LCB File No. R121-07

PROPOSED REGULATION OF THE COMMISSIONER OF INSURANCE

PROPOSED REGULATION CONCERNING
LONG-TERM CARE INSURANCE

AUTHORITY: NRS 679B.130

A REGULATION to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

Section 1. Chapter 687B of the NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 25, inclusive, of this regulation.

Sec. 2. ***1. "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means an individual or group insurance contract that meets the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as amended, as follows:***

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

(b) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act, as amended, or would be so reimbursable but for the application of a deductible or

coinsurance amount. The requirements of this subparagraph do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payor. A contract shall not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

(c) The contract is guaranteed renewable, within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended;

(d) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in paragraph e of subsection 1 of section 2;

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

(f) The contract meets the consumer protection provisions set forth in Section 7702B(g) of the Internal Revenue Code of 1986, as amended.

2. "Qualified long-term care insurance contract" or "federally tax-qualified long term care insurance contract" also means the portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of Sections 7702B(b) and (e) of the Internal Revenue Code of 1986, as amended.

Sec. 3. ***"Similar policy forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy***

form being considered. Certificates of groups that meet the definition in section 1 of NAC 687B.025 are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

Sec. 4. *If an application for a long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than thirty (30) days after the date of approval.*

Sec. 5. *1. An insurer or other entity may provide commission or other compensation to an agent or other representative for the sale of a long-term care insurance policy or certificate only if the first year commission or other first year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.*

2. The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for a reasonable number of renewal years.

3. No entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing insurer on renewal policies.

4. For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

Sec. 6. ***Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include:***

1. Any long-term care benefits paid out during the month;

2. An explanation of any changes in the policy, e.g. death benefits or cash values, due to long-term care benefits being paid out; and

3. The amount of long-term care benefits existing or remaining.

Sec. 7. ***1. Group long-term care insurance issued in this state on or after April 1, 2008 shall provide covered individuals with a basis for continuation or conversion of coverage.***

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

3. For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the

group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

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

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

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

- ***(a) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or***
- ***(b) The terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage:***

(1) Providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

(2) The premium for which is calculated in a manner consistent with the requirements of subsection 5 of this section.

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

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

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

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

Sec. 8. *1. In the case of a group defined in section 1 of NAC 687B.025, any requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:*

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

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

(c) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and "privileged information" as defined by NRS679B.560 to 679B.750, inclusive, is maintained.

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

Sec. 9. *Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:*

1. (a) Notice before lapse or termination. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional

persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice." The insurer shall notify the insured of the right to change this written designation, no less often than once every two (2) years.

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

(c) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to paragraph

a of subsection 1, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing.

2. Reinstatement. In addition to the requirement in Subsection 1, a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five (5) months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

Sec. 10. *1. Renewability. Individual long-term care insurance policies shall contain a renewability provision.*

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

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

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

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

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

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

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

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

8. A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in subparagraph 4 of paragraph d of subsection 3 of section 27 that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

9. A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in subparagraph 4 of paragraph d of subsection 3 of section 27 that the policy is not intended to be a qualified long-term care insurance contract.

Sec. 11. 1. This section applies to any long-term care policy or certificate issued in this state on or after April 1, 2008.

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

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

(b) An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option 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 premium rate or rate schedule adjustments that shall include:

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

(2) The right to a revised premium rate or rate schedule as provided in Paragraph c if the premium rate or rate schedule is changed;

(e) (1) Information regarding each premium rate increase on this policy form or similar policy forms over the past ten (10) years for this state or any other state that, at a minimum, identifies:

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

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

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

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

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

(4) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before April 1, 2008 or the end of a twenty-four-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with subparagraph 1 of this paragraph.

(5) If the acquiring insurer in Subparagraph 4 above files for a subsequent rate increase, even within the twenty-four-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in subparagraph 4, the acquiring insurer shall make all disclosures required by paragraph e, including disclosure of the earlier rate increase referenced in subparagraph 4.

3. An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under paragraph a of subsection 2 and paragraph e of subsection 2. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

4. An insurer shall use the forms prescribed by the commissioner to comply with the requirements of subsections 2 and 3 of this section.

5. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least 60 days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information equired by subsection 2 when the rate increase is implemented.

Sec. 12. *1. This section shall not apply to life insurance policies or annuity contracts that accelerate benefits for long term care*.

2. An insurer shall provide the information listed in this subsection to the Commissioner for approval prior to making a long-term care insurance form available for sale:

(a) A copy of the disclosure documents required in section 7; and

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

(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 form with no future premium increases anticipated;

(2) A statement that the policy design and coverage provided 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 form, to include:

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

(ii) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

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

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

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

(II) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under subsection 3 based on a standard age distribution; and

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

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

(6) An actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

Sec. 13. *Insurers shall maintain records with respect to the training of its producers concerning the distribution of its Partnership policies that will allow the state insurance department to provide assurance to the state Medicaid agency that producers have received the training and demonstrated an understanding of the Partnership policies and their relationship to public and private coverage of long-term care, including Medicaid, in this state. These records shall be maintained in accordance with the state's record retention requirements and shall be made available to the commissioner upon request.*

Sec. 14. *1. Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.*

2. Every insurer shall report annually by June 30 the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by subsection 1 above.

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.

4. Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

5. Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.

6. Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied.

7. For purposes of this section:

(a) "Policy" means only long-term care insurance;

(b) Subject to Paragraph c, "claim" means a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

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

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

8. Reports required under this section shall be filed with the commissioner.

Sec. 15. *1. This section shall not apply to life insurance policies or annuity contracts that accelerate benefits for long-term care.*

2. An insurer shall file for approval any premium rate schedule increase and shall include:

(a) Information required by Section 11;

(b) An actuarial memorandum prepared in accordance with all applicable Actuarial Standards of practice, which shall include:

(1) A description of the benefits provided under the policy,

(2) Actuarial demonstration that benefits are reasonable in relation to the premiums,

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

(4) The history of each of the prior approved rate increase. The history should include the date each of prior rate increases were effective and the percentage of each of the prior rate increases,

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

(6) Actual to expected experience analysis for claims, premiums, lapses and mortality,

(7) The loss ratios expected at the time of the most recent premium filing and the initial rate filing on a year by year basis, including a side by side comparison of actual to expected loss ratios,

(8) The number of insureds in Nevada and Nationwide. If there are less than 2000 insureds nationwide, the experience required in subparagraphs 6 and 7 shall be provided both when combined with all similar policy forms and for the specific policy form,

(9) If a reduction in benefits if offered to counterbalance 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.

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

Sec. 16. *1. Every insurer, health care service plan or other entity providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio or television medium to the Commissioner of Insurance of this state for review or approval by the commissioner to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer, health care service plan or other entity for at least three (3) years from the date the advertisement was first used.*

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

Sec. 17. *1. This section shall not apply to life insurance policies that accelerate benefits for long-term care.*

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

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

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

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

3. (a) To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take the following into consideration:

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

(2) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

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

(b) The issuer, and where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in Paragraph a above. The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in subsection 4, in not less than twelve (12) point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the commissioner.

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

(d) The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet is prohibited.

4. The "Long-Term Care Insurance Personal Worksheet." shall contain a statement in substantially the following form, set out conspicuously in the following format:

Long Term Care Insurance
Personal Worksheet

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

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

Premium Information

Policy Form Numbers_____

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

Type of Policy (noncancellable/guaranteed renewable): _____

The Company's Right to Increase Premiums: _____

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

Rate Increase History

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

Questions Related to Your Income

How will you pay each year's premium?
☐From my Income ☐From my Savings/Investments ☐My Family will Pay

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

What is your annual income? (check one)☐Under $10,000 ☐$[10-20,000] ☐$[20-30,000] ☐ $[30-50,000] ☐Over $50,000

How do you expect your income to change over the next 10 years? (check one)
☐No change ☐Increase ☐Decrease

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

Will you buy inflation protection? (check one) ☐ Yes ☐ No
If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?
☐From my Income ☐From my Savings/Investments ☐My Family will Pay

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

In the above statement, the second figure equals 163% of the first figure.

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

How are you planning to pay for your care during the elimination period? (check one)☐From my Income ☐From my Savings/Investments ☐My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)
☐Under $20,000 ☐$20,000-$30,000 ☐$30,000-$50,000 ☐Over $50,000

How do you expect your assets to change over the next ten years? (check one)
☐Stay about the same ☐Increase ☐Decrease

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

Disclosure Statement

☐ ☐	***The answers to the questions above describe my financial situation.*** ***Or*** ***I choose not to complete this information.*** ***(Check one.)***
☐	***I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. I understand that the rates for this policy may increase in the future. (This box must be checked).***

Signed: _____ _____
(Applicant) (Date)

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

Signed: _____ _____
(Agent) (Date)

Agent's Printed Name:_____]

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

[My 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: _____ _____]
(Applicant) (Date)

Drafting Note: Choose the appropriate sentences depending on whether this is a direct mail or agent sale.

The company may contact you to verify your answers.

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

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

7. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter containing a statement in substantially the following form, set out conspicuously in the following format:

Dear [Applicant]:

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

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

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

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

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

Please check one box and return in the enclosed envelope.

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

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

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

However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

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

Sec.18. *At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in not less than twelve (12) point type and shall contain a statement in substantially the following form, set out conspicuously in the following format:*

Things You Should Know Before You Buy
Long-Term Care Insurance

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

Medicaid	• ***Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.***
	• ***Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.***
	• ***When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.***
	• ***Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.***
Shopper's Guide	• ***Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.***
Counseling	• ***Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.***
Facilities	• ***Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.***

Sec. 19. ***If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.***

Sec. 20. ***1. An insurer shall notify policyholders of the availability of a new long-term policy series that provides coverage for new long-term care services or providers material in nature and not previously available through the insurer to the general public. The notice shall be provided within twelve (12) months of the date of the new policy series is made available for sale in this state.***

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

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

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

(b) By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium

credits toward the premiums for the new policy or certificate. The premium credits shall be based on premiums paid or reserves held for the prior policy or certificate;

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

(d) By an alternative program developed by the insurer that meets the intent of this section if the program is filed with and approved by the commissioner.

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

5. Policies issued pursuant to this section shall be considered exchanges and not replacements. These exchanges shall not be subject to section 17, NAC 687B.125, 687B.127, 687B.130, 687B.135, and the reporting requirements of subsections 1 to 5, inclusive, of section 16 of this regulation.

6. Where the policy is offered through an employer, labor organization, professional, trade or occupational association, the required notification in Subsection A above shall be made to the

offering entity. However, if the policy is issued to a group defined in section 4 of NAC 687B.025, the notification shall be made to each certificateholder.

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

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

Sec. 21. *1. (a) Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:*

(1) Reducing the maximum benefit; or

(2) Reducing the daily, weekly or monthly benefit amount.

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

2. The provision shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

3. The age to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force.

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

5. If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by paragraph c of subsection1 of section 9 of this regulation.

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

Sec. 22. *1. Except as provided in subsection 2, a long-term care insurance policy may not be delivered or issued for delivery in this state unless the policyholder or certificateholder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the*

form of a rider that is attached to the policy. In the event the policyholder or certificateholder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates.

2. When a group long-term care insurance policy is issued, the offer required in Subsection A shall be made to the group policyholder. However, if the policy is issued as group long-term care insurance as defined in section 4 of NAC 687B.025, other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificateholder.

3. The commissioner shall promulgate regulations specifying the type or types of nonforfeiture benefits to be offered as part of long-term care insurance policies and

certificates, the standards for nonforfeiture benefits, and the rules regarding contingent benefit upon lapse, including a determination of the specified period of time during which a contingent benefit upon lapse will be available and the substantial premium rate increase that triggers a contingent benefit upon lapse as described in subsection 1.

Sec. 23. *1. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.*

2. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of section 22:

(a) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection 5; and

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

3. If the offer required to be made under section 22 is rejected, the insurer shall provide the contingent benefit upon lapse described in this Section. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in paragraph d of subsection 4 shall still apply.

4. (a) After rejection of the offer required under ~~[insert reference to section 23, for individual and group policies without nonforfeiture benefits issued after April 1,2008, the insurer shall provide a contingent benefit upon lapse.~~

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

(c) A contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%

~~Triggers for a Substantial Premium Increase~~

~~Issue Age~~	~~Percent Increase Over Initial Premium~~
~~63~~	~~58%~~
~~64~~	~~54%~~
~~65~~	~~50%~~
~~66~~	~~48%~~
~~67~~	~~46%~~
~~68~~	~~44%~~
~~69~~	~~42%~~
~~70~~	~~40%~~
~~71~~	~~38%~~
~~72~~	~~36%~~
~~73~~	~~34%~~
~~74~~	~~32%~~
~~75~~	~~30%~~
~~76~~	~~28%~~
~~77~~	~~26%~~
~~78~~	~~24%~~
~~79~~	~~22%~~
~~80~~	~~20%~~
~~81~~	~~19%~~
~~82~~	~~18%~~

~~Triggers for a Substantial Premium Increase~~

~~Issue Age~~	~~Percent Increase Over Initial Premium~~
~~83~~	~~17%~~
~~84~~	~~16%~~
~~85~~	~~15%~~
~~86~~	~~14%~~
~~87~~	~~13%~~
~~88~~	~~12%~~
~~89~~	~~11%~~
~~90 and over~~	~~10%~~

~~(d) A contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio in subparagraph 2 of paragraph f is forty percent (40%) or more. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.~~

~~Triggers for a Substantial Premium Increase~~	
~~Issue age~~	~~Percent Increase Over Initial~~

	Premium
Under 65 65-80 Over 80	50% 30% 10%

This provision shall be in addition to the contingent benefit provided by Paragraph c above and where both are triggered, the benefit provided shall be at the option of the insured.

(e) On or before the effective date of a substantial premium increase as defined in Paragraph c above, the insurer shall:

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

(2) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection 5. This option may be elected at any time during the 120-day period referenced in paragraph c of subsection 4; and

(3) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in paragraph c of subsection 4 shall be deemed to be the election of the offer to convert in Subparagraph 2 above unless the automatic option in sub-paragraph 3 of paragraph f applies.

(f) On or before the effective date of a substantial premium increase as defined in Paragraph d above, the insurer shall:

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

(2) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent (90%) of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in paragraph d of subsection 4; and

(3) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in paragraph d of subsection 4 shall be deemed to be the election of the offer to convert in Subparagraph 2 above if the ratio is forth percent (40%) or more.

5. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with paragraph c of subsection 4 but not paragraph d of subsection 4, are described in this subsection:

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

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

(c) The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Subsection 5.

(d) (1) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three (3) years as well as thereafter.

(2) Notwithstanding Subparagraph 1, for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

(i) The end of the tenth year following the policy or certificate issue date; or

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

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

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

7. There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

~~8. The requirements set forth in this section shall become effective twelve (12) months after adoption of this provision and shall apply as follows:~~

~~(a) Except as provided in Paragraph b and c below, the provisions of this section apply to any long-term care policy issued in this state on or after April 1, 2008.~~

~~(b) For certificates issued on or after April 1, 2008, under a group long-term care insurance policy as defined in section 1 of NAC 687B.025, which policy was in force at the time this amended regulation became effective, the provisions of this section shall not apply.~~

~~(c) The last sentence in subsection 3 and paragraph d of subsection 4 and paragraph f of subsection 4shall apply to any long-term care insurance policy or certificate issued in this state after six (6) months after their adoption, except new certificates on a group policy as defined in section 1 of NAC 687B.025 one year after adoption.~~

~~9. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of Section 17 or Sec6tion 31, whichever is applicable, treating the policy as a whole.~~

~~10. To determine whether contingent nonforfeiture upon lapse provisions are triggered under paragraph c of subsection 4 or paragraph d of subsection 4, a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.~~

~~11. A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:~~

~~(a) The nonforfeiture provision shall be appropriately captioned;~~

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

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

(1) Reduced paid-up insurance;

(2) Extended term insurance;

(3) Shortened benefit period; or

(4) Other similar offerings approved by the commissioner.

Sec. 24. 1. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment.

2. (a) Activities of daily living shall include at least the following as defined in Section 5 and in the policy:

(1) Bathing;

(2) Continence;

(3) Dressing;

(4) Eating;

(5) Toileting; and

(6) Transferring;

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

3. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in subsections 1 and 2.

4. For purposes of this section the determination of a deficiency shall not be more restrictive than:

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

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

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

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

7. (a) Except as provided in paragraph b, the provisions of this section apply to a long-term care policy issued in this state on or after April 1, 2008.

(b) For certificates issued on or after April 1, 2008, under a group long-term care insurance policy as defined in Section 1 of NAC 687B.025 that was in force at the time this amended regulation became effective, the provisions of this section shall not apply.

Sec. 25. 1. For purposes of this section the following definitions apply:

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

(b) (1) "Chronically ill individual" has the meaning prescribed for this term by section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

(i) Being unable to perform (without substantial assistance from another individual) at least two (2) activities of daily living for a period of at least ninety (90) days due to a loss of functional capacity; or

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

(2) The term "chronically ill individual" shall not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner has certified that the individual meets these requirements.

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

~~(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).~~

~~2. A qualified long term care insurance contract shall pay only for qualified long term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.~~

~~3. A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity or to severe cognitive impairment.~~

~~4. Certifications regarding activities of daily living and cognitive impairment required pursuant to subsection 3 shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury of the United States.~~

~~5. Certifications required pursuant to subsection 3 may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety-day period.~~

6. Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

Sec. 26. NAC 687B.075 is hereby amended to read as follows:

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

2. The outline of coverage must include:

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

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

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

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

3. The outline of coverage must:

(a) Be a separate and complete document;

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

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

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

[COMPANY NAME]

~~[ADDRESS-CITY & STATE]~~

~~[TELEPHONE NUMBER]~~

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

~~[Policy Number or Group Master Policy and Certificate Number]~~

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

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

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

2. This ~~[is]~~***[***~~is NOT~~~~]~~ ***a Partnership Plan as defined in Sec. 6021 of the Deficit Reduction Act of 2005***

~~[2.]~~***3.*** PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not a contract of insurance, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR ~~[POLICY]~~ ~~[CERTIFICATE]~~ CAREFULLY!

4. FEDERAL TAX CONSEQUENCES.

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

OR

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

~~[3.]~~***5.*** TERMS UNDER WHICH THE ~~[POLICY]~~ ~~[CERTIFICATE]~~ MAY BE CONTINUED IN FORCE OR DISCONTINUED.

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Policies of this category are designed to provide coverage for one or more necessary or medically necessary services related to diagnostic, preventative, therapeutic, rehabilitative, maintenance or personal care, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

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

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

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

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

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

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

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

~~[Describe:~~

~~(a) Preexisting conditions;~~

~~(b) Noneligible facility or provider;~~

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

~~(d) Exclusions or exceptions; and~~

~~(e) Limitations.]~~

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

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

~~[9.]~~***11.*** RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of services related to long-term care will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. ~~[As applicable, indicate the following:~~

~~(a) That the level of benefits will not increase over time;~~

~~(b) Any provisions regarding automatic adjustment of benefits;~~

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

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

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

~~[10.]~~**12.** ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS. ~~[State whether the [policy] [certificate]~~ provides coverage for an insured clinically

diagnosed as having Alzheimer's disease or a related degenerative and dementing illness. Specifically describe each screening of benefits or other provision in the policy or certificate that provides preconditions to the availability of benefits for such an insured.**]**

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

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

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

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

~~**[**(a) Indicate if medical underwriting is used.~~

~~(b) Describe other important features.**]**~~

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

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

Sec. 27. NAC 687B.080 is amended to read as follows:

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

1. “Medicare” must be defined as:

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

(b) “Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof,”; or

(c) Any words of similar import.

2. “Mental or nervous disorder” must not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or a mental or emotional disease or disorder.

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

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

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

6. “Adult day care” must be defined as a program, for six or more persons, of social and health-related services provided during the day in a community group setting for the purpose of

supporting frail, impaired, elderly or disabled adults who can benefit from care in a group setting outside the home.

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

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

9. "Activities of daily living" means at least bathing, continence, dressing, eating, toileting and transferring.

10. "Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

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

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

13. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

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

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

16. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

17. "Transferring" means moving into or out of a bed, chair or wheelchair.

Sec. 28. NAC 687B.090 is hereby amended to read as follows:

NAC 687B.090 1. A policy of insurance may not be delivered or issued for delivery in this State as long-term care insurance if the policy 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 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.

2. This section does not prohibit the exclusion or limitation of coverage by type of provider or territorial limitations.

3. 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.

4. No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 1 of NAC 687B.025 may exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within six (6) months following the effective date of coverage of an insured person.

Sec. 29. NAC 687B.121 is hereby amended to read as follows:

NAC 687B.121 ***1. This section shall apply to all long-term care insurance policies or certificates except those covered under Sections 12 and 15.***

2. ~~[B]~~***The Commissioner may deem b***enefits under an individual policy of long-term care insurance ~~[shall be deemed]~~ reasonable in relation to premiums charged if the expected loss ratio is at least 60 percent, calculated in a manner which provides for the adequate reserving of the

long-term care insurance risk. In evaluating the expected loss ratio, due consideration will be given to all relevant factors, including:

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Subsection 2 shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

(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 life insurance benefits meets the nonforfeiture requirements of NRS 688A.290 to 688A.360, inclusive;

(c) The policy meets the disclosure requirements of Sections 4, 6 and NAC 687B.075;

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

(e) An actuarial memorandum is filed with the insurance department 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 policy, 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 policy and dollars per unit of benefits, if any;

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

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

Sec. 30. This regulation becomes effective on April 1, 2008.