003.

(b) An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the Commissioner subject the Accident and Health Filing Reform Act (40 P. S. §§ 3801—3815) prior to the notice to the policyholders and shall include all of the following:

(1) Information required by § 89a.108 (relating to required disclosure of rating practices to consumers).

(2) Certification by a qualified actuary that:

(i) 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.

(ii) The premium rate filing is in compliance with this section.

(3) An actuarial memorandum justifying the rate schedule change request that includes the following:

(i) 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 assumptions that deviate from those used for pricing other forms currently available for sale.

(A) Annual values for the 5 years preceding and the 3 years following the valuation date shall be provided separately.

(B) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase.

(C) The projections shall demonstrate compliance with subsection (c).

(D) For exceptional increases, the projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase. If the Commissioner determines as provided in § 89a.103 (relating to definitions) that offsets may exist, the insurer shall use appropriate net projected experience.

(ii) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse.

(iii) 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.

(iv) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration.

(v) 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.

(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.

(5) Sufficient information for review subject to the Accident and Health Filing Reform Act of the premium rate schedule increase by the Commissioner.

(c) Premium rate schedule increases shall be determined in accordance with the following requirements:

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

(2) Premium rate schedule increases shall be calculated so that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(i) The accumulated value of the initial earned premium times 58%.

(ii) Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis.

(iii) The present value of future projected initial earned premiums times 58%.

(iv) Eighty-five percent of the present value of future projected premiums not in this subsection on an earned basis.

(3) If a policy form has both exceptional and other increases, the values in paragraph (2)(ii) and (iv) will also include 70% for exceptional rate increase amounts.

(4) The present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in Chapter 84a (relating to minimum reserve standards for individual and group health and accident insurance contracts). The actuary shall disclose as part of the actuarial memorandum the use of appropriate averages.

(d) For each rate increase that is implemented, the insurer shall file for review subject to the Accident and Health Filing Reform Act by the Commissioner, updated projections, as defined in subsection (b)(3)(i), annually for the next 3 years and include a comparison of actual results to projected values. The Commissioner may extend the period to greater than 3 years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection (k), the projections required by this subsection shall be provided to the policyholder in lieu of filing with the Commissioner.

(e) If a premium rate in the revised premium rate schedule is greater than 200% of the comparable rate in the initial premium schedule, lifetime projections, as defined in subsection (b)(3)(i), shall be filed for review subject to the Accident and Health Filing Reform Act by

the Commissioner every 5 years following the end of the required period in subsection (d). For group insurance policies that meet the conditions in subsection (k), the projections required by this subsection shall be provided to the policyholder in lieu of filing with the Commissioner.

(f) If the Commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection (c), the Commissioner may require the insurer to implement premium rate schedule adjustments, or other measures to reduce the difference between the projected and actual experience. In determining whether the actual experience adequately matches the projected experience, consideration should be given to subsection (b)(3)(v), 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 the following:

(1) A plan, subject to Commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the Commissioner may impose the condition in subsection (h).

(2) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection (c) had the greater of the original anticipated lifetime loss ratio or 58% been used in the calculations described in subsection (c)(1)(i) and (iii)

(h) For a rate increase filing that meets the following criteria, the Commissioner will 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:

(1) The rate increase is not the first rate increase requested for the specific policy form or forms.

(2) The rate increase is not an exceptional increase.

(3) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(i) If 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.

(1) 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.

(iii) Provide that maximum benefits under a new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

(2) 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.

(ii) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus 10%.

(j) If the Commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the Commissioner may, in addition to the provisions of subsection (h), prohibit the insurer from either of the following:

(1) Filing and marketing comparable coverage for up to 5 years.

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

(k) Subsections (a)—(j) do not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in § 89a.103 (relating to definitions), if the policy complies with the following conditions:

(1) The interest credited internally to determine cash value accumulations, including long-term care 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) An actuarial memorandum is filed with the Department that includes the following:

(i) A description of the basis on which the long-term care rates were determined.

(ii) A description of the basis for the reserves.

(iii) A summary of the type of policy, benefits, renewability, general marketing method and limits on ages of issuance.

(iv) A description and a table of each actuarial assumption used. For expenses, an insurer shall include percent of premium dollars per policy and dollars per unit of benefits.

(v) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives.

(vi) The estimated average annual premium per policy and the average issue age.

(vii) 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 types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or a dependent will be underwritten and when underwriting occurs.

(viii) 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.

(l) Subsections (f) and (h) do not apply to group insurance policies as defined in section 1103 of the act (40 P. S. § 991.1103) when either:

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

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

§ 89a.119. Filing requirement.

Prior to an insurer or similar organization offering group long-term care insurance to a resident of this Commonwealth under section 1104 of the act (40 P. S. § 991.1104), it shall file with the Commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this Commonwealth.

§ 89a.120. Standards for marketing.

(a) Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this Commonwealth, directly or through its producers, shall:

(1) Establish marketing procedures and producer training requirements to assure that marketing activities, including a comparison of policies, by its producers will be fair and accurate and excessive insurance is not sold or issued.

(2) Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following:

“Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.”

(3) Provide copies of the disclosure forms required in § 89a.108(c) (Appendices B and F) (relating to long term care insurance personal worksheet; and rate information) to the applicant.

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required.

(5) Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this subsection.

(6) Provide written notice to the prospective policyholder or certificateholder at solicitation that a senior insurance counseling program approved by the Commonwealth is available and the name, address and telephone number of the program.

(7) For long-term care health insurance policies and certificates, use the terms “noncancellable” or “level pre-

mium” only when the policy or certificate conforms to § 89a.105(a)(3) (relating to policy practices and provisions).

(8) Provide an explanation of contingent benefit upon lapse provided for in § 89a.123(d)(3) (relating to nonforfeiture benefit requirement).

(b) The following acts and practices are prohibited:

(1) *Twisting.* Knowingly making misleading representation or fraudulent comparison of insurance policies or insurers for the purpose of inducing, or tending to induce, a person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert an insurance policy or to take out a policy of insurance with another insurer.

(2) *High pressure tactics.* Employing a method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) *Cold lead advertising.* Making use directly or indirectly of a 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.

(4) *Misrepresentation.* Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

(5) *Other prohibited practices.* Other practices prohibited by the Unfair Insurance Practices Act (40 P. S. §§ 1171.1—1171.15).

(c) With respect to the obligations in this subsection, the primary responsibility of an association, as defined in paragraph (2) of the “group long-term care insurance” definition in section 1103 of the act (40 P. S. § 991.1103), 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.

(1) Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by the associations to ensure that members of the associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

(2) The insurer shall file with the Department the following material:

- (i) The policy and certificate.
- (ii) A corresponding outline of coverage.
- (iii) Advertisements requested by the Department.

(3) The association shall disclose the following in a long-term care insurance solicitation:

(i) The specific nature and amount of the compensation arrangements (including the fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members.

(ii) A brief description of the process under which the policies and the insurer issuing the policies were selected.

(4) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

(5) The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer or producer.

(6) The association shall do the following except that this does not apply to qualified long-term care insurance contracts:

(i) At the time of the association’s decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change.

(ii) Actively monitor the marketing efforts of the insurer and its agents.

(iii) Review and approve all marketing materials or insurance communications used to promote sales or sent to members regarding the policies or certificates.

(7) Group long-term care insurance policies or certificates may not be issued to an association unless the insurer files with the Department the information required in this subsection.

(8) The insurer may not issue a long-term care policy or certificate to an association or continue to market that policy or certificate unless the insurer certifies annually that the association has complied with this subsection.

(9) Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of the Unfair Insurance Practices Act.

§ 89a.121. Suitability.

(a) Every insurer, nonprofit hospital plan and professional health services plan corporation or other entity marketing long-term care insurance (the issuer) shall meet the following conditions:

(1) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant.

(2) Train its producers in the use of its suitability standards.

(3) Maintain a copy of its suitability standards and make them available for inspection upon request by the Commissioner.

(b) To determine whether the applicant meets the standards developed by the issuer, the producer and issuer shall develop procedures that take the items in paragraph (1) into consideration.

(1) The producer and issuer shall take the following into consideration:

(i) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage.

(ii) The applicant’s goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs.

(iii) The values, benefits and costs of the applicant’s existing insurance when compared to the values, benefits and costs of the recommended purchase or replacement.

(2) The issuer, and when a producer is involved, the producer shall make reasonable efforts to obtain the information in paragraph (1). The efforts shall include

presentation to the applicant, at or prior to application of 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 (relating to long-term care insurance personal worksheet), in at least 12 point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the Commissioner.

(3) A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

(4) The sale or dissemination outside the company or agency by the issuer or producer of information obtained through the personal worksheet in Appendix B is prohibited.

(c) The issuer shall use the suitability standards it has developed under this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

(d) Producers shall use the suitability standards developed by the issuer in marketing long-term care insurance.

(e) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix C (relating to things you should know before you buy long-term care insurance), in at least 12 point type.

(f) 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 the one presented in Appendix D (relating to long-term care insurance suitability letter). 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.

(g) The issuer shall report annually to the Commissioner the total number of applications received from residents of this Commonwealth, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards and the number of those who chose to confirm after receiving a suitability letter.

§ 89a.122. Prohibition against preexisting conditions and probationary periods in replacement policies or certificates.

If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

§ 89a.123. Nonforfeiture benefit requirement.

(a) Nonforfeiture benefits shall be offered under the following:

(1) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection (e).

(2) The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

(b) If the offer made for nonforfeiture benefits is rejected, the insurer shall provide the contingent benefit upon lapse described in this section.

(c) After rejection of the offer for nonforfeiture benefits for individual and group policies without nonforfeiture benefits issued after March 16, 2002, the insurer shall provide a contingent benefit upon lapse.

(1) If a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(2) The 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 in this paragraph 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 30 days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

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

<i>Issue Age</i>	<i>Percent Increase Over Initial Premium</i>
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

(3) On or before the effective date of a substantial premium increase as defined in paragraph (2), the insurer shall meet the following conditions:

(i) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased.

(ii) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection (e). This option may be elected during the 120-day period referenced in subsection (d)(3).

(iii) Notify the policyholder or certificateholder that a default or lapse during the 120-day period referenced in subsection (d)(3) shall be deemed to be the election of the offer to convert in subsection (d)(4).

(d) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in this subsection as follows:

(1) For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least 1% per year prior to age 50, and at least 3% per year beyond age 50.

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

(3) The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to 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 be at least 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subsection (f).

(4) The nonforfeiture benefit shall begin by the end of the 3rd year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first 3 years as well as thereafter. For a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of either the end of the 10th year following the policy or certificate issue date or the end of the 2nd year following the date the policy or certificate is no longer subject to attained age rating.

(5) Nonforfeiture credits may be used for the care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(e) The benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up

status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.

(f) There may not be a difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

(g) The requirements in this section are effective March 17, 2003, and apply as follows:

(1) Except as provided in paragraph (2), this section applies to a long-term care policy issued in this Commonwealth on or after March 16, 2002.

(2) For certificates issued on or after March 9 2002, under a group long-term care insurance policy as defined in section 1103 of the act (40 P. S. § 991.1103), which policy was in force on March 16, 2002, this section does not apply.

(h) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of § 89a.117 (relating to loss ratio) treating the policy as a whole.

(i) To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection (d)(3), a replacing insurer that purchased or otherwise assumed 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.

(j) A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets all of the following requirements:

(1) The nonforfeiture provision shall be appropriately captioned.

(2) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying contracts approved by the Commissioner for the same contract form.

(3) The nonforfeiture provision shall provide at least one of the following:

(i) Reduced paid-up insurance.

(ii) Extended term insurance.

(iii) Shortened benefit period.

(iv) Other similar offerings approved by the Commissioner.

§ 89a.124. Standards for benefit triggers.

(a) A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits may not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

(b) Insurers may use activities of daily living to trigger covered benefits in addition to those contained in paragraphs (1)—(6) as long as they are defined in the policy.

Activities of daily living shall include at least the following as defined in § 89a.104 (relating to policy definitions) and in the policy:

- (1) Bathing.
- (2) Continence.
- (3) Dressing.
- (4) Eating.
- (5) Toileting.
- (6) Transferring.

(c) An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate. The provisions may not restrict, and are not in lieu of, the requirements in subsections (a) and (b).

(d) For purposes of this section, the determination of a deficiency may not be more restrictive than either of the following:

- (1) Requiring the supervisory or hands-on assistance of another person to perform the prescribed activities of daily living.
- (2) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed to protect the insured or others.
- (e) Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

(f) Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

(g) The requirements in this section become effective March 16, 2003, and apply as follows:

- (1) Except as provided in paragraph (2), this section applies to a long-term care policy issued in this Commonwealth on or after March 16, 2002.
- (2) For certificates issued on or after March 16, 2002, under a group long-term care insurance policy as defined in section 1103 of the act (40 P. S. § 991.1103) that was in force on March 16, 2002, this section does not apply.

§ 89a.125. Additional standards for benefit triggers for qualified long-term care insurance contracts.

(a) For purposes of this section, the following definitions apply:

Chronically ill individual—Has the meaning prescribed for this term by section 7702B(c)(2) of the Internal Revenue Code of 1986 (26 U.S.C.A. § 7702B(c)(2)).

(i) Under this provision, a chronically ill individual means an individual who has been certified by a licensed health care practitioner as either of the following:

- (A) Being unable to perform (without substantial assistance from another individual) at least two activities of daily living for at least 90 days due to a loss of functional capacity.
- (B) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

(ii) The term does not include an individual otherwise meeting these requirements unless within the preceding 12-month period a licensed health care practitioner has certified that the individual meets these requirements.

Licensed health care practitioner—A physician, as defined in section 1861(r)(1) of the Social Security Act (42 U.S.C.A. § 1395x(r)(1)), a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the Secretary of the United States Treasury.

Maintenance or personal care services—Any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

Qualified long-term care services—Services that meet the requirements of section 7702(C)(1) of the Internal Revenue Code of 1986 (26 U.S.C.A. § 7702(C)(1)) as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided under a plan of care prescribed by a licensed health care practitioner.

(b) A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided under a plan of care prescribed by a licensed health care practitioner.

(c) A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.

(d) Certifications regarding activities of daily living and cognitive impairment required under subsection (c) shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the United States Treasury.

(e) Certifications required under subsection (c) may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least 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) Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

§ 89a.126. Standard format outline of coverage.

(a) This section implements, interprets and makes specific section 1111 of the act (40 P. S. § 911.1111) in prescribing a standard format and the content of an outline of coverage.

(b) The outline of coverage shall:

- (1) Be a free-standing document, using no smaller than 10-point type.
- (2) Contain no material of an advertising nature.

(c) Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

(d) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

(e) The standard format for outline of coverage is as follows:

[COMPANY NAME]

[ADDRESS—CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

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

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

1. This policy is [an individual policy of insurance] ([a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. FEDERAL TAX CONSEQUENCES.

This [POLICY] [CERTIFICATE] is intended to be a Federally tax-qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended.

OR

Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a Federally tax-qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986 as amended. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABIL-

ITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy.]

(c) [Describe waiver of premium provisions or state that there are not such provisions.]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return—"free look" provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) [For producers] Neither [insert company name] nor its producers represent Medicare, the Federal government or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the Federal government or any state government.

8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home. This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductibles, waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Noninstitutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.]

[Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions.

(b) Noneligible facilities and provider.

(c) Noneligible levels of care (for example, unlicensed providers, care or treatment provided by a family member, and the like).

(d) Exclusions and exceptions.

(e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 9 above.]

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

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

(a) That the benefit level will not increase over time.

(b) Any automatic benefit adjustment provisions.

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage.

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations.

(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

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

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

13. PREMIUM.

(a) State the total annual premium for the policy.

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

14. ADDITIONAL FEATURES.

(a) Indicate if medical underwriting is used.

(b) Describe other important features.]

15. CONTACT THE STATE HEALTH INSURANCE ASSISTANCE PROGRAM LISTED IN THE BROCHURE IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY (INSERT INSURANCE COMPANY NAME AND PHONE NUMBER) IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

§ 89a.127. Requirement to deliver shopper's guide.

A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the Commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

(1) In the case of producer solicitations, a producer shall deliver the shopper's guide prior to the presentation of an application or enrollment form.

(2) In the case of direct response solicitations, the shopper's guide shall be presented in conjunction with an application or enrollment form.

§ 89a.128. Penalties.

In addition to other penalties provided by the laws of the Commonwealth, an insurer or producer found to have violated requirements relating to the regulations of long-term care insurance or the marketing of long-term care insurance shall be subject to penalties under section 1114 of the act (40 P. S. § 991.1114).

§ 89a.129. Permitted compensation arrangements.

(a) An insurer or other entity may provide commission or other compensation to a producer for the sale of a long-term care insurance policy or certificate only if the first year commission or other compensation is not greater than 50% of the first year premium.

(b) The commission or other compensation provided for a minimum of 5 subsequent (renewal) years may not exceed 10% of the renewal premium.

(c) When there is a replacement of an existing policy or duplication of coverage, an entity may not provide compensation to its producers and a producer may not receive compensation greater than the renewal compensation payable by the replacing or duplicative insurer.

(d) For purposes of this section, "compensation" includes pecuniary or nonpecuniary remuneration relating to the sale or renewal of the policy or certificate, including bonuses, gifts, prizes, awards and finders fees.

(e) Subsections (a) and (b) apply solely to producers who directly solicit applicants and insureds and who effect the sale of a policy or certificate and not to general agents or other entities who contract with or are otherwise employed by insurers.

Appendix A

**RESCISSION REPORTING FORM FOR
LONG-TERM CARE POLICIES FOR THE STATE
OF _____ FOR THE REPORTING YEAR 20[___]**

Company Name: _____

Address: _____

Phone Number: _____

Due: March 1 annually

Instructions:

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

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission
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Detailed reason for rescission:

Signature

Name and Title (please type)

Date

Appendix B

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long term care insurance may be expensive, and may not be right for everyone.

By Pennsylvania law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _____

The premium for the coverage you are considering will be [\$ _____ per month, or \$ _____ per year,] [a one-time single premium of \$ _____.]

Type of Policy (noncancellable/guaranteed renewable):

The Company's Right to Increase Premiums:

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies

in the same class in this State.] [Insurers shall use appropriate bracketed statement. Rate guarantees may not be shown on this form.]

Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for a long-term care policy it has sold in this State or another state.] [The company has not raised its rates for this policy form or similar policy forms in this State or another state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.]

Questions Related to Your Income

How will you pay each year's premium?

- From my Income From my Savings/Investments
- My Family will Pay

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

What is your annual income? (check one)

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

How do you expect your income to change over the next 10 years? (check one)

- No change Increase Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one)

- Yes No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

- From my Income From my Savings/Investments
- My Family will Pay

The National average annual cost of care in [insert year] was [insert \$ amount], but this figure varies across the country. In 10 years the National average annual cost would be about [insert \$ amount] if costs increase 5% annually.

What elimination period are you considering? Number of days _____ Approximate cost \$ _____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

- From my Income From my Savings/Investments
- My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

- Under \$20,000 \$20,000-\$30,000
- \$30,000-\$50,000 Over \$50,000

How do you expect your assets to change over the next ten years? (check one)

- Stay about the same Increase Decrease

If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

[] The answers to the questions above describe my financial situation.

Or

[] I choose not to complete this information.

(Check one.)

[] I acknowledge that the carrier and/or its producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** (This box must be checked).

Signed: (Applicant) (Date)

[[] I explained to the applicant the importance of completing this information.

Signed:

(Producer) (Date)

Producer's Printed Name: _____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My producer has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____]

(Applicant) (Date)

The company may contact you to verify your answers.

Appendix C

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

- Long-term care insurance** * A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- * [You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]
- * The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
- Medicare** * Medicare does not pay for most long-term care.
- Medicaid** * Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.

* Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.

* When Medicaid pays your spouse's healthcare service bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.

* Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

* Make sure the insurance company or producer gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back premium you have paid if you are dissatisfied for a reason or choose not to purchase the policy.

Counseling

* Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Appendix D

LONG-TERM CARE INSURANCE SUITABILITY LETTER

Dear [Applicant]:

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

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

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

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

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

Please check one box and return in the enclosed envelope.

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

[] **No**. I have decided not to buy a policy at this time.

 APPLICANT'S SIGNATURE DATE
 Please return to [issuer] at [address] by [date].

Appendix E

CLAIMS DENIAL REPORTING FORM LONG-TERM CARE INSURANCE

For the State of _____
 For the Reporting Year of _____
 Company Name: _____
 Due: June 30 annually
 Company Address:

 Company NAIC Number:

Contact Person: _____ Phone Number: _____
 Line of Business: _____ Individual _____
 Group _____

Instructions

The purpose of this form is to report all long-term care claim denials under in force long-term care insurance policies. "Denied" means a claim that is not paid for a reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

State Data *Nationwide Data¹*

- 1 Total Number of Long-Term Care Claims Reported
- 2 Total Number of Long-Term Care Claims Denied/Not Paid
- 3 Number of Claims Not Paid due to Preexisting Condition Exclusion
- 4 Number of Claims Not Paid due to Waiting (Elimination) Period Not Met
- 5 Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)
- 6 Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)
- 7 Number of Long-Term Care Claim Denied due to:
- 8 * Long-Term Care Services Not Covered under the Policy²
- 9 * Provider/Facility Not Qualified under the Policy³

State Data *Nationwide Data¹*

- 10 * Benefit Eligibility Criteria Not Met⁴
- 11 * Other

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.

2. Example—home health care claim filed under a nursing home only policy.

3. Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.

4. Examples—a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

Appendix F

RATE INFORMATION

Instructions:

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Insurers shall provide all of the following information to the applicant:

Long-Term Care Insurance
 Potential Rate Increase Disclosure Form

1. [Premium Rate] [Premium Rate Schedules]: [Premium rate] [Premium rate schedules] that [is] [are] applicable to you and that will be in effect until a request is made and [filed] [approved] for an increase [is] [are] [on the application] [\$ ____]

2. The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.

3. Rate Schedule Adjustments:

The company will provide a description of when premium rate or rate schedule adjustments will be effective (for example, next anniversary date, next billing date, and the like) (fill in the blank): ____ .

4. Potential Rate Revisions:

This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

* Pay the increased premium and continue your policy in force as is.

* Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)

* Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)

* Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

Turn the Page

*** Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

* Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table and

* You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (that is, new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

* You bought the policy at age 65 and paid the \$1,000 annual premium for 10 years, so you have paid a total of \$10,000 in premium.

* In the eleventh year, you receive a rate increase of 50%, or \$500 for a new annual premium of \$1,500, and you decide to lapse the policy (not pay more premiums).

* Your "paid-up" policy benefits are \$10,000 (provided you have a least \$10,000 of benefits remaining under your policy.)

Contingent Nonforfeiture

Cumulative Premium Increase over Initial Premium

That qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%

Issue Age	Percent Increase Over Initial Premium
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

Appendix G

LONG-TERM CARE INSURANCE REPLACEMENT AND LAPSE REPORTING FORM

For the State of _____ For the Reporting Year of _____

Company Name: _____ Due: June 30 annually
 Company Address: _____ Company NAIC Number: _____
 Contact Person: _____ Phone Number: (____) _____

Instructions

The purpose of this form is to report on a statewide basis information regarding long-term care insurance policy replacements and lapses. Specifically, every insurer shall maintain records for each agent on that agent's amount of long-term care insurance replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales. The tables below should be used to report the ten percent (10%) of the insurer's agents with the greatest percentages of replacements and lapses.

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

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

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

<i>Agent's Name</i>	<i>Number of Policies Sold By This Agent</i>	<i>Number of Policies Lapsed By This Agent</i>	<i>Number of Lapses As % of Number Sold By This Agent</i>

Company Totals

Percentage of Replacement Policies Sold to Total Annual Sales ___ %

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

Percentage of Lapsed Policies to Total Annual Sales ___ %

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

[Pa.B. Doc. No. 02-453. Filed for public inspection March 15, 2002, 9:00 a.m.]
