2. For policies and certificates which provide actuarially equivalent benefits, no additional reserves need to be established.

3. Policy liens and policy loans, including accrued interest, represent assets of the company for statutory reporting purposes. For any policy on which the policy lien exceeds the policy's statutory reserve liability such excess must be held as a non-admitted asset.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:644.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1409 (December 1992).

### §1523. Filing Requirement

A. The filing and prior approval of forms containing an accelerated benefit is required.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:644.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1409 (December 1992).

## Chapter 17. Regulation 45—Filing of Affirmative Action Plans

### §1701. Purpose

A. The purpose of this regulation is to implement R.S. 22:1923.A.(l), which requires an insurer to file an affirmative action plan upon the violation of a cease and desist order issued by the commissioner after hearing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1923.A.(1).
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1581 (December 1993).

### §1703. Applicability and Scope

A. This regulation applies to any insurer that is called for hearing before the commissioner for violating Part X of the Insurance Code (Equal Opportunity In Insurance) and found to be in violation of a Cease and Desist Order issued in accordance with the provisions of R.S. 22:1923.A. It sets forth the minimum content and procedures for the filing of an affirmative action plan by an insurer who violates Part X of the Insurance Code, and who then violates a cease and desist order issued by the commissioner after hearing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1923.A.(1).
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1581 (December 1993).

### §1705. Content and Procedure

A. The commissioner shall notify an insurer of its violation of a cease and desist order issued pursuant to Part X of the Insurance Code by Certified U.S. Mail, return receipt requested. Said notification shall also direct the insurer to file an affirmative action plan.

B. The notice shall require the insurer to file its plan within 20 days of receipt of the notice.

C. The insurer shall file its plan by means of the U.S. Mail, and it shall contain the minimum requirements stated in R.S. 22:1923.C(4)(a) and (b).

D. The insurer shall address the plan to the attention of the Office of Minority Affairs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1923.A.(1).
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1581 (December 1993).

### §1707. Effective Date

A. This regulation shall become effective upon final promulgation in the *Louisiana Register.*

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1923.A.(1).
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1581 (December 1993).

## Chapter 19. Regulation 46—Long-Term Care Insurance

### §1901. Purpose

A. The purpose of this regulation is to implement R.S. 22:1731-1741, Long-Term Care Insurance Act, to promote the public interest; to promote the availability of long-term care insurance coverage; to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices; to facilitate public understanding and comparison of long-term care insurance coverages; and to facilitate flexibility and innovation in the development of long-term care insurance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:462 (February 2005).

### §1903. Applicability and Scope

A. Except as otherwise specifically provided, this regulation applies to all long-term care insurance policies, including qualified long-term care contracts and life insurance policies that accelerate benefits for long-term care delivered, or issued for delivery, in this state on or after February 20, 2005, by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations; and all similar organizations to the extent they are authorized to issue life or health insurance. Certain provisions of this regulation apply only to qualified long-term care insurance contracts as noted. Renewal policies shall comply with this regulation as amended.

B. Additionally, this regulation is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if:

1. the benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;

2. the disability income policy is advertised, marketed or offered as insurance for long-term care services; or

3. benefits under the policy may commence after the policyholder has reached Social Security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

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

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

**§1905. Definitions**

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

*Exceptional Increase*—

a. only those increases filed by an insurer as exceptional for which the commissioner determines the need for the premium rate increase is justified:

i. due to changes in laws or regulations applicable to long-term care coverage in this state; or

ii. due to increased and unexpected utilization that affects the majority of insurers of similar products;

b. except as provided in §1937, exceptional increases are subject to the same requirements as other premium rate schedule increases;

c. 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;

d. the commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

*Incidental* (as used in §1937.J)—that the value of the long-term care benefits provided is less than 10 percent 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.

*Qualified Actuary*—a member in good standing of the American Academy of Actuaries.

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

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

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

**§1907. Policy Definitions**

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

*Activities of Daily Living*—at least bathing, continence, dressing, eating, toileting, and transferring.

*Acute Condition*—that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

*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 any necessary braces, fasteners, or artificial limbs.

*Eating*—feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by 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 infirmed persons in their residences. Such services may include homemaker services, assistance with activities of daily living, and respite care services.

*Medicare*—"the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted, and any later amendments or substitutes thereof," or words of similar import.

*Mental or Nervous Disorder*—shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

*Personal Care*—the provision of hands-on services to assist an individual with activities of daily living.

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

*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.

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.

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

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

**§1909. Policy Practices and Provisions**

A. Renewability. The terms *guaranteed renewable* and *noncancellable* shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of §1913 of this regulation.

1. A policy issued to an individual shall not contain renewal provisions other than guaranteed renewable or noncancellable.

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

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

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

5. In addition to the other requirements of §1909.A, a qualified long-term insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

B. Limitations and Exclusions. A policy may not be delivered or issued for delivery in this state as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:

1. preexisting conditions or diseases;

2. mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;

3. alcoholism and drug addiction;

4. illness, treatment, or medical condition arising out of:

a. war or act of war (whether declared or undeclared);

b. participation in a felony, riot, or insurrection;

c. service in the armed forces or units auxiliary thereto;

d. suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or

e. aviation (this exclusion applies only to non-fare paying passengers);

5. treatment provided in a government facility (unless otherwise required by law); services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability, or occupational disease law, or any motor vehicle no-fault law; services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance;

6. expenses for services or items available or paid under another long-term care insurance or health insurance policy;

7. in the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount;

8. Subsection 1909.B is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

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

D. Continuation or Conversion

1. Group long-term care insurance issued in this state on or after the effective date of §1909 shall provide covered individuals with a basis for continuation or conversion of coverage.

2. For the purposes of §1909, a *basis for continuation of coverage* means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium, when due. Group policies which restrict provision of benefits and services to, or contain incentives to use certain providers and/or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans including, but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.

3. For the purposes of §1909, a *basis for conversion of coverage* means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

4. For the purposes of §1909, *converted policy* means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers and/or facilities, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans including, but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.

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

6. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

7. Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

a. termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

b. the terminating coverage is replaced not later than 31 days after termination by group coverage effective on the day following the termination of coverage:

i. providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

ii. the premium for which is calculated in a manner consistent with the requirements of §1909.D.6.

8. Notwithstanding any other provision of §1909, a converted policy issued to an individual who, at the time of conversion, is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

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

10. Notwithstanding any other provision of §1909, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

11. For the purposes of §1909, a *managed-care plan* is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management, or use of specific provider networks.

E. Discontinuance and Replacement. If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

1. shall not result in any exclusion for pre-existing conditions that would have been covered under the group policy being replaced; and

2. shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.

F.1. The premium charged to an insured shall not increase due to either:

a. the increasing age of the insured at ages beyond 65; or

b. the duration the insured has been covered under the policy.

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

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

G. Electronic Enrollment for Group Policies

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

a. the consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

b. the telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and

c. the telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and "privileged information" as defined by applicable state or federal law, 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.

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

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

**§1911. Unintentional Lapse**

A. Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following.

1. Notice before Lapse or Termination

a. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium or a written waiver, dated and signed by the applicant, electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state:

> "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

b. The insurer shall notify the insured of the right to change this written designation, no less often than once every two years.

c. 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 §1911.A.1.a need not be met until 60 days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

d. Lapse or Termination for Nonpayment of Premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to §1911.A.1.a, 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 five days after the date of mailing.

B. Reinstatement. In addition to the requirement in §1911.A.1, a long-term care insurance policy or certificate shall include a provision which provides for reinstatement of coverage, in the event of lapse, if the insurer is provided proof that the policyholder or certificateholder was

cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured, if requested within five months after termination, and shall allow for the collection of past due premium where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

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

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

**§1913. Required Disclosure Provisions**

A. Renewability. Individual long-term care insurance policies shall contain a renewability provision.

1. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or noncancellable. This provision shall not apply to policies which 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 where the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

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

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

D. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to pre-existing conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Pre-Existing Condition Limitations."

E. Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing post confinement, post-acute care, or recuperative benefits shall set forth a description of such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall clearly label such paragraph, "Limitations or Conditions on Eligibility for Benefits."

F. Disclosure of Tax Consequences. With regard to life insurance policies which provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider, and at the time the accelerated benefit payment request is submitted, that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. §1913.F shall not apply to qualified long-term care insurance contracts.

G. Benefit Triggers. Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the policy or certificate in a separate provision and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this provision. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

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

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

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

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

**§1915. Required Disclosure of Rating Practices to Consumers**

A. This Section shall apply as follows.

1. Except as provided in §1915.A.2, §1915 applies to any long-term care policy or certificate issued in this state on or after August 19, 2005.

2. For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in R.S. 22:1734(4), which policy

was in force at the time this amended regulation became effective, the provisions of §1915 shall apply on the policy anniversary following February 19, 2006.

B. 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 §1915.B 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 §1915 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:

a. a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and

b. the right to a revised premium rate or rate schedule as provided in §1915.B.3 if the premium rate or rate schedule is changed;

5.a. information regarding each premium rate increase on this policy form or similar policy forms over the past 10 years for this state or any other state that, at a minimum, identifies:

i. the policy forms for which premium rates have been increased;

ii. the calendar years when the form was available for purchase; and

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

b. the insurer may, in a fair manner, provide additional explanatory information related to the rate increases;

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

d. if an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of §1915 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 §1915.B.5.a of this Paragraph;

e. if the acquiring insurer in §1915.B.5.d above 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 §1915.B.5.d, the acquiring insurer shall make all disclosures required by §1915.B.5, including disclosure of the earlier rate increase referenced in §1915.B.5.d.

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 §1915.B.1 and 5. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

D. An insurer shall use the forms in Appendices B and F to comply with the requirements of §1915.B and §1915.C of this Section.

E. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by §1915.B when the rate increase is implemented.

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

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

**§1917. Initial Filing Requirements**

A. This Section applies to any long-term care policy issued in this state on or after August 19, 2005.

B. An insurer shall provide the information listed in §1917.B to the commissioner 45 days prior to making a long-term care insurance form available for sale:

1. a copy of the disclosure documents required in §1915; and

2. an actuarial certification consisting of at least the following:

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

b. a statement that the policy design and coverage provided have been reviewed and taken into consideration;

c. a statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

d. a complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

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

ii. a statement that the assumptions used for reserves contain reasonable margins for adverse experience;

iii. a statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and

iv. a statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur:

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

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

e.i. a statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

ii. a comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

C.1. The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

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

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

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

**§1919. Requirements to Offer Inflation Protection**

A. No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

1. increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than 5 percent;

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 shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5 percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

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

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

C. The offer in §1919.A shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

D.1. Insurers shall include the following information in or with the outline of coverage:

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

b. any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

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

E. Inflation protection benefit increases, under a policy which contains such 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 which provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. Such offer shall disclose, in a conspicuous manner, that the premium may change in the future, unless the premium is guaranteed to remain constant.

G.1. Inflation protection, as provided in §1919.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 §1919.G.1. The rejection may be either in the application or on a separate form.

2. The rejection shall be considered a part of the application and shall state:

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

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

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

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

A. All applications for long-term care insurance policies or certificates, except those which are guaranteed issue, shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

B.1. If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

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

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

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

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

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

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

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

a. a report of a physical examination;

b. an assessment of functional capacity;

c. an attending physician's statement; or

d. copies of medical records.

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

E. Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated, and shall annually furnish this information to the insurance commissioner in the format prescribed by the National Association of Insurance Commissioners in §1961, Appendix A.

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

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

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

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

1. by requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;

2. by requiring that the insured or claimant first, or simultaneously, receive nursing or therapeutic services, or both, in a home, community, or institutional setting before home health care services are covered;

3. by limiting eligible services to services provided by registered nurses or licensed practical nurses;

4. by requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

5. by excluding coverage for personal care services provided by a home health aide;

6. by requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

7. by requiring that the insured or claimant have an acute condition before home health care services are covered;

8. by limiting benefits to services provided by Medicare-certified agencies or providers;

9. by excluding coverage for adult day care services.

B. A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that

is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

C. Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

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

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

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

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer, except where the coverage is sold without a producer, containing such questions may be used. With regard to a replacement policy issued to a group defined by R.S. 22:1734(4)(a), the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement.

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

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

   a. If so, with which company?

   b. If that policy lapsed, when did it lapse?

3. Are you covered by Medicaid?

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

B. Producers shall list any other health insurance policies they have sold to the applicant.

1. List policies sold which are still in force.

2. List policies sold in the past five years which are no longer in force.

C. Solicitations Other than Direct Response. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its 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 such notice shall be retained by the applicant, and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner.

NOTICE TO APPLICANT
REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT
AND SICKNESS OR LONG-TERM CARE INSURANCE
[Insurance company's name and address]
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY PRODUCER
[BROKER OR OTHER REPRESENTATIVE]:
(Use additional sheets, as necessary.)

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

1. Health conditions which you may presently have (pre-existing 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 pre-existing conditions or probationary periods. The insurer will waive any time periods applicable to pre-existing 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 your sign it, reread it carefully to be certain that all information has been properly recorded.

_____
(Signature of Producer, Broker or Other Representative)
[Typed Name and Address of Producer or Broker]

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

_____ _____
(Applicant's Signature) (Date)

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

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

[Insurance company's name and address]

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

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (pre-existing 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 pre-existing conditions or probationary periods. Your insurer will waive any time periods applicable to pre-existing 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 thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

_____

(Company Name)

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

F. Life Insurance policies that accelerate benefits for long-term care shall comply with this Section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of Regulation 70. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

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

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

**§1927. Reporting Requirements (former §1923)**

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

B. Each insurer shall report annually, by June 30, the 10 percent of its producers with the greatest percentages of lapses and replacements, as measured by §1927.A (§1961, Appendix G).

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

D. Every insurer shall report annually, by June 30, the number of lapsed policies as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the end of the preceding calendar year (§1961, Appendix G).

E. Every insurer shall report annually, by June 30, the number of replacement policies sold as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the preceding calendar year (§1961, Appendix G).

F. Every insurer shall report annually, by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied (§1961, Appendix E).

G. For purposes of §1927:

1. *policy* means only long-term care insurance; and

2. subject to §1927.G.3, *claim* means a request for a payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

3. *denied* means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

4. *report* means on a statewide basis.

H. Reports required under this Section shall be filed with the commissioner.

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

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

**§1929. Licensing (former §1925)**

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

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

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

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

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

1. the modification or suspension would be in the best interest of the insureds;

2. the purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

3.a. the modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or

b. the policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

c. the modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

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

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

**§1933. Reserve Standards (former §1929)**

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

B. Reserves for policies and riders subject to §1933.B should be based on the multiple decrement model, utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit, assuming no long-term care benefit.

C.1. In the development and calculation of reserves for policies and riders subject to §1933.C, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures, and all other considerations which have an impact on projected claim costs including, but not limited to, the following:

a. definition of insured events;

b. covered long-term care facilities;

c. existence of home convalescence care coverage;

d. definition of facilities;

e. existence or absence of barriers to eligibility;

f. premium waiver provision;

g. renewability;

h. ability to raise premiums;

i. marketing method;

j. underwriting procedures;

k. claims adjustment procedures;

l. waiting period;

m. maximum benefit;

n. availability of eligible facilities;

o. margins in claim costs;

p. optional nature of benefit;

q. delay in eligibility for benefit;

r. inflation protection provisions; and

s. guaranteed insurability option.

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

D. When long-term care benefits are provided other than as in §1933.A, reserves shall be determined in accordance with prevailing NAIC actuarial standards.

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

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

**§1935. Loss Ratio (former §1931)**

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

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 percent, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

1. statistical credibility of incurred claims experience and earned premiums;

2. the period for which rates are computed to provide coverage;

3. experienced and projected trends;

4. concentration of experience within early policy duration;

5. expected claim fluctuation;

6. experience refunds, adjustments, or dividends;

7. renewability features;

8. all appropriate expense factors;

9. interest;

10. experimental nature of the coverage;

11. policy reserves;

12. mix of business by risk classification; and

13. product features such as long elimination periods, high deductibles, and high maximum limits.

C. Section 1935.B shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

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

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

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

4. any policy illustration that meets the applicable requirements of Regulation 55; and

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

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

b. a description of the basis for the reserves;

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

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

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

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

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

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

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

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

**§1937. Premium Rate Schedule Increases**

A. This Section shall apply as follows.

1. Except as provided in §1937.A.2, §1937 applies to any long-term care policy or certificate issued in this state on or after August 19, 2005.

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

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

1. information required by §1915;

2. certification by a qualified actuary that:

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

b. the premium rate filing is in compliance with the provisions of §1937;

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

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

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

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

iii. the projections shall demonstrate compliance with §1937.C; and

iv. for exceptional increases:

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

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

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

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

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

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

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

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

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

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

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

a. the accumulated value of the initial earned premium times 58 percent;

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

c. the present value of future projected initial earned premiums times 58 percent; and

d. 85 percent of the present value of future projected premiums not in §1937.C.2.c on an earned basis;

3. in the event that a policy form has both exceptional and other increases, the values in §1937.C.2.b and d will also include 70 percent for exceptional rate increase amounts; and

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

D. For each rate increase that is implemented, the insurer shall file for approval by the commissioner updated projections, as defined in §1937.B.3.a, annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in §1937.K, the projections required by §1937.D shall be provided to the policyholder in lieu of filing with the commissioner.

E. If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in §1937.B.3.a, shall be filed for approval by the commissioner every five years following the end of the required period in §1937.D. For group insurance policies that meet the conditions in §1937.K, the projections required by §1937.E shall be provided to the policyholder in lieu of filing with the commissioner.

F.1. If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in §1937.C, the commissioner may require the insurer to implement any of the following:

a. premium rate schedule adjustments; or

b. other measures to reduce the difference between the projected and actual experience.

2. In determining whether the actual experience adequately matches the projected experience, consideration should be given to §1937.B.3.e, if applicable.

G. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

1. a plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in §1937.H; and

2. the original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to §1937.C had the greater of the original anticipated lifetime loss ratio or 58 percent been used in the calculations described in §1937.C.2.a and c.

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

a. the rate increase is not the first rate increase requested for the specific policy form or forms;

b. the rate increase is not an exceptional increase; and

c. the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

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

a. The offer shall:

i. be subject to the approval of the commissioner;

ii. be based on actuarially sound principles, but not be based on attained age; and

iii. provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

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

i. the maximum rate increase determined based on the combined experience; and

ii. the maximum rate increase determined based only on the experience of the insureds originally issued the form plus 10 percent.

I. If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of §1937.H of this Section, prohibit the insurer from either of the following:

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

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

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

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

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

a. R.S. 22:168;

b. R.S. 22:173.1; and

c. R.S. 22:1500;

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

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

a. policy illustrations as required by Regulation 55;

b. disclosure requirements in Regulation 28;

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

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

b. a description of the basis for the reserves;

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

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

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

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

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

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

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

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

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

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

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

### §1939. Filing Requirement (former §1933)

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

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

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

### §1941. Filing Requirements for Advertising (former §1935)

A. Every insurer, health care service plan, or other entity providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state, whether through written, radio, or television medium, to the commissioner of insurance of this state for review or approval by the commissioner to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer, health care service plan, or other entity for at least three years from the date the advertisement was first used.

B. The commissioner may exempt from these requirements any advertising form or material when, in the commissioner's opinion, this requirement may not be reasonably applied.

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

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

### §1943. Standards for Marketing (former §1937)

A. Every insurer, health care service plan, or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

1. establish marketing procedures and producer training requirements to assure that:

a. any marketing activities, including any comparison of policies by its producers or other producers will be fair and accurate; and

b. excessive insurance is not sold or issued;

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

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

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

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

5. establish auditable procedures for verifying compliance with §1943.A;

6. if the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program, approved by the commissioner, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificateholder that such a program is available and the name, address and telephone number of the program;

7. for long-term care health insurance policies and certificates, use the terms *noncancellable* or *level premium* only when the policy or certificate conforms to §1909.A.3 of this regulation;

8. provide an explanation of contingent benefit upon lapse provided in §1949.D.3.

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

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

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

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

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

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

2. The insurer shall file with the insurance department the following material:

a. the policy and certificate;

b. a corresponding outline of coverage; and

c. all advertisements requested by the insurance department.

3. The association shall disclose in any long-term care insurance solicitation:

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

b. a brief description of the process under which the policies, and the insurer issuing the policies, were selected.

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

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

6.a. The association shall also:

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 producers; and

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

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

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

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

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

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

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

**§1945. Suitability (former §1939)**

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

B. Every insurer, health care service plan, or other entity marketing long-term care insurance (the *issuer*) shall:

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

2. train its producers in the use of its suitability standards; and

3. maintain a copy of its suitability standards and make them available for inspection, upon request, by the commissioner.

C.1. To determine whether the applicant meets the standards developed by the issuer, the producer and issuer shall develop procedures that take the following into consideration:

a. the ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

b. the applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

c. the values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

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

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 §1961, Appendix B, is prohibited.

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

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

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

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

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

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

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

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

A. If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to pre-existing 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.

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

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

### §1949. Nonforfeiture Benefit Requirement (former §1943)

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

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

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

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

C. If the offer required to be made under R.S. 22:1738 is rejected, the insurer shall provide the contingent benefit upon lapse described in §1949.

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

2. In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

3. 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 set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least 45 days prior to the due date of the premium reflecting the rate increase.

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

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

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

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

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

E. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in §1949.E.

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

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

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

4.a. The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three years as well as thereafter.

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

i. the end of the tenth year following the policy or certificate issue date; or

ii. the end of the second year following the date the policy or certificate is no longer subject to attained age rating.

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

F. All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would have been payable if the policy or certificate had remained in premium paying status.

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

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

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

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

I. Premiums charged for a policy or certificate containing nonforfeiture benefits or a continuing benefit on lapse shall be subject to the loss ratio requirements of §1935 treating the policy as a whole.

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

K. A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

1. the nonforfeiture provision shall be appropriately captioned;

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

3. the nonforfeiture provision shall provide at least one of the following:

a. reduced paid-up insurance;

b. extended term insurance;

c. shortened benefit period; or

d. other similar offerings approved by the commissioner.

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

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

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

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

B.1. Activities of daily living shall include at least the following as defined in §1907 and in the policy:

a. bathing;

b. continence;

c. dressing;

d. eating;

e. toileting; and

f. transferring.

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

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

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

1. requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

2. if the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

E. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses, or social workers.

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

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

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

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

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

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

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

A. For purposes of this Section the following definitions apply.

1. Qualified long-term care services means services that meet the requirements of Section 7702B(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

2.a. Chronically ill individual has the meaning prescribed for this term by Section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

i. being unable to perform (without substantial assistance from another individual) at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity; or

ii. requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

b. The term *chronically ill individual* shall 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.

3. Licensed health care practitioner means a physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the secretary of the treasury.

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

B. A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

C. A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's ability 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 pursuant to §1953.C shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the secretary of the treasury.

E. Certifications required pursuant to §1953.C 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 contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

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

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

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

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

B. The outline of coverage shall be a free-standing document, using no smaller than 10-point type.

C. The outline of coverage shall contain no material of an advertising nature.

D. 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.

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

F. Format for outline of coverage:

[COMPANY NAME]
[ADDRESS—CITY AND 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.**

(a) 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

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

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

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

(1) Policies and certificates that are guaranteed renewable shall contain the following statement:] **RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE**. This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [company name] cannot change any of the terms of your policy on its own, except that, in the future, **IT MAY INCREASE THE PREMIUM YOU PAY**.

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

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

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

5. **TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.**

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

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

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

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

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

(a) [For 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 deductible(s), 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) Pre-existing conditions;

(b) Noneligible facilities and provider;

(c) Noneligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions and exceptions;

(e) Limitations.]

[This Section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 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 SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

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

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

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

A. A long-term care insurance shopper's guide in the format developed by the NAIC, 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 must deliver the shopper's guide prior to the presentation of an application or enrollment form.

2. In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

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

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

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

## §1959. Penalties (former §1953)

A. In addition to any other penalties provided by the law, any insurer and any producer found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

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

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

## §1961. Appendices (former §1955)

A. Appendix A

**RESCISSION REPORTING FORM FOR LONG-TERM CARE POLICIES FOR THE STATE OF LOUISIANA 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 Number | Policy and Certificate Number | Name of Insured | Date of Policy Issuance | Date/s Claim/s Submitted | Date of Rescission |
|---|---|---|---|---|---|
| | | | | | |

Detailed reason for rescission:

_____

_____

_____

_____

_____

_____

_____

Signature

_____

Name and Title (please type)

_____

Date

## B. Appendix B

**LONG-TERM CARE INSURANCE**
**PERSONAL WORKSHEET**

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

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

**PREMIUM INFORMATION**

**Policy Form Numbers** _____

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

**Type of Policy (noncancellable/guaranteed renewable):** _____

**The Company's Right to Increase Premiums:** _____

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

**Rate Increase History**

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

**Questions Related to Your Income**

How will you pay each year's premiums?

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

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 percent of your income.*

Will you buy inflation protection? (check one) ☐ **Yes** ☐ **No**

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

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

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

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.<br>**or**<br>☐ I choose not to complete this information.<br>(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 explai
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.*

## C. 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 nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

**Shopper's Guide**

- Make sure the insurance company or 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 any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

**Counseling**

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

## D. Appendix D

**LONG-TERM CARE INSURANCE SUITABILITY LETTER**

Dear [Applicant]:

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

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

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

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

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

Please check one box and return in the enclosed envelope.

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

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

_____ _____

Applicant Signature Date

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

## E. Appendix E

**CLAIMS DENIAL REPORTING FORM**
**LONG-TERM CARE INSURANCE**

**For the State of _____**

**For the Reporting Year of _____**

Company Name: _____ Due: June 30 annually

Company Address: _____

_____

_____

Company NAIC Number: _____

Contact Person: _____ Phone Number:_____

Line of Business: _____Individual _____Group _____

Instructions

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

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

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

## F. Appendix F

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

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

**LONG-TERM CARE INSURANCE**
**POTENTIAL RATE INCREASE DISCLOSURE FORM**

1. **[Premium Rate] [Premium Rate Schedules]:** [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [filed][approved] for an increase [is][are] [on the application][$_____])
2. **The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.**
3. **Rate Schedule Adjustments:**

   The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): _____.
4. **Potential Rate Revisions:**

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

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

   - Pay the increased premium and continue your policy in force as is.
   - Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
   - Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
   - Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

*Turn the Page*

***Contingent Nonforfeiture**

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

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

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

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

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

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

**Example:**

- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are $10,000 (provided you have a least $10,000 of benefits remaining under your policy.)

*Turn the Page*

**Contingent Nonforfeiture**
**Cumulative Premium Increase over Initial Premium**
**That qualifies for Contingent Nonforfeiture**

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

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

## G. 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 producer on that producer's amount of long-term care insurance 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. The tables below should be used to report the ten percent (10%) of the insurer's producers with the greatest percentages of replacements and lapses.

**Listing of the 10% of Producers with the Greatest Percentage of Replacements**

| Producer's Name | Number of Policies Sold By This Producer | Number of Policies Replaced By This Producer | Number of Replacements As % of Number Sold By This Producer |
|---|---|---|---|
| | | | |

**Listing of the 10% of Producers with the Greatest Percentage of Lapses**

| Producer's Name | Number of Policies Sold By This Producer | Number of Policies Lapsed By This Producer | Number of Lapses As % of Number Sold By This Producer |
|---|---|---|---|
| | | | |

**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) ____%

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

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:480 (February 2005).

# Chapter 21. Regulation 47—Actuarial Opinion and Memorandum Regulation

## §2101. Purpose

A. The purpose of this regulation is to prescribe:

1. requirements for statements of actuarial opinion that are to be submitted in accordance with R.S. 22:162.1, and for memoranda in support thereof;

2. rules applicable to the appointment of an appointed actuary; and

3. guidance as to the meaning of "adequacy of reserves."

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:162.1 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2543 (October 2005).

## §2103. Authority

A. This regulation is issued pursuant to the authority vested in the commissioner of insurance of the State of Louisiana under R.S. 22:162.1. This regulation will take effect for annual statements for the year 2005.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:162.1 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2543 (October 2005).

## §2105. Scope

A. This regulation shall apply to all life insurance companies and fraternal benefit societies doing business in this state and to all life insurance companies and fraternal benefit societies that are authorized to reinsure life insurance, annuities or accident and health insurance business in this state. This regulation shall be applied in a manner that allows the appointed actuary to utilize his or her professional judgment in performing the asset analysis and developing the actuarial opinion and supporting memoranda, consistent with relevant actuarial standards of practice. However, the commissioner shall have the authority to specify methods of actuarial analysis particular to a company's business profile and may include specific actuarial methods and assumptions including, where appropriate, simplified actuarial methods and assumptions, when, in the commissioner's judgment, such specifications are necessary, or sufficient, to meet the objective of rendering an acceptable opinion as to the adequacy of the reserves and related items.

B. This regulation shall be applicable to all annual statements filed with the office of the commissioner after the effective date of this regulation. A statement of opinion on the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with §2111 of this regulation, and a memorandum in support thereof in accordance with §2113 of this regulation, shall be required each year.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:162.1 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2543 (October 2005).

## §2107. Definitions

*Actuarial Opinion*—the opinion of an appointed actuary regarding the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with §2111 of this regulation and with applicable Actuarial Standards of Practice.

*Actuarial Standards Board*—the board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice.

*Annual Statement*—that statement required by Section R.S. 22:1451 of the Insurance Law to be filed by the company with the office of the commissioner annually.

*Appointed Actuary*—an individual who is appointed or retained in accordance with the requirements set forth in §2109.C. of this regulation to provide the actuarial opinion and supporting memorandum as required by R.S. 22:162.1.