

State of Utah
Administrative Rule Analysis
Revised May 2024

NOTICE OF SUBSTANTIVE CHANGE

TYPE OF FILING: Repeal and Reenact

Rule or Section Number:

R590-148

Filing ID: Office Use Only

Date of Previous Publication (Only for CPRs):

Click or tap to enter a date.

Agency Information

1. Title catchline:	Insurance, Administration	
Building:	Taylorsville State Office Building	
Street address:	4315 S. 2700 W.	
City, state	Taylorsville, UT	
Mailing address:	PO Box 146901	
City, state and zip:	Salt Lake City, UT 84114-6901	
Contact persons:		
Name:	Phone:	Email:
Steve Gooch	801-957-9322	sgooch@utah.gov
Please address questions regarding information on this notice to the persons listed above.		

General Information

2. Rule or section catchline:
R590-148. Long-Term Care Insurance Rule
3. Purpose of the new rule or reason for the change:
The rule is being changed in compliance with Executive Order 2021-12. During the review of this rule, the department discovered a number of minor issues that needed to be amended.
4. Summary of the new rule or change:
The majority of the changes are being done to fix style issues to bring the rule text more in line with current rulewriting standards. Other changes make the language of the rule more clear, and update the Severability section to use the department's current language. The changes do not add, remove, or change any regulations or requirements.

Fiscal Information

5. Provide an estimate and written explanation of the aggregate anticipated cost or savings to:
A) State budget:
There is no anticipated cost or savings to the state budget. The changes are largely clerical in nature, and will not change how the department functions.
B) Local governments:
There is no anticipated cost or savings to local governments. The changes are largely clerical in nature, and will not affect local governments.
C) Small businesses ("small business" means a business employing 1-49 persons):
There is no anticipated cost or savings to small businesses. The changes are largely clerical in nature, and will not affect small businesses.
D) Non-small businesses ("non-small business" means a business employing 50 or more persons):
There is no anticipated cost or savings to non-small businesses. The changes are largely clerical in nature, and will not affect non-small businesses.
E) Persons other than small businesses, non-small businesses, state, or local government entities ("person" means any individual, partnership, corporation, association, governmental entity, or public or private organization of any character other than an agency):

There is no anticipated cost or savings to any other persons. The changes are largely clerical in nature.

F) Compliance costs for affected persons (How much will it cost an impacted entity to adhere to this rule or its changes?):

There are no compliance costs for any affected persons. The changes are largely clerical in nature.

G) Regulatory Impact Summary Table (This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts will be included in narratives above.)

Regulatory Impact Table			
Fiscal Cost	FY2025	FY2026	FY2027
State Government	\$0	\$0	\$0
Local Governments	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0
Other Persons	\$0	\$0	\$0
Total Fiscal Cost	\$0	\$0	\$0
Fiscal Benefits	FY2025	FY2026	FY2027
State Government	\$0	\$0	\$0
Local Governments	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0
Other Persons	\$0	\$0	\$0
Total Fiscal Benefits	\$0	\$0	\$0
Net Fiscal Benefits	\$0	\$0	\$0

H) Department head comments on fiscal impact and approval of regulatory impact analysis:

The Commissioner of the Insurance Department, Jonathan T. Pike, has reviewed and approved this regulatory impact analysis.

Citation Information

6. Provide citations to the statutory authority for the rule. If there is also a federal requirement for the rule, provide a citation to that requirement:

Section 31A-2-201	Section 31A-22-1404	

Incorporations by Reference Information

7. Incorporations by Reference (if this rule incorporates more than two items by reference, please include additional tables):

A) This rule adds or updates the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*):

Official Title of Materials Incorporated (from title page)	
Publisher	
Issue Date	
Issue or Version	

B) This rule adds or updates the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*):

Official Title of Materials Incorporated (from title page)	
Publisher	
Issue Date	
Issue or Version	

Public Notice Information

8. The public may submit written or oral comments to the agency identified in box 1. (The public may also request a hearing by submitting a written request to the agency. See Section 63G-3-302 and Rule R15-1 for more information.)		
A) Comments will be accepted until:	10/15/2024	
B) A public hearing (optional) will be held:		
Date (mm/dd/yyyy):	Time (hh:mm AM/PM):	Place (physical address or URL):
To the agency: If more space is needed for a physical address or URL, refer readers to Box 4 in General Information. If more than two hearings will take place, continue to add rows.		

9. This rule change MAY become effective on:	10/22/2024
NOTE: The date above is the date the agency anticipates making the rule or its changes effective. It is NOT the effective date.	

Agency Authorization Information

To the agency: Information requested on this form is required by Sections 63G-3-301, 63G-3-302, 63G-3-303, and 63G-3-402. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the <i>Utah State Bulletin</i> and delaying the first possible effective date.			
Agency head or designee and title:	Steve Gooch, Public Information Officer	Date:	08/23/2024

R590. Insurance, Administration.

R590-148. Long-Term Care Insurance Rule.

~~R590-148-1. Authority.~~

~~_____ This rule is issued pursuant to the authority vested in the commissioner under Sections 31A-2-201 and 31A-22-1404.~~

~~R590-148-2. Purpose.~~

~~_____ The purpose of this rule is to implement standards for full and fair disclosure of the manner, content, and required disclosures for long term care insurance to promote the public interest, to promote the availability of long term care insurance coverage, to protect applicants for long term care insurance, as defined, from unfair or deceptive sales enrollment practices, to facilitate public understanding and comparison of long term care insurance coverages, and to facilitate flexibility and innovation in the development of long term care insurance.~~

~~R590-148-3. Applicability and Scope.~~

~~_____ Except as otherwise specifically provided, this rule applies to all long term care insurance, as defined in 31A-1-301, delivered or issued for delivery in this state on or after January 1, 1993, by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations.~~

~~_____ Additionally, this rule 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.~~

~~R590-148-4. Incorporation by Reference.~~

~~_____ The following tables and appendices are hereby incorporated by reference within this rule and are available for public inspection at the Insurance Department during normal business hours or at <http://www.insurance.utah.gov/ruleindex.html>. These tables and appendices were adopted by the National Association of Insurance Commissioners' Long Term Care Insurance Model Regulation #641, as approved April 2000.~~

~~_____ (1) Table I, Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance.~~

~~_____ (2) Table II, Notice to Applicant Regarding Replacement of Accident and Sickness or Long Term Care Insurance.~~

~~_____ (3) Table III, Triggers for a Substantial Premium Increase.~~

~~_____ (4) Table IV, Long Term Care Insurance Outline of Coverage.~~

~~_____ (5) Appendix A, Rescission Reporting Form.~~

~~_____ (6) Appendix B, Long Term Care Insurance Personal Worksheet.~~

~~_____ (7) Appendix C, Things You Should Know Before You Buy Long Term Care Insurance.~~

~~_____ (8) Appendix D, Long Term Care Insurance Suitability Letter.~~

~~_____ (9) Appendix E, Claims Denial Reporting Form Long Term Care Insurance.~~

_____ (10) Appendix F, Worksheet Potential Rate Increase Disclosure Form.

_____ (11) Appendix G, Replacement and Lapse Reporting Form.

R590-148-5. Definitions.

_____ (1) For the purpose of this rule, the terms "applicant," "long-term care insurance," "certificate," "commissioner," and "policy" shall have the meanings set forth in Sections 31A-1-301 and 31A-22-1402.

_____ (2) In addition, the following definitions apply:

_____ (a) "Activities of daily living" means at least bathing, continence, dressing, eating, toileting and transferring.

_____ (b) "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain the individual's health status.

_____ (c) "Adult day care" means a program for three or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or disabled adults who can benefit from care in a group setting outside the home.

_____ (d) "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.

_____ (e) "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.

_____ (f) "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.

_____ (g)(i) "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:

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

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

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

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

_____ (i) "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.

_____ (j)(i) "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 and rules 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.

_____ (ii) Except as provided in Section R590-148-24, exceptional increases are subject to the same requirements as other premium rate schedule increases.

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

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

_____ (k) "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.

_____ (l) "Home health care services" means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

_____ (m) "Incidental" means that the value of the long-term care benefits provided is less than 10% of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

_____ (n) "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.

_____ (o) "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.

_____ (p) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

_____ (q) "Mental or nervous disorder" may not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or any other mental or emotional disease or disorder which does not have a demonstrable organic cause.

_____ (r) "Personal care" means the provision of hands-on services to assist an individual with activities of daily living, for example bathing, eating, dressing, transferring and toileting.

_____ (s) "Qualified actuary" means a member in good standing of the American Academy of Actuaries.

_____ (t) "Qualified long-term care services" means services that meet the requirements of Section 7702(e)(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.

_____ (u) "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 are not considered similar to certificates or policies otherwise issued as long term care insurance, but are similar to other comparable certificates with the same long term care benefit classifications. For purposes of determining similar policy forms, long term care benefit classifications are defined as follows:

_____ (i) institutional long term care benefits only;

_____ (ii) non institutional long term care benefits only; or

_____ (iii) comprehensive long term care benefits.

_____ (v) "Skilled nursing care," "intermediate care," "personal care," "home care," and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

_____ (w) "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

_____ (x) "Transferring" means moving into or out of a bed, chair or wheelchair.

_____ (3) All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal care facility," and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

R590 148 6. Required Provisions and Practices.

_____ (1) Renewability.

_____ The terms "guaranteed renewable" and "noncancellable" may not be used in any individual long term care insurance policy without further explanatory language in accordance with the disclosure requirements of Subsection R590 148 6(1)(b).

_____ (a) No policy issued to an individual may contain renewal provisions other than "guaranteed renewable" or "noncancellable."

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

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

_____ (b) Individual long term care insurance policies shall contain a renewability provision. This provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. This provision may not apply to policies which do not contain a renewability provision, and under which the right to non-renew is reserved solely to the policyholder.

_____ (c) In addition to the other requirements of this subsection, a qualified long term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

_____ (2) Limitations and Exclusions.

_____ (a) No policy may 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 as follows:

_____ (i) preexisting conditions or diseases;

_____ (ii) mental or nervous disorders; however, this may not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease, or any other mental or nervous disorder of organic origin;

_____ (iii) alcoholism and drug addiction;

_____ (iv) illness, treatment or medical condition arising out of:

_____ (A) war or act of war, whether declared or undeclared;

_____ (B) participation in a felony, riot or insurrection;

_____ (C) service in the armed forces or auxiliary units;

_____ (D) suicide, sane or insane, attempted suicide or intentionally self-inflicted injury; or

_____ (E) aviation for non-fare paying passengers;

_____ (v) treatment provided in a government facility, unless otherwise required by law;

_____ (vi) services for which benefits are paid under:

_____ (A) Medicare or other governmental program, except Medicaid;

_____ (B) any state or federal workers' compensation;

_____ (C) employer's liability or occupational disease law; or

_____ (D) any motor vehicle no-fault law;

_____ (vii) services provided by a member of the covered person's immediate family;

_____ (viii) services for which no charge is normally made in the absence of insurance;

_____ (ix) benefits provided for a level of care cannot be conditioned on a requirement that the care be in a facility licensed for higher levels of care.

_____ (b) Subsection R590 148 6(2)(a) is not intended to prohibit exclusions and limitations by type of provider or territorial

limitations outside the United States.

———— (3) Preexisting Condition Limitation. 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."

———— (4) Benefit Triggers. Activities of daily living and cognitive impairment may 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 paragraph. 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.

———— (5) Extension of Benefits. Termination of long term care insurance shall 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. The extension of benefits beyond the period the long term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

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

———— (a) may not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

———— (b) may not vary or otherwise depend on the individual's health or disability status, claim experience or use of long term care services.

———— (7) Premiums.

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

———— (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.

———— (c) The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under Section R590-148-14, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

———— (d) A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under Section R590-148-14, the initial annual premium shall be based on the reduced benefits.

———— (8) Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long term care insurance policy, all riders or endorsements added to an individual long term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing 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, this premium charge shall be set forth in the policy, rider or endorsement.

———— (9) Payment of Benefits. A long term care insurance policy or certificate 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.

———— (10) Eligibility for Benefits Limitations and Conditions. A long term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in Section 31A-22-1407 shall set forth a description of these limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label the paragraph "Limitations or Conditions on Eligibility for Benefits."

———— (11) Disclosure of Tax Consequences. With regard to life insurance policies which provide for long term care, a disclosure statement is required at the time of application for the policy or rider and at the time the benefit payment request is submitted that receipt of these 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.

———— (12) Qualified Contracts. A qualified long term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage that the policy is intended to be a qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

———— (13) Nonqualified Contracts. A nonqualified long term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage that the policy is not intended to be a qualified long term care insurance contract.

———— (14) Long term care insurance sold in conjunction with another insurance product, including but not limited to life insurance or annuities shall be in the form of a separate rider complying with all provisions of this Rule. Long term care insurance shall not be incorporated into a life insurance policy or annuity contract.

R590-148-7. Minimum Standards for Home Health and Community Care Benefits in Long Term Care Insurance Policies.

———— (1) A long term care insurance policy or certificate shall not, if it provides benefits for home health care services, limit or exclude benefits:

- _____ (a) by requiring that the insured would need care in a skilled nursing facility if home health care services were not provided;
- _____ (b) by requiring that the insured first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before home health care services are covered;
- _____ (c) by limiting eligible services to services provided by registered nurses or licensed practical nurses;
- _____ (d) by requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of the aid or worker's licensure or certification;
- _____ (e) by excluding coverage for personal care services provided by a home health aide;
- _____ (f) by requiring that the provision of home health care services be at a level of certification or licensure greater than that required for the eligible service;
- _____ (g) by requiring that the insured have an acute condition before home health care services are covered;
- _____ (h) by limiting benefits to services provided by Medicare-certified agencies or providers; or
- _____ (i) by excluding coverage for adult day care services.
- _____ (2) Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.
- _____ (3) A long term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement may not apply to policies or certificates issued to residents of continuing care retirement communities.

~~R590-148-8. Standards for Benefit Triggers.~~

- _____ (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 3 of the activities of daily living or the presence of cognitive impairment.
- _____ (2) Insurers may use activities of daily living to trigger covered benefits in addition to those contained in Subsection R590-148-5(2)(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 R590-148-8(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 cuing 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) The requirements set forth in this section shall be effective January 1, 2003 and shall apply as follows:
 - _____ (a) Except as provided in Subsection R590-148-8(7)(b), the provisions of this section apply to a long term care policy issued in this state on or after July 1, 2002.
 - _____ (b) For certificates issued on or after July 1, 2002, under a group long term care insurance policy that was in force at the time this rule became effective, the provisions of this section shall not apply.

~~R590-148-9. Additional Standards for Benefit Triggers for Qualified Long Term Care Insurance Contracts.~~

- _____ (1) 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.
- _____ (2) A qualified long term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.
- _____ (3) Certifications regarding activities of daily living and cognitive impairment required pursuant to Subsection R590-148-9(2) 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.
- _____ (4) Certifications required pursuant to Subsection R590-148-9(2) may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the 90-day period.
- _____ (5) Qualified long term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

~~R590-148-10. Continuation and Conversion.~~

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

_____ (2) For the purposes of this section:

_____ (a) "a basis for continuation of coverage" means a policy provision which 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 which restrict provision of benefits and services to, or contain incentives to use certain providers, facilities, or both, may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

_____ (b) "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 the individual is covered, without evidence of insurability.

_____ (c) "converted policy" means an individual policy of long term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers, facilities, or both, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non managed care plans, including provider system arrangements, service availability, benefit levels and administrative complexity.

_____ (d) 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.

_____ (3) 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 60 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.

_____ (4) 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.

_____ (5) The premium for the individual converted policy shall not exceed the insurer's customary rate at the time of the termination, which is applicable to the form and amount of the individual policy, and to the class of risk to which the person belonged when terminated from the group policy.

_____ (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 31 days after termination, by group coverage effective on the day following the termination of coverage:

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

_____ (ii) the premium for which is calculated in a manner consistent with the requirements of Subsection R590-148-10(4).

_____ (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 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% of incurred expenses. This 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, may 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, any insured individual whose eligibility for group long term care coverage is based upon the individual's relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

R590-148-11. Unintentional Lapse and Reinstatement.

_____ 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 30 days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

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

_____ (c) When the policyholder or certificateholder pays premium for a long term care insurance policy or certificate through a payroll or pension deduction plan the requirements contained in Subsection R590 148 11(1)(a) need not be met until 60 days after the policyholder or certificateholder is no longer on a payroll or pension deduction plan.

_____ (d) Lapse or termination for nonpayment of premium. No individual long term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to Subsection R590 148 11(1)(a), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.

_____ (2) Reinstatement. In addition to the requirement in Subsection R590 148 11(1)(a), a long term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage in the event of lapse if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

R590 148 12. Applications, Enrollment and Replacement of Coverage.

_____ (1) All applications for long term care insurance policies or certificates except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

_____ (2)(a) If an application for long term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

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

_____ (3) All applications shall clearly indicate the payment plan selected by the applicant.

_____ (4) Except for policies or certificates which are guaranteed issue:

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

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

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

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

_____ (5) Prior to issuance of a long term care policy or certificate to an applicant age 80 or older, the insurer shall obtain one of the following:

_____ (a) a report of a physical examination;

_____ (b) an assessment of functional capacity;

_____ (c) an attending physician's statement; or

_____ (d) copies of medical records.

_____ (6) A copy of the completed application or enrollment form, whichever is applicable, shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

_____ (7) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long term care insurance policy or certificate in force or whether a long term care policy or certificate is intended to replace any other accident and sickness or long term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing these questions may be used. With regard to a replacement policy issued to a group, other than employee and labor union groups, the following questions may be modified only to the extent necessary to elicit information about health or long term care insurance policies other than the group policy being replaced; provided, however, that the certificateholder has been notified of the replacement.

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

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

_____ (i) If so, with which company?

- _____ (ii) If that policy lapsed, when did it lapse?
- _____ (c) Are you covered by Medicaid?
- _____ (d) Do you intend to replace any of your medical or health insurance coverage with this policy/certificate?
- _____ (8) Agents shall list any other health insurance policies they have sold to the applicant.
- _____ (a) List policies sold which are still in force.
- _____ (b) List policies sold in the past five years which are no longer in force.
- _____ (9) ~~Solicitations Other than Direct Response. Upon determining that a sale will involve replacement, an insurer; other than an insurer using direct response solicitation methods, or its agent; shall furnish the applicant, prior to issuance or delivery of the individual long term care insurance policy, a notice regarding replacement of accident and sickness or long term care coverage. One copy of this notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the manner detailed in Table I, Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance.~~
- _____ (10) ~~Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the manner detailed in Table II, Notice to Applicant Regarding Replacement of Accident and Sickness or Long Term Care Insurance.~~
- _____ (11) ~~Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. The notice shall be made within five working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.~~
- _____ (12) ~~Life insurance policies and certificates that provide benefits for long term care shall comply with this section if the policy being replaced is a long term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of R590-93, Replacement of Life Insurance and Annuities. If a life insurance policy that provide 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.~~
- _____ (13) ~~Electronic Enrollment for Group Policies:~~
- _____ (a) ~~In the case of a group policy, any requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:~~
- _____ (i) ~~the consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;~~
- _____ (ii) ~~the telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and~~
- _____ (iii) ~~the telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the confidentiality of individually identifiable information and "privileged information" as defined by the Utah Government Records Access and Management Act, Section 63G-2-202, is maintained.~~
- _____ (b) ~~The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.~~

R590-148-13. Requirement to Offer Inflation Protection.

- _____ (1) ~~No insurer may offer a long term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:~~
- _____ (a) ~~increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than 5%;~~
- _____ (b) ~~guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The premium rate for the additional benefit shall not exceed the insurer's customary rate at the time the offer is made, which is applicable to the form and amount of the policy, the class of risk to which the person belonged at the time of issue of the policy, and to the age attained on the effective date of the increase. The amount of the additional benefit may be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5% for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or~~
- _____ (c) ~~covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.~~
- _____ (2) ~~Where the policy is issued to a group, except a continuing care retirement community center, the required offer in Subsection R590-148-13(1) shall be made to the group policyholder and to each proposed certificateholder.~~
- _____ (3) ~~Insurers shall include the following information in or with the outline of coverage:~~
- _____ (a) ~~a graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period; and~~
- _____ (b) ~~any expected premium increases or additional premiums to pay for automatic or optional benefit increases. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.~~
- _____ (4) ~~Inflation protection benefit increases under a policy which contains this benefit shall continue without regard to an~~

insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

_____ (5) An offer of inflation protection which provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

_____ (6)(a) Inflation protection as provided in Subsection R590-148-13(1)(a) shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection. The rejection may be either in the application or on a separate form.

_____ (b) The rejection shall be considered a part of the application and shall state:

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

R590-148-14. Nonforfeiture and Contingent Benefit Requirements.

_____ (1) To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of Section 31A-22-1412:

_____ (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 R590-148-14(4); 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.

_____ (2) If the offer required to be made under Section 31A-22-1412 is rejected, the insurer shall provide the contingent benefit upon lapse described in this section.

_____ (3)(a) After rejection of the offer required under Section 31A-22-1412, for individual and group policies without nonforfeiture benefits issued after July 1, 2002, 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) The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in Table III, Triggers for a Substantial Premium Increase, based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least 30 days prior to the due date of the premium reflecting the rate increase.

_____ (d) On or before the effective date of a substantial premium increase as defined in Subsection R590-148-14(3)(c), the insurer shall:

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

_____ (ii) offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Subsection R590-148-14(4). This option may be elected at any time during the 120-day period referenced in Subsection R590-148-14(3)(c); and

_____ (iii) notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in Subsection R590-148-14(3)(c) shall be deemed to be the election of the offer to convert in Subsection R590-148-14(3)(d)(ii).

_____ (4) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, 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 with age at least 1% per year prior to age 50, and at least 3% per year beyond age 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 Subsection R590-148-14(4)(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 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 R590-148-14(5).

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

_____ (ii) Notwithstanding Subsection R590-148-14(4)(d)(i), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

_____ (A) the end of the tenth year following the policy or certificate issue date; or

_____ (B) 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.

_____ (5) 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.

_____ (6) There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

_____ (7) The requirements set forth in this section shall become effective January 1, 2003 and shall apply as follows:

_____ (a) Except as provided in Subsection R590 148 14(7)(b), the provisions of this section apply to any long term care policy issued in this state on or after July 1, 2002.

_____ (b) For certificates issued on or after July 1, 2002, under a group long term care insurance policy, which policy was in force at the time this rule became effective, the provisions of this section shall not apply.

_____ (8) 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 R590 148 22 treating the policy as a whole.

_____ (9) To determine whether contingent nonforfeiture upon lapse provisions are triggered under Subsection R590 148 14(3)(c), 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.

_____ (10) 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:

_____ (i) reduced paid-up insurance;

_____ (ii) extended term insurance;

_____ (iii) shortened benefit period; or

_____ (iv) other similar offerings approved by the commissioner.

R590 148 15. Standard Format Outline of Coverage.

_____ This section of the rule implements, interprets and prescribes a standard format of an outline of coverage for the provisions in Subsection 31A 22 1409(2).

_____ (1) The outline of coverage shall be a free standing document, using no smaller than ten point type.

_____ (2) The outline of coverage may contain no material of an advertising nature.

_____ (3) Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to capitalization or underscoring.

_____ (4) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

_____ (5) The format for outline of coverage can be found in Table IV, Long Term Care Insurance Outline of Coverage.

R590 148 16. Requirement to Deliver Shopper's Guide.

_____ (1) A long term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the commissioner, shall be provided to all prospective applicants of a long term care insurance policy or certificate.

_____ (a) In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

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

_____ (2) Life insurance policies or riders that provide long term care benefits are not required to furnish the above referenced guide if the long term care benefits are incidental, but shall furnish the policy summary required under Subsection 31A 22 1409(8).

R590 148 17. Suitability.

_____ (1) Every insurer 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.

_____ (2)(a) To determine whether the applicant meets the standards developed by the insurer, the agent and insurer shall develop procedures that take the following into consideration:

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

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

_____ (iii) 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 insurer, and where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in Subsection R590 148 17(2)(a). 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 insurer shall contain, at a minimum, the information in the format contained in Appendix B, in not less than 12 point type. The insurer may request the applicant to provide additional information to comply with its suitability standards. A copy of the insurer's personal worksheet shall be filed with the commissioner.

_____ (c) A completed personal worksheet shall be returned to the insurer prior to the insurer'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 insurer or agent of information obtained through the personal worksheet in Appendix B is prohibited.

_____ (3) The insurer 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.

_____ (4) Agents shall use the suitability standards developed by the insurer in marketing long term care insurance.

_____ (5) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix C in not less than 12 point type.

_____ (6) If the insurer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the insurer may reject the application. In the alternative, the insurer shall send the applicant a letter similar to Appendix D, Long Term Care Insurance Suitability Letter. However, if the applicant has declined to provide financial information, the insurer 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.

_____ (7) 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.

R590-148-18. Marketing Standards.

_____ (1) Every insurer shall:

_____ (a) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

_____ (b) Establish marketing procedures to assure excessive insurance is not sold or issued.

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

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

_____ (d) Provide copies of the disclosure forms required in Subsection R590-148-19(2) to the applicant. See Appendix B, Long Term Care Insurance Personal Worksheet, and Appendix F, Potential Rate Increase Disclosure Form.

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

_____ (f) Every insurer or entity marketing long term care insurance shall establish audit able procedures for verifying compliance with this Subsection R590-148-18(1).

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

_____ (h) For long term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to Subsections R590-148-6(1)(a)(ii) and R590-148-6(6)(a).

_____ (i) Provide an explanation of contingent benefit upon lapse provided for in Subsection R590-148-14(3)(c).

_____ (2) In addition to the practices prohibited in Part 3, Chapter 23 of Title 31A, the following acts and practices are prohibited:

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

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

_____ (c) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

_____ (d) Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long term care insurance policy.

R590-148-19. Required Disclosure of Rating Practices to Consumer.

_____ (1) This section shall apply as follows:

_____ (a) Except as provided in Subsection R590-148-19(1)(b), this section applies to any long term care policy or certificate issued in this state on or after January 1, 2003.

_____ (b) For certificates issued on or after July 1, 2002, under a group long term care insurance policy, which policy was in force at the time this rule became effective, the provisions of this section shall apply on the policy anniversary following January 1, 2003.

_____ (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:

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

_____ (ii) the right to a revised premium rate or rate schedule as provided in Subsection R590-148-19(2)(b) if the premium rate or rate schedule is changed.

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

_____ (A) the policy forms for which premium rates have been increased;

_____ (B) the calendar years when the form was available for purchase; and

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

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

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

_____ (iv) If an acquiring insurer files for a rate increase on a long term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the effective date of this section, or the end of a 24 month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with Subsection R590-148-19(2)(e)(i).

_____ (v) If the acquiring insurer in Subsection R590-148-19(2)(e)(iv) files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in Subsection R590-148-19(2)(e)(iv), the acquiring insurer shall make all disclosures required by Subsection R590-148-19(2)(e), including disclosure of the earlier rate increase referenced in Subsection R590-148-19(2)(e)(iv).

_____ (3) An applicant shall sign an acknowledgment 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 Subsections R590-148-19(2)(a) and (e). If due to the method of application the applicant cannot sign an acknowledgment 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 in Appendix B, Personal Worksheet, and Appendix F, Potential Rate Increase Disclosure Form, to comply with the requirements of Subsections R590-148-19(1) and (2).

_____ (5) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by Subsection R590-148-19(2) when the rate increase is implemented.

R590-148-20. Filing Requirements.

_____ (1) Prior to an insurer or similar organization offering group long term care insurance to a resident of this state pursuant to Section 31A-22-1403, it shall file with the commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long term care insurance requirements substantially similar to those adopted in this state.

_____ (2)(a) Every insurer shall provide a copy of any long term care insurance advertisement intended for use in Utah whether through written, radio or television medium to the insurance commissioner of this state upon request.

_____ (b) All advertisements shall be retained by the insurer, health care service plan or other entity for at least three years from the date the advertisement was first used.

_____ (c) 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.

R590-148-21. Initial Filing Requirements.

_____ (1) This section shall apply to any long term care policy issued in this state on or after January 1, 2003.

_____ (2) An insurer shall file the information listed in this subsection to the commissioner prior to making a long term care insurance form available for sale:

_____ (a) a copy of the disclosure documents required in Section R590-148-19; and

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

- _____ (i) a statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;
- _____ (ii) a statement that the policy design and coverage provided have been reviewed and taken into consideration;
- _____ (iii) a statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;
- _____ (iv) a complete description of the basis for contract reserves that are anticipated to be held under the form, to include:
 - _____ (A) sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;
 - _____ (B) a statement that the assumptions used for reserves contain reasonable margins for adverse experience;
 - _____ (C) a statement that the net valuation premium for renewal years does not increase, except for attained age rating where permitted; and
 - _____ (D) a statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if 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; and
- _____ (II) if the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under Subsection R590-148-21(3) based on a standard age distribution;
- _____ (v)(A) 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
- _____ (B) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.
- _____ (3) The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.
- _____ (4) The premiums charged to an insured for long term care insurance may not increase due to either:
 - _____ (a) the increasing age of the insured at ages beyond 65; or
 - _____ (b) the duration the insured has been covered under the policy.

R590-148-22. Loss Ratio.

- _____ (1) This section shall apply to all individual long term care insurance policies except those covered in Sections R590-148-21 and R590-148-24.
- _____ (2) Benefits under individual long term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least 60%, calculated in a manner which provides for adequate reserving of the long term care insurance risk.
- _____ (3) In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:
 - _____ (a) 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) concentration of experience within early policy duration;
 - _____ (e) expected claim fluctuation;
 - _____ (f) experience refunds, adjustments or dividends;
 - _____ (g) renewability features;
 - _____ (h) all appropriate expense factors;
 - _____ (i) interest;
 - _____ (j) experimental nature of the coverage;
 - _____ (k) policy reserves;
 - _____ (l) mix of business by risk classification; and
 - _____ (m) product features such as long elimination periods, high deductibles and high maximum limits.
- _____ (4) The premiums charged to an insured for long term care insurance may not increase due to either:
 - _____ (a) the increasing age of the insured at ages beyond 65; or
 - _____ (b) the duration the insured has been covered under the policy.
- _____ (5) Rate filings documents must contain all information required in R590-85-4.

R590-148-23. Reserve Standards.

- _____ (1) When long term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to these policies, policy reserves for these benefits shall be determined in accordance with Subsection 31A-17-504(7). Claim reserves must also be established when the policy or rider is in claim status.
- _____ Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long term care benefits. However, in no event may the reserves for the long term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no

long term care benefit.

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

- ~~_____ (a) definition of insured events;~~
- ~~_____ (b) covered long term care facilities;~~
- ~~_____ (c) existence of home convalescence care coverage;~~
- ~~_____ (d) definition of facilities;~~
- ~~_____ (e) existence or absence of barriers to eligibility;~~
- ~~_____ (f) premium waiver provision;~~
- ~~_____ (g) renewability;~~
- ~~_____ (h) ability to raise premiums;~~
- ~~_____ (i) marketing method;~~
- ~~_____ (j) underwriting procedures;~~
- ~~_____ (k) claims adjustment procedures;~~
- ~~_____ (l) waiting period;~~
- ~~_____ (m) maximum benefit~~
- ~~_____ (n) availability of eligible facilities;~~
- ~~_____ (o) margins in claim costs;~~
- ~~_____ (p) optional nature of benefit;~~
- ~~_____ (q) delay in eligibility for benefit;~~
- ~~_____ (r) inflation protection provisions; and~~
- ~~_____ (s) guaranteed insurability option.~~

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

~~_____ (2) When long term care benefits are provided other than as in Subsection R590 148 23(1), reserves shall be determined in accordance with Minimum Reserve Standards for Individual and Group Health Insurance Contracts, Appendix A 010, Accounting Practices and Procedures Manual, edition March 2001, published by the National Association of Insurance Commissioners.~~

R590 148 24. Premium Rate Schedule Increases.

~~_____ (1) This section shall apply as follows:~~

~~_____ (a) except as provided in Subsection R590 148 24(1)(b), this section applies to any long term care policy or certificate issued in this state on or after January 1, 2003.~~

~~_____ (b) for certificates issued on or after July 1, 2002, under a group long term care insurance policy, which policy was in force at the time this rule became effective, the provisions of this section shall apply on the policy anniversary following January 1, 2003.~~

~~_____ (2) An insurer shall file notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner prior to the notice to the policyholders and shall include:~~

~~_____ (a) information required by Section R590 148 19;~~

~~_____ (b) certification by a qualified actuary that:~~

~~_____ (i) if the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;~~

~~_____ (ii) the premium rate filing is in compliance with the provisions of this section;~~

~~_____ (c) an actuarial memorandum justifying the rate schedule change request that includes:~~

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

~~_____ (A) annual values for the five years preceding and the three years following the valuation date shall be provided separately;~~

~~_____ (B) the projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;~~

~~_____ (C) the projections shall demonstrate compliance with Subsection R590 148 24(3); and~~

~~_____ (D) for exceptional increases:~~

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

~~_____ (II) in the event the commissioner determines as provided in Section R590-148-5(2)(j)(iv) that offsets may exist, the insurer shall use appropriate net projected experience;~~

~~_____ (ii) disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;~~

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

~~_____ (iv) a statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and~~

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

~~_____ (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 of the premium rate schedule increase by the commissioner.~~

~~_____ (3) All premium rate schedule increases shall be determined in accordance with the following requirements:~~

~~_____ (a) exceptional increases shall provide that at least 70% of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;~~

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

~~_____ (i) the accumulated value of the initial earned premium times 58%;~~

~~_____ (ii) 85% percent of the accumulated value of prior premium rate schedule increases on an earned basis;~~

~~_____ (iii) the present value of future projected initial earned premiums times 58%; and~~

~~_____ (iv) 85% percent of the present value of future projected premiums not in Subsection R590-148-24(3)(b)(iii) on an earned basis;~~

~~_____ (c) in the event that a policy form has both exceptional and other increases, the values in Subsections R590-148-24(3)(b)(ii) and (iv) will also include 70% for exceptional rate increase amounts; and~~

~~_____ (d) all present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves which is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the health insurance contract. The actuary shall disclose as part of the actuarial memorandum, the use of any appropriate averages.~~

~~_____ (4)(a) The insurer may request a premium rate schedule increase that is lower than the rate increase necessary to provide the certification required in R590-148-24(2)(b)(i) and the commissioner may accept such premium rate schedule increase, without submission of the certification required in R590-148-24(2)(b)(i), if:~~

~~_____ (i) in the opinion of the commissioner accepting such lower premium rate schedule increase is in the best interest of Utah policyholders;~~

~~_____ (ii) the actuarial memorandum discloses the rate increase necessary to provide the certification required in R590-148-24(2)(b)(i); and~~

~~_____ (iii) the rate increase filing satisfies all other requirements of this section.~~

~~_____ (b) The commissioner may condition the acceptance of the premium rate schedule increase under Subsection R590-148-24(4)(a) upon:~~

~~_____ (i) the disclosure, to the affected policyholders, of the premium rate schedule increase necessary to provide the certification required in R590-148-24(2)(b)(i); and~~

~~_____ (ii) the extension of a contingent nonforfeiture benefit upon lapse to policyholders who would have been eligible for contingent nonforfeiture benefit upon lapse based on the premium rate schedule increase necessary to provide certification required in R590-148-24(2)(b)(i).~~

~~_____ (5) For each rate increase that is implemented, the insurer shall file for review by the commissioner updated projections, as defined in Subsection R590-148-24(2)(c)(i), annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Subsection R590-148-24(12), the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.~~

~~_____ (6) 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 R590-148-24(2)(c)(i), shall be filed for review by the commissioner every five years following the end of the required period in Subsection R590-148-24(5). For group insurance policies that meet the conditions in Subsection R590-148-24(12), the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.~~

~~_____ (7)(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 R590-148-24(3), the commissioner may require the insurer to implement any of the following:~~

~~_____ (i) premium rate schedule adjustments; or~~

~~_____ (ii) 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 R590-148-24(2)(c)(v), if applicable.~~

~~_____ (8) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:~~

~~_____ (a) a plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in Subsection R590-148-24(9); and~~

~~_____ (b) the original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to Subsection R590-148-24(3) had the greater of the original anticipated lifetime loss ratio or 58% been used in the calculations described in Subsection R590-148-24(3)(a)(i) and (iii).~~

~~_____ (9)(a) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant~~

adverse lapsation has occurred or is anticipated:

- ~~_____ (i) the rate increase is not the first rate increase requested for the specific policy form or forms;~~
- ~~_____ (ii) the rate increase is not an exceptional increase; and~~
- ~~_____ (iii) the majority of the policies 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.~~

- ~~_____ (i) The offer shall:~~
 - ~~_____ (A) be subject to the approval of the commissioner;~~
 - ~~_____ (B) be based on actuarially sound principles, but not be based on attained age; and~~
 - ~~_____ (C) provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.~~

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

- ~~_____ (A) the maximum rate increase determined based on the combined experience; and~~
- ~~_____ (B) the maximum rate increase determined based only on the experience of the insureds originally issued the form plus 10%.~~

~~_____ (10) If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long term care insurance, the commissioner may, in addition to the provisions of Subsection R590 148 24(9), 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.~~

~~_____ (11) Subsections R590 148 24(1) through (10) shall not apply to policies for which the long term care benefits provided by the policy are incidental, as defined in Subsection R590 148 5(2)(m), 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 insurance benefits other than long term care coverage meets the nonforfeiture requirements as applicable in any of the following:~~

- ~~_____ (i) Section 31A 22 408; and~~
- ~~_____ (ii) Section 31A 22 409;~~
- ~~_____ (c) the policy meets the disclosure requirements of Subsections 31A 22 1409(7) and (8) and 31A 22 1410;~~
- ~~_____ (d) the portion of the policy that provides insurance benefits other than long term care coverage meets the requirements as applicable in the following:~~

- ~~_____ (i) policy illustrations as required by R590 177; and~~
- ~~_____ (ii) disclosure requirements in R590 133;~~
- ~~_____ (e) an actuarial memorandum is filed with the insurance department that includes:~~
 - ~~_____ (i) a description of the basis on which the long term care rates were determined;~~
 - ~~_____ (ii) a description of the basis for the reserves;~~
 - ~~_____ (iii) a summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;~~
 - ~~_____ (iv) a description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;~~
 - ~~_____ (v) a description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;~~

- ~~_____ (vi) the estimated average annual premium per policy and the average issue age;~~
- ~~_____ (vii) a statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the 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~~
- ~~_____ (viii) a description of the effect of the long term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long term care claim status.~~

~~_____ (12) Subsections R590 148 24(7) and (9) shall not apply to group insurance policies 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 certificateholders, 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.~~

R590 148 25. Reporting Requirements.

- ~~_____ (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.

_____ (a) Every insurer shall report the 10% of its agents with the greatest percentages of lapses and replacements as measured by Subsection R590 148 25(1).

_____ (b) Every insurer shall report 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.

_____ (c) Every insurer shall report 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.

_____ (d) The reports required by Subsection R590 148 25(1)(a),(b), and (c) must be reported on the "Replacement and Lapse Reporting Form," Appendix G.

_____ (e) 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.

_____ (2) Every insurer shall report, for qualified long term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. The report used by the insurer shall contain, at a minimum, the information in the format contained in Appendix E, Claims Denial Reporting Form Long Term Care Insurance, in not less than 12 point type.

_____ (3) Every insurer shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated and shall annually report this information in the format currently prescribed by the National Association of Insurance Commissioners.

_____ (4) Every insurer shall report 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. The report must be submitted on the Suitability Reporting Form, Appendix H.

_____ (5) For purposes of this section:

_____ (a) "policy" shall mean only long term care insurance;

_____ (b) "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 that 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.

_____ (6) Reports required under this section shall be filed with the commissioner annually on or before June 30. All reports must be submitted in compliance with Rule R590 220 13, Submission of Accident and Health Insurance Filings: Additional Procedures for Long Term Products.

R590 148 26. Licensing.

_____ A producer is not authorized to sell, solicit or negotiate with respect to long term care insurance except as authorized by Chapter 23 of Title 31A.

R590 148 27. Discretionary Powers of Commissioner.

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

_____ (1) the modification or suspension would be in the best interest of the insured; and

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

_____ (3) one of the following occur:

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

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

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

R590 148 28. Penalties.

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

R590 148 29. Enforcement Date.

_____ Effective July 1, 2002, the department will enforce all sections of the rule that do not have a different compliance date.

R590 148 30. Severability.

_____ If any provision or clause of this rule or its application to any person or situation is held invalid, such invalidity may not

~~affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this and the provisions of this rule are declared to be severable.]~~

R590-148-1. Authority.

This rule is promulgated by the commissioner pursuant to Sections 31A-2-201 and 31A-22-1404.

R590-148-2. Purpose and Scope.

(1) The purpose of this rule is to:

(a) implement standards for full and fair disclosure of the manner, content, and required disclosures for long-term care insurance;

(b) protect applicants from unfair or deceptive sales or enrollment practices;

(c) facilitate public understanding and comparison of long-term care insurance; and

(d) facilitate flexibility and innovation in the development of long-term care insurance.

(2)(a) This rule applies to long-term care insurance delivered to or issued for delivery in this state on or after January 1, 1993.

(b) This rule also applies to an income replacement policy offering indemnity benefits triggered by activities of daily living, if:

(i) the benefits are dependent on or vary in amount based on the receipt of long-term care services;

(ii) the income replacement policy is advertised, marketed, or offered as insurance for long-term care services; or

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

R590-148-3. Definitions.

Terms used in this rule are defined in Sections 31A-1-301 and 31A-22-1402. Additional terms are defined as follows:

(1) "Attained age rating" means a schedule of premiums starting from the issue date that increases with age at least 1% per year before age 50, and at least 3% per year beyond age 50.

(2)(a) "Benefit trigger" means a provision conditioning the payment of a benefit on a determination of the insured's:

(i) ability to perform activities of daily living; and

(ii) cognitive impairment.

(b) "Benefit trigger," when used in a tax-qualified long-term care insurance contract, includes a determination by a licensed health care practitioner that an insured is a chronically ill individual.

(3) "Cold lead advertising" means using, directly or indirectly, any method of marketing that fails to disclose in a conspicuous manner the method of marketing is a solicitation of insurance and that contact will be made by a producer or an insurer.

(4) "Chronically ill individual" has the same meaning as defined in Section 7702B(c)(2), Internal Revenue Code.

(5) "Continuation of coverage" means a provision that:

(a) maintains coverage under the existing group policy when the coverage would otherwise terminate; and

(b) is subject only to the continued timely payment of premium when due.

(6) "Conversion of coverage" means a 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, is entitled to the issuance of a converted policy by the insurer, without evidence of insurability, if the individual was continuously insured under the group policy or another group policy that it replaced six months immediately before termination.

(7) "Exceptional increase" means a premium rate increase filed by an insurer as exceptional that the commissioner determines is justified due to:

(a) a change in laws applicable to long-term care insurance; or

(b) an increased and unexpected utilization that affects the majority of insurers of a similar product.

(8) "High pressure tactics" means using a method of marketing to induce, or tend to induce, the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(9) "Incidental" means the value of the long-term care benefits provided is less than 10% of the total value of the benefits provided over the life of the policy measured as of the date of issue.

(10) "Independent review organization" means an organization that conducts an independent review of a long-term care benefit trigger decision.

(11) "Licensed health care practitioner" has the same meaning as defined in Section 7702B(c)(4), Internal Revenue Code.

(12) "Licensed health care professional" means an individual qualified by education and experience in an appropriate field to determine, by record review, an insured's actual functional or cognitive impairment.

(13)(a) "Maintenance or personal care services" means any care that is primarily intended to provide needed assistance with any disability that causes an individual to be certified as a chronically ill individual.

(b) "Maintenance or personal care services" includes protection from threats to health and safety due to severe cognitive impairment.

(14) "Managed care plan" means 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.

(15) "Misrepresentation" means presenting a material fact in an incomplete, incorrect, partially complete, or partially correct manner when selling or offering to sell a policy or certificate.

(16) "Policy" means a long-term care insurance policy, contract subscriber agreement, rider, or endorsement that is delivered

or issued in this state.

(17) "Qualified actuary" means a member in good standing of the American Academy of Actuaries.

(18) "Qualified long-term care services" has the same meaning as defined in Section 7702B(c), Internal Revenue Code.

(19)(a) "Similar policy forms" means all 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.

(b) A group long-term care insurance certificate issued under Subsection 31A-22-504(1)(a) is not considered similar to policies or certificates otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications.

(c) For purposes of determining "similar policy forms," a long-term care benefit classification is defined as:

(i) institutional long-term care benefits only;

(ii) non-institutional long-term care benefits only; or

(iii) comprehensive long-term care benefits.

(20) "Twisting" means knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policy or insurer to induce, or tend to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out an insurance policy with another insurer.

R590-148-4. Policy Definitions.

A policy may not use the terms in this section unless the terms are defined and comply with Section R590-148-3 and this section.

(1) "Activities of daily living" means bathing, continence, dressing, eating, toileting, and transferring.

(2) "Acute condition" means an individual is medically unstable and requires frequent monitoring by a medical professional, such as a physician or registered nurse, to maintain their health status.

(3)(a) "Adult day care" means a facility licensed and operating within the scope of the license.

(b) An adult day care facility may not be defined more restrictively than a program, for three or more individuals, of social and health-related services provided during the day in a community group setting to support frail, impaired, elderly, or other disabled adults who can benefit from care in a group setting outside the home.

(4) "Bathing" means washing oneself:

(a) by sponge bath; or

(b) in either a tub or shower, including the task of getting into or out of the tub or shower.

(5) "Cognitive impairment" means a deficiency in a person's:

(a) short-term or long-term memory;

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

(c) deductive or abstract reasoning; or

(d) safety awareness judgment.

(6) "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.

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

(8) "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.

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

(10)(a) "Home health care services" means medical and nonmedical services provided to an ill, disabled, or infirm individual in the individual's residence.

(b) "Home health care services" may include homemaker services, assistance with activities of daily living, and respite care services.

(11) "Mental or nervous disorder" means, and may not be defined more restrictively than, a neurosis, psychoneurosis, psychopathy, psychosis, or other mental or emotional disease or disorder that does not have a demonstrable organic cause.

(12) "Personal care" means hands-on services to assist an individual with activities of daily living.

(13) "Skilled nursing care," "intermediate care," "personal care," "home care," "assisted living care," and any other service shall be defined in relation to the level of skill required, the nature of the care, and the setting where the care is delivered.

(14)(a) "Skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal care facility," "home care agency," and any other provider of services shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration, or degree status of those providing or supervising the services.

(b) When the definition requires the provider to be appropriately licensed, certified, or registered, it shall also state what requirements a provider must meet in lieu of licensure, certification, or registration when the state where 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.

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

(16) "Transferring" means moving into or out of a bed, chair, or wheelchair.

R590-148-5. Required Forms, Reports, and Disclosures.

The documents in this section shall be used by an insurer offering a long-term care insurance policy or certificate. The documents were adopted by the NAIC, Long-Term Care Insurance Model Regulation, number 641, and are available on the department's website, <http://insurance.utah.gov>:

- (1) Claims Denial Reporting Form Long-Term Care Insurance Rescission Reporting Form;
- (2) Long-Term Care Insurance Outline of Coverage;
- (3) Long-Term Care Insurance Personal Worksheet;
- (4) Long-Term Care Insurance Suitability Letter;
- (5) Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance;
- (6) Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance;
- (7) Rescission Reporting Form;
- (8) Replacement and Lapse Reporting Form;
- (9) Suitability Reporting Form;
- (10) Things You Should Know Before You Buy Long-Term Care Insurance;
- (11) Triggers for a Substantial Premium Increase; and
- (12) Worksheet Potential Rate Increase Disclosure Form.

R590-148-6. Required Provisions and Practices.

(1) The terms "guaranteed renewable" and "noncancellable" may not be used in an individual policy without further explanatory language in accordance with the disclosure requirements of Subsection (1)(b).

(a) An individual policy may not contain a renewal provision other than "guaranteed renewable" or "noncancellable."

(i) The term "guaranteed renewable" may be used only when:

(A) an insured has the right to continue the policy in force by the timely payment of premiums; and

(B) an insurer does not have a unilateral right to make a change in a policy or rider provision while the insurance is in force, and may not decline to renew, except that rates may be revised by the insurer on a class basis.

(ii) The term "noncancellable" may be used only when an insured has the right to continue the policy in force by the timely payment of premiums during which period the insurer does not have a right to unilaterally make any change to any policy provision or the premium rate.

(b)(i) An individual policy shall contain a renewability provision.

(ii) The provision shall:

(A) be appropriately captioned;

(B) appear on the first page of the policy;

(C) clearly state the duration, when limited, of renewability and the duration of the term of coverage for which the policy is issued; and

(D) how the policy may be renewed.

(iii) The provision does not apply to a policy when the right to non-renew the policy is reserved solely to the policyholder.

(c) A qualified long-term care insurance contract shall be guaranteed renewable as defined in Section 7702B(b)(1)(C),

Internal Revenue Code.

(2)(a) Except as provided in Subsection (2)(b), a policy may not be delivered or issued for delivery in this state if the policy limits or excludes coverage by type of illness, treatment, medical condition, or accident.

(b) An insurer may have an exclusion or limitation:

(i) by provider type; or

(ii) for territorial limitations outside the United States.

(3) If a policy or certificate contains a preexisting condition limitation, the limitation shall appear as a separate paragraph of the policy or certificate and be labeled as "Preexisting Condition Limitations."

(4)(a) Activities of daily living and cognitive impairment may be used to measure an insured's need for long-term care benefits and shall be described in the policy or certificate as a separate paragraph, including any additional benefit triggers, and be labeled "Eligibility for the Payment of Benefits."

(b) Any additional benefit triggers shall also be explained in the paragraph.

(c) If the triggers differ for different benefits, an explanation of each trigger shall accompany each benefit description.

(d) If an attending physician or other specified person is required to certify a certain level of functional dependency to qualify for benefits, the requirements shall be specified.

(5)(a) Termination of long-term care insurance shall be without prejudice to any benefit payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination.

(b) The extension of a benefit beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefit and may be subject to any policy waiting period and any other applicable policy provision.

(6)(a) If a group policy is replaced by another group policy issued to the same policyholder, the succeeding insurer shall offer coverage to each person covered under the previous group policy on the date of termination.

(b) Coverage provided or offered to an individual and the premium charged to an insured under the new group policy may not:

(i) result in an exclusion for a preexisting condition that would have been covered under the group policy being replaced; or

(ii) vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.

(7)(a) The term "level premium" may be used only if an insurer may not change the premium.

(b) A policy or certificate, other than one for which an insurer may not change the premium, shall include a statement that premium rates may change.

(c) For the calculation required under Section R590-148-14:

(i)(A) the purchase of additional coverage is not considered a premium rate increase; and

(B) the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium; and

(ii)(A) a reduction in a benefit is not considered a premium change; and

(B) the initial annual premium shall be based on the reduced benefits under Section R590-148-14.

(8)(a) A rider or endorsement added to a policy after the date of issue or at reinstatement or renewal that reduces or eliminates a benefit or coverage in the policy shall require a signed acceptance by the insured, unless the insurer:

(i) is effectuating a request made in writing by the insured; or

(ii) is exercising a specifically reserved right under a policy.

(b) After the issue date of a policy, a rider or endorsement that increases a benefit or coverage with an associated increase in premium during the policy term shall be agreed to in writing and signed by the insured, unless the increased benefit or coverage is required by law.

(c) When a separate additional premium is charged for a benefit provided in connection with a rider or endorsement, the premium charge shall be set forth in the policy, rider, or endorsement.

(9) A policy or certificate providing payment of a benefit based on a standard described as "usual and customary," "reasonable and customary," or similar language, shall include a definition of the term and an explanation of the term in the outline of coverage.

(10) If a policy or certificate contains a limitation or condition for eligibility, other than those prohibited in Section 31A-22-1407, the limitation, including any required number of days of confinement, shall appear in a separate paragraph of the policy or certificate and be labeled "Limitations or Conditions on Eligibility for Benefits."

(11)(a) A life insurance policy that includes a long-term care benefit shall include a disclosure statement, at the time of application for a policy or a rider and at the time a benefit payment request is submitted, that receipt of these benefits may be taxable and that assistance should be sought from a personal tax advisor.

(b) The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related document.

(c) This subsection does not apply to a qualified long-term care insurance contract.

(12) A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage stating that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b), Internal Revenue Code.

(13) A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage stating that the policy is not intended to be a qualified long-term care insurance contract.

(14)(a) Long-term care insurance sold in conjunction with another insurance product, including a life insurance policy or annuity contract, shall be in a separate rider and shall comply with this rule.

(b) Long-term care insurance may not be incorporated into a life insurance policy or an annuity contract.

R590-148-7. Minimum Standards for Home Health and Community Care Benefits in a Long-Term Care Insurance Policy.

(1) If a policy or certificate provides benefits for home health care services, it may not limit or exclude benefits by:

(a) requiring the insured would need care in a skilled nursing facility if home health care services are not provided;

(b) requiring the insured first or simultaneously receive nursing or therapeutic services, or both, in a home, community, or institutional setting before covering home health care services;

(c) limiting eligible services to services provided by a registered nurse or a licensed practical nurse;

(d) requiring that a nurse or therapist provide covered services that can be provided by a home health aide or other licensed or certified home care worker acting within the scope of the aide or worker's licensure or certification;

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

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

(g) requiring that the insured have an acute condition before covering home health care services;

(h) limiting benefits to services provided by a Medicare-certified agency or provider; or

(i) excluding coverage for adult day care services.

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

(3)(a) A policy or certificate, if it provides for home care or community care services, shall provide total home care or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, when covered home care or community care services are received.

(b) The requirement in Subsection (3)(a) does not apply to a policy or certificate issued to a resident of a continuing care retirement community.

R590-148-8. Benefit Trigger Standards.

- (1)(a) A policy shall condition the payment of benefits on a determination of the insured's:
- (i) ability to perform activities of daily living; or
 - (ii) cognitive impairment.
- (b) Eligibility for the payment of benefits may not be more restrictive than requiring either:
- (i) a deficiency in the ability to perform not more than three of the activities of daily living; or
 - (ii) the presence of cognitive impairment.
- (2) An insurer may use additional activities of daily living to trigger covered benefits in addition to those listed in Section R590-148-4 if the terms are defined in the policy.
- (3) An insurer may use additional provisions to determine when benefits are payable, but the provisions may not restrict, and are not in lieu of, the requirements under Subsections (1) and (2).
- (4) For purposes of this section, the determination of a deficiency may 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, needing supervision or verbal cuing by another person to protect the insured or others.
- (5) An assessment of activities of daily living or cognitive impairment shall be performed by a licensed or certified professional, such as a physician, nurse, or social worker.
- (6) A policy shall include a clear description of the process for appealing and resolving a benefit determination.
- (7) The requirements in this section are effective January 1, 2003.
- (a) This section applies to a policy issued in this state on or after July 1, 2002.
 - (b) This section does not apply to a certificate issued on or after July 1, 2002, under a group policy that was in force before July 1, 2002.

R590-148-9. Benefit Trigger Standards for Qualified Long-Term Care Insurance Contracts.

- (1) A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided under a plan of care prescribed by a licensed health care practitioner.
- (2) A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform the activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or severe cognitive impairment.
- (3) A certification regarding the activities of daily living or cognitive impairment required under Subsection R590-148-9(2) shall be performed by a licensed or certified:
- (a) physician;
 - (b) registered professional nurse;
 - (c) social worker; or
 - (d) another individual who meets the requirements prescribed by the Secretary of the Treasury.
- (4)(a) Except as provided in Subsection (4)(b), a certification required under Subsection (2) may be performed by a licensed health care professional at the direction of the insurer as reasonably necessary for a specific claim.
- (b) When a licensed health care practitioner certifies that an insured is unable to perform the activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and an additional certification may not be performed until after the expiration of the 90-day period.
- (5) A qualified long-term care insurance contract shall include a clear description of the process for appealing and resolving a dispute with respect to a benefit determination.

R590-148-10. Continuation and Conversion.

- (1) A group policy issued in this state on or after July 1, 2002, shall include a provision for continuation of coverage or conversion of coverage.
- (2)(a) A group policy that restricts benefits and services or contains incentives to use certain providers or facilities may provide continuation of coverage or conversion of coverage benefits that are substantially equivalent to the benefits of the existing group policy.
- (b) The commissioner shall make a determination as to the substantial equivalency of benefits, taking into consideration the differences between managed care and non-managed care plans, including provider system arrangements, service availability, benefit levels, and administrative complexity.
- (3)(a) The insured shall make a written application for the converted policy and pay the first premium, if any, as directed by the insurer within 60 days after the termination of coverage under the group policy.
- (b) The converted policy shall be issued effective on the day following the termination of coverage under the group policy and shall be renewable annually.
- (4)(a) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated based on the insured's age at inception of coverage under the group policy replaced.
- (b) If the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated based on the insured's age at inception of coverage under the group policy replaced.
- (5) The premium for the individual converted policy may not exceed the insurer's premium rate at the time of the termination

applicable to:

- (a) the policy form;
- (b) the benefit amount of the individual policy; and
- (c) the class of risk to which the individual belonged when terminated from the group policy.
- (6) Continuation of coverage or issuance of a converted policy is mandatory, except when:
 - (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 within 31 days after termination by group coverage effective on the day following the termination of coverage:
 - (i) providing benefits identical to, or benefits determined by the commissioner to be substantially equivalent to or in excess of, those provided by the terminating coverage; and
 - (ii) having premiums calculated in a manner consistent with the requirements of Subsection (4).
- (7)(a) 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 an incurred expense, 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, result in payment of more than 100% of incurred expenses.
 - (b) Subsection (7)(a) applies only if the converted policy provides for a premium decrease or refund that reflects the reduction in benefits payable.
- (8) The converted policy may provide that the converted policy benefits, together with the benefits payable under the group policy from which conversion is made, not exceed what would have been payable had the individual's coverage under the group policy remained in force and in effect.
- (9) Notwithstanding any other provision of this section, if an insured's eligibility for a group policy is based upon the insured's relationship to another insured, the insured is entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

R590-148-11. Unintentional Lapse and Reinstatement.

- (1)(a) An applicant may designate at least one person to receive the notice of lapse or termination, in addition to the applicant.
 - (i) Designation of an additional person does not constitute acceptance of any liability on the third party for services provided to the insured.
 - (ii) The form used for the written designation shall provide space clearly designated for listing at least one additional person, including each person's full name and home address.
 - (iii) A policy or certificate may not be issued until the insurer has received from the applicant:
 - (A) 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
 - (B) a written waiver dated and signed by the applicant electing not to designate an additional person to receive notice of lapse or termination.
 - (iv) If an applicant elects not to designate an additional person, the waiver shall state, "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."
 - (v) The form used for the written designation shall provide a space clearly designated for listing at least one person that includes each person's full name and home address.
 - (vi) The insurer shall notify the insured of the right to change their written designation at least once every two years.
- (b) If an insured pays a premium through a payroll or pension deduction plan, the insurer shall meet the requirements of this subsection within 60 days after the insured is no longer on the payment plan.
 - (c)(i) A policy or certificate may not lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, gives notice to the insured and each person designated under Subsection (1)(a), at the address provided by the insured for receiving notice of lapse or termination.
 - (ii) The notice in Subsection (1)(c)(i):
 - (A) shall be given by postage prepaid first-class United States mail;
 - (B) may not be given until 30 days after a premium is due and unpaid; and
 - (C) is considered given five days after the date of mailing.
 - (2) A policy or certificate shall include a provision for providing for reinstatement of coverage in the event of lapse if the insurer is provided proof that the insured was cognitively impaired or had a loss of functional capacity before the grace period expired.
 - (a) The option in this subsection shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium, when appropriate.
 - (b) The standard of proof of cognitive impairment or loss of functional capacity may not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy or certificate.

R590-148-12. Requirements for Application Forms and Replacement Coverage.

- (1) An application or enrollment form for a policy or certificate, except those that are guaranteed issue, shall contain clear

and unambiguous questions designed to ascertain the health condition of the applicant.

(2)(a) If an application or enrollment form contains a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the prescribed medication.

(b) If the prescribed medications listed in the application are known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate may not be rescinded for that condition.

(3) An application or enrollment form shall clearly state the payment plan selected by the applicant.

(4) Except for a policy or certificate that is guaranteed issue:

(a) the following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application or enrollment form, "Caution: If your answers on this application are incorrect or untrue, (company) has the right to deny benefits or rescind your policy."; and

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

(5) Before issuing a policy or certificate to an applicant age 80 or older, the insurer shall obtain:

(a) a report of a physical examination;

(b) an assessment of functional capacity;

(c) an attending physician's statement; or

(d) copies of medical records.

(6) A copy of the completed application or enrollment form shall be delivered to the insured with the policy or certificate, unless it was provided to the applicant at the time of application.

(7)(a) An application or enrollment form shall include questions designed to elicit information as to whether, as of the date of the application:

(i) the applicant currently has another long-term care insurance policy or certificate in force; or

(ii) the long-term care policy or certificate is intended to replace any other accident and health insurance or long-term care insurance policy or certificate currently in force.

(b) A supplementary application or other form signed by the applicant and producer may be used, except when the coverage is sold without a producer.

(c) For a replacement policy issued to a group, other than an employee or labor union group, the questions may be modified to the extent necessary to elicit information about other accident and health insurance or long-term care insurance other than the group policy being replaced, provided that the certificate holders have been notified of the replacement.

(d) The questions in Subsection (7)(a) shall include:

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

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

If so, with which company?

If that policy lapsed, when did it lapse?";

(iii) "Are you covered by Medicaid?"; and

(iv) "Do you intend to replace any of your medical or health insurance coverage with this policy/certificate?";

(8) A producer shall list all other accident and health insurance policies they have sold to the applicant, including a list of each policy sold:

(a) that is still in force; and

(b) in the past five years, that is no longer in force.

(9)(a) An insurer using a solicitation method other than direct response shall, upon determining that a sale involves a replacement, provide to the applicant, before issuance or delivery of the individual policy, a notice regarding replacement of accident and health insurance or long-term care insurance.

(b) A copy of the notice shall be provided to the applicant and an additional copy signed by the applicant shall be retained by the insurer.

(c) The required notice shall be provided in a manner substantially similar to the Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance.

(10)(a) An insurer using a direct response solicitation method shall deliver a notice regarding replacement of accident and health insurance or long-term care insurance to the applicant upon issuance of the policy.

(b) The required notice in Subsection (10)(a) shall be provided in a manner substantially similar to the Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance.

(11)(a) If replacement is intended, the replacing insurer shall notify the existing insurer in writing of the proposed replacement, identifying the insurer, the insured, and the policy number or address including zip code.

(b) The notice shall be made within five working days from the date the application is received by the insurer or the date the policy or certificate is issued, whichever is sooner.

(12)(a) A life insurance policy or certificate that provides long-term care benefits shall comply with this section if the policy

being replaced is a long-term care insurance policy.

(b) If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of Rule R590-93.

(c) If a life insurance policy that provides long-term care benefits is replaced by another similar policy, the replacing insurer shall comply with both the long-term care insurance and the life insurance replacement requirements in Subsections (12)(a) and (12)(b).

(13) A requirement under a group policy that a signature of an insured be obtained by a producer or an insurer is satisfied if:

(a) consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer;

(b) verification of enrollment information is provided to the enrollee; and

(c) telephonic or electronic enrollment provides necessary and reasonable safeguards to assure:

(i) accuracy, retention, and prompt retrieval of records; and

(ii) the ongoing confidentiality of individually identifiable information and privileged information under Section 63G-2-202.

R590-148-13. Requirement to Offer Inflation Protection.

(1) An insurer may not offer a policy unless the insurer also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations that account for reasonably anticipated increases in the cost of long-term care services covered by the policy.

(a) An insurer shall offer to a policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than the following:

(i) increases benefit levels that are compounded annually at a rate not less than 5%;

(ii) guarantees the insured the right to periodically increase benefit levels without providing evidence of insurability or health status if the option for the previous period was not declined; or

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

(b) The offer under Subsection (1)(a)(ii) shall comply with this subsection.

(i) The premium rate for the additional benefit may not exceed the insurer's customary rate at the time the offer is made, that applies to:

(A) the form and amount of the policy;

(B) the class of risk to which the person belonged at the time of issue of the policy; and

(C) the age attained on the effective date of the increase.

(ii) The amount of the additional benefit may not be less than the difference between the existing policy benefit and the benefit compounded annually at a rate of at least 5% for the period beginning with the purchase of the existing benefit and extending until the year the offer is made.

(2) If a policy is issued to a group, except a continuing care retirement community center, the offer under Subsection (1) shall be made to the group policyholder and to each proposed certificate holder.

(3)(a) An insurer shall include the following information in or with the outline of coverage:

(i) a graphic comparison of the benefit levels over at least a 20-year period of a policy that increases benefits over the policy period with a policy that does not increase benefits; and

(ii) any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

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

(4) Inflation protection benefit increases under a policy that contains this benefit shall continue without regard to an insured's age, claim status, claim history, or the length of time the individual has been insured under the policy.

(5)(a) An inflation protection offer that provides for automatic benefit increases shall include an offer of a premium that the insurer expects to remain constant.

(b) The offer shall disclose, in a conspicuous manner, that the premium may change in the future unless the premium is guaranteed to remain constant.

(6)(a) Inflation protection under Subsection (1)(a)(i) shall be included unless an insurer obtains a rejection of inflation protection signed by the policyholder or certificate holder, either in the application or on a separate form.

(b) The rejection is considered a part of the application and shall state, "I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans (indicate), and I reject inflation protection."

R590-148-14. Nonforfeiture and Contingent Benefit Requirements.

(1) To comply with the requirement to offer a nonforfeiture benefit under Section 31A-22-1412:

(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;

(b) the nonforfeiture benefit included in the offer shall be the benefit described in Subsection (4); and

(c) 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.

(2) If the offer required under Section 31A-22-1412 is rejected, the insurer shall provide the contingent benefit upon lapse as described in this section.

(3)(a) After rejection of the offer required under Section 31A-22-1412, for individual and group policies without

nonforfeiture benefits issued after July 1, 2002, the insurer shall provide a contingent benefit upon lapse.

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

(c)(i) A contingent benefit upon lapse shall be triggered each time an insurer:

(A) increases the premium rates to a level that results in a cumulative increase of the annual premium, based on the insured's issue age, equal to or exceeding the percentage of the insured's initial annual premium shown in the Triggers for a Substantial Premium Increase; and

(B) the policy or certificate lapses within 120 days of the due date of the increased premium.

(ii) Unless otherwise required, each policyholder shall be notified at least 30 days before the due date of the increased premium.

(d) On or before the effective date of a substantial premium increase, the insurer shall:

(i) offer to reduce policy benefits provided by the current coverage without additional underwriting so required premium payments are not increased;

(ii) offer to convert the coverage to a paid-up status with a shortened benefit period under Subsection (4), if elected at any time during the 120-day period referenced in Subsection (3)(c)(i)(B); and

(iii) notify the insured that a default or lapse at any time during the 120-day period referenced in Subsection (3)(c)(i)(B) is an election of the offer to convert in Subsection (3)(d)(ii).

(4) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in this subsection.

(a)(i) For purposes of this subsection, the nonforfeiture benefit shall be a shortened benefit period providing paid-up long-term care insurance coverage after lapse;

(ii) the same benefits, amounts, and frequency in effect at the time of lapse, but not increased thereafter, will be payable for a qualifying claim; and

(iii) the lifetime maximum dollars or days of benefits shall be determined under Subsection (4)(b).

(b)(i) The standard nonforfeiture credit shall be equal to 100% of the sum of all premiums paid, including the premiums paid before any changes in benefits.

(ii) An insurer may offer additional shortened benefit period options, if the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration.

(iii) The minimum nonforfeiture credit may not be less than 30 times the daily nursing home benefit at the time of lapse.

(iv) The calculation of the nonforfeiture credit is subject to Subsection (5).

(c)(i)(A) The nonforfeiture benefit shall begin no later than the end of the third year following the policy or certificate issue date.

(B) The contingent benefit upon lapse shall be effective during the first three years and thereafter.

(ii) Notwithstanding Subsection (4)(c)(i), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

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

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

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

(5) All benefits paid by the insurer while the policy or certificate is in premium paying status, and in the paid-up status, may not exceed the maximum benefits that would be payable if the policy or certificate had remained in premium paying status.

(6) There is no difference in the minimum nonforfeiture benefits under this section for a group or individual policy.

(7)(a) Except as provided in Subsection (7)(b), the requirements set forth in this section are effective January 1, 2003, and apply to a policy issued in this state on or after July 1, 2002.

(b) This section does not apply to a certificate issued on or after July 1, 2002, under a group policy that was in force on January 1, 2002.

(8) A premium charged for a policy or certificate containing a nonforfeiture benefit or a contingent benefit upon lapse is subject to the loss ratio requirements of Section R590-148-22 treating the policy as a whole.

(9) To determine whether a contingent nonforfeiture upon lapse provision is triggered under Subsection (3)(c), a replacing insurer that purchased or otherwise assumed a block of 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.

(10) A nonforfeiture benefit for a qualified long-term care insurance contract offering a level premium shall:

(a) be appropriately captioned;

(b) provide a benefit available in the event of a default in the payment of a premium and state that the amount of the benefit may be adjusted after being initially granted as necessary to reflect a change in claims, persistency, and interest as reflected in a change in rates for a premium paying contract approved by the commissioner for the same contract form; and

(c) provide at least one of the following:

(i) reduced paid-up insurance;

(ii) extended term insurance;

(iii) shortened benefit period; or

(iv) a similar offering approved by the commissioner.

R590-148-15. Standard Format Outline of Coverage.

- (1) An insurer shall use an outline of coverage that conforms with the Long-Term Care Insurance Outline of Coverage.
- (2) The outline of coverage shall be in at least ten-point font.
- (3) The outline of coverage may not contain advertising material.
- (4) Capitalized or underscored text in the standard format outline of coverage may be emphasized by other means that provide equal prominence to capitalization or underscoring.
- (5) The text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically stated.

R590-148-16. Requirement to Deliver Shopper's Guide.

- (1)(a) A long-term care insurance shopper's guide, in the format developed by the NAIC, shall be provided to a prospective applicant.
- (b) A producer shall deliver the shopper's guide before the presentation of an application or enrollment form.
- (c) For a direct response solicitation, the shopper's guide must be presented in conjunction with an application or enrollment form.
- (2) A life insurance policy or rider that provides incidental long-term care benefits:
 - (a) is not required to furnish the shopper's guide; and
 - (b) shall furnish the policy summary required under Subsection 31A-22-1409(8).

R590-148-17. Suitability.

- (1) An insurer 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 producers in its suitability standards; and
 - (c) maintain a copy of its suitability standards.
- (2)(a) To determine whether an applicant meets the insurer's standards, the producer and insurer shall develop a procedure that considers:
 - (i) the applicant's ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
 - (ii) the applicant's goals or needs regarding long-term care and the advantages and disadvantages of insurance to meet those goals or needs; and
 - (iii) 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)(i) The insurer and producer shall:
 - (A) make a reasonable effort to obtain the information in Subsection (2)(a); and
 - (B) present to the applicant, at or before application, the Long-Term Care Insurance Personal Worksheet, in at least 12-point font.
- (ii) The insurer may request that the applicant provide additional information to comply with the insurer's suitability standards.
- (c)(i) A completed Long-Term Care Insurance Personal Worksheet shall be returned to the insurer before the insurer considers the applicant for coverage.
- (ii) The Long-Term Care Insurance Personal Worksheet is not required for a sale to an employee and their spouse under an employer group policy.
- (d) The sale or dissemination, outside the company or agency by the insurer or producer, of information obtained through the Long-Term Care Insurance Personal Worksheet is prohibited.
- (3) An insurer shall use its suitability standards to determine whether issuing long-term care insurance coverage to an applicant is appropriate.
- (4) A producer shall use the insurer's suitability standards.
- (5) When the Long-Term Care Insurance Personal Worksheet is provided to the applicant, the Things You Should Know Before You Buy Long-Term Care Insurance disclosure shall be provided in at least 12-point font.
- (6)(a) If an insurer determines that the applicant does not meet its suitability standards, or if the applicant declines to provide the requested information, the insurer may reject the application.
 - (b)(i) The insurer shall send the applicant a letter similar to the Long-Term Care Insurance Suitability Letter.
 - (ii) If the applicant declines to provide financial information, the insurer may use another method to verify the applicant's intent.
 - (c) Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.
- (7) If replacing a policy or certificate, the replacing insurer shall waive all time periods applicable to a preexisting condition and probationary period in the new policy or certificate for a similar benefit, to the extent the exclusions were satisfied under the original policy.

R590-148-18. Marketing Standards.

- (1) An insurer shall:

- (a) establish marketing procedures to assure that a comparison of policies by its producers is fair and accurate;
- (b) establish marketing procedures to assure excessive insurance is not sold or issued;
- (c) display prominently, on the first page of the outline of coverage and the policy, "Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.";
- (d) provide to the applicant a copy of the Long-Term Care Insurance Personal Worksheet and the Worksheet Potential Rate Increase Disclosure Form;
- (e)(i) identify whether a prospective applicant for long-term care insurance has accident and health or long-term care insurance, including the insurance types and amounts;
- (ii) in the case of a qualified long-term care insurance contract, an inquiry into whether a prospective applicant has accident and health insurance is not required;
- (f) establish an audit procedure to verify compliance with this Subsection (1);
- (g) provide written notice to the prospective insured that a senior insurance counseling program is available, with the name, address, and telephone number of the program;
- (h) use the terms "noncancellable" or "level premium" only when the policy or certificate complies with Subsections R590-148-6(1)(c) and R590-148-6(1)(d); and
- (i) provide an explanation of contingent benefits upon lapse under Subsection R590-148-14(3)(c).
- (2) In addition to the practices prohibited in Title 31A, Chapter 23a, Part 4, Marketing Practices, the following acts and practices are prohibited:
 - (a) cold lead advertising;
 - (b) high pressure tactics;
 - (c) misrepresentation; and
 - (d) twisting.

R590-148-19. Required Disclosure of Rating Practices to Consumer.

- (1)(a) Except as provided in Subsection (1)(b), this section applies to a policy or certificate issued on or after January 1, 2003.
- (b) For a certificate issued on or after July 1, 2002, under a group policy that was in force on July 1, 2002, this section shall apply on the first policy anniversary after January 1, 2003.
- (2)(a) Except for a policy for which no applicable premium rate or rate schedule increase can be made, an insurer shall provide the information in Subsection (3) to the applicant at the time of application or enrollment.
- (b) If the method of application or enrollment does not allow for delivery at the time of application or enrollment, an insurer shall provide the information in this Subsection (3) to the applicant or enrollee no later than at delivery of the policy or certificate.
- (3)(a) The information to be disclosed under Subsection (2) includes:
 - (i) a statement that the policy may be subject to rate increases in the future;
 - (ii) an explanation of potential future premium rate revisions that includes the insured's options in the event of a premium rate revision;
 - (iii) the premium rate or rate schedule in effect until a request is made for an increase;
 - (iv) a general explanation for applying a premium rate or rate schedule adjustment that includes:
 - (A) a description of when a premium rate or rate schedule adjustment will be effective, such as the next policy anniversary date or the next billing date; and
 - (B) the right to a revised premium rate or rate schedule under Subsection (3)(b), if the premium rate or rate schedule is changed;
 - (v) information regarding each premium rate increase on the policy form or a similar policy form during the past ten years for this state or any other state that, at a minimum, identifies:
 - (A) each policy form for which a premium rate has been increased;
 - (B) each calendar year the policy form was available for purchase; and
 - (C) the amount, percent, and date of implementation for each increase, expressed as a percentage of the premium rate before the increase, or as a minimum and a maximum percentage, if the rate increase is variable by rating characteristics; and
 - (vi) additional explanatory information related to the rate increases, as necessary.
- (b)(i) An insurer may exclude from the disclosure a premium rate increase that only applies to a block of business acquired from a nonaffiliated insurer or the policies acquired from a nonaffiliated insurer when the increase occurred before the acquisition.
- (ii) If an acquiring insurer files a rate increase on a policy form or a block of policy forms acquired from a nonaffiliated insurer on or before the effective date of this section, or the end of a 24-month period following the acquisition, the acquiring insurer may exclude that rate increase from the disclosure, however, the selling company shall include the disclosure of the rate increase under this subsection.
- (iii) If the acquiring insurer files for a subsequent rate increase on the same policy form or block of policy forms acquired from a nonaffiliated insurer, the acquiring insurer shall make each disclosure required by this subsection, including disclosure of an earlier rate increase.
- (4)(a) An applicant shall sign an acknowledgment at the time of application that the insurer made the disclosure required under this subsection, unless the method of application does not allow for signature at that time.
- (b) If, due to the method of application, the applicant cannot sign an acknowledgment at the time of application, the

applicant shall sign the acknowledgment no later than at delivery of the policy or certificate.

(5) An insurer shall use the Long-Term Care Insurance Personal Worksheet and Worksheet Potential Rate Increase Disclosure Form to comply with this section.

(6) An insurer shall provide notice of an upcoming premium rate schedule increase to each insured, if applicable, at least 45 days before the implementation of a premium rate schedule increase.

R590-148-20. Filing Requirements for Advertising.

(1) Upon request, an insurer shall file with the commissioner a copy of any long-term care insurance advertisement intended for use in this state.

(2) An insurer shall retain an advertisement for at least three years from the date the advertisement was first used.

R590-148-21. Initial Filing Requirements for Long-Term Care Policies Issued After January 1, 2003.

(1) An insurer shall file the following information before making a policy form available for sale:

(a) a copy of the disclosure documents required under Section R590-148-19; and

(b) an actuarial certification that includes:

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

(ii) a statement that the policy design and coverage provided have been reviewed and considered;

(iii) a statement that the underwriting and claim adjudication processes have been reviewed and considered;

(iv) a complete description of the basis for contract reserves anticipated to be held under the form, including:

(A) sufficient detail or sample calculations to ensure a complete depiction of the reserve amounts to be held;

(B) a statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(C) a statement that the net valuation premium for renewal years does not increase, except for attained age rating when permitted; and

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

(I) an aggregate distribution of anticipated issues may be used if the underlying gross premiums maintain a reasonably consistent relationship; and

(II) if the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under Subsection (2) based on a standard age distribution; and

(v)(A) 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

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

(2)(a) The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums.

(b) The actuarial demonstration shall include:

(i) premium and claim experience on similar policy forms, adjusted for any premium or benefit differences;

(ii) relevant and credible data from other studies; or

(iii) both.

(3) The premium charged to an insured may not increase due to:

(a) the increasing age of the insured at an age beyond 65; or

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

R590-148-22. Loss Ratio.

(1) This section applies to all individual long-term care insurance policies except those covered in Sections R590-148-21 and R590-148-24.

(2) Benefits under an individual policy are considered reasonable in relation to the premium if the expected loss ratio is at least 60%, calculated in a manner that provides for adequate reserving of the long-term care insurance risk.

(3) In evaluating the expected loss ratio, consideration shall be given to each relevant factor, including:

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

(b) the period that rates are computed to provide coverage;

(c) experienced and projected trends;

(d) concentration of experience within early policy duration;

(e) expected claim fluctuation;

(f) experience refunds, adjustments, or dividends;

(g) renewability features;

(h) all appropriate expense factors;

(i) interest;

(j) experimental nature of the coverage;

(k) policy reserves;

- (l) mix of business by risk classification; and
- (m) product features such as long elimination periods, high deductibles, and high maximum limits.
- (4) The premium charged to an insured may not increase due to:
 - (a) the increasing age of the insured at an age beyond 65; or
 - (b) the duration the insured has been covered under the policy.
- (5) Rate filing documents shall contain the information required in Section R590-85-4.

R590-148-23. Reserve Standards.

- (1)(a) When long-term care benefits are provided through the acceleration of benefits under a life insurance policy or rider, policy reserves for the benefits shall be determined in accordance with Subsection 31A-17-504(7).
- (b) Claim reserves shall be established when the policy or rider is in claim status.
- (c)(i) Reserves for a policy or rider subject to this subsection shall be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates.
 - (ii) Single decrement approximations are acceptable if the calculation produces similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial.
 - (iii) The calculations may consider the reduction in life insurance benefits due to the payment of long-term care benefits, however in no event may the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.
- (d) In the development and calculation of reserves for policies and riders subject to this subsection, due consideration shall be given to the applicable policy provisions, marketing methods, administrative procedures, and all other considerations that have an impact on projected claim costs, including:
 - (i) definition of insured events;
 - (ii) covered long-term care events;
 - (iii) existence of home convalescence care coverage;
 - (iv) definition of facilities;
 - (v) existence or absence of barriers to eligibility;
 - (vi) premium waiver provision;
 - (vii) renewability;
 - (viii) ability to raise premiums;
 - (ix) marketing method;
 - (x) underwriting procedures;
 - (xi) claims adjustment procedures;
 - (xii) waiting period;
 - (xiii) maximum benefit;
 - (xiv) availability of eligible facilities;
 - (xv) margins in claim costs;
 - (xvi) optional nature of benefit;
 - (xvii) delay in eligibility for benefit;
 - (xviii) inflation protection provisions; and
 - (xix) guaranteed insurability option.
- (e) Any applicable valuation morbidity table shall be certified, as appropriate, as a statutory valuation table by a member of the American Academy of Actuaries.
- (2) When long-term care benefits are provided other than as in Subsection (1), reserves shall be determined according to the Minimum Reserve Standards for Individual and Group Health Insurance Contracts, Appendix A-010, Accounting Practices and Procedures Manual, edition March 2001, published by the NAIC.

R590-148-24. Premium Rate Schedule Increases.

- (1)(a) This section applies to a policy or certificate issued in this state on or after January 1, 2003; and
- (b) for a certificate issued on or after July 1, 2002, under a group policy that was in force on July 1, 2002, this section shall apply on the first policy anniversary after January 1, 2003.
- (2) An insurer shall file notice of a pending premium rate schedule increase, including an exceptional increase, with the commissioner before sending the notice to a policyholder. The notice shall include:
 - (a) information required under Section R590-148-19;
 - (b) certification by a qualified actuary that:
 - (i) if the requested premium rate schedule increase is implemented and the underlying assumptions that reflect moderately adverse conditions are realized, no further premium rate schedule increases are anticipated; and
 - (ii) the premium rate filing complies with this section;
 - (c) an actuarial memorandum justifying the rate schedule change request that includes:
 - (i)(A) lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase and the method and assumptions used to determine the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;
 - (B) the projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(C) the projections shall demonstrate compliance with Subsection (3); and

(D) for an exceptional increase:

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

(II) in the event the commissioner determines that offsets may exist, the insurer shall use appropriate net projected experience;

(ii) disclosure of how reserves are incorporated in this rate increase when the rate increase triggers contingent benefit upon lapse;

(iii) disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions are not realized and why, and what other actions taken by the insurer were relied on by the actuary;

(iv) a statement that policy design, underwriting, and claim adjudication practices were considered; and

(v) if it is necessary to maintain a consistent premium rate for a new certificate and a certificate receiving a rate increase, the insurer shall 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 of the premium rate schedule increase.

(3) A premium rate schedule increase shall be determined using the following requirements:

(a) an exceptional increase shall provide that at least 70% of the present value of projected additional premium from the exceptional increase will be returned to a policyholder in benefits;

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

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

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

(iii) the present value of future projected initial earned premium times 58%; and

(iv) 85% of the present value of future projected premium not included in Subsection (3)(b)(iii) on an earned basis;

(c) if a policy form has both exceptional and other increases, the values in Subsections (3)(b)(ii) and (3)(b)(iv) shall also include 70% for exceptional rate increase amounts; and

(d) all present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves that is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the health insurance policy.

(4) The actuary shall disclose, as part of the actuarial memorandum, the use of any appropriate averages.

(5)(a) An insurer may request a premium rate schedule increase that is lower than the rate increase necessary to provide the certification required in Subsection (2)(b)(i) and the commissioner may accept such premium rate schedule increase, without submission of the certification required in Subsection (2)(b)(i), if:

(i) in the opinion of the commissioner, accepting a lower premium rate schedule increase is in the best interest of Utah insureds;

(ii) the actuarial memorandum discloses the rate increase necessary to provide the certification required in Subsection (2)(b)(i); and

(iii) the rate increase filing satisfies each requirement of this section.

(b) The commissioner may condition the acceptance of the premium rate schedule increase under Subsection (4)(a) upon:

(i) the disclosure, to the affected policyholder, of the premium rate schedule increase necessary to provide the certification required in Subsection (2)(b)(i); and

(ii) the extension of a contingent nonforfeiture benefit upon lapse to policyholders who would have been eligible for contingent nonforfeiture benefit upon lapse based on the premium rate schedule increase necessary to provide certification required in Subsection (2)(b)(i).

(6)(a) For each rate increase that is implemented, an insurer shall annually file a report with the commissioner for the next three years updated projections, as provided in Subsection (2)(c)(i), and include a comparison of actual results to projected values.

(b) The commissioner may extend the period to more than three years if actual results are not consistent with projected values from prior projections.

(c) For a group insurance policy that meets the conditions in Subsection (13), the projections required by this Subsection (6) shall be provided to the policyholder in lieu of filing with the commissioner.

(7)(a) 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, under Subsection (2)(c)(i), shall be filed every five years following the end of the required period in Subsection (6).

(b) For a group insurance policy that meets the conditions in Subsection (13), the projections required by Subsection (6) shall be provided to the policyholder in lieu of filing with the commissioner.

(8)(a) If the commissioner determines 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:

(i) premium rate schedule adjustments; or

(ii) other measures to reduce the difference between the projected and actual experience.

(b) To determine whether the actual experience adequately matches the projected experience, Subsection (2)(c)(v) shall be considered, if applicable.

(9) If the majority of the policies or certificates to which the increase applies are eligible for the contingent benefit upon lapse, the insurer shall file:

(a) a plan, subject to commissioner approval, for improved administration or claim processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect, otherwise the commissioner may impose the conditions in Subsection (10); and

(b) the original anticipated lifetime loss ratio and the premium rate schedule increase calculated according to Subsection (3) had the greater of the original anticipated lifetime loss ratio or 58% been used in the calculations under Subsections (3)(a)(i) and (3)(a)(iii).

(10)(a) The commissioner shall review, for each policy 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, for a rate increase filing that:

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

(ii) the rate increase is not an exceptional increase; and

(iii) the majority of the policies or certificates to which the increase applies 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.

(i) Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to each in force insured 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. The offer shall:

(A) be subject to the approval of the commissioner;

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

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

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

(A) the maximum rate increase determined based on the combined experience; or

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

(11) If the commissioner determines that an insurer exhibits a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to Subsection (10), prohibit the insurer from:

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

(b) offering any other similar coverages and limit marketing of new applications to the products subject to recent premium rate schedule increases.

(12) Subsections (1) through (11) do not apply to a policy when the long-term care benefits provided by the policy are incidental, if the policy complies with 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:

(i) Section 31A-22-408; or

(ii) Section 31A-22-409;

(c) the policy meets the disclosure requirements of Subsections 31A-22-1409(7) and 31A-22-1409(8) and Section 31A-22-1410;

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

(i) policy illustrations under Rule R590-177; and

(ii) disclosure requirements under Rule R590-133; and

(e) an actuarial memorandum is filed with the commissioner that includes:

(i) a description of the basis on how the long-term care rates were determined;

(ii) a description of the basis for the reserves;

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

(iv) a description and a table of each actuarial assumption used, and for expenses, an insurer shall include percent of premium dollars per policy and dollars per unit of benefits, if any;

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

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

(vii)(A) a statement as to whether underwriting is performed at the time of application;

(B) the statement shall indicate whether underwriting is used and, if used, shall include a description of the type or types of

underwriting used, such as medical underwriting or functional assessment underwriting; and

(C) for a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting will occur; and

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

(13) Subsections (8) and (10) do not apply to a group policy when:

(a) the policy insures 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 holders, pays a material portion of the premium that is not less than 20% of the total premium for the group in the calendar year before the year a rate increase is filed.

(14)(a) An exceptional increase is subject to the same requirements as other premium rate schedule increases.

(b) The commissioner may request that an independent actuary, or a professional actuarial body, review the basis for an insurer's request for an exceptional increase.

(c) The commissioner, in determining that the necessary basis for an exceptional increase exists, shall determine any potential offsets to higher claims costs.

R590-148-25. Reporting Requirements.

(1)(a) An insurer shall maintain records for each producer detailing the:

(i) producer's number of replacement sales as a percent of the agent's total annual sales; and

(ii) amount of lapses of long-term care insurance policies sold by the producer as a percent of the producer's total annual sales.

(b) An insurer shall report the 10% of its producers with the greatest percentage of lapses and replacements under Subsection (1)(a).

(c) An insurer shall report the number of:

(i) 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; and

(ii) 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 end of the preceding calendar year.

(d) The reports required by this subsection shall be reported on the Replacement and Lapse Reporting Form.

(e) Reported replacement and lapse rates do not, by themselves, constitute a violation of Utah laws nor do they necessarily imply wrongdoing. The reports are for reviewing producer activities regarding the sale of long-term care insurance.

(2)(a) An insurer shall report, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied.

(b) The report shall include, at a minimum, the information contained in the Claims Denial Reporting Form Long-Term Care Insurance.

(3) An insurer shall maintain a record of each policy or certificate rescission, both state and nationwide, except those the insured voluntarily effectuated, and shall annually report this information on the Rescission Reporting Form.

(4)(a) An insurer shall report the total number of applications received from Utah residents, 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.

(b) The report shall be submitted on the Suitability Reporting Form.

(5) For purposes of this section:

(a) "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;

(b) "denied" means that an insurer refused to pay a claim for any reason other than for claims not paid for failure to meet a waiting period or due to a preexisting condition; and

(c) "report" means a report filed on a statewide basis.

(6) A report required under this section shall be filed with the commissioner annually on or before June 30 and in compliance with Rule R590-220.

R590-148-26. Licensing.

A producer is not authorized to sell, solicit, or negotiate long-term care insurance except as authorized by Title 31A, Chapter 23a, Insurance Marketing - Licensing Agents, Brokers, Consultants and Reinsurance Intermediaries.

R590-148-27. Discretionary Powers of the Commissioner.

The commissioner may, upon written request and after a hearing, issue an order modifying or suspending a provision of this rule upon a finding that:

(1) the modification or suspension is in the best interest of the insured;

(2) the purpose of the provision cannot 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, reasonable approach for insuring long-term care;

(b) the policy or certificate will 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 the community; or

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

R590-148-28. Severability.

If any provision of this rule, Rule R590-148, or its application to any person or situation is held invalid, such invalidity does not affect any other provision or application of this rule that can be given effect without the invalid provision or application. The remainder of this rule shall be given effect without the invalid provision or application.

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