ADOPTED REGULATION OF

THE COMMISSIONER OF INSURANCE

LCB File No. R121-07

Effective October 1, 2008

EXPLANATION – Matter in ***italics*** is new; matter in brackets **[**~~omitted material~~**]** is material to be omitted.

AUTHORITY: §§1-41, NRS 679B.130.

A REGULATION relating to insurance; revising provisions governing long-term care insurance; requiring certain policies of long-term care insurance to contain a renewability clause; requiring insurers to provide an applicant for a policy of long-term care insurance the opportunity to designate at least one other person to receive any notice of lapse or termination of coverage for nonpayment of premium; requiring insurers to make certain disclosures to applicants for policies of long-term care insurance concerning potential federal tax liabilities relating to the acceleration of benefits for long-term care; requiring insurers to provide certain forms and information to an applicant for a policy of long-term care insurance; revising provisions concerning the payment of commissions or other compensation to an agent or other representative for the sale, replacement or renewal of a policy of long-term care insurance; requiring insurers to keep certain records relating to the sale of policies of long-term care insurance; requiring insurers to submit to the Commissioner of Insurance for approval certain advertisements relating to the sale of policies of long-term care insurance; requiring insurers to provide a contingent benefit upon lapse to insureds in certain circumstances; revising provisions concerning eligibility for payment of benefits for long-term care; and providing other matters properly relating thereto.

Section 1. Chapter 687B of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 35, inclusive, of this regulation.

Sec. 2. ***"Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means:***

1. Any individual insurance contract or group insurance contract that meets the requirements of 26 U.S.C. § 7702B(b); or

2. The portion of any life insurance contract which provides long-term care insurance coverage by rider or as part of the contract and which satisfies the requirements of 26 U.S.C. §§ 7702B(b) and 7702B(e).

Sec. 3. *"Qualified state long-term care insurance partnership contract" or "partnership contract" means a qualified long-term care insurance contract that:*

1. Provides coverage for insureds who are residents of Nevada on the date that coverage under the contract first becomes effective;

2. Is issued on or after January 1, 2007;

3. Satisfies all the requirements of 42 U.S.C. § 1396p(b)(1)(C)(iii)(I) to 1396p(b)(1)(C)(iii)(IV), inclusive;

4. Is filed with and approved by the Commissioner as a partnership contract;

5. Is issued by an insurer who complies with the provisions of 42 U.S.C. § 1396p(b)(1)(C)(iii)(VI); and

6. Is sold by a producer who has received training in and has demonstrated an understanding of partnership contracts and how partnership contracts relate to public and private coverage for long-term care.

Sec. 4. *"Similar organization" means a company other than an insurer that is authorized to offer long-term care insurance contracts pursuant to the provisions of chapter 695A, 695B, 695C or 695F of NRS.*

Sec. 5. *1. "Similar policy forms" means all policies and certificates of long-term care insurance issued by an insurer within the same classification of long-term care benefits as the policy form being considered.*

2. A policy or certificate of long-term care insurance delivered to any group described in subsection 1 of NAC 687B.025 shall be deemed not similar to other policies and certificates of long-term care insurance, except that such a policy or certificate shall be deemed similar to other comparable policies and certificates of long-term care insurance with the same long-term care benefit classification.

3. For the purpose of determining whether policy forms are similar, the long-term care benefits provided by policies and certificates of long-term care insurance must be classified as:

(a) Institutional long-term care benefits only;

(b) Noninstitutional long-term care benefits only; or

(c) Comprehensive long-term care benefits.

Sec. 6. *If an insurer approves an application for long-term care insurance, the insurer shall deliver the policy or certificate for the long-term care insurance to the applicant not later than 30 days after the date on which the application is approved.*

Sec. 7. *1. An insurer or similar organization may pay compensation to an agent for the sale of a policy or certificate of long-term care insurance, except that the amount of the compensation paid in the first year in which the compensation is paid must not exceed 200 percent of the amount of the compensation payable in the second or any subsequent year.*

2. The amount of the compensation payable in any year following the second year must be equal to that paid in the second year and must be provided for a reasonable number of renewal years.

3. The amount of the compensation payable to an agent for the sale or replacement of a policy or certificate of long-term care insurance must not exceed the compensation payable to the agent for the renewal of a policy or certificate of long-term care insurance.

4. As used in this section, "compensation" means any pecuniary or nonpecuniary remuneration of any kind relating to the sale, replacement or renewal of a policy or certificate of long-term care insurance, including, without limitation, any commission, bonus, gift, prize, award or finder's fee.

Sec. 8. *If an insured is receiving benefits for long-term care through the acceleration of benefits under a group or individual policy of life insurance, a rider to that policy or an annuity contract, the insurer shall provide a monthly report to the insured. The report must include, without limitation:*

1. A statement of any benefits for long-term care paid during that month;

2. An explanation of any changes to the policy or contract, including, without limitation, any change to the death benefit or cash value of the policy or contract resulting from the payment of any benefits for long-term care; and

3. The amount of any remaining benefits for long-term care.

Sec. 9. *1. For the enrollment of an insured in a policy of long-term care insurance that applies to a group described in subsection 1 of NAC 687B.025, any requirement that the signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:*

(a) The necessary consent to enrollment is obtained from the insured by telephonic or electronic enrollment by the group policyholder or insurer;

(b) The enrollment provides necessary and reasonable safeguards to ensure the accuracy, retention and prompt retrieval of records; and

(c) The enrollment provides necessary and reasonable safeguards to ensure the confidentiality of individually identifiable and privileged information.

2. Verification of the enrollment information obtained in the manner set forth in subsection 1 must be provided to the insured.

3. Upon request, the insurer shall make available to the Commissioner any records that demonstrate the ability of the insurer to confirm enrollment and coverage amounts.

Sec. 10. *1. Except as otherwise provided in subsection 3, an insurer shall not issue an individual policy of long-term care insurance in this State unless the insurer has received from the applicant:*

(a) A written designation of at least one person, in addition to the applicant, who must receive notice of any lapse or termination of coverage under the policy for nonpayment of premium; or

(b) A written waiver dated and signed by the applicant stating that the applicant has chosen not to designate another person to receive notice of any lapse or termination of coverage for nonpayment of premium.

2. The designation pursuant to subsection 1 of another person to receive notice of any lapse or termination of coverage for nonpayment of premium does not constitute acceptance of any liability by the other person for services provided to the applicant. The form used for the written designation of another person to receive notice of any lapse or termination of coverage for nonpayment of premium must provide space clearly designated for listing at least one such person. The designation must include the full name and home address of each person designated by the applicant to receive notice of any lapse or termination of coverage for nonpayment of premium. If an applicant does not designate another person to receive notice of any lapse or termination of coverage for nonpayment of premium, the waiver must state, in substantially similar language: "Protection against unintended lapse. I understand that I have

the right to designate at least one person other than myself to receive notice of any lapse or termination of coverage under this policy of long-term care insurance for nonpayment of premium. I understand that notice will not be given until 30 days after the date on which a premium is due and unpaid. I choose NOT to designate a person to receive this notice." The insurer shall notify an insured of the right to change the written designation described in this section not less than once every 2 years.

3. If an insured who pays premiums for long-term care insurance through a payroll or pension deduction plan ceases to make such payments through the plan, the insurer shall comply with the requirements of subsections 1 and 2 not later than 60 days after the date on which the premiums are no longer paid through the plan. The application or enrollment form for a policy or certificate of long-term care insurance for which the premium is paid through a payroll or pension deduction plan must clearly indicate the payment plan selected by the applicant.

4. An individual policy of long-term care insurance must not lapse or be terminated by the insurer for nonpayment of premium unless the insurer, not less than 30 days after a premium is due and unpaid and not less than 30 days before the effective date of the lapse or termination, has given notice by first-class mail, postage prepaid, to the policyholder and to each person designated by the policyholder to receive notice pursuant to subsection 1. The notice required by this subsection shall be deemed to have been given 5 days after the date on which the insurer mails the notice.

5. An individual policy of long-term care insurance must provide for the reinstatement of coverage in the event of a lapse in coverage if the insurer is provided proof that the insured was cognitively impaired or had a loss of functional capacity before the grace period contained

in the policy expired. The policy must provide that an insured may request such reinstatement not later than 5 months after the date of termination and may provide for the collection of past due premiums, if any. The standard of proof of cognitive impairment or loss of functional capacity must not be more stringent than the criteria to determine eligibility for benefits contained in the policy.

Sec. 11. *1. Except for a policy of long-term care insurance under which the right not to renew is reserved solely to the policyholder, a policy of long-term care insurance must contain a renewability provision that:*

(a) Is appropriately captioned;

(b) Appears on the first page of the policy; and

(c) Clearly states that the coverage is guaranteed renewable or noncancellable.

2. An individual policy of long-term care insurance, other than one for which the insurer does not have the right to change the premium, must include a provision that premium rates may change.

Sec. 12. *1. Except for a rider or endorsement by which an insurer effectuates a request made in writing by the policyholder under an individual policy of long-term care insurance, any rider or endorsement added to an individual policy of long-term care insurance after the date of issue or at reinstatement or renewal that reduces or eliminates benefits or coverage must be agreed to in writing and be signed by the policyholder.*

2. After the date of issue of a policy, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the term of an individual policy of long-term care insurance must be agreed to in writing and signed by the policyholder unless the increased benefits or coverage are required by law.

3. If a separate additional premium is charged to a policyholder for benefits provided in connection with riders or endorsements, the premium charge must be set forth separately in the policy, rider or endorsement.

Sec. 13. *A policy or certificate of long-term care insurance that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or similar words must include a definition of those terms and an explanation of the terms in the outline of coverage that accompanies the policy or certificate.*

Sec. 14. *1. If a policy or certificate of long-term care insurance contains any limitations with respect to preexisting conditions, the limitations must appear as a separate paragraph in the policy or certificate that must be labeled as "Preexisting Condition Limitations."*

2. If a policy or certificate of long-term care insurance contains any limitations or conditions on eligibility for benefits, a description of the limitations or conditions must appear as a separate paragraph in the policy or certificate that must be labeled as "Limitations or Conditions on Eligibility for Benefits."

Sec. 15. *If a policy of life insurance or a rider to a policy of life insurance, other than a qualified long-term care insurance contract, provides for an accelerated benefit for long-term care, the insurer shall provide a disclosure statement at the time of application for the policy or rider and at the time a request for payment of accelerated benefits is submitted which provides that receipt of any accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement must be prominently displayed on the first page of the policy or rider and any other related documents.*

Sec. 16. *1. Activities of daily living and cognitive impairment must be used to measure the needs of an insured for long-term care and must be described in a policy or certificate of*

long-term care insurance in a separate paragraph that must be labeled as "Eligibility for the Payment of Benefits." Any additional benefit triggers must also be explained and must include, without limitation, whether:

(a) Any such benefit triggers differ for different benefits; and

(b) An attending physician or other specified person is required to certify a certain level of functional dependency for the insured to be eligible for benefits.

2. The description of any benefit in a policy or certificate of long-term care insurance must include an explanation of the benefit trigger.

Sec. 17. *1. A qualified long-term care insurance contract must include a disclosure statement in the contract and in the outline of coverage that the contract is intended to be a qualified long-term care insurance contract under 26 U.S.C. § 7702B(b).*

2. A policy that is not a qualified long-term care insurance contract must include a disclosure statement in the policy and in the outline of coverage that the policy is not intended to be a qualified long-term care insurance contract under 26 U.S.C. § 7702B(b).

Sec. 18. *1. For any policy or certificate of long-term care insurance issued in this State on or after October 1, 2008, other than a policy or certificate for which no applicable increases in premium rates or rate schedules can be made, the insurer shall provide to the applicant:*

(a) A statement that the policy or certificate may be subject to rate increases in the future;

(b) An explanation of potential future premium rate revisions, and the options available to the applicant in the event of a premium rate revision;

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

(d) A general explanation for applying adjustments to premium rates or rate schedules that must include:

(1) A description of when such adjustments will be effective; and

(2) A statement that the applicant must be provided with a revised premium rate or rate schedule if the premium rate or rate schedule is changed; and

(e) Except as otherwise provided in subsection 3, information relating to each increase in premium rates on the policy form or similar policy forms during the previous 10 years for this State or any other state, including, without limitation, information that identifies:

(1) The policy forms for which premium rates have increased;

(2) The calendar years when the policy form was available for purchase; and

(3) The amount or percentage of each rate increase which may be expressed as a percentage of the premium rate before the increase or as minimum and maximum percentages if the rate increase is variable by rating characteristics.

2. In addition to the requirements of subsection 1, if an insurer or similar organization acquires a block of policy forms from a nonaffiliated insurer or similar organization and the premium rates for the block of policy forms increase within 24 months after the block of policy forms is acquired, the nonaffiliated insurer or similar organization shall provide a statement of the increase in premium rates to the applicant.

3. The provisions of paragraph (e) of subsection 1 do not apply to:

(a) Any increase in premium rates for any block of policy forms acquired by the insurer from a nonaffiliated insurer if the increases occurred before the acquisition or not later than 24 months after the acquisition; or

(b) Any increase in premium rates for policies of long-term care insurance acquired by the insurer from a nonaffiliated insurer if the increases occurred before the acquisition or not later than 24 months after the acquisition.

4. The insurer shall provide the information required by subsection 1 to the applicant:

(a) At the time of application; or

(b) If the method of application does not allow for delivery of the policy or certificate at the time of application, not later than the time of delivery of the policy or certificate.

5. An applicant must sign an acknowledgment that the insurer provided the information required by subsection 1:

(a) At the time of application; or

(b) If the method of application does not allow for the signing of the acknowledgment at the time of application, not later than the time of delivery of the policy or certificate.

6. An insurer shall use the forms prescribed by the Commissioner to comply with the requirements of this section.

7. An insurer shall provide notice of any increase in a premium rate schedule to all affected policyholders or certificate holders not less than 60 days before the effective date of the increase. The notice must include, without limitation, the information required by subsection 1.

Sec. 19. *1. The provisions of this section do not apply to a policy of life insurance, a rider to a policy of life insurance or an annuity contract that contains accelerated benefits for long-term care.*

2. An insurer shall not offer for sale any form of long-term care insurance in this State unless the insurer submits to the Commissioner and the Commissioner approves:

(a) A copy of the disclosures described in section 18 of this regulation; and

(b) An actuarial certification that includes, without limitation:

(1) 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 policy with no anticipated future premium increases;

(2) A statement that the policy design and the coverage provided by the policy have been reviewed and taken into consideration;

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

(4) A complete description of the basis for contract reserves that are anticipated to be held under the policy, which must include, without limitation:

(I) Sufficient detail or sample calculations so as to provide a complete and accurate depiction of the amount of reserves 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 ratings if such increases are authorized; 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 any situations in which this does not occur;

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

(6) An actuarial demonstration that benefits are reasonable in relation to premiums, which must include:

(I) Premium and claims experience on similar policy forms adjusted for any premium or benefit differences;

(II) Relevant and credible data from other studies; or

(III) A combination of premium and claims experience on similar policy forms and relevant and credible data from other studies; and

(7) A statement that the actuarial certification was made by a person qualified to make such a certification.

3. For the purposes of sub-subparagraph (IV) of subparagraph (4) of paragraph (b) of subsection 2, an aggregate distribution of anticipated issues may be used if the underlying gross premiums maintain a reasonably consistent relationship in accordance with generally accepted standards of actuarial practice. If the gross premiums for certain age groups appear to be inconsistent, the Commissioner may request a demonstration by the insurer that gross premiums maintain a reasonably consistent relationship based on a standard age distribution in accordance with generally accepted standards of actuarial practice.

Sec. 20. *An insurer that provides qualified state long-term care insurance partnership contracts shall:*

1. On or before March 1 of each year, provide certification to the Commissioner that all partnership contracts issued by the insurer during the immediately preceding calendar year were sold by producers who have received adequate training and have demonstrated an understanding of the partnership policies and their relationship to public and private coverage of long-term care, including Medicaid, in this State; and

2. Maintain records with respect to the training of its producers concerning the sale of partnership contracts that will allow the Commissioner to provide adequate assurances to the Division of Health Care Financing and Policy of the Department of Health and Human Services that the producers have received adequate training and have demonstrated an understanding of the partnership policies and their relationship to public and private coverage of long-term care, including Medicaid, in this State. The insurer shall maintain the records for not less than 5 years and shall make the records available to the Commissioner upon request.

Sec. 21. *1. An insurer shall maintain records for each agent which:*

(a) Specify the amount of replacement sales by the agent as a percentage of the total annual sales by the agent; and

(b) Specify the amount of lapses in policies sold by the agent as a percentage of the total annual sales by the agent.

2. On or before June 30 of each year, an insurer shall provide to the Commissioner the names of its agents in this State who, as measured by the records maintained pursuant to subsection 1, rank in the top 10 percent of all its agents in this State with the highest percentages of:

(a) Replacement sales in this State; and

(b) Lapses in policies sold by the agent in this State.

3. On or before June 30 of each year, an insurer shall report to the Commissioner the number of lapsed policies issued by the insurer in this State as a percentage of the total annual sales of the insurer in this State and as a percentage of the total number of policies issued by the insurer in this State which are in force on December 31 of the immediately preceding calendar year in this State.

4. On or before June 30 of each year, an insurer shall report to the Commissioner the number of replacement policies issued by the insurer in this State as a percentage of the total annual sales of the insurer in this State and as a percentage of the total number of policies issued by the insurer in this State which are in force on December 31 of the immediately preceding calendar year in this State.

5. On or before June 30 of each year, an insurer shall report to the Commissioner, for qualified long-term care insurance contracts issued by the insurer in this State, the number of claims denied in this State for each class of business, expressed as a percentage of all claims denied in this State.

6. As used in this section:

(a) "Claim" means a request for payment of benefits under a policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.

(b) "Denied" means the refusal of an insurer to pay a claim for any reason other than:

(1) Failure of the insured to meet an applicable waiting period; or

(2) An applicable preexisting condition.

(c) "Policy" means a policy of long-term care insurance.

Sec. 22. ***1. The provisions of this section do not apply to a policy of life insurance, a rider to a policy of life insurance or an annuity contract that contains accelerated benefits for long-term care.***

2. An insurer shall file with the Commissioner for approval any increase in a premium rate schedule. The filing must include, without limitation:

(a) The information required by section 18 of this regulation;

(b) An actuarial memorandum prepared in accordance with all applicable standards of practice which must include:

(1) A description of the benefits provided under the affected policy;

(2) An actuarial demonstration that the benefits are reasonable in relation to the premiums;

(3) An explanation of the reasons for the rate increase;

(4) The history of any previously approved rate increase, which must include the effective date of each previous rate increase and the percentage increase of each previous rate increase;

(5) A description of any actuarial assumptions and any related tables, including any changes in actuarial assumptions since the last rate increase and since the initial filing of policy rates;

(6) An analysis of the expected and the actual experience and projections for claims, premiums, loss ratios, lapses and mortality;

(7) The annual loss ratios expected at the time of the most recent premium filing and the initial rate filing, which must include a comparison of the expected and the actual loss ratios;

(8) The number of its insureds in this State and nationwide;

(9) If a reduction in benefits is offered to offset the rate increase, a complete actuarial justification that the premium changes are actuarially equivalent to the benefit reduction; and

(10) The basis for the interest rate used; and

(c) The percentage amount of the rate increase stated in the filing description of the uniform transmittal document.

3. If the insurer has fewer than 2,000 insureds nationwide, the information required pursuant to subparagraphs (6) and (7) of paragraph (b) of subsection 2 must be provided:

(a) When combined with all similar policy forms; and

(b) For a specific policy form.

Sec. 23. *1. Except as otherwise provided in subsection 2, every insurer or other organization that markets or offers policies or certificates of long-term care insurance in this State shall provide to the Commissioner for review and approval a copy of any written, radio or television advertisement for the sale of long-term care insurance intended for use in this State.*

2. The Commissioner may exempt an advertisement from the requirements of subsection 1 if, in the opinion of the Commissioner, the provisions of subsection 1 may not be reasonably applied to the advertisement.

Sec. 24. *1. The provisions of this section do not apply to a policy of life insurance or a rider to a policy of life insurance that contains accelerated benefits for long-term care.*

2. Every insurer or other organization that markets or offers policies or certificates of long-term care insurance in this State shall:

(a) Develop standards of suitability to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of an applicant;

(b) Train its agents in the use of the standards of suitability; and

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

3. An insurer shall use the standards of suitability developed pursuant to subsection 2 in determining whether it is appropriate to issue long-term care insurance to an applicant.

4. An agent shall use the standards of suitability developed by the insurer pursuant to subsection 2 in marketing long-term care insurance.

5. To determine whether an applicant meets the standards of suitability developed pursuant to subsection 2 for the purchase or replacement of long-term care insurance, the insurer and its agents shall develop policies and procedures that take into consideration:

(a) The ability of the applicant to pay for the proposed coverage;

(b) Any other pertinent financial information relating to the proposed purchase;

(c) The goals or needs of the applicant with respect to long-term care and the advantages and disadvantages of insurance to meet those goals or needs; and

(d) The values, benefits and costs of the existing insurance of the applicant, if any, as compared to the values, benefits and costs of the proposed purchase or replacement.

6. The insurer and its agents shall make reasonable efforts to obtain the information required pursuant to subsection 5, including, without limitation, presenting to the applicant at or before the time of application the worksheet described in subsection 9. The insurer may request that the applicant provide additional information to comply with the standards of suitability.

7. An insurer shall not consider an application unless the applicant completes the worksheet described in subsection 9 and returns the completed worksheet to the insurer, except that the insurer may consider an application without receiving a completed worksheet if the applicant is offered the coverage through a sale of group long-term care insurance to employees and their spouses.

8. An insurer and its agents shall not sell or disseminate outside the company any information obtained from a worksheet described in subsection 9.

9. An insurer shall provide to each applicant a "Long-Term Care Insurance Personal Worksheet" which must contain a statement in substantially the following form, set out conspicuously in the following format, in not less than 12-point type:

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET

People buy long-term care insurance for many reasons. Some do not 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 do not want their family to have to pay for care or do not 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.]*

Rate Increase History

The company has sold long-term care insurance since [_____ (insert year)] and has sold this policy since [_____ (insert 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 Relating to Your Income

How will you pay each year's premium?

☐ From my income ☐ From my savings and investments ☐ My family will pay

Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20 percent? (check one)

☐ Yes ☐ No

What is your annual income? (check one)

☐ Less than $10,000 ☐ $10,000-$19,999 ☐ $20,000-$29,999 ☐ $30,000-$49,999

☐ $50,000 or more

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 and investments* ☐ *My family will pay*

*The national average annual cost of care in [_____ (insert year)] was $_____, but this figure varies across the country. In 10 years the national average annual cost would be about $_____ if costs increase 5 percent 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 and investments* ☐ *My family will pay*

Questions Relating to Your Savings and Investments

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

☐ *Less than $20,000* ☐ *$20,000-$29,999* ☐ *$30,000-$49,999* ☐ *$50,000 or more*

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

☐ *Stay about the same* ☐ *Increase* ☐ *Decrease*

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

Disclosure Statement

☐ ***The answers to the questions above describe my financial situation.***

Or

☐ ***I choose not to complete this information.***

(Check one.)

☐ ***I acknowledge that the insurance company or its agent 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).***

The company may contact you to verify your answers.

Signed: _____ ***Date:*** _____

(Applicant)

☐ ***I explained to the applicant the importance of completing this information.***

Signed: _____ Date: _____

(Agent)

Agent's Printed Name: _____

[In order for us to process your application, please return this signed statement to _____ (insert name of company), along with your application.] [My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.]*

Signed: _____ Date: _____

(Applicant)

****Drafter's note: Insurers must use the appropriate bracketed statement. Rate guarantees must not be shown on this form.***

*****Drafter's note: In this statement, the second figure equals 163 percent of the first figure.***

******Drafter's note: Choose the appropriate sentences depending on whether this is a direct mail or agent sale.***

10. An insurer shall file with the Commissioner a copy of the worksheet described in subsection 9.

Sec. 25. *1. If an insurer determines that an applicant does not meet the standards of suitability developed pursuant to section 24 of this regulation, or if the applicant declines to provide any information required by section 24 of this regulation, the insurer may:*

(a) Reject the application; or

(b) Mail a letter to the applicant which contains a statement in substantially the following form, set out conspicuously in the following format:

Dear [_____ (Insert name of applicant)]:

Your recent application for long-term care insurance included a "Long-Term Care Insurance 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 persons 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 entitled "A Shopper's Guide to Long-Term Care Insurance" and the form entitled "Things You Should Know Before Buying Long-Term Care Insurance." The Division of Insurance 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 a policy to you.

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.***

Signed: _____ ***Date:*** _____

(Applicant)

Please return to [_____ (Insert name of insurer)] at [_____ (Insert address of insurer)] by [_____ (Insert date)].

****Drafter's note: Choose the appropriate sentences depending on the information received from the applicant.***

2. If an applicant declines to provide any financial information required pursuant to section 24 of this regulation, the insurer may use any other method to verify the intent of the applicant.

3. The insurer shall include in the file of the applicant:

(a) The returned letter described in paragraph (b) of subsection 1; or

(b) A record of the alternative method of verification of the intent of the applicant.

Sec. 26. *An insurer shall report annually to the Commissioner:*

1. The number of applications for long-term care insurance received by the insurer from residents of this State;

2. The number of applicants who declined to provide information on the worksheet described in subsection 9 of section 24 of this regulation;

3. The number of applicants who did not meet the standards of suitability developed by the insurer pursuant to section 24 of this regulation; and

4. The number of applicants who chose to purchase long-term care insurance after receiving the letter described in paragraph (b) of subsection 1 of section 25 of this regulation.

Sec. 27. *When an insurer or its agent provides the worksheet described in subsection 9 of section 24 of this regulation to an applicant, the insurer or its agent shall provide to the applicant a form entitled "Things You Should Know Before You Buy Long-Term Care Insurance," which must be printed in not less than 12-point type and which must contain a statement in substantially the following form, set out conspicuously in the following format:*

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 in other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you purchase the policy.***
	• ***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 the Division of Health Care Financing and Policy of the Department of Health and Human Services.***

Shopper's Guide

- ***Make sure the insurance company or agent gives you a copy of a booklet entitled "A Shopper's Guide to Long-Term Care Insurance" by the National Association of Insurance Commissioners. 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 be refunded 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 the Nevada State Health Insurance Advisory Program of the Aging Services Division of the Department of Health and Human Services. Contact the Aging Services Division for more information about the Nevada State Health Insurance Advisory Program.***

Facilities

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

Sec. 28. *If a policy or certificate of long-term care insurance replaces another policy or certificate of long-term care insurance, the replacing insurer must waive any period applicable to preexisting conditions and any probationary periods in the new policy or certificate for similar benefits to the extent that similar periods have been satisfied under the original policy or certificate.*

Sec. 29. *1. The provisions of this section do not apply to a policy of life insurance or a rider to a policy of life insurance that contains accelerated benefits for long-term care.*

2. Except as otherwise provided in subsections 3, 6 and 7, an insurer shall notify each policyholder or certificate holder of the availability of any new series of policies of long-term care insurance that provides material coverage for long-term care services or providers that was not previously available through the insurer to the general public, not later than 12 months after the date the new series of policies is made available for sale in this State.

3. The notification required by subsection 2 is not required for any policy or certificate issued:

(a) Before October 1, 2008; or

(b) To any policyholder or certificate holder who:

(1) Is currently eligible for benefits;

(2) Is within an elimination period;

(3) Previously received benefits under the policy or certificate; or

(4) Is not eligible to apply for the new coverage because of limitations under the new policy relating to the issue age of the insured.

4. The insurer may require that the insured meet all eligibility requirements, including, without limitation, any underwriting requirements and payment of premiums to add any new coverage described in subsection 2.

5. The insurer shall make any new coverage described in subsection 2 available:

(a) By adding a rider to the existing policy and charging a separate premium for the rider based on the attained age of the insured;

(b) By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate based on premiums paid or reserves held for the previous policy or certificate;

(c) By exchanging the existing policy or certificate for a new policy or certificate in which:

(1) Consideration for past insured status must be recognized by setting the premium for the new policy or certificate at the issue age of the insured for the policy or certificate being exchanged; and

(2) The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or

(d) By an alternative program developed by the insurer and approved by the Commissioner.

6. An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel except that the insurer must notify any policyholder who purchases such a proprietary policy when a new series of policies of long-term care insurance that provides material coverage for new long-term care services or providers is made available to that limited distribution channel. As used in this subsection, "limited distribution channel" means a discrete entity, including, without limitation, a financial institution or brokerage, through or for which specialized products are available that are not available for sale to the general public.

7. If the new series of policies of long-term care insurance is offered through an employer, labor organization, or professional, trade or occupational association, the insurer is only required to provide notice to the offering entity.

8. A policy or certificate issued pursuant to this section:

(a) Shall be deemed an exchange; and

(b) Is not subject to the provisions of NAC 687B.125, 687B.127, 687B.130 and 687B.135.

9. The provisions of this section do not prohibit an insurer from offering any policy, rider, certificate or change in coverage to any policyholder or certificate holder.

10. Upon request, any policyholder or certificate holder may apply for any currently available coverage that includes any new services or providers described in subsection 2.

Sec. 30. *1. The provisions of this section do not apply to a policy of life insurance or a rider to a policy of life insurance that contains accelerated benefits for long-term care.*

2. Each policy or certificate of long-term care insurance must include a provision that allows the policyholder or certificate holder to reduce coverage and lower the premium by reducing:

(a) The maximum benefit; or

(b) The daily, weekly or monthly benefit amount.

3. In addition to the provisions of subsection 2, an insurer may include a provision that allows the policyholder or certificate holder to reduce coverage and lower the premium by offering any other option to reduce the premium that is consistent with the other provisions of the policy or certificate or the administrative processes of the insurer.

4. Any provision that allows the policyholder or certificate holder to reduce coverage and lower the premium must include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

5. For the purposes of reducing coverage pursuant to this section, the age of the insured used to determine the premium for the reduced coverage must be based on the age used to determine the premiums for the current amount of coverage.

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

7. If a policy or certificate of long-term care insurance is at risk of lapsing, the insurer shall, in addition to the notice required pursuant to section 10 of this regulation, provide written notice to the policyholder or certificate holder of his right to reduce coverage and premiums pursuant to this section. The insurer shall provide notice to the policyholder or certificate holder before the later of:

(a) The date 20 days before the end of the grace period provided by the policy or certificate; or

(b) The date on which the premium becomes past due.

Sec. 31. *1. Except as otherwise provided in subsection 2, an insurer shall not deliver or issue for delivery in this State a policy or certificate of long-term care insurance unless the policyholder or certificate holder has been offered the option to purchase a policy or certificate of long-term care insurance that includes a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. If the policyholder or certificate holder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that must be available to the policyholder or certificate holder for the period following a substantial increase in premium rates specified in section 32 of this regulation.*

2. Except as otherwise provided in subsection 3, if an insurer offers a policy of group long-term care insurance, the offer required by subsection 1 must be made only to the group policyholder.

3. If an insurer offers a policy of group long-term care insurance to a group described in subsection 4 of NAC 687B.025, other than a continuing-care retirement community or other similar entity, the offer required by subsection 1 must be made to each certificate holder.

Sec. 32. *1. The provisions of this section do not apply to a policy of life insurance or a rider to a policy of life insurance that contains accelerated benefits for long-term care.*

2. To satisfy the requirements of section 31 of this regulation:

(a) A policy or certificate of long-term care insurance offered with nonforfeiture benefits must include the elements of the coverage, requirements for eligibility, benefit triggers and length of benefits that are the same as the coverage issued without nonforfeiture benefits;

(b) If the offer of a nonforfeiture benefit required by section 31 of this regulation is not otherwise described in the outline of coverage or other materials provided to the applicant, the offer must be set out separately and be in writing; and

(c) The nonforfeiture benefit included in the offer must conform to the requirements of this section.

3. If an applicant rejects the offer of a nonforfeiture benefit required by section 31 of this regulation, the insurer shall provide a contingent benefit upon lapse in accordance with subsection 8.

4. If an applicant accepts the offer of a nonforfeiture benefit required by section 31 of this regulation, for a policy with a fixed or limited premium paying period, the insurer shall provide a contingent benefit upon lapse in accordance with subsection 8.

5. If an applicant rejects the offer of a nonforfeiture benefit required by section 31 of this regulation, for a policy or certificate of long-term care insurance without nonforfeiture benefits issued on or after October 1, 2008, the insurer shall provide a contingent benefit upon lapse in accordance with subsection 8.

6. If a group policyholder chooses to make the nonforfeiture benefit an option to a certificate holder, the certificate must provide the nonforfeiture benefit or the contingent benefit upon lapse in accordance with subsection 8.

7. A contingent benefit upon lapse is triggered if an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or greater

than the percentage of the initial annual premium of the policyholder or certificate holder, based on the issue age of the insured, as described in the following chart entitled "Triggers for a Substantial Premium Increase (I)," and the affected policy or certificate lapses within 120 days after the due date of the increased premium. Unless otherwise required, the insurer shall provide notice of the rate increase to a policyholder or certificate holder not less than 30 days before the due date of the premium that includes the rate increase. The chart must be set forth as follows:

Triggers for a Substantial Premium Increase (I)	
Issue Age	***Percent Increase Over Initial Premium***
29 and under	***200 percent***
30-34	***190 percent***
35-39	***170 percent***
40-44	***150 percent***
45-49	***130 percent***
50-54	***110 percent***
55-59	***90 percent***
60	***70 percent***
61	***66 percent***
62	***62 percent***
63	***58 percent***
64	***54 percent***

Triggers for a Substantial Premium Increase (I)	
Issue Age	*Percent Increase Over Initial Premium*
65	*50 percent*
66	*48 percent*
67	*46 percent*
68	*44 percent*
69	*42 percent*
70	*40 percent*
71	*38 percent*
72	*36 percent*
73	*34 percent*
74	*32 percent*
75	*30 percent*
76	*28 percent*
77	*26 percent*
78	*24 percent*
79	*22 percent*
80	*20 percent*
81	*19 percent*
82	*18 percent*
83	*17 percent*
84	*16 percent*

Triggers for a Substantial Premium Increase (I)	
Issue Age	*Percent Increase Over Initial Premium*
85	*15 percent*
86	*14 percent*
87	*13 percent*
88	*12 percent*
89	*11 percent*
90 and over	*10 percent*

8. A contingent benefit upon lapse is triggered for any policy with a fixed or limited premium paying period if the insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or greater than the percentage of the initial annual premium of the policyholder or certificate holder, based on the issue age of the insured, as described in the following chart entitled "Triggers for a Substantial Premium Increase (II)," the affected policy or certificate lapses not later than 120 days after the due date of the increased premium and the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period is 0.4 or more. The provision of this benefit is in addition to the benefit described in subsection 7, and if both benefits are triggered, the insured may choose which benefit must be provided. Unless otherwise required, the insurer shall provide notice of the rate increase to a policyholder or certificate holder not less than 30 days before the due date of the premium that includes the rate increase.

Triggers for a Substantial Premium Increase (II)	
Issue Age	*Percent Increase Over Initial Premium*
64 and under	*50 percent*
65-79	*30 percent*
80 and over	*10 percent*

9. On or before the effective date of a substantial premium increase described in subsection 7, 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 subsection 11; and

(c) Notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period described in subsection 7 shall be deemed to be the selection of the offer to convert described in paragraph (b), unless the provisions of paragraph (c) of subsection 10 apply.

10. On or before the effective date of a substantial premium increase described in subsection 8, the insurer shall:

(a) Offer to reduce 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 where the amount payable for each benefit is equal to 90 percent of the amount payable immediately before the lapse multiplied by the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period; and

(c) Notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period set forth in subsection 8 shall be deemed to be the selection of the offer to convert described in paragraph (b) if the ratio described in paragraph (b) is 0.4 or more.

11. For the purpose of determining benefits continued as nonforfeiture benefits, including the contingent benefits upon lapse described in subsection 7 but not the contingent benefits upon lapse described in subsection 8:

(a) "Attained age rating" means a schedule of premiums starting from the issue date which increases with age.

(b) The nonforfeiture benefit must be for a shortened benefit period providing paid-up long-term care insurance after lapse. The same benefit amounts and frequency of benefits in effect at the time of lapse must be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits must be determined as specified in paragraph (c).

(c) The standard nonforfeiture benefit must be equal to 100 percent of the sum of all premiums paid, including the premiums paid before any change in benefits. The insurer may offer additional options for shortened benefit periods if the benefits for each period are equal to or greater than the standard nonforfeiture benefit for that period, except that the minimum nonforfeiture benefit must not be less than 30 times the daily nursing home benefit in effect at the time of the lapse.

(d) Except as otherwise provided in paragraph (f), the nonforfeiture benefit must begin not later than the end of the third year following the date of issue of the policy or certificate.

(e) Except as otherwise provided in paragraph (f), the contingent benefit upon lapse must be effective from the date of issue of the policy or certificate.

(f) For a policy or certificate with attained age rating, the nonforfeiture benefit must begin on the earlier of:

(1) The end of the 10th year following the date of issue of the policy or certificate; or

(2) The end of the second year following the date on which the policy or certificate is no longer subject to attained age rating.

(g) Nonforfeiture benefits 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.

12. All benefits paid by an insurer while a policy or certificate is not in premium-paying status and in a paid-up status must not exceed the maximum benefits which would be payable if the policy or certificate remained in premium-paying status.

13. The minimum nonforfeiture benefits required by this section must be the same for group and individual policies of long-term care insurance.

14. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit upon lapse are subject to the loss ratio requirements applicable to the policy as a whole.

15. To determine whether the provisions of paragraph (c) of subsection 9 and paragraph (c) of subsection 10 apply, a replacing insurer that purchases or otherwise assumes a block or blocks of policies of long-term care insurance from another insurer shall calculate the

percentage increase based on the initial annual premium paid by the policyholder or certificate holder when the policy was first purchased by the policyholder or certificate holder.

16. An insurer shall offer a nonforfeiture benefit for any qualified long-term care insurance contract that is a level premium contract. The nonforfeiture benefit provision must:

(a) Be appropriately captioned;

(b) Provide a benefit available in the event of a default in the payment of any premiums;

(c) State that the amount of the benefit may be adjusted only as is 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

(d) Provide:

(1) Reduced paid-up insurance;

(2) Extended-term insurance;

(3) A shortened benefit period; or

(4) Any other similar offerings approved by the Commissioner.

Sec. 33. *1. Except as otherwise provided in this section, the provisions of section 32 of this regulation apply to any policy or certificate of long-term care insurance issued in this State on or after October 1, 2008.*

2. The provisions of section 32 of this regulation do not apply to a certificate issued on or after October 1, 2008, to a group described in subsection 1 of NAC 687B.025 under a group policy of long-term care insurance which was in force on October 1, 2008.

3. The provisions of subsections 4, 8 and 10 of section 32 of this regulation do not apply to new certificates issued to a group described in subsection 1 of NAC 687B.025 under a group policy of long-term care insurance issued on or after April 1, 2009.

4. Except as otherwise provided in subsections 2 and 3, the provisions of subsections 4, 8 and 10 of section 32 of this regulation apply to any policy or certificate of long-term care insurance issued in this State on or after January 1, 2009.

Sec. 34. *1. A policy or certificate of long-term care insurance must condition the payment of benefits on a determination of the ability of the insured to perform activities of daily living and on the cognitive impairment of the insured. Eligibility for the payment of benefits must not be more restrictive than requiring a determination that the insured:*

(a) Is unable to perform more than three of the activities of daily living; or

(b) Has a cognitive impairment.

2. For the purpose of determining the ability of an insured to perform the activities of daily living pursuant to subsection 1, such activities include, without limitation:

(a) Bathing;

(b) Continence;

(c) Dressing;

(d) Eating;

(e) Toileting;

(f) Transferring; and

(g) Any other activity of daily living defined in the policy or certificate.

3. For the purposes of this section, the determination of a deficiency in the ability of the insured to perform the activities of daily living must not be more restrictive than a determination that the insured:

(a) Requires the hands-on assistance of another person to perform the prescribed activities of daily living; and

(b) If the deficiency is due to a cognitive impairment, requires supervision or verbal cues by another person to protect the insured or other persons.

4. Determinations regarding activities of daily living and cognitive impairment must be performed by a licensed health care practitioner.

5. In addition to the criteria set forth in subsections 1 to 4, inclusive, an insurer may use any other criteria for determining when benefits are payable under a policy or certificate of long-term care insurance that are not more restrictive than the criteria set forth in subsection 1.

6. A policy or certificate of long-term care insurance must include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

7. Except for certificates issued on or after October 1, 2008, under a group policy of long-term care insurance to a group described in subsection 1 of NAC 687B.025 that was in force on October 1, 2008, the provisions of this section apply to any policy or certificate of long-term care insurance issued in this State on or after October 1, 2008.

8. As used in this section, "licensed health care practitioner" means a person licensed pursuant to chapters 630 to 633, inclusive, of NRS, a licensed social worker or other individual who meets the requirements prescribed by the Secretary of the Treasury pursuant to 26 U.S.C. § 7702B(c)(4).

Sec. 35. *1. A qualified long-term care insurance contract must pay only for qualified long-term care services:*

(a) Received by a chronically ill individual; and

(b) Provided pursuant to a plan of care prescribed by a licensed health care practitioner.

2. The payment of benefits under a qualified long-term care insurance contract must be conditioned on a certification of the inability of the insured to perform the activities of daily living for an expected period of at least 90 days because of a loss of functional capacity or severe cognitive impairment.

3. Certifications pursuant to subsection 2 regarding activities of daily living and cognitive impairment:

(a) Must be performed by a licensed health care practitioner.

(b) May be performed by a licensed health care practitioner at the direction of the insurer as is reasonably necessary with respect to a specific claim, except that if 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 because of a loss of functional capacity and the insured is receiving benefits, the certification may not be rescinded and additional certifications must not be performed until after the expiration of the 90-day period.

4. A qualified long-term care insurance contract must include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

5. As used in this section:

(a) "Chronically ill individual" has the meaning ascribed to it in 26 U.S.C. § 7702B(c)(2).

(b) "Licensed health care practitioner" means a person licensed pursuant to chapters 630 to 633, inclusive, of NRS, a licensed social worker or other individual who meets the requirements prescribed by the Secretary of the Treasury pursuant to 26 U.S.C. § 7702B(c)(4).

(c) "Qualified long-term care services" has the meaning ascribed to it in 26 U.S.C. § 7702B(c)(1).

Sec. 36. NAC 687B.005 is hereby amended to read as follows:

687B.005 As used in NAC 687B.005 to 687B.140, inclusive, ***and sections 2 to 35, inclusive, of this regulation,*** unless the context otherwise requires, the words and terms defined in NAC 687B.010 to 687B.032, inclusive, ***and sections 2 to 5, inclusive, of this regulation*** have the meanings ascribed to them in those sections.

Sec. 37. NAC 687B.040 is hereby amended to read as follows:

687B.040 A policy of insurance may not be advertised, marketed or offered as long-term care insurance or insurance which provides coverage for care received in a nursing home unless it complies with the provisions of NAC 687B.005 to 687B.140, inclusive ~~[.]~~ ***, and sections 2 to 35, inclusive, of this regulation.***

Sec. 38. NAC 687B.075 is hereby amended to read as follows:

687B.075 1. An outline of coverage must be delivered to an applicant for a policy or certificate of long-term care insurance at the time of application. In the case of direct-response solicitations, the insurer shall deliver the outline of coverage upon the applicant's request, or not later than at the time the policy is delivered.

2. The outline of coverage must include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions and limitations contained in the policy;

(c) A statement of the renewal provisions, including any reservation in the policy of a right to change premiums; and

(d) A statement that the outline of coverage is a summary of the policy issued or applied for, and that the policy should be examined to determine governing contractual provisions.

3. The outline of coverage must:

(a) Be a separate and complete document;

(b) Be printed in type no smaller than 10-point;

(c) Not include any material of an advertising nature; and

(d) Contain a statement in substantially the following form, set out conspicuously in the following format:

[COMPANY NAME]

[ADDRESS-CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for a policy or certificate that is guaranteed issue, the following statement of caution, or a substantially similar statement, must appear in the outline of coverage.]

Caution: The issuance of this [policy] [certificate] of long-term care insurance 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] [certificate]. The best time to clear up any questions is now, before a claim arises! If, for

any reason, any of your answers is 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 policy was issued].

2. ***This [policy][certificate] [is][is NOT] intended to be a qualified state long-term care insurance partnership contract.***

3. 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 a contract of insurance, 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] [CERTIFICATE] CAREFULLY!

~~[3.]~~ ***4. FEDERAL TAX CONSEQUENCES.***

This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under 26 U.S.C. § 7702B(b).

OR

Federal Tax Implications of this [POLICY] [CERTIFICATE].

This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified long-term care insurance contract under 26 U.S.C. § 7702B(b). Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

5. TERMS UNDER WHICH THE [POLICY] [CERTIFICATE] MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) [For a policy or certificate of long-term care insurance, describe one of the following permissible provisions regarding renewability of the policy or certificate:

(1) Policies and certificates that are guaranteed renewable must 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] [certificate] as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your [policy] [certificate] on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancellable must contain the following statement:] RENEWABILITY: THIS [POLICY] [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your [policy] [certificate], to continue this [policy] [certificate] as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your [policy] [certificate] on its own and cannot change the premium you currently pay. However, if your [policy] [certificate] contains a feature to protect against inflation 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 the provisions for continuation and conversion applicable to the certificate and group policy.]

(c) [Describe the provisions regarding waiver of premium or state that there are no such provisions.]

(d) [State whether or not the company has a right to change the premium ~~[,]~~ and **,** if this right exists, describe clearly and concisely each circumstance under which the premium may change.]

~~[4.]~~ ***6.*** TERMS UNDER WHICH THE [POLICY] [CERTIFICATE] MAY BE RETURNED AND PREMIUM REFUNDED.

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

(b) [Include a statement whether the policy or certificate contains provisions for a refund or partial refund of the premium upon the death of an insured or surrender of the policy or certificate. If the policy or certificate contains such provisions, include a description of them.]

~~[5.]~~ ***7.*** THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from the insurance company.

(a) [For agents] Neither [Company Name] nor its agents represent Medicare, the Federal Government or any state government.

(b) [For direct-response] [Company Name] is not representing Medicare, the Federal Government or any state government.

~~[6.]~~ ***8.*** LONG-TERM CARE COVERAGE.

(a) Policies of this category are designed to provide coverage for one or more necessary or medically necessary services related to diagnostic, preventative, therapeutic,

rehabilitative, maintenance or personal care, 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.

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

~~[7.]~~ ***9.*** BENEFITS PROVIDED BY THIS [POLICY] [CERTIFICATE].

(a) [Describe covered services, related deductible(s), waiting periods, elimination periods and maximums of benefits.]

(b) [Describe institutional benefits, by skill level.]

(c) [Describe noninstitutional benefits, by skill level.]

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

~~[8.]~~ ***10.*** LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Noneligible facility or provider;

(c) Noneligible levels of care (for example, unlicensed providers, care or treatment provided by a family member);

(d) Exclusions or exceptions; and

(e) Limitations.]

[This section should provide a brief, specific description of any provision in the policy or certificate which limits, excludes, restricts, reduces, delays or in any other manner operates to qualify payment of benefits for one or more necessary or medically necessary services related to diagnostic, preventative, therapeutic, rehabilitative, maintenance or personal care.]

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

~~[9.]~~ ***11.*** RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of services related to long-term care 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 level of benefits will not increase over time;

(b) Any provisions regarding automatic adjustment of benefits;

(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 screening of health will be required, the frequency and amounts of the options for upgrading and any significant restrictions or limitations; and

(e) Describe whether there will be any additional charge in premiums imposed and **,** if so, how the additional charge will be calculated.]

~~[10.]~~ ***12.*** ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS. [State whether the [policy] [certificate] provides coverage for an insured clinically diagnosed as having Alzheimer's disease or a related degenerative and dementing illness. Specifically describe each screening of benefits or other provision in the policy or certificate that provides preconditions to the availability of benefits for such an insured.]

~~[11.]~~ ***13.*** PREMIUM.

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

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

~~[12.]~~ ***14.*** ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used.

(b) Describe other important features.]

15. CONTACT THE NEVADA STATE HEALTH INSURANCE ADVISORY PROGRAM OF THE AGING SERVICES DIVISION OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR POLICY OR CERTIFICATE.

4. Text of the outline of coverage which is capitalized or italicized in the format set out in paragraph (d) of subsection 3 may be emphasized in the outline of coverage by other means which provide prominence equivalent to capitalization or italicizing.

Sec. 39. NAC 687B.080 is hereby amended to read as follows:

687B.080 A policy of long-term care insurance delivered or issued for delivery in this State may not use the following terms unless the terms are defined in the policy as follows:

1. ***"Activities of daily living" must be defined as including, without limitation, bathing, continence, dressing, eating, toileting and transferring.***

2. "Acute condition" must be defined as a condition making a person medically unstable and requiring frequent monitoring of the person by providers of health care, including physicians and registered nurses, in order to maintain his status of health.

3. "Adult day care" must be defined as a program, for six or more persons, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired, elderly or disabled adults who can benefit from care in a group setting outside the home.

4. "Bathing" must be defined as washing oneself by sponge bath, in a tub or in a shower, including, without limitation, the task of getting into or out of the tub or shower.

5. "Cognitive impairment" must be defined as a deficiency in:

(a) The short or long-term memory of the person;

(b) Orientation as to person, place and time;

(c) Deductive or abstract reasoning; or

(d) Judgment as it relates to safety awareness.

6. "Continence" must be defined as:

(a) The ability of a person to maintain control of bowel and bladder function; or

(b) If a person is unable to maintain control of bowel or bladder function, the ability of a person to perform associated personal hygiene, including, without limitation, caring for a catheter or colostomy bag.

7. "Dressing" must be defined as putting on and taking off all items of clothing, including, without limitation, any necessary braces, fasteners or artificial limbs.

8. "Eating" must be defined as feeding oneself by getting food into the body, including, without limitation:

(a) From a receptacle, including, without limitation, a plate, cup or table;

(b) By feeding tube; or

(c) Intravenously.

9. "Hands-on assistance" must be defined as physical assistance without which the person would not be able to perform the activity of daily living.

10. "Medicare" must be defined as:

(a) "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended";

(b) "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

(c) Any words of similar import.

~~[2.]~~ ***11.*** "Mental or nervous disorder" must not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or a mental or emotional disease or disorder.

~~[3.]~~ ***12. "Provider of services," including, without limitation, a "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal***

care facility" or "home care agency" must be defined in relation to the services and facilities required to be available and the level of the licenses or degrees required for persons providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

13. "Services related to home health care" must be defined as medical and nonmedical services provided to ill, disabled or infirm persons in their residences. Covered services may include the services of a homemaker, assistance with activities of daily living and respite care.

14. "Services related to personal care" must be defined as the provision of personal services to assist a person with activities of daily living, including, but not limited to, bathing, eating, dressing and toileting.

15. "Skilled nursing care," "intermediate care," "personal care," "home care" and any other care received must be defined in relation to the level of skill required, the nature of the care and the setting in which the care must be provided.

~~[4. A provider of services, including, but not limited to, a "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal care facility" or "home care agency" must be defined in relation to the services and facilities required to be available and the level of the licenses or degrees of those persons providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.~~

~~5. "Acute condition" must be defined as a condition making a person medically unstable and requiring frequent monitoring of the person by providers of health care, including physicians and registered nurses, in order to maintain his status of health.~~

~~6. "Adult day care" must be defined as a program, for six or more persons, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired, elderly or disabled adults who can benefit from care in a group setting outside the home.~~

~~7. "Services related to home health care" must be defined as medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Covered services may include the services of a homemaker, assistance with activities of daily living and respite care.~~

~~8. "Services related to personal care" must be defined as the provision of personal services to assist a person with activities of daily living, including, but not limited to, bathing, eating, dressing and toileting.~~**]**

16. "Toileting" must be defined as:

(a) Getting to and from the toilet;

(b) Getting on and off the toilet; and

(c) Performing associated personal hygiene.

17. "Transferring" must be defined as moving into or out of a bed, chair or wheelchair.

Sec. 40. NAC 687B.121 is hereby amended to read as follows:

687B.121 ~~[Benefits under]~~

1. For an individual policy of long-term care insurance ***issued before October 1, 2008, the Commissioner*** shall ~~[be deemed]~~ ***deem the benefits*** reasonable in relation to premiums charged if the expected loss ratio is at least 60 percent, calculated in a manner which provides for the adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration will be given to all relevant factors, including:

~~[1.]~~ ***(a)*** The statistical credibility of incurred claims experience and earned premiums;

~~[2.]~~ ***(b)*** The period for which rates are computed to provide coverage;

~~[3.]~~ ***(c)*** Experienced and projected trends;

~~[4.]~~ ***(d)*** The concentration of experience within early policy duration;

~~[5.]~~ ***(e)*** Expected claim fluctuation;

~~[6.]~~ ***(f)*** Experience refunds, adjustments or dividends;

~~[7.]~~ ***(g)*** Renewability features;

~~[8.]~~ ***(h)*** All appropriate expense factors;

~~[9.]~~ ***(i)*** Interest;

~~[10.]~~ ***(j)*** The experimental nature of the coverage;

~~[11.]~~ ***(k)*** Policy reserves;

~~[12.]~~ ***(l)*** The mix of business by risk classification; and

~~[13.]~~ ***(m)*** Product features such as long elimination periods, high deductibles and high maximum limits.

2. For a policy of life insurance or a rider to a policy of life insurance that contains accelerated benefits for long-term care, the Commissioner shall deem the benefits reasonable in relation to the premiums charged if:

(a) The interest credited internally to determine cash value accumulations, including long-term care, are guaranteed not to be less than the minimum guaranteed interest rate for cash-value accumulations without long-term care set forth in the policy;

(b) The portion of the policy that provides benefits for life insurance meets the nonforfeiture requirements of NRS 688A.290 to 688A.360, inclusive;

(c) The policy meets the disclosure requirements of NAC 687B.075 and section 8 of this regulation;

(d) Any policy illustration provided satisfies the requirements of NAC 686A.460 to 686A.479, inclusive; and

(e) An actuarial memorandum is filed with, and approved by, the Commissioner that includes, without limitation:

(1) A description of the basis on which the long-term care rates are determined;

(2) A description of the basis for the reserves;

(3) A summary of the type of policy, benefits, provisions for renewal, general marketing method and limits on ages of issuance;

(4) A description and a table of each actuarial assumption used and, for expenses, the percent of premium dollars per policy and dollars per unit of benefits;

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

(6) The estimated average annual premium per policy and the average issue age;

(7) A statement which:

(I) Must indicate whether underwriting is performed at the time of application;

(II) If underwriting is performed at the time of application, must include a description of the type or types of underwriting used; and

(III) If the policy is a policy of group long-term care insurance, must indicate whether the enrollee or any dependent will be underwritten and when such underwriting occurs; and

(8) A description of the effect of the long-term care benefits on the required premiums, nonforfeiture values and reserves on the underlying policy of life insurance, both for active lives and those in long-term care claim status.

3. For an annuity contract that pays for benefits for long-term care entirely by accessing the contract value, the Commissioner shall deem the benefits reasonable in relation to the premium charged if:

(a) The interest credited internally to determine cash value accumulations, including long-term care, are guaranteed not to be less than the minimum guaranteed interest rate for cash-value accumulations without long-term care set forth in the contract;

(b) The portion of the contract that provides benefits for long-term care meets the nonforfeiture requirements of NRS 688A.361 to 688A.369, inclusive;

(c) The contract meets the disclosure requirements of NAC 687B.075 and section 8 of this regulation; and

(d) An actuarial memorandum is filed with, and approved by, the Commissioner that includes, without limitation:

(1) A description of the basis on which the long-term care rates are determined;

(2) A description of the basis for the reserves;

(3) A summary of the type of contract, benefits, provisions for renewal, general marketing method and limits on ages of issuance;

(4) A description and a table of each actuarial assumption used and, for expenses, the percent of premium dollars per contract and dollars per unit of benefits;

(5) A description and a table of the anticipated contract reserves and additional reserves to be held in each future year for active lives;

(6) The estimated average annual premium per contract and the average issue age;

(7) A statement which:

(I) Must indicate whether underwriting is performed at the time of application; and

(II) If underwriting is performed at the time of application, must include a description of the type or types of underwriting used; and

(8) A description of the effect of the long-term care benefits on the required premiums, nonforfeiture values and reserves on the underlying annuity contract, both for active lives and those insureds who are receiving benefits for long-term care.

Sec. 41. This regulation becomes effective on October 1, 2008.

NOTICE OF ADOPTION OF PROPOSED REGULATION
LCB File No. R121-07

The Commissioner of Insurance adopted regulations assigned LCB File No. R121-07 which pertain to chapter 687B of the Nevada Administrative Code.

INFORMATIONAL STATEMENT

A workshop was held on December 17, 2007, and continued on May 1, 2008, and a hearing was held on May 13, 2008, at the offices of the Department of Business and Industry, Division of Insurance (Division), 788 Fairview Drive, Suite 300, Carson City, Nevada 89701, with a simultaneous video-conference conducted at the Bradley Building, 2501 E. Sahara Avenue, Real Estate Division Conference Room, 2nd Floor, Las Vegas, Nevada 89104, regarding the adoption of the regulation concerning long term care insurance.

Public comment was solicited by posting notice of the hearing in the following public locations: the Division's Carson City and Las Vegas offices, Carson City Courthouse, Office of the Attorney General, Capitol Building lobby, Capitol Building press room, Blasdel Building, Legislative Counsel Bureau, and the State Library. In addition, the Division maintains a general list of interested parties, comprised mainly of insurance companies, agencies and other persons regulated by the Division. These persons were also notified of the hearing and that copies of the regulation could be obtained from or examined at the offices of the Division in Carson City.

The workshop was attended by one interested party in Carson City. Oral testimony, in the form of suggested changes to the existing regulation, was provided by Rebecca Alvarado, Actuary I, representing the Division, and by John Mangan, representing the American Council of Life Insurers (ACLI).

The hearing was attended by one interested party in Las Vegas. During the hearing, oral testimony was provided by Rebecca Alvarado, Actuary I, Van Mouradian, Chief Insurance Examiner, and Amy Parks, Esq., Insurance Counsel, all representing the Division; by Joanna Grigoriev, Esq., Deputy Attorney General, also representing the Division; and by John Mangan, representing the ACLI.

The Division received written comments in the form of a joint letter from ACLI and America's Health Insurance Plans (AHIP). These written comments were discussed during the workshop. Additional comments which were received in the interim between the workshop and hearing were discussed at the hearing.

Mr. Mangan (ACLI) had questions about compensation paid to producers that are not agents. Ms. Alvarado explained that unless a producer is appointed by the company as its agent, the company could not pay commissions to the producer. Amy Parks, Esq., indicated that this is outlined in NRS 683A.361. The hearing officer stated that the regulation only applies to compensation paid to an agent and does not alter any other applicable law

addressing compensation. Mr. Mangan then indicated that he felt the amended language presented by the Division appropriately addressed his stated concerns.

Mr. Mangan (ACLI) next expressed concerns regarding the outline of coverage and the long term care insurance contract indicating the policy is intended to meet the requirements of the Partnership Program. He indicated that the statement in the outline of coverage and the policy may obligate the company if Nevada or the federal government decides to discontinue the Partnership Program. Ms. Alvarado and Mr. Mouradian explained that Nevada Medicaid had contacted the Centers for Medicare and Medicaid Services (CMS) about this issue and was instructed that the contract should prominently state at the beginning of the contract whether it is intended to be a partnership contract. Although the Life and Health Section of the Division is currently reviewing the partnership policy requirements, the instructions provided by CMS must be followed.

Based upon written comments and the testimony received at the hearing, the proposed regulation, LCB File No. R121-07, is amended as shown in **EXHIBIT "A"** attached hereto (*See* red typeface for portions amended at the hearing).

After considering the testimony and written comments, the Commissioner issued an order adopting the regulation, as amended, hereto attached as **EXHIBIT "A"**, as a permanent regulation of the Division.

The economic effects of the regulation are as follows:

(a) On the business which it regulates: The proposed regulation should have no economic impact on the industry that the Division of Insurance regulates.

(b) On the public: The proposed regulation should have no economic impact on the public.

There should be only minimal cost to the Division to review forms updated to comply with the regulation. The Division is not aware of any overlap or duplication of the regulation with any state, local or federal regulation.