

## **R590. Insurance, Administration.**

### **R590-285. Limited Long-Term Care Insurance.**

#### **R590-285-1. Purpose.**

The purpose of this regulation is to implement Title 31A, Chapter 22, Part 20, Limited Long-Term Care Insurance Act, to promote the public interest, to promote the availability of limited long-term care insurance coverage, to protect applicants for limited long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of limited long-term care insurance coverages, and to facilitate flexibility and innovation in the development of limited long-term care insurance.

#### **R590-285-2. Authority.**

This regulation is issued pursuant to the authority vested in the commissioner under Subsection 31A-2-201(3)(a) and Section 31A-22-2006.

#### **R590-285-3. Applicability and Scope.**

Except as otherwise specifically provided, this regulation applies to all limited long-term care insurance policies delivered or issued for delivery in this state on or after July 1, 2021.

#### **R590-285-4. Definitions.**

In addition to the definitions in Sections 31A-1-301 and 31A-22-2002, the following definitions shall apply for the purpose of this rule.

- (1) "Activities of daily living" means at least bathing, continence, dressing, eating, toileting, and transferring.
- (2) "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 his or her health status.
- (3) "Adult day care" means a facility duly licensed and operating within the scope of such license. 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 for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.
- (4) "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.
- (5) "Benefit trigger" for the purposes of independent review, means a contractual provision in the insured's policy of limited long-term care insurance conditioning the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment.
- (6) "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.
- (7) "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.
- (8) "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- (9) "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.
- (10) "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.
- (11) "Home 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.
- (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) "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.
- (14) "Mental or nervous disorder" may not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.
- (15) "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.
- (16) "Qualified actuary" means a member in good standing of the American Academy of Actuaries.
- (17)(a) "Similar policy forms" means all of the limited long-term care insurance policies and certificates issued by an insurer in the same limited long-term care benefit classification as the policy form being considered.
  - (b) Certificates of groups that meet the definition in Subsection 31A-22-2002(3) are not considered similar to certificates or policies otherwise issued as limited long-term care insurance, but are similar to other comparable certificates with the same limited long-term care benefit classifications.
  - (c) For purposes of determining similar policy forms, limited long-term care benefit classifications are defined as:
    - (i) institutional limited long-term care benefits only;
    - (ii) non-institutional limited long-term care benefits only; or
    - (iii) comprehensive limited long-term care benefits.
- (18) "Skilled nursing care," "personal care," "home care," "specialized care," "assisted living 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.
- (19) "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- (20) "Transferring" means moving into or out of a bed, chair, or wheelchair.
- (21) "Skilled nursing facility," "extended care facility," "convalescent nursing home," "personal care facility," "specialized care providers," "assisted living facility," "home care agency," and all other providers 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. When the definition requires that the provider 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 in which the service is to be furnished does not require a provider of these services to be licensed, certified, or registered, or when the state licenses, certifies, or registers the provider of services under another name.

#### **R590-285-5. Policy Practices and Provisions.**

(1) Renewability. The terms "guaranteed renewable" and "noncancellable" may not be used in any individual limited long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section R590-285-7.

(a) A policy issued to an individual may not contain renewal provisions other than "guaranteed renewable" or "noncancellable."

(b) The term "guaranteed renewable" may be used only when the insured has the right to continue the limited 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.

(c) The term "noncancellable" may be used only when the insured has the right to continue the limited 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.

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

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

(i) alcoholism and drug addiction;

(ii) 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, when the insured is a voluntary participant;

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

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

(E) aviation, only to a non-fare-paying passenger;

(iii) mental or nervous disorders; however, this may not permit exclusion or limitation of benefits on the basis of cognitive impairment;

(iv) preexisting conditions or diseases; and

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

(b)(i) This Subsection R590-285-5(2), is not intended to prohibit exclusions and limitations by type of provider. However, no limited long-term care issuer may deny a claim because services are provided in a state other than the state of policy issued under the following conditions:

(A) when the state other than the state of policy issue does not have the provider licensing, certification, or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification, or registration; or

(B) when the state other than the state of policy issue licenses, certifies, or registers the provider under another name.

(ii) For purposes of this subsection, "state of policy issue" means the state in which the individual policy or certificate was originally issued.

(iii) This subsection is not intended to prohibit territorial limitations outside of the United States.

(3) Extension of Benefits.

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

(b) The extension of benefits beyond the period the limited 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.

(4) Continuation or Conversion.

(a) Group limited long-term care insurance issued in this state shall provide covered individuals with a basis for continuation or conversion of coverage.

(b) For the purposes of this Subsection R590-285-5(4):

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

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

(iii) "converted policy" means an individual policy of limited 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 or facilities, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.

(c) 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.

(d) 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.

(e) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

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

or

(ii) the terminating coverage is replaced not later than 31 days after termination, by group coverage effective on the day following the termination of coverage:

(A) 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

(B) the premium for which is calculated in a manner consistent with the requirements of Subsection R590-285-5(4)(d).

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

(g) 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.

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

(5) Discontinuance and Replacement. If a group limited long-term care policy is replaced by another group limited 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 an 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 limited long-term care services.

(6) Premium Changes.

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

(i) the increasing age of the insured at age 66 or older; or

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

(b) The purchase of additional coverage may not be considered a premium rate increase, but for purposes of the calculation required under Section R590-285-22, the portion of the premium attributable to the additional coverage shall be added to, and considered part of, the initial annual premium.

(c) A reduction in benefits may not be considered a premium change, but for purposes of the calculation required under Section R590-285-22, the initial annual premium shall be based on the reduced benefits.

(7) Electronic Enrollment for Group Policies.

(a) In the case of a group defined in Subsection 31A-22-2002(3), 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 that the confidentiality of individually identifiable information and privileged information 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.

#### **R590-285-6. Unintentional Lapse.**

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

(1)(a) Notice before lapse or termination.

(i) No individual limited 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.

(ii) The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured.

(iii) Designation may not constitute acceptance of any liability on the third party for services provided to the insured.

(iv) The form used for the written designation must provide space clearly designated for listing at least one person.

(v) The designation shall include each person's full name and home address.

(vi) 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 limited 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."

(vii) The insurer shall notify the insured of the right to change this written designation, no less often than once every two (2) years.

(b) When the policyholder or certificateholder pays premium for a limited long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in Subsection R590-285-6(1) need not be met until 60 days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

(c) Lapse or termination for nonpayment of premium.

(i) No individual limited 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 R590-285-6(1), at the address provided by the insured for purposes of receiving notice of lapse or termination.

(ii) 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.

(iii) Notice shall be deemed to have been given as of five days after the date of mailing.

(2) Reinstatement.

(a) In addition to the requirement in Subsection R590-285-6(1), a limited 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.

(b) 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.

(c) 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 and certificate.

#### **R590-285-7. Required Disclosure Provisions.**

(1) Renewability. Individual limited long-term care insurance policies shall contain a renewability provision.

(a) The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or noncancellable.

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

(2) Riders and Endorsements.

(a) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual limited long-term care insurance policy, all riders or endorsements added to an individual limited long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured.

(b) After the date of policy issue, any rider or endorsement that 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.

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

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

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

(5) Other Limitations or Conditions on Eligibility for Benefits. A limited long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in Subsection 31A-22-2004(3)(b) shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

(6) Benefit Triggers.

(a) Activities of daily living and cognitive impairment shall be used to measure an insured's need for limited long-term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this section.

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

(c) 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.

#### **R590-285-8. Required Disclosure of Rating Practices to Consumers.**

(1) This section shall apply as follows:

(a) Except as provided in Subsection R590-285-8(2), this section applies to any limited long-term care policy or certificate issued in this state on or after July 1, 2021.

(b) For certificates issued on or after the effective date of this regulation under a group limited long-term care insurance policy as defined in Subsection 31A-22-2002(3), which policy was in force at the time this regulation became effective, the provisions of this section shall apply on the policy anniversary following January 1, 2022.

(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 options 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 R590-285-8(2)(c) 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 10 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 or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(ii) The insurer may 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 limited 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 limited long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers, on or before the later of the effective date of 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 R590-285-8(2)(e)(i).

(v) If the acquiring insurer in Subsection R590-285-8(2)(e)(iv) files for a subsequent rate increase, even within the twenty-four-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in Subsection R590-285-8(2)(e)(iv), the acquiring insurer shall make all disclosures required by R590-285-8(2)(e), including disclosure of the earlier rate increase referenced in Subsection R590-285-8(2)(e)(iv).

(3) An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under Subsection R590-285-8(2)(a) and (e). If, due to the method of application, the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

(4) An insurer shall use the form in Appendix A to comply with the requirements of Subsections R590-285-8(2) and (3).

(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 R590-285-8(2) when the rate increase is implemented.

#### **R590-285-9. Initial Filing Requirements.**

(1) This section applies to any limited long-term care policy issued in this state on or after July 1, 2021.

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

(a) a copy of the disclosure documents required in Section R590-285-8;

(b) a complete rate schedule; and

(c) an actuarial memorandum that shall include:

(i) a statement regarding actuary's qualifications;

(ii) an explanation of the review performed by the actuary;

(iii) complete description of all pricing assumptions, including sources and credibility of data;

(iv) development of the anticipated lifetime loss ratio supported by an exhibit showing lifetime projection of earned premiums and incurred claims based upon the pricing assumptions;

(v) a statement that the premium rate schedule is expected to result in a lifetime loss ratio not less than 55%;

(vi) a statement that the policy design and coverage provided have been reviewed and taken into consideration;

(vii) a statement that the underwriting and claim adjudication processes have been reviewed and taken into consideration;

(viii) a sensitivity analysis of the anticipated lifetime loss ratio to the changes in the individual assumptions, including sensitivity to the mix of business;

(ix) a statement that the reserve requirements have been reviewed and taken in consideration;

(x) a description of the valuation assumptions with sufficient detail or sample calculation as to have a complete depiction of the reserve amounts to be held;

(xi) 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 statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship; and

(xii) an actuarial certification dated and signed by the qualified actuary that all information presented in the actuarial memorandum is accurate and complete.

(3) Retention Requirements.

(a) An insurer offering a limited long-term care policy shall retain sufficient documentation from the initial pricing that a qualified actuary could recreate the initial rates at a later date.

(i) The documentation shall be sufficient to provide actual to expected analyses of:

(A) claims;

(B) incidence rates;

(C) persistency;

(D) mix of business; and

(E) loss ratios at the same level of detail used in the initial pricing.

(ii) If an insurer retains a consultant to price a limited long-term care product, the insurer shall require that the documentation be provided to the insurer, rather than being retained solely by the consultant.

(iii) If an insurer sells or cedes complete risk responsibility for a limited long-term care product, the insurer or cedant shall provide to the buyer or reinsurer the initial pricing documentation.

(b) An insurer that requests a future premium rate schedule increase but has not retained the initial pricing documentation shall be limited to a lifetime loss ratio not less than 80%.

(c) The insurer shall retain the initial pricing documentation at least until one year after the final policyholder is no longer eligible for benefits under the policy.

#### **R590-285-10. Prohibition Against Post-Claims Underwriting.**

(1) All applications for limited long-term care insurance policies or certificates 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 for limited long-term care insurance contains a question that 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) Except for policies or certificates that 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 limited long-term care insurance policy or certificate: "Caution: If your answers on this application are incorrect or untrue, (insert name of insurer) 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 limited long-term care insurance policy or certificate at the time of delivery: "Caution: The issuance of this limited long-term care insurance (insert either policy or certificate) is based upon your responses to the questions on your application. A copy of your (insert either application or enrollment form) (insert either is enclosed or was retained by you when you applied). If your answers are incorrect or untrue, the insurer 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)."

(c) 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.

#### **R590-285-11. Minimum Standards for Home and Community Care Benefits in Limited Long-Term Care Insurance Policies.**

(1) A limited long-term care insurance policy or certificate may not, if it provides benefits for home care or community care services, limit or exclude benefits:

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

(b) by requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community, or institutional setting before home 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 his or her 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 care services be at a level of certification or licensure greater than that required by the eligible service;

(g) by requiring that the insured or claimant have an acute condition before home 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) A limited long-term care insurance policy or certificate, if it provides for home or community care services, shall provide total home or community care coverage that is a dollar amount equivalent to at least one-half of the coverage available for nursing home benefits under the policy or certificate, at the time covered home or community care services are being received. This requirement may not apply to policies or certificates issued to residents of continuing care retirement communities.

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

#### **R590-285-12. Requirement to Offer Inflation Protection.**

(1) No insurer may offer a limited 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 that are meaningful to account for reasonably anticipated increases in the costs of limited 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 that the increases are compounded annually at a rate not less than 3%;

(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 amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 3% 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, the required offer in Subsection R590-285-12(1) shall be made to the group policyholder and to each proposed certificateholder.

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

(i) 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

(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 these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

(5) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium that 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 R590-285-12(1)(a) shall be included in a limited 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 \_\_\_\_\_, and I reject inflation protection."

#### **R590-285-13. Requirements for Application Forms and Replacement Coverage.**

(1) 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 limited long-term care insurance policy or long-term care insurance policy, or certificate in force, or whether a limited long-term care policy, or long-term care insurance policy, or certificate is intended to replace any other accident and sickness, or limited long-term care policy, or long-term care insurance policy, or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent

containing the questions may be used, except where the coverage is sold without an agent. With regard to a replacement policy issued to a group, the following questions may be modified only to the extent necessary to elicit information about health or limited long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement.

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

(b) Did you have another limited long-term care insurance policy, or long-term care insurance policy, or certificate in force during the last twelve (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 or certificate?

(2) Agents shall list any other health insurance policies they have sold to the applicant.

(a) List policies sold that are still in force.

(b) List policies sold in the past five years that are no longer in force.

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

(a) 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. 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.

(b) 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 limited long-term care insurance policy, a notice regarding replacement of accident and sickness or limited long-term care or long-term care coverage. One copy of the 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 described in Appendix B.

#### **R590-285-14. 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 limited long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

(2) Every insurer shall report annually by June 30 the 10% of its agents with the greatest percentages of lapses and replacements as measured by Subsection R590-285-14(1).

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

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

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

(6) For purposes of this section:

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

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

(7) Reports required under this section shall be filed with the commissioner.

(8) Annual rate certification requirements.

(a) This subsection applies to any limited long-term care policy issued in this state on or after July 1, 2021.

(b) The following annual submission requirements apply subsequent to initial rate filings for individual limited long-term care insurance policies made under this section.

(c) An actuarial certification prepared, dated and signed by a qualified actuary who provides the information shall be included and shall provide at least the following information:

(i) a statement of the sufficiency of the current premium rate schedule;

(ii) for the rate schedules that are no longer marketed;

(A) that the premium rate schedule continues to be sufficient to cover anticipated costs under best estimate assumptions; or

(B) that the premium rate schedule may no longer be sufficient. In this situation, the insurer shall provide to the commissioner, within 60 days of the date the actuarial certification is submitted to the commissioner, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience; and

(iii) a description of the review performed that led to the statement.

(d) An actuarial memorandum dated and signed by a qualified actuary who prepares the information shall be prepared to support the actuarial certification and provide at least the following information:

(i) a detailed explanation of the data sources and review performed by the actuary prior to making the statement;

(ii) a complete description of experience assumptions and their relationship to the initial pricing assumptions;

(iii) a description of the credibility of the experience data; and

(iv) an explanation of the analysis and testing performed in determining the current presence of margins.

(e) The actuarial certification required pursuant to Subsection R590-285-14(8)(c) must be based on calendar year data and submitted annually no later than May 1 of each year, starting in the second year following the year in which the initial rate schedules are first used. The actuarial memorandum required pursuant to R590-285-14(8)(d) must be submitted at least once every three years with the certification.

#### **R590-285-15. Premium Rate Schedule Increases.**

(1) This section applies to any limited long-term care policy or certificate issued in this state, on or after July 1, 2021.

(2) No rate increase may be requested by an insurer until the projected lifetime loss ratio, under best estimate assumptions, exceeds the anticipated lifetime loss ratio plus 2%.

(3) An insurer shall provide notice of a pending premium rate schedule increase to the commissioner prior to the notice to the policyholders and shall include:

- (a) a revised rate schedule;
  - (b) an actuarial memorandum that shall include:
    - (i) a statement regarding the actuary's qualifications;
    - (ii) an explanation of the review performed by the actuary;
    - (iii) complete description of all pricing assumptions and any changes from the initial and any prior filing;
    - (iv) an exhibit showing policy count, actual incurred claims, and earned premiums by duration both on a state and nationwide basis, and any revised projections based on the revised pricing assumptions;
    - (v) an exhibit showing actual to expected loss ratios by duration;
    - (vi) a statement that the revised premium schedule is expected to result in a lifetime loss ratio not less than 55%;
    - (vii) a sensitivity analysis of the anticipated lifetime loss ratio to the changes in the individual assumptions, including any revised assumptions, including sensitivity to the mix of business;
    - (viii) a description of the valuation assumptions, including any revisions since the initial and any prior filing, with sufficient detail or sample calculation to have a complete depiction of the reserve amounts to be held; and
    - (ix) 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 statement cannot be made, a complete description of the situation where this does not occur; and
  - (c) an actuarial certification dated and signed by the actuary that all information presented in the actuarial memorandum is accurate and complete.
- (4) An insurer that is granted a premium rate schedule increase shall retain similar documentation related to the rate increase request as is required in Section R590-285-9(3).

#### **R590-285-16. Filing Requirements for Advertising.**

(1) Every insurer providing limited long-term care insurance or benefits in this state shall provide a copy of any limited long-term care insurance advertisement intended for use or used in this state, whether through written, radio, or television medium to the commissioner, for review or approval by the commissioner, when requested.

(2) All advertisements shall be retained for at least three years from the date the advertisement was first used.

#### **R590-285-17. Standards for Marketing.**

- (1) Every insurer or other entity marketing limited long-term care insurance coverage in this state, directly or through a producer, shall:
- (a)(i) establish marketing procedures and training requirements to assure that:
    - (ii) any marketing activities, including any comparison of policies, by its producers will be fair and accurate; and
    - (b) 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 limited 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 form required in Appendix A to the applicant;
    - (e) inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for limited long-term care or long-term care insurance already has accident and sickness or limited long-term care insurance and the types and amounts of any such insurance;
    - (f) establish auditable procedures for verifying compliance with Subsection R590-285-17(1);
    - (g) use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to Subsection R590-285-5(1)(c) or (d), as applicable; and
    - (h) provide an explanation of contingent benefit upon lapse provided for in Subsection R590-285-22(4).
- (2) In addition to the practices prohibited in Section 31A-23a-402, 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 limited long-term care insurance policy.
- (3)(a) An insurer offering a limited long-term care policy to an association, shall require the association:
- (i) when endorsing or selling limited long-term care insurance to educate its members concerning limited long-term care issues in general so that its members can make informed decisions;
  - (ii) to provide objective information regarding limited long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold; and
  - (iii) disclose in any limited long-term care insurance solicitation:
    - (A) the specific nature and amount of the compensation arrangements, including all fees, commissions, administrative fees, and other forms of financial support, that the association receives from endorsement or sale of the policy or certificate to its members; and
    - (B) a brief description of the process under which the policies and the insurer issuing the policies were selected.
- (b) If the association and the insurer have interlocking directorates or trustee arrangements, the insurer shall require the association to disclose that fact to its members.
- (c) The insurer shall require the board of directors of associations selling or endorsing limited long-term care insurance policies or certificates to review and approve the insurance policies as well as the compensation arrangements made with the insurer.
- (d) The insurer shall also:
- (i) actively monitor the marketing efforts of the association and any producer; and



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

(e) The insurer may not issue a limited long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this subsection.

(f) An insurer's failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of Section 31A-23a-402.

**R590-285-18. Suitability.**

(1) An insurer marketing limited long-term care insurance shall:

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

(b) include in its suitability standards and procedures:

(i) consideration of the advantages and disadvantages of insurance to meet the needs of the applicant; and

(ii) discussion with applicants of how the benefits and costs of limited long-term care insurance compare with long-term care insurance;

(c) train its producers in its suitability standards and procedures; and

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

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

**R590-285-19. Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates.**

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

**R590-285-20. Availability of New Services or Providers.**

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

(2) Notwithstanding Subsection R590-285-20(1), notification is not required for any policy issued prior to the effective date of this rule or to any policyholder or certificateholder who is currently eligible for benefits, within an elimination period or on a claim, or who previously had been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

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

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

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

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

(d) by an alternative program developed by the insurer that meets the intent of this section.

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

(5) Policies issued pursuant to this Section R590-285-20 shall be considered exchanges and not replacements. These exchanges may not be subject to Sections R590-285-13 and R590-285-19, and the reporting requirements of Subsections R590-285-14(1) through (5).

(6) Where the policy is offered through an employer, labor organization, professional, trade, or occupational association, the required notification in Subsection R590-285-20(1) shall be made to the offering entity. However, if the policy is issued to a group under Subsection 31A-22-701(2)(b) or (c), the notification shall be made to each certificateholder.

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

(8) This section does not apply to life insurance policies or riders containing accelerated limited long-term care benefits.

(9) This section shall become effective on policies issued on or after July 1, 2021.

**R590-285-21. Right to Reduce Coverage and Lower Premiums.**

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

(i) reducing the maximum benefit; or

(ii) reducing the daily, weekly, or monthly benefit amount.

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

(c) In the event the reduction in coverage involves the reduction or elimination of the inflation protection provision, the insurer shall allow the policyholder to continue the benefit amount in effect at the time of the reduction.

- (2) The provision shall include a description of the process for requesting and implementing a reduction in coverage.
- (3) The premium for the reduced coverage shall:
  - (a) be based on the same age and underwriting class used to determine the premium for the coverage currently in force; and
  - (b) be consistent with the approved rate table.
- (4) The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.
- (5) If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of the policyholder's or certificateholder's right to reduce coverage and premiums in the notice required by Subsection R590-285-6(1)(c) of this regulation.
- (6) The requirements of Subsections R590-285-21(1) through (5) shall apply to any limited long-term care policy issued in this state on or after January 1, 2022.
- (7)(a) A premium increase notice required by Subsection R590-285-8(5) shall include:
  - (i) an offer to reduce policy benefits provided by the current coverage consistent with the requirements of this section; and
  - (ii) a disclosure stating that all options available to the policyholder may not be of equal value.
- (b) The requirements of this Subsection R590-285-21(7) shall apply to any rate increase implemented in this state on or after January 1, 2022.

**R590-285-22. Nonforfeiture Benefit Requirement.**

- (1) To comply with the option to offer a nonforfeiture benefit pursuant to the provisions of Section 31A-22-2005:
  - (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 R590-285-22(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) Should the offer made under Section 31A-22-2005 be rejected, the insurer shall provide the contingent benefit upon lapse described in this section. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in Subsection R590-285-22(3)(d) shall still apply.
- (3)(a) After rejection of the offer made under Section 31A-22-2005, for individual and group policies without nonforfeiture benefits, the insurer shall provide a contingent benefit upon lapse.
- (b) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.
- (c) A contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding 50% of the insured's initial annual premium. Unless otherwise required, policyholders shall be notified at least 45 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 R590-285-22(3)(c), the insurer shall:
  - (i) offer to reduce policy benefits provided by the current coverage consistent with the requirements of Section R590-285-21 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 R590-285-22(4). This option may be elected at any time during the 45-day period referenced in Subsection R590-285-22(3)(c); and
  - (iii) notify the policyholder or certificateholder that a default or lapse at any time during the 45-day period referenced in Subsection R590-285-22(3)(c) shall be deemed to be the election of the offer to convert in Subsection R590-285-22(3)(d)(ii).
- (4) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with Subsection R590-285-22(3)(c), are described in this subsection.
  - (a) For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up limited 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 R590-285-22(4)(c).
  - (b) 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. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Subsection R590-285-22(5).
  - (c) The nonforfeiture benefit shall begin no 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.
  - (d) 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 that 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) To determine whether contingent nonforfeiture upon lapse provisions are triggered under Subsection R590-285-22(3)(c) or (d), a replacing insurer that purchased or otherwise assumed a block or blocks of limited 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.

**R590-285-23. Standards for Benefit Triggers.**

- (1) A limited 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 may not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.
- (2)(a) Activities of daily living shall include at least the following as defined in Subsection R590-285-4(1) and in the policy:
  - (i) bathing;
  - (ii) continence;
  - (iii) dressing;
  - (iv) eating;

- (v) toileting; and
- (vi) transferring.
- (b) Insurers may use activities of daily living to trigger covered benefits in addition to those contained in Subsection R590-285-23(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 may not restrict, and are not in lieu of, the requirements contained in Subsections R590-285-23(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, supervision or verbal cueing by another person is needed in order to protect the insured or others.
- (5) Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses, or social workers.
- (6) Limited long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

**R590-285-24. Appealing an Insurer's Determination That the Benefit Trigger is Not Met.**

- (1) For purposes of this section, "authorized representative" is authorized to act as the covered person's personal representative within the meaning of 45 CFR 164.502(g) promulgated by the Secretary under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act and means the following:
  - (a) a person to whom a covered person has given express written consent to represent the covered person in an external review;
  - (b) a person authorized by law to provide substituted consent for a covered person; or
  - (c) a family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent.
- (2) If an insurer determines that the benefit trigger of a limited long-term care insurance policy has not been met, it shall provide a clear, written notice to the insured and the insured's authorized representative, if applicable, of all of the following:
  - (a) the reason that the insurer determined that the insured's benefit trigger has not been met;
  - (b) the insured's right to internal appeal in accordance with Subsection R590-285-24(3), and the right to submit new or additional information relating to the benefit trigger denial with the appeal request; and
  - (c) the insured's right, after exhaustion of the insurer's internal appeal process, to have the benefit trigger determination reviewed under the independent review process in accordance with Section R590-285-25.
- (3) Internal Appeal.
  - (a) The insured or the insured's authorized representative may appeal the insurer's adverse benefit trigger determination by sending a written request to the insurer, along with any additional supporting information, within 180 days after the insured and the insured's authorized representative, if applicable, receives the insurer's benefit determination notice.
  - (b) The internal appeal shall be considered by an individual or group of individuals designated by the insurer, provided that the individual or individuals making the internal appeal decision may not be the same individual or individuals who made the initial benefit determination.
  - (c) The internal appeal shall be completed, and written notice of the internal appeal decision shall be sent to the insured and the insured's authorized representative, if applicable, within 30 calendar days of the insurer's receipt of all necessary information upon which a final determination can be made.
  - (d) If the insurer's original determination is upheld after the internal appeal process has been exhausted and new or additional information has not been provided to the insurer, the insurer shall provide a written description of the insured's right to request an independent review of the benefit determination as described in Section R590-285-25 to the insured and the insured's authorized representative, if applicable.
  - (e) As part of the written description of the insured's right to request an independent review, an insurer shall include the following, or substantially equivalent, language: "We have determined that the benefit eligibility criteria ("benefit trigger") of your (policy) (certificate) has not been met. You may have the right to an independent review of our decision conducted by long-term care professionals who are not associated with us. Please send a written request for independent review to us at (address). You must inform us, in writing, of your election to have this decision reviewed within 180 days of receipt of this letter. We will choose an independent review organization for you and refer the request for independent review to it."
  - (f) If the insurer does not believe the benefit trigger decision is eligible for independent review, the insurer shall inform the insured and the insured's authorized representative, if applicable, in writing and include in the notice the reasons for its determination of independent review ineligibility.
  - (g) The appeal process is not deemed to be a "new service or provider" as referenced in Section R590-285-20 and therefore does not trigger the notice requirements of that section.

**R590-285-25. Independent Review of Benefit Trigger Determination.**

- (1) Request. The insured or the insured's authorized representative may request an independent review of the insurer's benefit trigger determination after the internal appeal process outlined in Subsection R590-285-24(3) has been exhausted. A written request for independent review may be made by the insured or the insured's authorized representative to the insurer within 180 days after the insurer's written notice of the final internal appeal decision is received by the insured and the insured's authorized representative, if applicable.
- (2) Cost. The cost of the independent review shall be borne by the insurer.
- (3) Independent Review Process.
  - (a) Within five business days of receiving a written request for independent review, the insurer shall refer the request to the independent review organization. The insurer shall choose an independent review organization approved by the commissioner. The insurer shall vary its selection of authorized independent review organizations on a rotating basis.
  - (b) The insurer shall refer the request for independent review of a benefit trigger determination to an independent review organization, subject to the following:
    - (i) the independent review organization shall be on a list of approved independent review organizations that satisfy the requirements of a qualified long-term care insurance independent review organization contained in this section;

(ii) the independent review organization may not have any conflicts of interest with the insured, the insured's authorized representative, if applicable, or the insurer; and

(iii) such review shall be limited to the information or documentation provided to and considered by the insurer in making its determination, including any information or documentation considered as part of the internal appeal process.

(c) If the insured or the insured's authorized representative has new or additional information not previously provided to the insurer, whether submitted to the insurer or the independent review organization, such information shall first be considered in the internal review process, as set forth in Subsection R590-285-24(3).

(i) While this information is being reviewed by the insurer, the independent review organization shall suspend its review and the time period for review is suspended until the insurer completes its review.

(ii) The insurer shall complete its review of the information and provide written notice of the results of the review to the insured and the insured's authorized representative, if applicable, and the independent review organization within five business days of the insurer's receipt of such new or additional information.

(iii)(A) If the insurer maintains its denial after such review, the independent review organization shall continue its review, and render its decision within the time period specified in Subsection R590-285-25(3)(i).

(B) If the insurer overturns its decision following its review, the independent review request shall be considered withdrawn.

(d) The insurer shall acknowledge in writing to the insured and the insured's authorized representative, if applicable, and the commissioner that the request for independent review has been received, accepted, and forwarded to an independent review organization for review. Such notice will include the name and address of the independent review organization.

(e) Within five business days of receipt of the request for independent review, the independent review organization assigned shall notify the insured and the insured's authorized representative, if applicable, and the insurer, that it has accepted the independent review request and identify the type of licensed health care professional assigned to the review. The assigned independent review organization shall include in the notice a statement that the insured or the insured's authorized representative may submit in writing to the independent review organization, within seven days following the date of receipt of the notice, additional information and supporting documentation that the independent review organization should consider when conducting its review.

(f) The independent review organization shall review all of the information and documents that are provided to the independent review organization. The independent review organization shall provide copies of any documentation or information provided by the insured or the insured's authorized representative to the insurer for its review, if it is not part of the information or documentation submitted by the insurer to the independent review organization. The insurer shall review the information and provide its analysis of the new information in accordance with Subsection R590-285-25(3)(h).

(g) The insured or the insured's authorized representative may submit, at any time, new or additional information not previously provided to the insurer but that is pertinent to the benefit trigger denial. The insurer shall consider such information and affirm or overturn its benefit trigger determination. If the insurer affirms its benefit trigger determination, the insurer shall promptly provide such new or additional information to the independent review organization for its review, along with the insurer's analysis of such information.

(h) If the insurer overturns its benefit trigger determination:

(i) the insurer shall provide notice to the independent review organization, the insured, and the insured's authorized representative, if applicable, of its decision; and

(ii) the independent review process shall immediately cease.

(i) The independent review organization shall provide the insured and the insured's authorized representative, if applicable, and the insurer written notice of its decision, within 30 days from receipt of the referral. If the independent review organization overturns the insurer's decision, it shall:

(i) establish the precise date within the specific period of time under review that the benefit trigger was deemed to have been met; and

(ii) specify the specific period of time under review for which the insurer declined eligibility, but during which the independent review organization deemed the benefit trigger to have been met.

(j) The decision of the independent review organization with respect to whether the insured met the benefit trigger will be final and binding on the insurer.

(k) The independent review organization's determination shall be used solely to establish liability for benefit trigger decisions, and is intended to be admissible in any proceeding only to the extent it establishes the eligibility of benefits payable.

(l) Nothing in this section shall restrict the insured's right to submit a new request for benefit trigger determination after the independent review decision, should the commissioner review organization uphold the insurer's decision.

(m)(i) The commissioner shall utilize the criteria set forth in Appendix F, Guidelines for Long-Term Care Independent Review Entities, in approving entities to review long-term care insurance benefit trigger decisions.

(ii) The commissioner shall accept another state's certification of an independent review organization, provided such state requires the independent review organization to meet substantially similar qualifications as those contained in Appendix F.

(n) The commissioner shall maintain and periodically update a list of approved independent review organizations.

(4) Certification of Long-Term Care Insurance Independent Review Organizations. The commissioner shall certify or approve a qualified long-term care insurance independent review organization, provided the independent review organization demonstrates to the satisfaction of the commissioner that it is unbiased and meets the following qualifications:

(a) have on staff, or contract with, a qualified and licensed health care professional in an appropriate field for determining an insured's functional or cognitive impairment such as physical therapy, occupational therapy, neurology, physical medicine, and rehabilitation, to conduct the review;

(b) neither it nor any of its licensed health care professionals may, in any manner, be related to or affiliated with an entity that previously provided medical care to the insured;

(c) utilize a licensed health care professional who is not an employee of the insurer or related in any manner to the insured;

(d) neither it nor its licensed health care professional who conducts the reviews may receive compensation of any type that is dependent on the outcome of the review;

(e) be approved by the commissioner to conduct such reviews if the state requires such approvals or certifications;

(f) provide a description of the fees to be charged by it for independent reviews of a limited long-term care insurance benefit trigger decision. Such fees shall be reasonable and customary for the type of limited long-term care insurance benefit trigger decision under review; and

(g) provide the name of the medical director or health care professional responsible for the supervision and oversight of the independent review procedure.

(5) Maintenance of Records and Reporting Obligations by Independent Review Organizations. Each certified independent review organization shall comply with the following:

(a) maintain written documentation establishing the date it receives a request for independent review, the date each review is conducted, the resolution, the date such resolution was communicated to the insurer and the insured, the name and professional status of the reviewer conducting such review in an easily accessible and retrievable format for the year in which it received the information, plus three calendar years;

(b) be able to document measures taken to appropriately safeguard the confidentiality of such records and prevent unauthorized use and disclosures in accordance with applicable federal and state law;

(c) report annually to the commissioner, by June 1 for the previous calendar year, in the aggregate and for each limited long-term care insurer all of the following:

(i) the total number of requests received for independent review of limited long-term care benefit trigger decisions;

(ii) the total number of reviews conducted and the resolution of such reviews;

(iii) the number of reviews withdrawn prior to review; and

(iv) the percentage of reviews conducted within the prescribed timeframe set forth in Subsection R590-285-25(3)(i); and

(d) report immediately to the commissioner any change in its status which would cause it to cease meeting any of the qualifications required of an independent review organization performing independent reviews of limited long-term care benefit trigger decisions.

(6) Additional Rights. Nothing contained in this section shall limit the ability of an insurer to assert any rights an insurer may have under the policy related to:

(a) an insured's misrepresentation;

(b) changes in the insured's benefit eligibility; and

(c) terms, conditions, and exclusions of the policy, other than failure to meet the benefit trigger.

**R590-285-26. Standard Format Outline of Coverage.**

(1) The outline of coverage shall be substantially similar to Appendix D.

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

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

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

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

**R590-285-27. Documents Incorporated by Reference.**

(1) Appendix A. Potential Premium Increase Disclosure Form, January 2021 revision.

(2) Appendix B. Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Limited Long-Term Care Insurance or Long-Term Care Insurance, January 2021 revision.

(3) Appendix C. Notice to Applicant Regarding Replacement of Accident and Sickness or Limited Long-Term Care Insurance or Long-Term Care Insurance, January 2021 revision.

(4) Appendix D. Outline of Coverage, January 2021 revision.

(5) Appendix E. Replacement and Lapse Reporting Form, January 2021 revision.

(6) Appendix F. Guidelines for Long-Term Care Independent Review Entities, January 2021 revision.

**R590-285-28. Effective Date.**

The commissioner will begin enforcing the provisions of this rule on July 1, 2021.

**R590-285-29. Severability.**

If any provision of this rule, R590-285, or its application to any person or situation is held invalid, such invalidity does not affect any other provision or application of this rule which 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.

**KEY: insurance, health, long-term care**

**Date of Enactment or Last Substantive Amendment: February 23, 2021**

**Authorizing, and Implemented or Interpreted Law: 31A-2-201(3)(a), 31A-22-2006**