PROPOSED REGULATION OF
THE COMMISSIONER OF INSURANCE

LCB File No. R028-10

February 1, 2010

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

AUTHORITY: §§1-81, NRS 679B.130.

A REGULATION relating to insurance; revising provisions governing long-term care insurance; requirements for the Nevada Partnership Program; incorporating model regulations required for federal compliance with respect to partnership contracts; summary requirements for accelerated benefits for long-term care; requiring explanation and support for denial of claims on request; establishing conditions that allow either rescission for misrepresentation on the part of the insured or incontestability; establishing severability for all long-term care regulations; yielding to statutes on producer authorization; replacing existing regulations on premium rate schedule increases with rate stabilization language; establishing and fine-tuning definitions in use within, and the scope of, long-term care regulations; requiring premium refunds for returns or denials to be issued timely; adjustments to the outline of coverage; allowing the Commissioner to extend limitation periods for preexisting conditions; elaborating on training requirements for producers; elaborating on allowed exclusions and limitations; eliminating duplication of regulations in chapter 687B introduced by R121-07 through repeal and edit of appropriate sections; establishing conditions for applicability of the older regulation for reserve requirements; ensuring that premium rate increase language in the nonforfeiture section includes the correct minimum statutory time period; making references to new form numbers; applying adjustments for timeframe, contract type or other applicability as appropriate; replacing "policy" with "long-term care insurance contract" as appropriate; recommending the order of sections to be mapped into NAC 687B; and providing for 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 12, inclusive, of this regulation.

Sec. 2. ***1. "Long-term care insurance contract" means, for the purposes of the long-term care portion of this chapter:***

(a) An insurance policy or contract, or any portion thereof;

(b) A rider or endorsement to a policy of life insurance, a policy of disability income insurance or an annuity contract, or any portion thereof;

Delivered or issued for delivery in this State that principally provides direct or supplemental coverage for long-term care insurance.

2. "Insurance policy or contract" has the definition attributed to it in NAC 686A.627. Subscriber agreements are intended for inclusion in this definition.

3. The term "long-term care insurance contract" includes the following:

(a) Qualified long-term care insurance contracts; and

(b) Qualified State long-term care insurance partnership contracts.

4. Long-term care insurance contracts may be issued by an insurer or similar organization.

Sec. 3. *1. "Exceptional increase" means only those increases filed by an insurer as exceptional for which the Commissioner determines the need for the premium rate increase is justified:*

(a) Due to changes in laws or regulations applicable to long-term care coverage in this State; or

(b) Due to increased and unexpected utilization that affects the majority of insurers of similar products.

2. Exceptional increases are subject to the same requirements as other premium rate schedule increases, except as provided in section 11 of this regulation.

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

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

Sec. 4. *"Incidental", as used in subsection 10 of section 11 of this amended regulation, means that the value of the long-term care benefits provided is less than 10% of the total value of benefits provided over the life of the long-term care insurance contract. These values shall be measured as of the date of issue.*

Sec. 5. *1. For purposes of this section only, "Academy" refers to the American Academy of Actuaries or its successor organization.*

2. For the purposes of the long-term care insurance regulations of this chapter, a "qualified health actuary" means a person who:

(a) (1) Is a member in good standing of the Academy; or

(2) Is recognized by the Academy; and

(b) Meets the Academy's qualification standards for actuaries issuing statements of actuarial opinion relating to health insurance in the United States of America.

Sec. 6. *Long-Term Care Insurance Partnership Program.*

1. The provisions of this section must apply to any qualified State long-term care insurance partnership contract.

2. An insurer or agent, soliciting or offering to sell a long-term care insurance contract that is intended to qualify as a partnership contract, shall provide to each prospective applicant a Partnership Program Notice. The Partnership Program Notice must:

(a) Outline the requirements and benefits of a partnership contract.

(b) Be provided with the required Outline of Coverage.

(c) Take the following form, unless a similar form is filed with, and approved by, the Commissioner:

Partnership Program Notice

Important Consumer Information Regarding the Nevada Long-Term Care Insurance Partnership Program

Some long-term care insurance contracts or certificates sold in Nevada may qualify for the Nevada Long-Term Care Insurance Partnership Program (the "Partnership Program"). The Partnership Program is a partnership between State government and private insurance companies to assist individuals in planning their long-term care needs. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance contracts or certificates that qualify as Partnership Contracts or Certificates may protect the policyholder's or certificate holder's assets through a feature known as "Asset Disregard" under Nevada's Medicaid program.

Asset Disregard means that an amount of the policyholder's or certificate holder's assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Contract or Certificate will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership Contract or Certificate without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply

and special rules may apply to persons whose home equity exceeds $500,000. Asset Disregard is not available under a long-term care insurance contract or certificate that is not a Partnership Contract or Certificate. Therefore, you should consider if Asset Disregard is important to you, and whether a Partnership Contract or Certificate meets your needs. The purchase of a Partnership Contract does not automatically qualify you for Medicaid.

What are the Requirements for a Partnership Contract or Certificate? In order for a long-term care insurance contract or certificate to qualify as a Partnership Contract or Certificate, it must, among other requirements:

- ***be issued to an individual after January 1, 2007;***
- ***cover an individual who was a Nevada resident when coverage first became effective under the long-term care insurance contract or certificate;***
- ***be a federally tax-qualified long-term care insurance contract under Section 7702(B)(b) of the Internal Revenue Code of 1986;***
- ***meet stringent consumer protection standards; and***
- ***meet the following inflation requirements:***
    - ***For ages 60 or younger – provides compound annual inflation protection;***
    - ***For ages 61 to 75 – provides some level of inflation protection; and***
    - ***For ages 76 and older – no purchase of inflation protection is required.***

If you apply and are approved for long-term care insurance coverage, your insurer will provide you with written documentation as to whether or not your long-term care insurance contract or certificate qualifies as a Partnership Contract or Certificate.

What Could Disqualify a Long-Term Care Insurance Contract or Certificate as a Partnership Policy? Certain types of changes to a Partnership Contract or Certificate could affect whether or not such policy or certificate continues to be a Partnership Contract or Certificate. If you purchase a Partnership Contract or Certificate and later decide to make any changes, you should first consult with your insurer to determine the effect of a proposed change. In addition, if you move to a State that does not maintain a Partnership Program or does not recognize your long-term care insurance contract or certificate as a Partnership Policy or Certificate, you would not receive beneficial treatment of your long-term care insurance contract or certificate under the Medicaid program of that State. The information contained in this disclosure is based on current Nevada and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your long-term care insurance contract or certificate under Nevada's Medicaid program.

3. A partnership contract delivered or issued for delivery in Nevada must be accompanied by a Partnership Disclosure Notice. The Partnership Disclosure Notice must:

(a) Explain the benefits associated with a partnership contract;

(b) Indicate that the long-term care insurance contract is, at the time of issuance, intended to be a qualified State long-term care insurance partnership contract;

(c) Include a statement which indicates that the insured does not automatically qualify for Medicaid by purchasing this partnership policy; and

(d) Take the following form, unless a similar form is filed with, and approved by, the Commissioner:

Partnership Status Disclosure Notice

Important Information Regarding Your Long-Term Care Insurance Contract's or Certificate's Long-Term Care Insurance Partnership Status

This disclosure notice is issued in conjunction with your long-term care insurance contract:

Some long-term care insurance contracts or certificates sold in Nevada qualify for the Nevada Long-Term Care Insurance Partnership Program. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance contracts or certificates that qualify as Partnership Policies or Certificates may be entitled to special treatment, and in particular an "Asset Disregard" under Nevada's Medicaid program.

Asset Disregard means that an amount of the policyholder's or certificate holder's assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Contract or Certificate will be disregarded for the purposes of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership Policy or Certificate without affecting a person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply and special rules may apply to persons whose home equity exceeds $500,000. Asset Disregard is not available under a long-term care insurance contract or certificate that is not a

Partnership Contract or Certificate. The purchase of a Partnership Contract does not automatically qualify you for Medicaid.

Partnership Contract or Certificate Status. Your long-term care insurance contract or certificate is intended to qualify as a Partnership Contract or Certificate under the Nevada long-Term Care Partnership Program as of your contract's or certificate's effective date.

What Could Disqualify Your Long-Term Care Insurance Contract or Certificate as a Partnership Contract or Certificate? If you make any changes to your long-term care insurance contract or certificate, such changes could affect whether your long-term care insurance contract or certificate continues to be a Partnership Contract or Certificate. Before you make any changes, you should consult with your insurer to determine the effect of a proposed change. In addition, if you move to a State that does not maintain a Partnership Program or does not recognize your long-term care insurance contract or certificate as a Partnership Contract or Certificate, you would not receive beneficial treatment of your long-term care insurance contract or certificate under the Medicaid program of that State. The information contained in this Notice is based on current State and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your long-term care insurance contract or certificate under Nevada's Medicaid program.

Additional Information. If you have questions regarding your long-term care insurance contract or certificate please contact your insurer. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Nevada Medicaid office.

4. *A partnership contract or certificate shall not be delivered or issued for delivery in Nevada unless filed with and approved by the Commissioner.*
5. *Any long-term care insurance contract submitted for certification as a partnership contract shall be accompanied by an Issuer Certification Form and a Partnership Certification form.*

(a) *Unless a similar form is filed with and approved by the Commissioner, form NDOI-951 will be used as, or provide substantially the format for, the Issuer Certification form.*

(b) *Unless a similar form is filed with and approved by the Commissioner, form NDOI-952 will be used as, or provide substantially the format for, the Partnership Certification form.*

6. *Insurers requesting to make use of a previously approved long-term care insurance contract form as a qualified State long-term care partnership contract shall submit to the Commissioner an Issuer Certification Form signed by an officer of the company. An Issuer Certification Form shall be required for each long-term care insurance contract form submitted for partnership qualification.*

Sec. 7. *At the time of policy delivery, a policy summary must be delivered for an individual life insurance policy that provides long-term care benefits, whether by rider or within the policy. In the case of direct-response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make delivery no later*

than at the time of insurance policy or contract delivery. In addition to complying with all applicable requirements, the summary must also include:

1. *An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;*
2. *An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;*
3. *Any exclusions, reductions and limitations on benefits of long-term care;*
4. *A statement that any long-term care inflation protection option required by NAC 687B.076 is not available under this policy;*
5. *If applicable to the policy type, the summary shall also include:*

(a) A disclosure of the effects of exercising other rights under the policy;

(b) A disclosure of guarantees related to long-term care costs of insurance charges; and

(c) Current and projected lifetime benefits; and

6. *The provisions of the policy summary listed above may be incorporated into a basic illustration required to be delivered in accordance with NAC 686A.460 to NAC 686A.479, inclusive, or into the life insurance policy summary which is required to be delivered in accordance with NAC 688A.120.*

Sec. 8. *If a claim under a long-term care insurance contract is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificate holder, or a representative thereof:*

1. *Provide a written explanation of the reasons for the denial; and*
2. *Make available all information directly related to the denial.*

Sec. 9. *Incontestability Period*

1. *For a long-term care insurance contract or certificate that has been in force for less than six months an insurer may rescind a long-term care insurance contract or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.*
2. *For a long-term care insurance contract or certificate that has been in force for at least six months but less than two years an insurer may rescind a long-term care insurance contract or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.*
3. *After a long-term care insurance contract or certificate has been in force for two years it is not contestable upon the grounds of misrepresentation alone; such long-term care insurance contract or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.*
4. *(a) A long-term care insurance contract or certificate may be field issued if the compensation to the field issuer is not based on the number of long-term care insurance contracts or certificates issued.*

(b) For purposes of this section, "field issued" means a long-term care insurance contract or certificate issued by a producer or a third-party administrator pursuant to the underwriting authority granted to the producer or third party administrator by an insurer and using the insurer's underwriting guidelines.

5. *If an insurer has paid benefits under the long-term care insurance contract or certificate, the benefit payments may not be recovered by the insurer in the event that the long-term care insurance contract or certificate is rescinded.*

6. *In the event of the death of the insured, this section shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies shall be governed by NRS 688A.080. In all other situations, this section shall apply to life insurance policies that accelerate benefits for long-term care.*

Sec. 10. *A producer is not authorized to sell, solicit or negotiate with respect to long-term care insurance except as authorized by chapter 683A of NRS.*

Sec. 11. *1. This section applies as follows:*

(a) Except as provided in paragraph (b), this section applies to any long-term care insurance contract or certificate issued in this State, beginning six months after the effective date of this regulation.

(b) For certificates issued on or after the effective date of this amended regulation under the type of group long-term care insurance policy as defined in NAC 687B.025(1), which policy was in force at the time this amended regulation became effective, the provisions of this section must apply on the policy anniversary following twelve months after the effective date of this regulation.

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

(a) Information required by section 65 of this regulation;

(b) Certification by a qualified health actuary that:

(1) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are materialized, no further premium rate schedule increases are anticipated;

(2) The premium rate filing is in compliance with the provisions of this section;

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

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

(I) Annual values for the five years preceding and the three years following the valuation date shall be provided separately;

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

(III) The projections shall demonstrate compliance with subsection 3; and

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

(V) For exceptional increases, in the event the Commissioner determines that offsets may exist, the insurer shall use appropriate net projected experience;

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

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

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

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

(d) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the Commissioner; and

(e) Sufficient information for review and approval of the premium rate schedule increase by the Commissioner.

3. All premium rate schedule increases must be determined in accordance with the following requirements:

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

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

(1) The accumulated value of the initial earned premium times 58%;

(2) 85% of the accumulated value of prior premium rate schedule increases on an earned basis;

(3) The present value of future projected initial earned premiums times 58%; and

(4) 85% of the present value of future projected premiums not in subparagraph (3) on an earned basis.

(c) In the event that a long-term care insurance contract form has both exceptional and other increases, the values in paragraph (b)(2) and (4) will also include 70% for exceptional rate increase amounts; and

(d) All present and accumulated values used to determine rate increases must use the maximum valuation interest rate for contract reserves as specified in NRS 681B.120(2)(a). The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

4. For each rate increase that is implemented, the insurer shall file for approval by the Commissioner updated projections, as defined in subsection 2(c)(1), annually for the next three years and include a comparison of actual results to projected values. The Commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group long-term care insurance contracts that meet the conditions in subsection 11, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the Commissioner.

5. If any premium rate in the revised premium rate schedule is greater than 200% of the comparable rate in the initial premium schedule, lifetime projections, as defined in subsection 2(c)(1), shall be filed for approval by the Commissioner every five years

following the end of the required period in subsection 4. For group long-term care insurance policies that meet the conditions in subsection 11, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the Commissioner.

6. (a) If the Commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection 3, the Commissioner may require the insurer to implement any of the following:

(1) Premium rate schedule adjustments; or

(2) Other measures to reduce the difference between the projected and actual experience.

(b) In determining whether the actual experience adequately matches the projected experience, consideration should be given to subsection 2(c)(5), if applicable.

7. If the majority of the long-term care insurance contracts or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(a) A plan, subject to Commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the long-term care insurance contract form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the Commissioner may impose the condition in subsection 8 of this section; and

(b) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection 3 had the greater of the original anticipated lifetime loss ratio or 58% been used in the calculation described in subsection 3(b)(1) and (3).

8. (a) For a rate increase filing that meets the following criteria, the Commissioner shall review, for all long-term care insurance contracts included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

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

(2) The rate increase is not an exceptional increase; and

(3) The majority of the long-term care insurance contracts or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

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

(1) The offer shall:

(I) Be subject to the approval of the Commissioner;

(II) Be based on actuarially sound principles, but not be based on attained age; and

(III) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing long-term care insurance contract.

(2) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the long-term care insurance contract forms. In the event of a request for a rate increase on the long-term care insurance contract form, the rate increase shall be limited to the lesser of:

(I) The maximum rate increase determined based on the combined experience; and

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

9. If the Commissioner determines that the insurer has established a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of subsection 8 of this section, prohibit the insurer from either of the following:

(a) Filing and marketing comparable coverage for a period of up to five years; or

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

10. Subsections 1 through 9, inclusive, must not apply to long-term care insurance contracts for which the long-term care benefits provided by the long-term care insurance contract are incidental, as defined in section 4 of this amended regulation, if the long-term care insurance contract complies with all of the following provisions:

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

(b) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in either of the following:

(1) NRS 688A.290 to NRS 688A.360, inclusive, for life insurance; or

(2) NRS 688A.361 to NRS 688A.369, inclusive, for individual deferred annuities;

(c) The policy meets the disclosure requirements of sections 6 and 8 of R121-07 and section 7 of this regulation;

(d) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

(1) Policy illustrations as required in NAC 686A.460 to NAC 686A.479, inclusive, for life insurance; or

(2) Disclosure requirements in NAC 688A.470, for deferred annuities.

(e) An actuarial memorandum is filed with the Division of Insurance that includes:

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

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

(3) A summary of the type of long-term care insurance contract, benefits, renewability, general marketing method, and limits on ages of issuance;

(4) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per long-term care insurance contract and dollars per unit of benefits, if any;

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

(6) The estimated average annual premium per long-term care insurance contract and the average issue age;

(7) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group long-term care insurance contract, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

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

11. Subsections 6 and 8 shall not apply to group insurance policies as defined in NAC 687B.025(1) where:

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

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

Sec. 12. *If any provision of this chapter or the application thereof to any person is for any reason held to be invalid, the remainder of the regulations in this chapter pertaining to long-*

term care and the application of such provision to other persons or circumstances must not be affected thereby.

Sec. 13. Section 36 of R121-07 is hereby amended as follows:

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 ***R121-07; and sections 2 to 12, 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 ***R121-07; and sections 3 to 5, inclusive, plus section 2 of*** this regulation have the meanings ascribed to them in those sections.

Sec. 14. NAC 687B.010 is hereby amended to read as follows:

687B.010 "Applicant" means:

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

Sec. 15. NAC 687B.015 is hereby amended to read as follows:

687B.015 "Certificate" means any certificate issued under a group ~~[policy of]~~ long-term care insurance ***contract*** which is delivered or issued for delivery in this State.

Sec. 16. NAC 687B.019 is hereby amended to read as follows:

687B.019 "Converted policy" means an individual ~~[policy of]~~ long-term care insurance ***contract*** providing benefits identical to, or benefits determined by the Commissioner to be substantially equivalent to, or in excess of, those provided under the group ~~[policy of]~~ long-term care insurance ***contract*** from which conversion is made.

Sec. 17. NAC 687B.025 is hereby amended to read as follows:

687B.025 "Group long-term care insurance" means a ~~[policy of]~~ long-term care insurance ***contract*** which is delivered or issued for delivery in this State to:

1. One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or both, for employees or former employees, or both, or for members or former members, or both, of the labor organizations;

2. Any professional, trade or occupational association for its members or former or retired members, or any combination thereof, if the association:

(a) Is composed of persons who are or were actively engaged in the same profession, trade or occupation; and

(b) Has been maintained in good faith for purposes other than obtaining insurance;

3. An association or trust, or the trustee of a fund, established, created or maintained for the benefit of members of one or more associations; or

4. Any other group, if the Commissioner finds that:

(a) The issuance of the ~~[policy]~~ ***long-term care insurance contract*** to that group is not contrary to the best interests of the public;

(b) The issuance of the ~~[policy]~~ ***long-term care insurance contract*** would result in economies of acquisition or administration; and

(c) The benefits are reasonable in relation to the premiums charged.

Sec. 18. NAC 687B.030 is hereby amended to read as follows:

687B.030 1. "Long-term care insurance" means any ~~[policy of insurance or rider]~~ ***group or individual insurance*** advertised, marketed, offered or designed to provide coverage for

not less than 24 consecutive months for each ~~[person covered by the policy]~~ ***covered person*** on an expense-incurred, indemnity, prepaid or other basis, for necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services provided in a setting other than an acute care unit of a hospital.

2. The term includes ~~[group and individual policies or riders whether issued by insurers, fraternal benefit societies, nonprofit medical, hospital and medical service corporations, health maintenance organizations or any other similar organization]~~ ***insurance that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity***.

3. The term does not include ~~[any policy of]~~ insurance which is offered primarily to provide:

(a) Basic coverage to supplement Medicare;

(b) Basic coverage for hospital expenses;

(c) Basic coverage for medical-surgical expenses;

(d) Indemnity coverage for confinement in a hospital;

(e) Coverage for major medical expenses;

(f) Coverage to protect income received for***, or to protect assets in the event of,*** a disability ***(except if the conditions of paragraph (b) of subsection 6 of NAC 687B.035 apply)***;

(g) Coverage for accidents only;

(h) Coverage for specified diseases or accidents; or

(i) Limited benefit health coverage.

4. With regard to life insurance, this term does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of

terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

5. Notwithstanding any other provision in this chapter related to long-term care, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this chapter related to long-term care.

Sec. 19. NAC 687B.031 is hereby amended to read as follows:

687B.031 "~~[~~Provision~~]~~ ***A basis*** for continuation of coverage" means a provision ~~[~~allowing coverage to be maintained~~]~~ ***that maintains coverage*** under the existing group ~~[~~policy~~]~~ ***long-term care insurance contract***, subject only to the continued timely payment of premiums, when such coverage would otherwise terminate.

Sec. 20. NAC 687B.032 is hereby amended to read as follows:

687B.032 "~~[~~Provision~~]~~ ***A basis*** for conversion of coverage" means a provision that a person:

1. Whose coverage under the group ~~[~~policy~~]~~ ***long-term care insurance contract*** would otherwise terminate, or whose coverage has been terminated for any reason, including discontinuance of the group ~~[~~policy~~]~~ ***long-term care insurance contract*** in its entirety or with respect to an insured class; and
2. Who has been continuously insured under the group ~~[~~policy~~]~~ ***long-term care insurance contract*** and any group ~~[~~policy~~]~~ ***long-term care insurance contract*** which it replaced for at least the 6 months immediately preceding the date of termination,

➥ is entitled to the issuance of a converted policy by the insurer under whose group ~~[~~policy~~]~~ ***long-term care insurance contract*** he is covered, without evidence of insurability.

Sec. 21. NAC 687B.035 is hereby amended to read as follows:

687B.035 1. Except as otherwise provided in this subsection, the provisions of ~~[NAC 687B.005 to 687B.135, inclusive,]~~***NAC 687B.005, NAC 687B.010, NAC 687B.015, NAC 687B.025, NAC 687B.030, NAC 687B.035, NAC 687B.050, NAC 687B.055, NAC 687B.065, NAC 687B.070, NAC 687B.075, NAC 687B.080, NAC 687B.085, NAC 687B.090, NAC 687B.095, NAC 687B.100, NAC 687B.105, NAC 687B.111, NAC 687B.121, NAC 687B.125, NAC 687B.130 and NAC 687B.135*** apply to a ~~[policy of insurance]~~ ***long-term care insurance contract*** delivered or issued for delivery in this State on or after November 21, 1988. The provisions of ***NAC 687B.040, NAC 687B.045,*** NAC 687B.113, 687B.116 and 687B.118 apply to a ~~[policy of insurance]~~ ***long-term care insurance contract*** delivered or issued for delivery in this State on or after January 11, 1991. ***The provisions of NAC 687B.019, NAC 687B.031, NAC 687B.032, NAC 687B.066, N AC 687B.067, NAC 687B.068, NAC 687B.076, NAC 687B.077, NAC 687B.078, NAC 687B.079, NAC 687B.115, NAC 687B.117, NAC 687B.119, NAC 687B.122, NAC 687B.127 and NAC 687B.140 apply to a long-term care insurance contract delivered or issued for delivery in this State on or after December 15, 1994. The provisions of R121-07 sections 2 to 35, inclusive, apply to a long-term care insurance contract delivered or issued for delivery in this State on or after October 1, 2008. The provisions of sections 2 to 12, inclusive, of this amended regulation apply to a long-term care insurance contract delivered or issued for delivery in this State on or after the effective date of this amended regulation.***

2. The provisions of NAC 687B.005 to ~~[687B.135]~~***687B.140***, inclusive, ***and of R121-07 sections 2 to 35, inclusive, and of sections 2 to 12, inclusive, of this amended***

regulation, do not supersede the obligations of entities subject to them to comply with other applicable regulations insofar as they do not conflict with the provisions of NAC 687B.005 to ~~[687B.135]~~***687B.140***, inclusive***, R121-07 sections 2 to 35, inclusive, and sections 2 to 12, inclusive, of this amended regulation***.

3. Applicable regulations governing ~~[policies of]~~ insurance ***contracts*** which supplement Medicare do not apply to policies of long-term care insurance.

4. A policy of insurance which is not advertised, marketed or offered as long-term care insurance or nursing home insurance is not required to comply with the provisions of NAC 687B.005 to ~~[687B.135]~~***687B.140***, inclusive***; R121-07 sections 2 to 35, inclusive; or sections 2 to 12, inclusive, of this amended regulation***.

5. NAC 688B.010 and 689B.010 to 689B.080, inclusive, do not apply to ~~[policies of]~~ long-term care insurance ***contracts***.

6. (a) Except as otherwise specifically provided, this regulation applies to all long-term care insurance contracts, including qualified long-term care insurance contracts, partnership contracts, annuity contracts and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in this State on or after the effective date of this amended regulation by insurers and all similar organizations. Certain provisions apply to specific types of contracts as noted.

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

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

(2) The disability income policy is advertised, marketed or offered as insurance for long-term care services; or

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

Sec. 22. Section 37 of R121-07 is hereby amended as follows:

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

687B.040 ***1.*** A policy of insurance ***or rider*** 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 ***R121-07; and sections 2 to 12, inclusive, of*** this regulation.

2. The regulatory provisions specified in subsection 1 must apply to any policy of insurance or rider that is advertised, marketed or offered as given in subsection 1.

Sec. 23. NAC 687B.045 is hereby amended to read as follows:

687B.045 The Commissioner may, upon receiving a written request therefor and after an administrative hearing, issue an order to modify or suspend any provision of NAC 687B.005 to 687B.140, inclusive, with respect to a specific ~~[policy or certificate of]~~ long-term care insurance ***contract or certificate***, upon a written finding that:

1. The modification or suspension would be in the best interest of the insureds;
2. The purposes to be achieved would not be effectively or efficiently achieved without the modification or suspension; and
3. One of the following:

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

(b) The ~~[policy]~~ ***long-term care insurance contract*** or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly, and the modification or suspension is reasonably related to the special needs or nature of that community; or

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

Sec. 24. NAC 687B.050 is hereby amended to read as follows:

687B.050 1. Before advertising, marketing or offering a ~~[policy of]~~ group long-term care insurance ***contract*** within this State, the insurer of an association shall file evidence with the Commissioner that it has complied with NAC 679B.036, and that the association has:

(a) At the outset, at least 100 members;

(b) Been organized and maintained in good faith for purposes other than that of obtaining insurance;

(c) Been in active existence for at least 1 year; and

(d) A constitution and bylaws which provide that:

(1) The association holds regular meetings not less than annually to further the purposes of the members;

(2) Except for credit unions, the association collects dues or solicits contributions from members; and

(3) The members have voting privileges and are represented on the governing board and committees.

2. ~~[Thirty]~~ ***Forty five*** days after filing the evidence required by subsection 1, the association shall be deemed to satisfy those organizational requirements, unless the Commissioner finds otherwise.

Sec. 25. NAC 687B.055 is hereby amended to read as follows:

687B.055 1. No ~~[policy of group long-term insurance]~~ ***group long-term care insurance coverage*** may be offered to a resident of this State under a group ~~[policy]~~ ***long-term care insurance contract*** issued in another state to a group described in subsection 4 of NAC 687B.025, unless this State or another ~~[state]~~ ***State*** having statutory and regulatory requirements for long-term care insurance substantially similar to those adopted in this State, has made a determination that those requirements have been met.

2. Before an insurer or similar organization offers group long-term care insurance to a resident of this State pursuant to this section, it shall file with the Commissioner evidence that the group ~~[policy]~~ ***long-term care insurance contract*** or certificate issued pursuant thereto has been approved by a ~~[state with similar statutory or regulatory requirements as]~~ ***State having statutory or regulatory long-term care insurance requirements substantially similar to*** those adopted in this State.

Sec. 26. NAC 687B.060 is hereby amended to read as follows:

687B.060 1. ~~[The holder of an individual policy of long-term care insurance may]~~ ***A long-term care insurance applicant shall have the right to*** return the ~~[policy]~~ ***long-term care insurance contract or certificate*** within 30 days ~~[after its delivery and]~~ ***of its delivery and to*** have the premium refunded if, after ~~[examining the policy, he]~~ ***examination of the long-term care insurance contract or certificate, the applicant*** is not satisfied for any reason.

2. ~~[An individual policy of long-term care insurance must contain]~~ ***Long-term care insurance contracts and certificates must have*** a notice prominently printed on the first page ~~[of the policy]~~ or attached thereto stating in substance that the ~~[policyholder may]~~ ***applicant shall have the right to*** return the ~~[policy]~~ ***long-term care insurance contract or certificate*** within 30 days ~~[after its delivery and]~~ ***of its delivery and to*** have the premium refunded if, after ~~[examining the policy, he]~~ ***examination of the long-term care insurance contract or certificate, other than a certificate issued pursuant to a policy issued to a group defined in NAC 687B.025(1), the applicant*** is not satisfied for any reason.

3. This section also applies to denials of applications.

4. Any refund must be made within 30 days of the return or denial.

Sec. 27. NAC 687B.066 is hereby amended to read as follows:

687B.066 1. A ~~[policy or certificate of]~~ long-term care insurance ***contract or certificate*** must include a provision which provides that, in the event of a lapse in coverage, coverage will be reinstated if:

(a) The insured provides proof of ~~[cognitive impairment]~~ ***being cognitively impaired or experiencing loss of functional capacity before the grace period contained in the policy or certificate expired***;

(b) The insured requests reinstatement of coverage within 5 months of the date of termination of coverage; and

(c) The insured pays any premiums which are past due.

2. For the purposes of subsection 1, the standard of proof of cognitive impairment ***or loss of functional capacity*** must not be more stringent than any criteria regarding cognitive

impairment ***or loss of functional capacity*** used in the policy or certificate to determine eligibility for benefits.

Sec. 28. NAC 687B.067 is hereby amended to read as follows:

687B.067 1. An application for a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ that is not guaranteed issue must contain clear and unambiguous questions designed to ascertain the condition of the applicant's health.

2. If an application for a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ contains a question which asks whether the applicant has had medication prescribed by a physician, the applicant must be required to list any medication that has been prescribed. If an insurer knows, or should know, at the time of application that a medication listed by the applicant on the application is directly related to a medical condition for which coverage would otherwise be denied, the insurer shall not later rescind the ~~[policy]~~ ***long-term care insurance contract*** or certificate for that condition.

3. Except for a ~~[policy]~~ ***long-term care insurance contract*** or certificate that is guaranteed issue:

(a) A statement in the following form must be set out conspicuously and in close proximity to the block for the applicant's signature on an application for a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~:

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

(b) A statement in substantially the following form must be set out conspicuously on the ~~[~~policy~~]~~ ***long-term care insurance contract*** or certificate ~~[~~of long-term care insurance~~]~~at the time of delivery:

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].

(c) Prior to issuing a policy ~~[~~policy~~]~~ ***long-term care insurance contract*** or certificate ~~[~~of long-term care insurance~~]~~ to an applicant who is at least 80 years old, an insurer shall obtain one of the following:

(1) A report of a physical examination;

(2) An assessment of functional capacity;

(3) An attending physician's statement; or

(4) Copies of medical records.

Sec. 29. NAC 687B.068 is hereby amended to read as follows:

687B.068 An insurer shall deliver a copy of the completed application or enrollment form, whichever is applicable, to the insured no later than at the time of delivery of the ~~[~~policy~~]~~ ***long-***

term care insurance contract or certificate ~~[of long-term care insurance]~~ unless a copy is retained by the applicant at the time of application.

Sec. 30. NAC 687B.069 is hereby amended to read as follows:

687B.069 An insurer or other entity selling or issuing benefits for long-term care insurance shall maintain a record of all rescissions of its ~~[policies]~~ ***long-term care insurance contracts*** or certificates in this State or in any other state, except those which the insured voluntarily effectuated, and shall, on or before March 1 of each year, furnish this information to the Commissioner ~~[in the following format:~~

~~RESCISSION REPORTING FORM FOR POLICIES OR~~

~~CERTIFICATES OF LONG-TERM CARE INSURANCE~~

~~FOR THE STATE OF NEVADA~~

~~FOR THE REPORTING YEAR .....~~

~~Company Name: .....~~

~~Address: .....~~

~~.....~~

~~.....~~

~~Phone Number: .....~~

~~Due: March 1 annually~~

~~Instructions:~~

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

~~Date of Date/s~~

~~Policy Policy and Name of Policy Claim/s Date of~~

~~Form # Certificate # Insured Issuance Submitted Rescission~~

~~Detailed reason for rescission:.....~~

~~.....~~

~~.....~~

~~.....~~

~~.....~~

~~.....~~

~~Signature~~

~~.....~~

~~Name and Title (please type)~~

~~.....~~

~~Date~~~~]~~

using, or in the format of, form NDOI-929.

Sec. 31. R121-07 section 38 is hereby amended to read as follows:

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]~~ ***prior to the presentation of an application or enrollment form***. 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 Commissioner shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.

3. In the case of a policy issued to a group defined in NAC 687B.025(1), an outline of coverage shall not be required to be delivered, provided that the information described in subsection 4 is contained in other materials relating to enrollment. Upon request, these other materials shall be made available to the commissioner.

~~[2.]~~***4.*** 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***. For group coverage, provisions for continuation or conversion shall be specifically described***; ~~[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~~[.]~~***;***

(e) A description of the terms under which the policy or certificate may be returned and the premium refunded;

(f) A brief description of the relationship of cost of care and benefits; and

(g) A statement that discloses to the policyholder or certificate holder whether the policy is intended to be a federally tax-qualified long-term care insurance contract.

~~[3.]~~***5.*** 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] ***[will be attached to any issued policy] [will be enclosed with any issued policy]***. 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].

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

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.]~~*2.* PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not 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!

~~[4.]~~*3.* 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.]~~*4.* 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)]~~ ***5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.***

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

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.]

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.

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.]

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.]

(d) Eligibility for Payment of Benefits

~~[[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.]]~~

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage. Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Noneligible 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.

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.]

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS. [State ~~[whether the [policy] [certificate]~~] ***that the policy or 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.**]**

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.]

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]~~ ***underscored*** 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]~~ ***underscoring***.

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

Sec. 32. NAC 687B.076 is hereby amended to read as follows:

687B.076 1. An insurer shall not offer a ~~[policy of]~~ long-term care insurance ***contract*** unless the insurer also offers to the policyholder, in addition to any other protection from inflation, the option to purchase a ~~[policy]~~ ***long-term care insurance contract*** that provides for increasing levels of benefits and increasing maximum benefits at reasonable durations which account for reasonably anticipated increases in the costs of services related to long-term care covered by the ~~[policy]~~ ***long-term care insurance contract***. An insurer shall offer to each policyholder, at the time of purchase, the option to purchase a ~~[policy]~~ ***long-term care insurance contract*** with a feature to protect against inflation that is no less favorable than one of the following:

(a) Increases levels of benefits annually in a manner so that the increases are compounded annually at a rate not less than 5 percent;

(b) Guarantees the insured the right to periodically increase levels of benefits without providing evidence of insurability or status of health so long as the option for the previous period has not been declined. The amount of the additional benefit must be no less than the difference between the existing benefit and that benefit compounded annually at a rate of at least 5 percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

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

2. Except as otherwise provided in subsection 3, if the ~~[policy]~~ ***long-term care insurance contract*** is issued to a group, the insurer shall make the offer required by subsection 1 to the group policyholder.

3. If the ~~[policy]~~ ***long-term care insurance contract*** is issued to a group described in ***subsection 4 of*** NAC 687B.025, other than to a retirement community which provides continuing care, the insurer shall make the offer required pursuant to subsection 1 to each proposed holder of a certificate.

4. An insurer offering a ~~[policy of]~~ long-term care insurance ***contract*** shall include the following information in or with the outline of coverage:

(a) A comparison of the levels of benefits of a ~~[policy]~~ ***long-term care insurance contract*** that increases benefits over the ~~[policy]~~ ***long-term care insurance contract*** period with a ~~[policy]~~ ***long-term care insurance contract*** that does not increase benefits. The comparison must be made through the use of graphs and must show the levels of benefits over a period of at least 20 years.

(b) Any expected increases in premiums or additional premiums to pay for automatic or optional increases in benefits.

➥ An insurer may use a reasonable hypothetical for the purpose of complying with the requirements of this subsection.

5. Increases in benefits under a ~~[policy]~~ ***long-term care insurance contract*** which provides for increased benefits to protect against inflation must continue without regard to an insured's age, status regarding claims or history of claims or the length of time the person has been insured under the ~~[policy]~~ ***long-term care insurance contract***.

6. An offer of protection against inflation which provides for automatic increases in benefits must include an offer of a premium which the insurer expects to remain constant and must disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

7. A ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ must include protection against inflation as provided in subsection 1 unless the insurer obtains a rejection of protection against inflation signed by the policyholder. A rejection must be included as a part of the application and must state:

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

8. In addition to inflation protection requirements for long-term care insurance contracts, a partnership contract has the following obligation, based on the age as of the date of purchase of the individual to whom it is sold:

(a) If the purchaser has not attained age 61, then compound inflation protection must be provided.

(b) If the purchaser has attained age 61 but has not attained age 76, then some level of inflation protection must be provided.

(c) If the purchaser has attained age 76, then the provision of some level of inflation protection is optional.

~~[8.]~~ ***9.*** 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.

Sec. 33. NAC 687B.077 is hereby amended to read as follows:

687B.077 An insurer, health care plan or other entity who markets, directly or through its agents or other producers, long-term care insurance in this State shall:

1. Establish procedures regarding marketing to assure that any comparison of ~~[policies]~~ ***long-term care insurance contracts*** by its agents or other producers will be fair and accurate.
2. Establish procedures regarding marketing to assure excessive insurance is not sold or issued.
3. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy, a statement in substantially the following form:

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

4. Provide the applicant with copies of forms NDOI-949 and NDOI-953.

~~[4.]~~ ***5.*** Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has a policy for accidents and sickness or ***a*** long-term care insurance ***contract*** and the types and amounts of any such insurance~~[.]~~***, except in the case of qualified long-term care insurance contracts, an***

inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required.

~~[5.]~~***6.*** Establish auditable procedures for verifying compliance with this section.

~~[6.]~~***7.*** At the time of solicitation, provide a written notice to the prospective policyholder or holder of a certificate:

(a) Informing him of the availability of a program which provides counseling to elderly persons concerning health insurance; and

(b) Providing the name, address and telephone number of the program.

8. Provide an explanation of contingent benefit upon lapse provided for in subsection 7 of section 32 of R121-07 and, if applicable, the additional contingent benefit upon lapse provided to long-term care insurance contracts with fixed or limited premium paying periods in subsection 8 of section 32 of R121-07.

Sec. 34. NAC 687B.078 is hereby amended to read as follows:

687B.078 An insurer, health care plan or other entity marketing long-term care insurance in this State, directly or through its agents or other producers, shall not use the terms “noncancellable” or “level premium” in reference to a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ unless the ~~[policy]~~ ***long-term care insurance contract*** or certificate provides that the insured may continue the long-term care insurance by the timely payment of premiums during which period the insurer may not unilaterally make any change in any provision of the insurance or in the premium rate.

AUTHORITY (Sec. 35): NRS 679B.130, 686A.030, 686A.050, 687B.120, 687B.130

Sec. 35. NAC 687B.079 is hereby amended to read as follows:

687B.079 An insurer, health care plan or other entity marketing long-term care insurance in this State, directly or through its agents or other producers, shall not engage in the following acts or practices:

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

~~[1.]~~***2.*** High pressure tactics, including:

(a) Any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright or threat, whether explicit or implied; and

(b) Undue pressure to purchase or recommend the purchase of insurance.

~~[2.]~~***3.*** Directly or indirectly making use of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company, commonly referred to as "cold lead advertising."

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

5. The provisions of sections NRS 686A.010 to NRS 686A.325, inclusive, are applicable to all long-term care insurance contracts.

Sec. 36. Section 39 of R121-07 is hereby amended as follows:

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

687B.080 A ~~[policy of]~~ long-term care insurance ***contract*** delivered or issued for delivery in this State may not use the following terms unless the terms are defined in the ~~[policy]~~ ***long-term care insurance contract*** 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]~~ ***such as*** 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]~~ ***by sponge bath, or 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.

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.

12. "Provider of services," including, without limitation, a "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home,"

"personal care facility~~[" or]~~***," "specialized care providers," "assisted living facility" and*** "home care agency" must be defined in relation to the services and facilities required to be available and the level of the licenses***, certificates, registrations*** or degrees required for persons providing or supervising the services. ~~[The definition may require]~~ ***When the definition requires*** that the provider be appropriately licensed ~~[or certified]~~***, certified or registered, it must also state what requirements a provider must meet in lieu of licensure, certification or registration when the State in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or when the State licenses, certifies or registers the provider of services under another name***.

13. "~~[Services related to home health care]~~ ***Home health care services***" 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]~~ ***Personal*** care" must be defined as the provision of ~~[personal]~~ ***hands-on*** 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"***, "specialized care", "assisted living 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.

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. 37. NAC 687B.085 is hereby amended to read as follows:

687B.085 1. The terms "guaranteed renewable" and "noncancellable" may not be used in any individual ~~[policy of]~~ long-term care insurance ***contract*** without further explanatory language conforming to the disclosure requirements of NAC 687B.100.

2. No individual ~~[policy of]~~ long-term care insurance ***contract*** may contain renewal provisions other than "guaranteed renewable" or "noncancellable."

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

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

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

6. In addition to the other requirements of this section, a qualified long-term care insurance contract shall be guaranteed renewable, in conformance with 26 U.S.C. §7702B(b)(1)(c).

Sec. 38. NAC 687B.090 is hereby amended to read as follows:

687B.090 1. A ~~[policy of insurance]~~ ***long-term care insurance contract*** may not be delivered or issued for delivery in this State as long-term care insurance if the ~~[policy]~~ ***long-term care insurance contract*** limits or excludes coverage by type of illness, treatment, medical condition or accident, except for:

(a) Preexisting conditions or diseases.

(b) Mental or nervous disorders ~~[, except for the]~~***; however, this shall not permit*** exclusion or limitation of benefits on the basis of Alzheimer's Disease.

(c) Alcoholism and drug addiction.

(d) Any illness, treatment or medical condition arising out of:

(1) A war or an act of war, whether declared or undeclared.

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

(3) Service in the Armed Forces or units auxiliary thereto.

(4) Suicide, attempted suicide or intentionally self-inflicted injury.

(5) Aviation. This exclusion applies only to passengers who do not pay fares.

(e) Treatment provided in a governmental facility, unless otherwise required by law, services for which benefits are available under Medicare or another governmental program, except Medicaid, and treatment received pursuant to any state or federal program for workmens' compensation, employer's liability or occupational disease.

(f) Treatment provided pursuant to any law governing no-fault insurance for motor vehicles.

(g) Services provided by a member of the insured person's immediate family.

(h) Services for which no charge is normally made in the absence of insurance.

(i) Services or items available from, or paid by, another long-term care insurance contract.

(j) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Medicare or would be so reimbursable but for the application of a deductible or coinsurance amount.

2. (a) This section is not intended to prohibit exclusions and limitations by type of provider. However, no long-term care issuer may deny a claim because services are provided in a State other than the State of long-term care insurance contract issue under the following circumstances:

(1) When the State other than the State of long-term care insurance contract issue does not have the provider licensing, certification or registration required in the long-term care insurance contract, but where the provider satisfies the long-term care insurance contract requirements outlined for providers in lieu of licensure, certification or registration; or

(2) When the State other than the State of long-term care insurance contract issue licenses, certifies or registers the provider under another name.

(b) For purposes of this paragraph, "State of long-term care insurance contract issue" means the State in which the individual long-term care insurance contract or certificate was originally issued.

~~[~~2.~~]~~*3.* This section does not prohibit ~~[the exclusion or limitation of coverage by type of provider or]~~ territorial limitations.

~~[3.]~~ ***4.*** For the purposes of this section, "preexisting condition" means a medical condition of a person for which he has received treatment during the 6 months preceding the effective date of the ~~[policy]~~ ***long-term care insurance contract***.

Sec. 39. NAC 687B.095 is hereby amended to read as follows:

687B.095 1. Any termination of long-term care insurance must be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination.

2. Such an extension of benefits beyond the period the long-term care insurance is in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits, and may be subject to any waiting period contained in the ~~[policy]~~ ***long-term care insurance contract*** or any other applicable provision of the ~~[policy]~~ ***long-term care insurance contract***.

3. An insurer or similar organization issuing a group ~~[policy of]~~ long-term care insurance ***contract*** shall include in the group ~~[policy]~~ ***long-term care insurance contract***:

(a) A provision for continuation of coverage; or

(b) A provision for conversion of coverage.

4. A group ~~[policy of]~~ long-term care insurance ***contract*** which restricts the provision of benefits and services to certain providers or facilities or which contains incentives to use certain providers or facilities may comply with subsection 3 by containing a provision for the continuation of coverage under a ~~[policy]~~ ***long-term care insurance contract*** which provides benefits which are substantially equivalent to the benefits of the existing group ~~[policy]~~ ***long-term care insurance contract***. The Commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, may take into

consideration the differences between plans with and without managed care, ***including, but not limited to,*** the arrangement of providing benefits under the plans, the availability of service under the plans, the levels of benefits under the plans and the administrative complexity of the plans.

5. As used in this section, "plan with managed care" means an arrangement for health care or assisted living designed to coordinate care of patients or to control costs through a system that provides, at a minimum, for review of the necessity and appropriateness of the allocation of health care resources and services provided or proposed to be provided to an insured, through management of cases or through use of specific networks of providers.

Sec. 40. NAC 687B.100 is hereby amended to read as follows:

687B.100 1. An individual ~~[policy of]~~ long-term care insurance ***contract*** must contain a provision for renewability***, except for a policy under which the right not to renew is reserved solely to the policyholder***. Such a provision must be appropriately captioned, appear on the first page of the ~~[policy]~~ ***long-term care insurance contract***, and clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the ~~[policy]~~ ***long-term care insurance contract*** is issued and for which it may be renewed. ***If the long-term care insurance contract is not of limited duration, the provision must also clearly state that the coverage is either guaranteed renewable or noncancellable as appropriate.***

2. An individual long-term care insurance contract, 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.

~~[2.]~~***3.*** Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual ~~[policy of]~~ long-term care insurance ***contract***, all riders or endorsements added to an individual ~~[policy of]~~ long-term care insurance ***contract*** after the date the ~~[policy]~~ ***long-term care insurance contract*** is issued or when the ~~[policy]~~ ***long-term care insurance contract*** is reinstated or renewed~~[,]~~ which reduce or eliminate benefits or coverage in the ~~[policy]~~ ***long-term care insurance contract*** must be ***agreed to in writing and be*** signed by the insured. After the date the ~~[policy]~~ ***long-term care insurance contract*** is issued, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the term of the ~~[policy]~~ ***long-term care insurance contract*** must be agreed to in writing ***and be signed*** by the insured, unless the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charged must be set forth in the ~~[policy]~~ ***long-term care insurance contract***, rider or endorsement.

~~[3.]~~***4.*** A ~~[policy of]~~ long-term care insurance ***contract*** which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import must include a definition and explanation of those terms in its accompanying outline of coverage.

~~[4.]~~***5.*** If a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ contains any limitations with respect to preexisting conditions, the limitations must appear as a separate paragraph of the ~~[policy]~~ ***long-term care insurance contract*** or certificate and be labeled as "Preexisting Condition Limitations."

~~[5.]~~*6.* If a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ contains any limitations or conditions with respect to eligibility other than those prohibited pursuant to NAC 687B.116, a statement concerning the limitations or conditions must appear as a separate paragraph of the ~~[policy]~~ ***long-term care insurance contract*** or certificate, must be labeled as "Limitations or Conditions on Eligibility for Benefits" and must include a description of the limitations or conditions, including information regarding any required number of days of confinement.

~~[6.]~~*7.* If a policy of life insurance or a rider on a policy of life insurance provides accelerated benefits for long-term care, at the time of application for the policy or rider, a statement disclosing that receipt of accelerated benefits may be taxable and that assistance should be sought from a ~~[consultant on taxes]~~ ***personal tax advisor*** must be prominently displayed on the first page of the policy or rider and any other related documents. When a request for payment of accelerated benefits is submitted, a copy of the statement disclosing that receipt of accelerated benefits may be taxable and that assistance should be sought from a ~~[consultant on taxes must]~~ ***personal tax advisor must also*** be provided to the insured. ***This subsection does not apply to qualified long-term care insurance contracts.***

8. (a) If a qualified annuity contract or a rider on a qualified annuity contract contains benefits for long-term care insurance, at the time of application for the contract or rider, a statement disclosing that receipt of long-term care benefits may be taxable and that assistance should be sought from a personal tax advisor must be prominently displayed on the first page of the contract or rider and any other related documents. When a request for payment of long-term care benefits is submitted, a copy of the

statement disclosing that receipt of such benefits may be taxable and that assistance should be sought from a personal tax advisor must also be provided to the insured.

(b) If a nonqualified annuity contract or a rider on a nonqualified annuity contract contains nonqualified benefits for long-term care insurance, at the time of application for the contract or rider, a statement disclosing that receipt of long-term care benefits may be taxable and that assistance should be sought from a personal tax advisor must be prominently displayed on the first page of the contract or rider and any other related documents. When a request for payment of long-term care benefits is submitted, a copy of the statement disclosing that receipt of such benefits may be taxable and that assistance should be sought from a personal tax advisor must also be provided to the insured. This paragraph does not apply to qualified long-term care insurance contracts.

Sec. 41. NAC 687B.105 is hereby amended to read as follows:

687B.105 No ~~[policy of]~~ long-term care insurance ***contract*** may:

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

Sec. 42. NAC 687B.108 is hereby amended to read as follows:

687B.108 ***1.*** The premium charged to an insured for long-term care insurance must not increase because of:

~~[1.]~~***(a)*** The increasing age of the insured beyond age 65; or

~~[2.]~~***(b)*** The duration the insured has been covered under the policy.

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

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

Sec. 43. NAC 687B.111 is hereby amended to read as follows:

687B.111 1. A ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~, other than a ~~[policy]~~ ***long-term care insurance contract*** or certificate issued to a group described in subsection 1 of NAC 687B.025, may not:

(a) Define "preexisting condition" in a more restrictive manner than as a condition for which medical advice or treatment was recommended by, or received from a provider of health care within the 6 months preceding the effective date of coverage of the insured.

(b) Exclude coverage for a loss or confinement which is the result of a preexisting condition unless the loss or confinement begins within the 6 months following the effective date of coverage of the insured.

2. The Commissioner may extend the limitation periods set forth in subsection 1 as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

~~[2.]~~ ***3.*** An insurer may use an application form designed to elicit the complete medical history of an applicant, and, on the basis of the answers on that application, underwrite a ~~[policy of insurance]~~ ***long-term care insurance contract*** in accordance with that insurer's established underwriting standards. Unless otherwise provided in the ~~[policy]~~ ***long-term care insurance contract*** or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in paragraph (b) of subsection 1 expires. A ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ may not exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in that paragraph.

Sec. 44. NAC 687B.113 is hereby amended to read as follows:

687B.113 1. Except as otherwise provided in this section, a shopper's guide to long-term care insurance must be furnished to each prospective applicant. In the case of a group policy, the guide may be delivered to the policyholder for distribution to the certificate holders. The guide must be one developed and approved by the Commissioner or must be in the format developed by the National Association of Insurance Commissioners.

2. An agent who is soliciting an application for long-term care insurance in person shall furnish the prospective applicant with the shopper's guide before giving him an application or enrollment form. In the case of a direct-response solicitation, the shopper's guide must be ~~[furnished upon request, but in any event not later than the time the policy is issued]~~ ***presented in conjunction with any application or enrollment form***.

3. An insurer who offers a life insurance policy or rider that contains accelerated long-term care benefits is not required to furnish the shopper's guide, but shall furnish the outline of coverage required by NAC 687B.075 within the time provided by that section.

Sec. 45. NAC 687B.114 is hereby amended to read as follows:

1. A professional, trade or occupational association, as described in subsection 2 of NAC 687B.025, which endorses or sells long-term care insurance to its members, shall educate its members concerning general issues involving long-term care so that its members can make informed decisions regarding the long-term care insurance.
2. The professional, trade or occupational association shall provide objective information regarding ~~[~~policies~~]~~ ***long-term care insurance contracts*** or certificates ~~[~~of long-term care~~]~~ endorsed or sold by the association and ensure that members of the association receive a complete explanation of the features in the ~~[~~policies~~]~~ ***long-term care insurance contracts*** or certificates that are being endorsed or sold.

3. The insurer shall file with the Division the following material:

(a) The long-term care insurance contract and certificate;

(b) A corresponding outline of coverage; and

(c) All advertisements requested by the Division.

~~[~~3.~~]~~***4.*** The professional, trade or occupational association shall disclose in any solicitation for long-term care insurance:

(a) The specific nature and amount of compensation, including all fees, commissions and other forms of financial support, that the association receives from endorsement or sale of ~~[~~policies~~]~~ ***long-term care insurance contracts*** or certificates to its members; and

(b) A brief description of the process under which such ~~[~~policies~~]~~ ***long-term care insurance contracts*** and the insurer issuing such ~~[~~policies~~]~~ ***long-term care insurance contracts*** were selected.

~~[~~4.~~]~~***5.*** If a professional, trade or occupational association and an insurer have common ownership or management, the association shall disclose that fact to its members.

~~[~~5.~~]~~***6.*** The board of directors of a professional, trade or occupational association which sells or endorses ~~[~~policies~~]~~ ***long-term care insurance contracts*** or certificates ~~[~~of long-term care insurance~~]~~ shall review and approve the ~~[~~policies~~]~~ ***long-term care insurance contracts*** and the agreement regarding compensation it receives from endorsement or sale of ~~[~~policies~~]~~ ***long-term care insurance contracts*** or certificates to its members.

~~[~~6.~~]~~***7.*** A professional, trade or occupational association shall:

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

~~[~~(a)~~]~~***(b)*** Actively monitor the efforts regarding marketing of the insurer and its agents or other producers; and

~~[~~(b)~~]~~***(c)*** Review and approve all marketing materials or other communications regarding ~~[~~policies~~]~~ ***long-term care insurance contracts*** or certificates ~~[~~of long-term care insurance~~]~~ used to promote sales or sent to members.

(d) Paragraphs (a) through (c) shall not apply to qualified long-term care insurance contracts.

Sec. 46. NAC 687B.115 is hereby amended to read as follows:

687B.115 1. An insurer shall not issue a group ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ to a professional, trade or occupational association unless the insurer files with the Division the following material:

(a) The policy ~~[or]~~ ***and*** certificate; ~~[and]~~

(b) A corresponding outline of coverage~~[.]~~***; and***

(c) Any other materials required by this section or NAC 687B.114.

2. An insurer shall not issue a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ to a professional, trade or occupational association, or continue to market such a ~~[policy]~~ ***long-term care insurance contract*** or certificate, unless the insurer certifies on or before December 31 of each year that the association has complied with the requirements set forth in NAC 687B.114.

3. Failure to comply with the requirements regarding filing and certification contained in this section constitutes an undefined unfair trade practice pursuant to NRS 686A.170.

Sec. 47. NAC 687B.116 is hereby amended to read as follows:

687B.116 1. A ~~[policy of]~~ long-term care insurance ***contract*** delivered or issued for delivery in this State may not:

(a) Condition any benefit upon the hospitalization of the insured;

(b) Condition any benefit for an insured who is institutionalized upon his receiving a higher level of institutional care; or

(c) Condition any benefit, other than a waiver of premium or benefits for postconfinement care, postacute care or any recuperative benefit, upon the institutionalization of the insured.

2. If a ~~[policy]~~ ***long-term care insurance contract*** conditions coverage for noninstitutional care upon the receipt of institutional care, the required period of institutional care must not exceed 30 days.

Sec. 48. NAC 687B.117 is hereby amended to read as follows:

687B.117 1. A ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ that provides benefits for services related to home health care or community care must not limit or exclude benefits:

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

(b) By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services in a home, community or institutional setting before services related to home health care are covered;

(c) By limiting eligible services provided by registered nurses or licensed practical nurses;

(d) By requiring that a nurse or therapist provide services covered by the ~~[policy]~~ ***long-term care insurance contract*** that can be provided by a home health aide, or other licensed or certified person providing home health care acting within the scope of his licensure or certification;

(e) By excluding coverage for services related to personal care provided by a home health aide;

(f) By requiring that the provision of services related to home health care be at a level of certification or licensure greater than that required by the eligible service;

(g) By requiring that the insured or claimant have an acute condition before services related to home health care are covered;

(h) By limiting benefits to services provided by agencies or providers certified by Medicare; or

(i) By excluding coverage for services related to adult day care.

2. Except as otherwise provided in subsection 3, a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ that provides for services related to home health care or community care must provide total coverage for home health care or community care in an amount equivalent in dollars to at least one-half of 1 year's benefits for care received in a nursing home pursuant to the coverage available under the ~~[policy]~~ ***long-term care insurance contract*** or certificate at the time covered services related to home health care or community care are being received.

3. The provisions of subsection 2 do not apply to a ~~[policy]~~ ***long-term care insurance contract*** or certificate issued to a resident of a retirement community which provides continuing care.

4. For the purpose of determining the maximum coverage under the terms of the ~~[policy]~~ ***long-term care insurance contract*** or certificate, coverage for home health care may be applied to the benefits provided in the ~~[policy]~~ ***long-term care insurance contract*** or certificate for care other than home health care.

Sec. 49. NAC 687B.118 is hereby amended to read as follows:

687B.118 Each ~~[policy of]~~ long-term care insurance ***contract*** which provides coverage for postconfinement care, postacute care or recuperative services, and each certificate issued under such a ~~[policy]~~ ***long-term care insurance contract***, must contain a prominent statement of any limitations or conditions upon these benefits. The statement:

1. Must be contained in a separate paragraph of the ~~[policy]~~ ***long-term care insurance contract*** or certificate entitled “limitations or conditions on benefits”; and

2. Must specify the length in days of any period that the insured is required to be confined in an institution as a condition of receiving these benefits.

Sec. 50. NAC 687B.119 is hereby amended to read as follows:

687B.119 1. When benefits for long-term care are provided through the acceleration of benefits under a group or an individual policy of life insurance or a rider to that policy, the reserves for the benefits must be determined in accordance with the provisions of paragraph (g) of subsection 2 of NRS 681B.120. Reserves for a claim must also be established when a policy or rider is in claim status.

2. Reserves for policies and riders subject to the provisions of ~~[this section]~~ ***subsection 1*** must be based on a multiple decrement model using all relevant decrements except those for rates for voluntary termination. An approximation based upon a single decrement model may be used if the calculation produces similar reserves as the multiple decrement model, the reserves are more conservative than the multiple decrement model or the reserves are immaterial. The calculation may take into account the reduction in benefits for life insurance as the result of payment of benefits for long-term care. However, the reserves for the benefit for long-term care and the benefit for life insurance must not be less than the reserves for the benefit for life insurance assuming no benefit for long-term care.

3. In the development and calculation of reserves for policies and riders subject to the provisions of ~~[this section]~~ ***subsection 1***, consideration must be given to the applicable provisions of the policy, ***marketing methods,*** administrative procedures and all other

factors which have an impact on projected costs of claims, including, but not limited to, the following:

(a) Definition of insured events;

(b) Covered facilities for long-term care;

(c) Existence of coverage for convalescent care at home;

(d) Definition of facilities;

(e) Existence or absence of barriers to eligibility;

(f) Provisions regarding waiver of premiums;

(g) Renewability;

(h) Ability to raise premiums;

(i) Methods of marketing;

(j) Procedures regarding underwriting;

(k) Procedures regarding adjustment of claims;

(l) Waiting periods;

(m) Maximum benefits;

(n) Availability of eligible facilities;

(o) Margins in costs of a claim;

(p) Optional nature of benefits;

(q) Delay in eligibility for benefits;

(r) Provisions regarding protection against inflation; and

(s) Option of guaranteed insurability.

➥ Any valuation table for morbidity consulted in the development and calculation of reserves must be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

4. When benefits for long-term care are provided other than by the method described in subsection 1, reserves must be determined using a table that is:

(a) Established by a qualified ***health*** actuary for the purpose of setting reserves; and

(b) Acceptable to the Commissioner.

5. As used in this section, "multiple decrement model" means a model in which people in a defined status at any age are subject to more than one contingency at the next age.

6. As used in this section, "single decrement model" means a model in which people in a defined status at any age are subject to only one contingency during the next age.

Sec. 51. Section 40 of R121-07 is hereby amended as follows:

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

687B.121 ***1. This section applies to all long-term care insurance contracts or certificates, except those for which sections 12 or 31 of this amended regulation apply.***

~~[1.]~~***2.*** For ~~[an individual policy of]~~ ***a*** long-term care insurance ***contract or certificate*** ~~[issued before October 1, 2008]~~, the Commissioner shall 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:

(a) The statistical credibility of incurred claims experience and earned premiums;

(b) The period for which rates are computed to provide coverage;

(c) Experienced and projected trends;

(d) The concentration of experience within early ~~[~~policy~~]~~ ***long-term care insurance contract*** duration;

(e) Expected claim fluctuation;

(f) Experience refunds, adjustments or dividends;

(g) Renewability features;

(h) All appropriate expense factors;

(i) Interest;

(j) The experimental nature of the coverage;

(k) ~~[~~Policy~~]~~ ***Long-term care insurance contract*** reserves;

(l) The mix of business by risk classification; and

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

~~[~~2.~~]~~***3. Subsection 2 shall not apply to life insurance policies that accelerate benefits for long-term care.*** 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]~~ ***R121-07***;

(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.]~~ ***4.*** 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]~~ ***R121-07***; 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. 52. NAC 687B.122 is hereby amended to read as follows:

687B.122 1. A written application by an insured for a converted policy must be made, and the first premium due, if any, must be paid as directed by the insurer within 31 days of the date of termination of coverage under a group ~~[policy of]~~ long-term care insurance ***contract***. The converted policy must be issued effective on the day following the termination of coverage under the group ~~[policy]~~ ***long-term care insurance contract*** and must be renewable annually.

2. Unless the group ~~[policy]~~ ***long-term care insurance contract*** from which conversion is made replaced previous group coverage, the premium for the converted policy must be calculated on the basis of the insured's age at inception of coverage under the group ~~[policy]~~ ***long-term care insurance contract*** from which conversion is made. If the group ~~[policy]~~ ***long-term care insurance contract*** from which conversion is made replaced previous group coverage, the premium for the converted policy must be calculated on the basis of the insured's age at inception of coverage under the initial group ~~[policy]~~ ***long-term care insurance contract*** that was replaced.

3. Upon termination of coverage under a group ~~[policy]~~ ***long-term care insurance contract***, the insurer shall provide each insured continuation of coverage or shall issue each insured a converted policy unless:

(a) Termination of group coverage resulted from the failure to make any required payment of premium or contribution when due; or

(b) Within 31 days from the date of termination of coverage, the ~~[policy]~~ ***long-term care insurance contract*** is replaced by a group ~~[policy]~~ ***long-term care insurance contract***:

(1) Effective on the day following the date of termination of coverage.

(2) The premium for which is calculated as set forth in subsection 2.

(3) Providing benefits identical to, or benefits determined by the Commissioner to be substantially equivalent to, or in excess of, those provided by the previous ~~[policy]~~ ***long-term care insurance contract***.

4. A converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group ~~[policy]~~ ***long-term care insurance contract*** from which conversion is made, must not exceed those that would have been payable had the person's coverage under the group ~~[policy]~~ ***long-term care insurance contract*** remained in force and effect.

5. Notwithstanding any other provision of this section, a converted policy issued to a person who at the time of conversion is covered by another ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100

percent of incurred expenses. The provision may be included in the converted policy only if the converted policy also provides for a decrease in the premium or a refund of a part of the premium which reflects the reduction in benefits payable.

6. Notwithstanding any other provision of this section, an insured individual whose eligibility for group long-term care coverage is based upon his relationship to another person is entitled to continuation of coverage under the group ~~[policy]~~ ***long-term care insurance contract*** upon termination of the qualifying relationship by death or dissolution of marriage.

Sec. 53. NAC 687B.125 is hereby amended to read as follows:

687B.125 Application forms for individual ~~[policies of]~~ long-term care insurance ***contracts*** must include the following questions designed to elicit information as to whether the proposed ~~[policy]~~ ***long-term care insurance contract*** is intended to replace any other policy for accidents and sickness or long-term care insurance presently in force:

TO BE COMPLETED BY THE APPLICANT

1. Do you currently have another policy or certificate of long-term care insurance in force (including a contract for health care services or a contract with a health maintenance organization)?

2. Have you had another policy or certificate of long-term care insurance in force during the last 12 months? If so, please answer questions (a) and (b).

(a) With what company was your policy or certificate?

(b) If your policy or certificate lapsed, when did it lapse?

3. Do you currently have coverage under Medicaid?

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

TO BE COMPLETED BY THE AGENT

1. Have you sold any other policy of health insurance to this applicant? If so, please answer questions 2 and 3.

2. List each policy you have sold to the applicant that is still in force.

3. List each policy you have sold to the applicant within the past 5 years that is no longer in force.

A supplementary application or other form to be signed by the applicant and the agent***, except where the coverage is sold without an agent,*** containing such questions may be used. ***With regard to a replacement long-term care insurance contract issued to a group defined by NAC 687B.025(1), the questions may be modified only to the extent necessary to elicit information about health or long-term care insurance contracts other than the group long-term care insurance contract being replaced, provided that the certificate holder has been notified of the replacement.***

Sec. 54. NAC 687B.127 is hereby amended to read as follows:

687B.127 1. If a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ replaces another ~~[policy]~~ ***long-term care insurance contract*** or certificate~~[of long-term care insurance]~~, the insurer replacing the ~~[policy]~~ ***long-term care insurance***

contract or certificate shall waive any period of time applicable to preexisting conditions and probationary periods in the new ~~[policy]~~ ***long-term care insurance contract*** or certificate for similar benefits to the extent that similar ~~[exclusions]~~ ***periods*** have been satisfied under the original ~~[policy]~~ ***long-term care insurance contract or certificate***.

2. Where replacement of the ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ is intended, the insurer replacing the ~~[policy]~~ ***long-term care insurance contract*** or certificate shall notify, in writing, the existing insurer of the proposed replacement. The insurer replacing the ~~[policy]~~ ***long-term care insurance contract*** or certificate shall identify the existing ~~[policy]~~ ***long-term care insurance contract*** or certificate by the name of the insurer, the name of the insured and either the number of the ~~[policy]~~ ***long-term care insurance contract*** or certificate or the address of the insured, including the zip code. The written notice must be given not less than 5 working days before the date the application is received by the insurer or the date the ~~[policy]~~ ***long-term care insurance contract*** is issued, whichever is sooner.

3. Life insurance policies that accelerate benefits for long-term care shall comply with sections NAC 687B.125 to NAC 687B.140, inclusive, if the coverage being replaced is a long-term care insurance contract. If the coverage being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of NAC 686A.510 to NAC 686A.570, inclusive. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

Sec. 55. NAC 687B.130 is hereby amended to read as follows:

687B.130 1. Upon determining that a sale will involve ~~[the]~~ replacement ~~[of a policy of insurance]~~, an insurer, other than an insurer using ~~[a]~~ direct-response solicitation ***methods***, or its agent, shall furnish the applicant, before the issuance or delivery of the individual ~~[policy of]~~ long-term care insurance ***contract***, a notice regarding the replacement of the policy for accidents and sickness or long-term care ~~[insurance]~~ ***coverage***. One copy of the notice must be retained by the applicant and an additional copy signed by the applicant must be retained by the insurer.

2. The notice required by subsection 1 must be provided ~~[in the following form:~~

~~NOTICE TO APPLICANT REGARDING REPLACEMENT~~

~~OF INDIVIDUAL POLICY FOR ACCIDENTS~~

~~AND SICKNESS OR LONG-TERM~~

~~CARE INSURANCE~~

~~According to [your application] [information you have furnished], you intend to let lapse or otherwise terminate an existing policy for accidents and sickness or long-term care insurance and replace it with an individual policy of long-term care insurance to be issued by [Company Name] Insurance Company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy.~~

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

~~term care is a prudent decision. For your own information and protection, you should be aware of and seriously consider the following factors which may affect the protection available to you under the new policy:~~

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

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

~~3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.~~

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

~~After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.~~

~~.....~~

~~(Company Name)~~**]** ***using form NDOI-954, unless a similar form is filed with, and approved by, the Commissioner.***

Sec. 56. NAC 687B.135 is hereby amended to read as follows:

687B.135 1. Insurers using a direct-response solicitation shall deliver a notice regarding the replacement of a policy for accidents and sickness or ***a*** long-term care insurance ***contract*** to the applicant upon issuance of the **[**~~policy~~**]** ***long-term care insurance contract***.

2. The notice required by subsection 1 must be provided **[**~~in the following form:~~

~~NOTICE TO APPLICANT REGARDING REPLACEMENT OF POLICY FOR ACCIDENTS AND SICKNESS OR LONG-TERM CARE INSURANCE~~

~~According to **[**your application**]** **[**information you have furnished**]**, you intend to let lapse or otherwise terminate an existing policy for accidents and sickness or long-term care insurance and replace it with the policy of long-term care insurance delivered with this notice and issued by **[**Company Name**]** Insurance Company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider~~

the following factors which may affect the protection available to you under the new policy:

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

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

3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to our new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [Company Name and Address] within 30 days if any

~~information is not correct and complete, or if any past medical history has been omitted from the application.~~

~~.....~~

~~(Company Name)~~**]** ~~)~~**]** ***using form NDOI-955, unless a similar form is filed with, and approved by, the Commissioner.***

3. The insurer is to collect and retain signed copies of the notice from the applicant. This requirement may be waived by the Commissioner in situations such as for electronic enrollment.

Sec. 57. NAC 687B.140 is hereby amended to read as follows:

687B.140 If a group ~~[policy of]~~ long-term care insurance ***contract*** is replaced by another group ~~[policy of]~~ long-term care insurance ***contract*** issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to an individual by the insurer and the premium charged to persons under the new group ~~[policy]~~ ***long-term care insurance contract*** must not:

1. Result in an exclusion for preexisting conditions that would have been covered under the group ~~[policy]~~ ***long-term care insurance contract*** being replaced; or
2. Vary or otherwise depend on the status of a person's health or disability, experience with claims or use of services related to long-term care.

Sec. 58. Section 3 of R121-07 is hereby amended to read as follows:

"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) to1396p(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.

7. "Partnership policy" as used in the long-term care portion of this chapter is included in the definition of partnership contract.

8. "Partnership certificate" as used in the long-term care portion of this chapter means a certificate issued under a group partnership contract.

9. Any long-term care insurance contract which also satisfies the requirements in subsections 1 to 6, inclusive, is also included in the definition of partnership contract.

Sec. 59. Section 5 of R121-07 is hereby amended as follows:

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

2. A ~~[policy]~~ ***long-term care insurance contract*** 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]~~ ***long-term care insurance contracts*** and certificates ~~[of long-~~

~~term care insurance]~~, except that such a ~~[policy]~~ ***long-term care insurance contract*** or certificate shall be deemed similar to other comparable ~~[policies]~~ ***long-term care insurance contracts*** and certificates ~~[of long-term care insurance]~~ with the same long-term care benefit classification.

3. For the purpose of determining whether ~~[policy]~~ ***long-term care insurance contract*** forms are similar, the long-term care benefits provided by ~~[policies]~~ ***long-term care insurance contracts*** 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. 60. Section 6 of R121-07 is hereby amended as follows:

If an insurer approves an application for long-term care insurance, the insurer shall deliver the ~~[policy]~~ ***long-term care insurance contract*** 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. 61. Section 9 of R121-07 is hereby amended as follows:

1. For the enrollment of an insured in a ~~[policy of]~~ long-term care insurance ***contract*** 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. 62. Section 10 of R121-07 is hereby amended as follows:

1. Except as otherwise provided in subsection ~~[3]~~ ***4***, an insurer shall not issue an individual ~~[policy of]~~ long-term care insurance ***contract*** 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 applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured.

~~[2.]~~ ***3.*** 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.~~]~~ ***4.*** 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]~~ ***requirements contained in subsections 1 to 3, inclusive, need not be met until*** 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 ***contract or certificate*** for which the premium is paid through a payroll or pension deduction plan must clearly indicate the payment plan selected by the applicant.

~~[~~4.~~]~~ ***5.*** An individual ~~[policy of]~~ long-term care insurance ***contract*** 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, ***at the address provided by the insured for purposes of receiving notice of lapse or termination***. 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. 63. Section 16 of R121-07 is hereby amended as follows:

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]~~ ***long-term care insurance contract*** 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]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ must include an explanation of the benefit trigger.

Sec. 64. Section 17 of R121-07 is hereby amended as follows:

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

Sec. 65. Section 18 of R121-07 is hereby amended as follows:

1. For any ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ issued in this State on or after October 1, 2008, other than a ~~[policy]~~ ***long-term care insurance contract*** 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]~~ ***long-term care insurance contract*** 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]~~ ***long-term care insurance contract*** 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]~~ ***long-term care insurance contract*** forms for which premium rates have increased;

(2) The calendar years when the ~~[policy]~~ ***long-term care insurance contract*** 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.

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

2. In addition to the requirements of subsection 1, if an insurer or similar organization acquires a block of ~~[policy]~~ ***long-term care insurance contract*** 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]~~ ***long-term care insurance contract*** 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 ***contracts*** 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]~~ ***long-term care insurance contract*** or certificate at the time of application, not later than the time of delivery of the ~~[policy]~~ ***long-term care insurance contract*** or certificate.

5. If an acquiring insurer files for a subsequent rate increase, even though it may be within the 24 month period, on the same long-term care insurance contract form or block of long-term care insurance contract forms acquired from nonaffiliated insurers, the acquiring insurer shall make all disclosures required by subsection 2 and paragraph (e) of subsection 1, including for the previous rate increase referenced in subsection 2.

~~[5.]~~***6.*** 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.]~~ ***7.*** An insurer shall use the forms ~~[prescribed by the Commissioner]~~ ***NDOI-949 and NDOI-953*** to comply with the requirements of this section.

~~[7.]~~ ***8.*** 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. 66. Section 19 of R121-07 is hereby amended as follows:

1. The provisions of this section do not apply to***:***

(a) A long-term care insurance contract issued prior to October 1, 2008;

(b) ~~[a]~~ ***A*** policy of life insurance~~[,]~~ ***or*** a rider to a policy of life insurance ~~[or an annuity contract]~~ that contains accelerated benefits for long-term care~~[.]~~***; or***

(c) An annuity contract or a rider to an annuity contract that contains 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***, 45 days prior,*** to the Commissioner and the Commissioner approves:

(a) A copy of the disclosures described in section ~~[18]~~ ***65*** 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, ***if requested by the Commissioner,*** 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) In the event the Commissioner asks for additional information under this provision, the period in subsection 2 does not include the period during which the insurer is preparing the requested information.

~~[(7)]~~***(8)*** A statement that the actuarial certification was made by a ~~[person qualified to make such a certification.]~~ ***qualified health actuary.***

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.

4. All initial filings for long-term care insurance must display the issue date clearly on the schedule of benefits page.

Sec. 67. Section 20 of R121-07 is hereby amended to read as follows:

1. (a) An individual may not sell, solicit or negotiate long-term care insurance unless the individual is licensed as an insurance producer for accident and sickness or health or

life and has completed a one-time training course and ongoing training every 24 months thereafter. The training shall meet the requirements set forth in subsection 2.

(b) The training requirements of subsection 2 may be approved as continuing education courses for licensure under NAC 683A.330. Courses must satisfy the requirements of NAC 683A.335 or they cannot be approved for continuing education toward licensure.

2. (a) The one-time training required by this section shall be no less than eight hours and the ongoing training required by this section shall be no less than four hours.

(b) The training required under paragraph (a) shall consist of topics related to long-term care insurance, long-term care services and, if applicable, qualified State long-term care insurance Partnership programs, including, but not limited to:

(1) State and federal regulations and requirements and the relationship between qualified State long-term care insurance Partnership programs and other public and private coverage of long-term care services, including Medicaid;

(2) Available long-term services and providers;

(3) Changes or improvements in long-term care services or providers;

(4) Alternatives to the purchase of private long-term care insurance;

(5) The effect of inflation on benefits and the importance of inflation protection; and

(6) Consumer suitability standards and guidelines.

(c) The training required by this section must not include training that is insurer or company product specific or that includes any sales or marketing information, materials, or training, other than those required by State or Federal law.

3. (a) Insurers subject to this section shall obtain verification that a producer receives the training required by paragraph (a) of subsection 1 before a producer is permitted to

sell, solicit or negotiate the insurer's long-term care insurance products, maintain records subject to Nevada's record retention requirements, and make that verification available to the Commissioner upon request.

(b) An insurer that provides qualified state long-term care insurance partnership contracts shall:

~~[1.]~~ ***(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***, as described in subsection 2,*** 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.]~~ ***(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]~~ ***of attendance and examination scores, per NAC 683A.340, for four*** years and shall make the records available to the Commissioner upon request.

(I) Initial partnership contract filings must be accompanied by a list of agents that have satisfied the training requirements of this section for partnership

contracts, where such agents are approved to market partnership contracts for the insurer or similar organization.

4. The satisfaction of these training requirements in any State shall be deemed to satisfy the training requirements in this State.

Sec. 68. Section 21 of R121-07 is hereby amended as follows:

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

~~[3.]~~***4.*** 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.]~~ ***5.*** 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.]~~ ***6.*** 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.

7. The Division reporting form to be used to satisfy the requirements of:

(a) Subsections 2 to 5, inclusive, is NDOI-946.

(b) Subsection 6 is NDOI-948.

8. For insurers or similar organizations issuing partnership contracts or certificates in this State, a report will be submitted for such issuances:

(a) On termination of a partnership contract or certificate;

(b) On provision of benefits under a partnership contract or certificate; or

(c) On request, either by the Commissioner or the Department of Health and Human Services of the State of Nevada.

A form prescribed by the Department of Health and Human Services is to be used for reporting. If benefits have been provided under a partnership contract or certificate, the amount of such benefits must be indicated in the appropriate part of the form.

~~[6.]~~9. 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.

(d) "Report" means on a statewide basis.

Sec. 69. Section 22 of R121-07 is hereby amended as follows:

1. ***(a)*** The provisions of this section do not apply to***:***

(1) Long-term care insurance contracts or certificates issued prior to October 1, 2008;

(2) ~~[a]~~ ***A*** policy of life insurance~~[,]~~ ***or*** a rider to a policy of life insurance ~~[or an annuity contract]~~ that contains accelerated benefits for long-term care***; or***

(3) An annuity contract or a rider to an annuity contract that contains benefits for long-term care.

(b) The provisions of this section apply to long-term care insurance contracts or certificates:

(1) Excluding those listed in paragraph (a) of subsection 1, and

(2) Issued before the date that section 11 of this amended regulation becomes applicable to such long-term care insurance contracts or certificates.

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]~~ ***65*** 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. 70. Section 23 of R121-07 is hereby amended as follows:

1. Except as otherwise provided in subsection 2, every insurer or other organization that markets or offers ~~[policies]~~ ***long-term care insurance contracts*** 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. ***In addition, all advertisements must be retained by the insurer, health care service plan or other entity for at least three years from the date the advertisement was first used.***

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. 71. Section 24 of R121-07 is hereby amended as follows:

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]~~ ***long-term care insurance contracts*** 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.~~**], *set out conspicuously, in not less than 12-point type, using (or substantially in the format of) form NDOI-949.***

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

Sec. 72. Section 25 of R121-07 is hereby amended as follows:

1. If an insurer determines that an applicant does not meet the standards of suitability developed pursuant to section 24 of ~~[this regulation]~~ ***R121-07***, or if the applicant declines to provide any information required by section 24 of ~~[this regulation]~~ ***R121-07***, 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.]~~ ***that uses, or that is substantially and conspicuously in the format of, form NDOI-950.***

2. If an applicant declines to provide any financial information required pursuant to section 24 of ~~[this regulation]~~ ***R121-07***, 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. 73. Section 26 of R121-07 is hereby amended as follows:

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]~~ ***R121-07***;
3. The number of applicants who did not meet the standards of suitability developed by the insurer pursuant to section 24 of ~~[this regulation]~~ ***R121-07***; 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]~~ ***R121-07***.

 The form to be used to satisfy the reporting requirements of this section is NDOI-947.

Sec. 74. Section 29 of R121-07 is hereby amended as follows:

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 ***contracts*** 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]~~ ***long-term care insurance contracts*** is made available for sale in this State.

3. The notification required by subsection 2 is not required for any ~~[policy]~~ ***long-term care insurance contract*** 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) Is on a claim;

~~[(3)]~~***(4)*** Previously received benefits under the ~~[policy]~~ ***long-term care insurance contract*** or certificate; or

~~[(4)]~~***(5)*** Is not eligible to apply for the new coverage because of limitations under the new ~~[policy]~~ ***long-term care insurance contract*** 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]~~ ***long-term care insurance contract*** and charging a separate premium for the rider based on the attained age of the insured;

(b) By exchanging the existing ~~[policy]~~ ***long-term care insurance contract*** 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]~~ ***long-term care insurance contract*** or certificate based on premiums paid or reserves held for the previous ~~[policy]~~ ***long-term care insurance contract*** or certificate***. The premium***

credits must be based on premiums paid or reserves held for the prior long-term care insurance contract or certificate;

(c) By exchanging the existing ~~[policy]~~ ***long-term care insurance contract*** or certificate for a new ~~[policy]~~ ***long-term care insurance contract*** or certificate in which:

(1) Consideration for past insured status must be recognized by setting the premium for the new ~~[policy]~~ ***long-term care insurance contract*** or certificate at the issue age of the insured for the ~~[policy]~~ ***long-term care insurance contract*** or certificate being exchanged; and

(2) The cost for the new ~~[policy]~~ ***long-term care insurance contract*** or certificate may recognize the difference in reserves between the new ~~[policy]~~ ***long-term care insurance contract*** or certificate and the original ~~[policy]~~ ***long-term care insurance contract*** 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]~~ ***long-term care insurance contract*** 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]~~ ***long-term care insurance contract*** when a new series of ~~[policies of]~~ long-term care insurance ***contracts*** 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 ***contracts*** 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. ***However, if the policy is issued to a group defined in NAC 687B.025(4), the notification shall be made to each certificate holder.***

8. A ~~[policy]~~ ***long-term care insurance contract*** 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. ***The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.***

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. 75. Section 30 of R121-07 is hereby amended as follows:

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]~~ ***long-term care insurance contract*** 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]~~ ***long-term care insurance contract*** 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]~~ ***long-term care insurance contract*** form and to those for which benefits will be available after consideration of claims paid or payable.

7. If a ~~[policy]~~ ***long-term care insurance contract*** 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]~~ ***R121-07***, 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. 76. Section 32 of R121-07 is hereby amended as follows:

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]~~ ***R121-07***:

(a) A ~~[policy]~~ ***long-term care insurance contract*** 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]~~ ***R121-07*** 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]~~ ***R121-07***, 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]~~ ***R121-07***, 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]~~ ***R121-07***, for a ~~[policy]~~ ***long-term care insurance contract*** 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 the long-term care insurance contract is issued to a group described in subsection 4 of NAC 687B.025, other than to a retirement community which provides continuing care, the insurer shall make the offer required pursuant to subsection 2 to each proposed holder of the certificate.*** 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]~~ ***long-term care insurance contract*** or certificate lapses within 120 days after the due date of the increased premium. ~~[Unless otherwise required, the]~~ ***The*** insurer shall provide notice of the rate increase to a policyholder or certificate holder not less than ~~[30]~~ ***60*** 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]~~ ***long-term care insurance contract*** 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]~~ ***long-term care insurance contract*** 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]~~ ***The*** insurer shall provide notice of the rate increase to a policyholder or certificate holder not less than ~~[30]~~ ***60*** 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]~~ ***long-term care insurance contract*** 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***. This option may be elected at any time during the 120-day period referenced in subsection 7***; 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***. This option may be elected at any time during the 120-day period referenced in subsection 8***; 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 ***at least 1% per year prior to age 50, and at least 3% per year starting at and beyond age 50***.

(b) The nonforfeiture benefit must be for a shortened benefit period providing paid-up long-term care insurance after lapse. The same benefit***s (***amounts and frequency of benefits in effect at the time of lapse ***but not increased thereafter)*** 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. ***Either way, the calculation of the nonforfeiture credit is subject to the limitation of subsection 12.***

(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]~~ ***long-term care insurance contract*** 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]~~ ***long-term care insurance contract*** or certificate.

(f) For a ~~[policy]~~ ***long-term care insurance contract*** 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]~~ ***long-term care insurance contract*** 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]~~ ***credits*** may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

12. All benefits paid by an insurer while a ~~[policy]~~ ***long-term care insurance contract*** 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]~~ ***long-term care insurance contract*** 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 ***contracts***.

14. Premiums charged for a ~~[policy]~~ ***long-term care insurance contract*** or certificate containing nonforfeiture benefits or a contingent benefit upon lapse are subject to the loss ratio requirements applicable to the ~~[policy]~~ ***long-term care insurance contract*** 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 ***contracts*** from another insurer shall calculate the percentage increase based on the initial annual premium paid by the policyholder or certificate holder when the ~~[policy]~~ ***long-term care insurance contract*** 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. 77. Section 34 of R121-07 is hereby amended as follows:

1. A ~~[policy]~~ ***long-term care insurance contract*** 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]~~ ***long-term care insurance contract*** 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]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ that are not more restrictive than the criteria set forth in subsection 1.

6. A ~~[policy]~~ ***long-term care insurance contract*** 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 ***contract*** 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]~~ ***long-term care insurance contract*** 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. 78. Section 35 of R121-07 is hereby amended as follows:

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).

(d) "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the

individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

Sec. 79. Section 1 of R053-09 is hereby amended as follows:

Section 7 of LCB File No. R121-07 is hereby amended to read as follows:

1. An insurer or similar organization may pay compensation to a producer for the sale of a ~~[~~policy~~]~~ ***long-term care insurance contract*** or certificate ~~[~~of long-term care insurance~~]~~ on the basis of a set schedule. The amount of the compensation paid for the replacement of a ~~[~~policy~~]~~ ***long-term care insurance contract*** or certificate ~~[~~of long-term care insurance~~]~~ must be made in accordance with the renewal schedule of the replacing insurer unless the ~~[~~policy~~]~~ ***long-term care insurance contract*** or certificate cannot be renewed by the original insurer.
2. The compensation provided by the insurer or similar organization for the renewal of a replacement ~~[~~policy~~]~~ ***long-term care insurance contract*** in subsequent years by the replacing insurer must be the same compensation schedule as provided by the replacing insurer unless the original insurer cannot renew the ~~[~~policy~~]~~ ***long-term care insurance contract*** or certificate ~~[~~of long-term care insurance~~]~~.
3. If long-term care insurance is provided as part of an annuity, life insurance policy***,*** ***disability income insurance policy*** or rider, the requirements of this section apply only to the compensation attributable to the long-term care insurance provided by the policy.
4. As used in this section, “compensation” has the meaning ascribed to it in NAC 683A.708.

Sec. 80. Sections 11 to 15, inclusive, and Section 28, of R121-07; and NAC 687B.065; are hereby repealed.

Sec. 81. This regulation becomes effective on XXXX XX, 20XX.

Note to Drafter: The following order of sections, from beginning to end, is recommended in applying this regulation, R121-07 and R053-09 into NAC 687B:

Section 13 of this regulation (amending Sec. 36 of R121-07 which amended NAC 687B.005); Section 14 of this regulation (amending NAC 687B.010); Section 15 of this regulation (amending NAC 687B.015); Section 16 of this regulation (amending NAC 687B.019); Section 17 of this regulation (amending NAC 687B.025); Section 18 of this regulation (amending NAC 687B.030); Section 2 of this regulation; Section 2 of R121-07; Section 58 of this regulation (amending Section 3 of R121-07); Section 19 of this regulation (amending NAC 687B.031); Section 20 of this regulation (amending NAC 687B.032); Sections 3 through 5, inclusive, of this regulation; Section 4 of R121-07; Section 59 of this regulation (amending Section 5 of R121-07); Section 21 of this regulation (amending NAC 687B.035); Section 22 of this regulation (amending Section 37 of R121-07 which amends NAC 687B.040); Section 23 of this regulation (amending NAC 687B.045); Section 24 of this regulation (amending NAC 687B.050); Section 25 of this regulation (amending NAC 687B.055); Section 62 of this regulation (amending Section 10 of R121-07); Section 26 of this regulation (amending NAC 687B.060 and replacing NAC 687B.065); Section 27 of this regulation (replacing subsection 5 of Section 10 of R121-07 and amending NAC 687B.066); Section 28 of this regulation (amending NAC 687B.067); Section 29 of this regulation (amending NAC 687B.068); Section 30 of this regulation (amending NAC 687B.069); NAC 687B.070; Section 60 of this regulation (amending Section 6 of R121-07); Section 7 of this regulation; Section 8 of R121-07; Section 8 of this regulation; Section 31 of this regulation (amending Section 38 of R121-07, which amends NAC 687B.075); Section 32 of this regulation (amending NAC 687B.076); Section 33 of this regulation (amending NAC

687B.077); Section 34 of this regulation (amending NAC 687B.078); Section 35 of this regulation (amending NAC 687B.079); Section 36 of this regulation (amending Section 39 of R121-07, which amended NAC 687B.080); Section 37 of this regulation (amending NAC 687B.085); Section 38 of this regulation (amending NAC 687B.090); Section 39 of this regulation (amending NAC 687B.095); Section 40 of this regulation (amending NAC 687B.100 and replacing Sections 11 to 15, inclusive, of R121-07); Section 63 of this regulation (amending Section 16 of R121-07); Section 64 of this regulation (amending Section 17 of R121-07); Section 6 of this regulation; Section 65 of this regulation (amending Section 18 of R121-07); Section 41 of this regulation (amending NAC 687B.105); Section 42 of this regulation (amending NAC 687B.108); Section 61 of this regulation (amending Section 9 of R121-07); Section 66 of this regulation (amending Section 19 of R121-07); Section 43 of this regulation (amending NAC 687B.111); Section 44 of this regulation (amending NAC 687B.113); Section 67 of this regulation (amending Section 20 of R121-07); Section 77 of this regulation (amending Section 34 of R121-07); Section 45 of this regulation (amending NAC 687B.114); Section 46 of this regulation (amending NAC 687B.115); Section 71 of this regulation (amending Section 24 of R121-07); Section 72 of this regulation (amending Section 25 of R121-07); Section 73 of this regulation (amending Section 26 of R121-07); Section 27 of R121-07; Section 74 of this regulation (amending Section 29 of R121-07); Section 75 of this regulation (amending Section 30 of R121-07); Section 31 of R121-07; Section 76 of this regulation (amending Section 32 of R121-07); Section 33 of R121-07; Section 78 of this regulation (amending Section 35 of R121-07); Section 47 of this regulation (amending NAC 687B.116); Section 48 of this regulation (amending NAC 687B.117); Section 49 of this regulation (amending NAC 687B.118); Section 50 of this

regulation (amending NAC 687B.119); Section 51 of this regulation (amending Section 40 of R121-07 which amended NAC 687B.121); Section 69 of this regulation (amending Section 22 of R121-07); Section 11 of this regulation; Section 70 of this regulation (amending Section 23 of R121-07); Section 52 of this regulation (amending NAC 687B.122); Section 53 of this regulation (amending NAC 687B.125); Section 54 of this regulation (amending NAC 687B.127 and replacing Section 28 of R121-07); Section 55 of this regulation (amending NAC 687B.130); Section 56 of this regulation (amending NAC 687B.135); Section 68 of this regulation (amending Section 21 of R121-07); Section 10 of this regulation; Section 57 of this regulation (amending NAC 687B.140); Section 9 of this regulation; Section 80 of this regulation (amending Section 1 of R053-09, which amended Section 7 of R121-07); and Section 12 of this regulation.