PROPOSED RULEMAKING

INSURANCE DEPARTMENT

[31 PA. CODE CH. 65]

Charter Amendments; Financial Requirements

The Insurance Department (Department) proposes to delete Chapter 65, Subchapter C (relating to charter amendments; financial requirements) to read as set forth in Annex A. This rulemaking is proposed under the authority of sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); sections 202, 206 and 601 of The Insurance Company Law of 1921 (40 P. S. §§ 382, 386 and 721) (act); and 15 Pa.C.S. §§ 21201—21208 (relating to GAA Amendments Act of 1990). The chapter applies to property and casualty insurers authorized to write automobile insurance coverages under section 202(c)(11) of the act. The subchapter provided for the automatic amendment of existing charters and established minimum capital and surplus requirements for domestic insurers affected by the act of November 27, 1968 (P. L. 118, No. 349) (Act 349).

Purpose

The purpose of this rulemaking is to delete §§ 65.21—65.26 to eliminate obsolete, unnecessary regulations. Section 202 of the act delineates the underwriting authorities of various types of insurers. Act 349 consolidated the underwriting authority to write automobile bodily injury liability and automobile property damage liability insurance coverages. The regulations were adopted May 16, 1969, to implement the provisions of Act 349 with respect to insurers writing automobile insurance coverages in this Commonwealth.

Section 65.23 (relating to charters automatically amended) provides for the automatic amendment of the existing charters of insurers that were authorized to write both of the consolidated coverages and delineated the effect of Act 349 on the authority of insurers that had one of the two consolidated underwriting powers. The GAA Amendments Act of 1990 updated the Commonwealth's business corporation laws relating to insurance companies. The updates included the repeal of provisions in the act requiring the Department's approval of charters for the creation of insurers. As a result of these updates, insurer charters are no longer required to specify underwriting authority. Therefore, the provisions in §§ 65.21—65.23 (relating to definition of act; authority for writing certain policies; and charters automatically amended) are outdated and no longer needed.

Sections 65.24—65.26 (relating to minimum paid-up capital for stock insurers; minimum surplus for mutual insurers; and determining compliance) establish minimum capital and surplus requirements for mutual insurers with the authority to write automobile liability insurance. The current minimum capital and surplus requirements for these insurers are now found in sections 206 and 601 of the act. Therefore, §§ 65.24—65.26 also are outdated and no longer needed.

Affected Parties

The deletion of the subchapter affects property and casualty insurers authorized to write automobile insurance coverages in this Commonwealth.

Fiscal Impact

There is no fiscal impact as a result of the deletion of the subchapter.

Paperwork

The deletion of the subchapter would impose no additional paperwork requirements on the Department or insurers.

Effectiveness/Sunset Date

This proposed rulemaking will become effective upon final publication in the *Pennsylvania Bulletin*. Because the rulemaking proposes to delete the subchapter, no sunset date has been assigned.

Contact Person

Questions or comments regarding the proposed rulemaking may be addressed in writing to Peter J. Salvatore, Regulatory Coordinator, Office of Special Projects, 1326 Strawberry Square, Harrisburg, PA 17120, (717) 787-4429 within 30 days following the publication of this notice in the *Pennsylvania Bulletin*. Questions or comments also may be e-mailed to psalvatorestate.pa.us or faxed to (717) 772-1969.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on September 26, 2001, the Department submitted a copy of this proposed rulemaking to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the Senate Banking and Insurance Committee and the House Committee on Insurance. In addition to submitting this proposed rulemaking, the Department has provided IRRC and the Committees with a copy of a detailed Regulatory Analysis Form prepared by the agency in compliance with Executive Order 1996-1, "Regulatory Review and Promulgation." A copy of this material is available to the public upon request.

Under section 5(g) of the Regulatory Review Act, if IRRC has objections to any portion of the proposed rulemaking, it will notify the Department within 10 days of the close of the Committees' review period. The notification shall specify the regulatory review criteria that have not been met by that portion. The Regulatory Review Act specifies detailed procedures for review, prior to final publication of the regulations by the Department, the General Assembly and the Governor of objections raised.

M. DIANE KOKEN,
Insurance Commissioner

Fiscal Note: 11-211. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 31. INSURANCE

PART II. AUTOMOBILE INSURANCE

CHAPTER 65. **[MISCELLANEOUS PROVISIONS] (Reserved)**

Subchapter C. **[CHARTER AMENDMENTS; FINANCIAL REQUIREMENTS] (Reserved)**

§ 65.21. **[Definition of act] (Reserved)**.

[When used in this subchapter, the term act shall mean the Insurance Company Law of 1921 (40 P. S. §§ 361—488.5), unless the context clearly indicates otherwise.]

§ 65.22. **[Authority for writing certain policies] (Reserved)**.

[Prior to November 27, 1968, the authority to write automobile bodily injury liability coverage was found in section 202(c)(4) of The Insurance Company Law (40 P. S. § 382(c)(4)), and the authority to write automobile property damage liability coverage was found in section 202(c)(11) of such act (40 P. S. § 382(c)(11)). The act has combined the authority for these two coverages in section 202(c)(11) (40 P. S. § 382(c)(11)).]

§ 65.23. **[Charters automatically amended] (Reserved)**.

[(a) It shall be the position of the Insurance Department that the act has automatically amended all affected existing charters of insurance companies to reflect the change indicated in § 65.22 (relating to authority for writing certain policies). Therefore, no insurer need formally amend its charter in order to retain the same authority which it had prior to the enactment of the act.

(b) An insurer licensed for section 202(c)(4) powers under the Insurance Company Law (40 P. S. § 382(c)(4)) but not section 202(c)(11) powers prior to the act (40 P. S. § 382(c)(11)) shall hold full section 202(c)(4) powers plus a limited section 202(c)(11) power permitting the writing of automobile bodily injury liability coverage but none of the other coverages authorized by section 202(c)(11).

(c) An insurer licensed for section 202(c)(11) powers but not section 202(c)(4) powers prior to the act does not, by virtue of the act, automatically obtain the authority to write automobile bodily injury liability coverage; such additional authority may be obtained only by a formal amendment to the charter.]

§ 65.24. **[Minimum paid-up capital for stock insurers] (Reserved)**.

[Domestic or foreign stock insurers which were authorized prior to November 27, 1968 to write policies of automobile liability insurance (whether bodily injury or property damage liability or both) in this Commonwealth shall, by November 27, 1973, have a minimum paid-up capital stock of $500,000.]

§ 65.25. **[Minimum surplus for mutual insurers] (Reserved)**.

[(a) *Nonassessable policies.* Domestic mutual insurance companies which were authorized prior to November 27, 1968, to write nonassessable policies of automobile liability insurance, whether bodily injury or property damage liability, or both, in this Commonwealth shall, by November 27, 1973, have and thereafter maintain unimpaired a minimum surplus of $500,000 for this class of insurance.

(b) *Only assessable policies.* Domestic mutual insurance companies which were authorized prior to November 27, 1968, to write only assessable policies of automobile liability insurance, whether bodily injury or property damage liability, or both, in this Commonwealth shall, by November 27, 1973, have and thereafter maintain unimpaired a minimum surplus of $100,000 for this class of insurance.

(c) *Foreign insurers.* Foreign mutual insurers which were licensed prior to November 27, 1968, to write such policies, whether assessable or nonassessable, in this Commonwealth shall meet the same respective minimum surplus requirement by November 27, 1973.]

§ 65.26. **[Determining compliance] (Reserved)**.

[The Insurance Department will contact each insurer not presently in compliance with the minimum financial requirement provisions of this subchapter in order to determine what course of action such insurer proposes to follow to meet the November 27, 1973, deadline.]

[Pa.B. Doc. No. 01-1804. Filed for public inspection October 5, 2001, 9:00 a.m.]

[31 PA. CODE CHS. 89 AND 89a]

Long-Term Care Insurance Form and Rate Filings

The Insurance Department (Department) proposes to delete §§ 89.901—89.921 and to establish Chapter 89a (relating to long-term care insurance model regulation) and Appendices A—F to read as set forth in Annex A. Chapter 89a sets forth the requirements for the content and filing of long-term care insurance form and rate filings.

Statutory Authority

The rulemaking is proposed under the authority contained in sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412) and sections 1101—1115 of The Insurance Company Law of 1921 (act) (40 P. S. §§ 991.1101—991.1115).

Purpose

Sections 89.901—89.921 (relating to long-term care insurance) was adopted in 1994. The purpose of the subchapter was to implement sections 1101—1115 of the act, to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance from unfair or deceptive sales or 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. This section provided filing and content requirements for long-term care insurance form and rate filings in this Commonwealth.

The Department is proposing to establish Chapter 89a and Appendices A—F to replace Chapter 89, Subchapter M to address the purposes of the act, to reflect changes in the long-term care insurance marketplace and to enhance consumer protection through revised rate filing requirements and required disclosure notices. However, certain sections have not been substantially changed from the current regulations.

The long-term care insurance market has grown and evolved dramatically since Chapter 89, Subchapter M was originally adopted in 1994. By its nature, long-term care insurance policies are generally purchased well in advance of their potential use. This type of advance purchase increases the need for rate stability and adequate consumer disclosure of policy coverages and past rate increases by an insurer. Concerns have been raised both in this Commonwealth and Nationally about the impact

of frequent rate hikes on consumers, especially those on a fixed income, and adequate disclosure to consumers of the terms and conditions of their long-term care insurance policies as well as premium rate increase histories of insurance carriers.

The amendments are based on the National Association of Insurance Commissioner's Long-Term Care Insurance Model Regulation (model regulation) adopted in August 2000. The Department is proposing to adopt these amendments to address these consumer protection and rating issues and to follow consistent National standards, when possible, to provide insurance carriers who market long-term care insurance policies in multiple states with consistent requirements within the scope of Commonwealth statutes and regulations.

Explanation of Regulatory Requirements

Substantive Modifications

The following sections contain substantive changes from the existing long-term care regulations found in Subchapter M.

Section 89a.103 (relating to definitions) is based on § 89.903 with additional definitions that are necessary for the revisions of the subchapter. The additional definitions include "exceptional increase," "incidental" "qualified actuary," and "qualified long-term care insurance contract or Federally tax-qualified long-term care insurance contract."

Section 89a.104 (relating to policy definitions) is based on § 89.904 with additional definitions that are necessary for the revisions of the subchapter and are based on the model regulation.

Section 89a.105 (relating to policy practices and provisions) is based on § 89.905 with additional language to define "level premium" and to address renewability for tax qualified long-term care policies. Additional language that was added under § 89a.105(b) is based on the model regulation and 75 Pa.C.S. §§ 1701—1798 (relating to Motor Vehicle Financial Responsibility Law). Additional language that was added under § 89a.105(f) is necessary for the revisions of the subchapter and § 89a.105(g) is based on the model regulation.

Section 89a.107 (relating to required disclosure provisions) is based on § 89.907 with additional language to address disclosure requirements regarding renewability and premium changes. Additional language was added under § 89a.107(f), (g) and (h). Changes are based on the model regulation.

Section 89a.108 (relating to required disclosure of rating practices to consumer) is new and contains all new language reflecting the consumer disclosure requirements on history of rate increases based on the model regulation.

Section 89a.109 (relating to initial filing requirements) is new and contains all new language reflecting the revised rate filing requirements based on the model regulation.

Section 89a.112 (relating to the requirement to offer inflation protection) is based on § 89.910 with additional language reflecting the required offer and disclosure of inflation protection based on the model regulation.

Section 89a.114 (relating to reporting requirements) is based on § 89.912 with additional language to require reporting of claims denied, definition of "denied," and reference to the sample claims denial format (Appendix E).

Section 89a.115 (relating to licensing) is new and contains all new language based on the model regulation.

Section 89a.116 (relating to reserve standards) is based on § 89.913 with additional language to reference the minimum reserve standards for individual and group health and accident contracts regulation.

Section 89a.117 (relating to loss ratio) is based on § 89.914 with additional language to reference revised rate filing requirements based on the model regulation.

Section 89a.118 (relating to premium rate schedule increases) is new and contains all new language based on the revised rate filing requirements consistent with the model regulation.

Section 89a.120 (relating to standards for marketing) is based on § 89.916 with additional language to reference consumer disclosure forms (Appendices B and F) and other references based on the model regulation.

Section 89a.121 (relating to suitability) is based on § 89.917 with additional language relating to consumer disclosure including the personal worksheet (Appendix B) for consistency with the model regulation.

Section 89a.123 (relating to nonforfeiture benefit requirement) is new and contains all new language. This section was added to be consistent with the model regulation.

Section 89a.124 (relating to standards for benefit triggers) is new and contains all new language. This section was added to be consistent with the model regulation.

Section 89a.125 (relating to additional standards for benefit triggers for qualified long-term care insurance contracts) is new and contains all new language. This section was added to be consistent with the model regulation.

Section 89a.126 (relating to standard format outline of coverage) is based on § 89.919 with additional disclosure language referencing Federal tax consequences, premium change and the Commonwealth Senior Health Insurance Assistance Program. Changes were made to be consistent with the model regulation.

Section 89a.128 (relating to penalties) is new and contains all new language. This section was added to be consistent with the model regulation.

Appendices A—F contain all new language based on the model regulation.

Minor Modifications

The following sections contain only minor changes from the existing long-term care regulations found in Subchapter M.

Section 89a.102 (relating to applicability and scope) is based on § 89.902 with revisions to address the concept of tax qualified long-term care policies which were created by the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191, 110 Stat. 1936).

Section 89a.106 (relating to unintentional lapse) is based on § 89.906 with revisions based on the model regulation and to clarify the reinstatement provision.

Section 89a.110 (relating to prohibition against post-claims underwriting) is based on § 89.908 with revisions consistent with the model regulation.

Section 89a.111 (relating to minimum standards for home health and community care benefits in long-term care insurance policies) is based on § 89.909 with revisions consistent with the model regulation.

Section 89a.113 (relating to requirements for application forms and replacement coverage) is based on § 89.911 with revisions consistent with the model regulation.

Section 89a.119 (relating to filing requirement) is based on § 89.915 with revisions consistent with the model regulation.

No Change

The following information represents sections that have been renumbered. No change has been made to the content of these sections. The Department therefore is not soliciting comments on these sections at this time.

Proposed Section Number and Title	*Current Section Number*
§ 89a.101. Purpose.	§ 89.901
§ 89a.122. Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates.	§ 89.918
§ 89a.127. Requirement to Deliver Shopper's Guide.	§ 89.920
§ 89a.129. Permitted Compensation Arrangements.	§ 89.921

Affected Parties

All companies who must follow the Department's form and content requirements of form and rate filings and doing the business of long-term care insurance in this Commonwealth.

Fiscal Impact

State Government

The proposed rulemaking will not have an impact on Department costs associated with monitoring industry compliance because this does not represent a major change from current policy.

General Public

The proposed rulemaking is not expected to have any cost impact on premiums paid by consumers for insurance policies.

Political Subdivisions

The proposed rulemaking has no impact on costs to political subdivisions.

Private Sector

The proposed rulemaking will not have any major impact on private sector costs because this does not represent a major change from current policy.

Paperwork

The proposed rulemaking imposes no additional paperwork requirements on the Department and modifies the paperwork requirements imposed on the insurance industry.

Effectiveness/Sunset Date

The proposed rulemaking will become effective upon final-form adoption and publication in the *Pennsylvania Bulletin* as a final-form rulemaking. No sunset date has been assigned.

Contact Person

Questions or comments regarding the proposed rulemaking may be addressed in writing to Peter J. Salvatore, Regulatory Coordinator, 1326 Strawberry Square, Harrisburg, PA 17120, within 30 days following publication of this notice in the *Pennsylvania Bulletin*.

Questions or comments may also be sent by e-mail to psalvatore@state.pa.us or faxed to (717) 772-1969.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on September 25, 2001, the Department submitted a copy of the proposed rulemaking to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the Senate Banking and Insurance Committee and the House Insurance Committee. In addition to submitting the proposed rulemaking, the Department has provided IRRC and the Committees with a copy of a detailed Regulatory Analysis Form prepared by the Department in compliance with Executive Order 1996-1, "Regulatory Review and Promulgation." A copy of this material is available to the public upon request.

Under section 5(g) of the Regulatory Review Act, if IRRC has any objections to any portion of the proposed rulemaking, it will notify the Department within 10 days of the close of Committees' review period. The notification shall specify the regulatory review criteria that have not been met by that portion of the proposed rulemaking. The Regulatory Review Act specifies detailed procedures for review, prior to final publication of the rulemaking, by the Department, the General Assembly and the Governor of objections raised.

M. DIANE KOKEN,
Insurance Commissioner

Fiscal Note: 11-208. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 31. INSURANCE

PART IV. LIFE INSURANCE

CHAPTER 89. APPROVAL OF LIFE, ACCIDENT AND HEALTH INSURANCE

Subchapter M. (Reserved)

§§ 89.901—89.921. (Reserved).

Chapter 89a. LONG-TERM CARE INSURANCE MODEL REGULATION

Sec.

§ 89a.101. Purpose.

The purpose of this chapter is to implement sections 1101—1115 of the act (40 P. S. §§ 991.1101—991.1115), 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 or 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.

§ 89a.102. Applicability and scope.

Except as otherwise specifically provided, this chapter applies to all long-term care insurance policies, including qualified long-term care contracts delivered or issued for delivery in this Commonwealth on or after _____ (*Editor's Note:* The blank refers to the effective date of adoption of this proposal.) by insurers, fraternal benefit societies, nonprofit hospital plan and professional health services plan corporations, prepaid health plans, health maintenance organizations and all similar organizations. Certain provisions of this chapter apply only to qualified long-term care insurance contracts as noted.

§ 89a.103. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Act—The Insurance Company Law of 1921 (40 P. S. §§ 341—991.2361)

Applicant—The term as defined in section 1103 of the act (40 P. S. § 991.1103).

Certificate—The term as defined in section 1103 of the act.

Commissioner—The Insurance Commissioner of the Commonwealth.

Department—The Insurance Department of the Commonwealth.

Exceptional increase—Only those increases filed by an insurer as exceptional for which the Commissioner determines the need for the premium rate increase is justified.

(i) Increases due to changes in laws or regulations applicable to long-term care coverage in this Commonwealth or due to increased and unexpected utilization that affects the majority of insurers of similar products.

(ii) Except as provided in § 89a.118 (relating to premium rate schedule increases), exceptional increases are subject to the same requirements as other premium rate schedule increases.

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

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

Functionally necessary—The term as defined in section 1103 of the act.

Group long-term care insurance—The term as defined in section 1103 of the act.

Incidental—As used in § 89a.118(j), 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.

Long-term care insurance—The term as defined in section 1103 of the act.

Medically necessary—The term as defined in section 1103 of the act.

Policy—The term as defined in section 1103 of the act.

Producer—An agent as defined in section 601 of the act (40 P. S. § 231), or a broker as defined in section 621 of the act (40 P. S. § 251).

Qualified actuary—A member in good standing of the American Academy of Actuaries.

Qualified long-term care insurance contract or *Federally tax-qualified long-term care insurance contract*—

(i) An individual or group insurance contract that meets all of the following requirements of section 7702B(b) of the Internal Revenue Code of 1986 (IRC) (26 U.S.C.A. § 77026B(b)):

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

(B) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act (42 U.S.C.A. §§ 1395—1395ggg) or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this subparagraph do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payor. A contract may not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(C) The contract is guaranteed renewable, within the meaning of section 7702B(b)(1)(C) of the IRC.

(D) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed.

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

(F) The contract meets the consumer protection provisions in section 7702B(g) of the IRC.

(ii) The term also means the portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of section 7702B(b) and (e) of the IRC.

Similar policy forms—All of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in section 1103 of the act (40 P. S. § 991.1103) 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) Noninstitutional long-term care benefits only.

(iii) Comprehensive long-term care benefits.

§ 89a.104. Policy definitions.

(a) A long-term care insurance policy delivered or issued for delivery in this Commonwealth may not use the terms set forth as follows, unless the terms are defined in the policy and the definitions satisfy the following requirements:

Activities of daily living—Bathing, continence, dressing, eating, toileting and transferring.

Acute condition—The term means that the individual is medically unstable. This individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, to maintain the individual's health status.

Adult day care—A program for 6 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.

Bathing—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 or drawing the water for a sponge bath and getting the equipment to the person or the person to the equipment.

Cognitive impairment—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.

Continence—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).

Dressing—Putting on and taking off all items of clothing and necessary braces, fasteners or artificial limbs.

Eating—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.

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

Home health care services—Medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. The services may include homemaker services, assistance with activities of daily living and respite care services.

Medicare—The program under the Health Insurance for the Aged Act in Title XVIII of the Social Security Amendments of 1965 (42 U.S.C.A. §§ 1395—1395ggg).

Mental or nervous disorder—The term may not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

Personal care—The provision of supervisory or hands-on services to assist an individual with activities of daily living.

Skilled nursing care, intermediate care, personal care, home care and other services—These terms 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.

Toileting—Getting to and from the toilet, getting on and off the toilet and performing associated personal hygiene.

Transferring—Moving into or out of a bed, chair or wheelchair.

(b) 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 when the licensure or certification of the provider is required by the Commonwealth.

§ 89a.105. Policy practices and provisions.

(a) *Renewability.* The terms "guaranteed renewable" and "noncancellable" may not be used in an individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of § 89a.108 (relating to required disclosure of rating practices to consumers).

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

(2) 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 a change in a 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.

(3) 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 a change in a provision of the insurance or in the premium rate.

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

(5) In addition to the 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 (26 U.S.C.A. §7702B(b)(1)(C)).

(b) *Limitations and exclusions.*

(1) A policy may not be delivered or issued for delivery in this Commonwealth 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 other related degenerative or dementing illnesses.

(iii) Alcoholism and drug addiction.

(iv) Illness, treatment or medical condition arising out of any of the following:

(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 units auxiliary thereto.

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

(E) Aviation (this exclusion applies only to nonfare-paying passengers).

(v) Treatment provided in a government facility (unless a charge is made and the insured is legally obligated to pay), services for which benefits are available under Medicare or other governmental program except Medicaid, a state or Federal workers' compensation, employer's liability or occupational disease law or 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.

(vi) Expenses for services or items available or paid under another long-term care insurance or health insurance policy.

(vii) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act (Medicare) (42 U.S.C.A. §§ 1395—1395ggg) or would be so reimbursable but for the application of a deductible or coinsurance amount.

(2) This subsection is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

(3) Benefits otherwise payable under a long-term care policy shall be payable in excess of and not in duplication of valid and collectable first party benefits under a state motor vehicle responsibility law. See 75 Pa.C.S. §§ 1701—1798 (relating to Motor Vehicle Financial Responsibility Law).

(c) *Extension of benefits*. Termination of long-term care insurance shall be without prejudice to 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 or to payment of the maximum benefits and may be subject to a policy waiting period and other applicable provisions of the policy.

(d) *Continuation or conversion*.

(1) Group long-term care insurance issued in this Commonwealth on or after _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposal.) shall provide covered individuals with a basis for continuation or conversion of coverage.

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

(3) For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for a 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 a group policy which it replaced), for at least 6 months immediately prior to termination, will be entitled to the issuance of a converted policy by the insurer under whose group policy the individual is covered, without evidence of insurability.

(4) For the purposes of this section, "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. When 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, will take into consideration the differences between managed care and nonmanaged care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

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

(6) When an insured converts from a group policy with rates based on the issue age of the insured to a conversion policy, the premium for the conversion policy shall be calculated on the basis of the insured's age at inception of continuous coverage on the original group policy and any other group policy which replaced the original group policy. When an insured converts from a group policy with rates based on the attained age of the insured, the premium for the conversion policy shall be calculated on the insured's age as of the date of conversion.

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

(i) Termination of group coverage resulted from an individual's failure to make the required payment of premium or contribution when due.

(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. Both of the following provisions apply:

(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.

(B) The premium for which is calculated in a manner consistent with paragraph (6).

(8) Notwithstanding this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that

provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100% 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.

(9) 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.

(10) Notwithstanding this section, an 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.

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

(e) *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 may not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced and may not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

(f) *Premium rate increase.*

(1) The premium charged to an insured may not increase due to either of the following:

(i) The increasing age of the insured at ages beyond 65.

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

(2) The purchase of additional coverage may not be considered a premium rate increase, but for purposes of the calculation required under § 89a.123 (relating to nonforfeiture benefit requirement), the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

(3) A reduction in benefits may not be considered a premium change, but for purpose of the calculation required under § 89a.123, the initial annual premium shall be based on the reduced benefits.

(g) *Electronic enrollment for group policies.*

(1) In the case of a group defined in section 1103 of the act (40 P. S. § 991.1103), a requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if the following conditions are met:

(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.

(iii) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information is maintained.

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

§ 89a.106. Unintentional lapse.

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

(1) *Notice before lapse or termination.* An individual long-term care policy or certificate may not 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 may not constitute acceptance of 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." The insured shall be able to change the written designation at any time. The insurer shall notify the insured of the right to change this written designation, at least once every 2 years.

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

(3) *Lapse or termination for nonpayment of premium.* No individual long-term care policy or certificate may 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 under paragraph (1), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of 5 days after the date of mailing.

(b) *Reinstatement.* In addition to the requirement in subsection (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 5 months after termination and shall allow for the collection of a past due premium, when appropriate. 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.

§ 89a.107 Required disclosure provisions.

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

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

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

(b) *Riders and endorsements.* Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, a rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. When 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.

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

(d) *Limitations.* If a long-term care insurance policy or certificate contains 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."

(e) *Other limitations or conditions on eligibility for benefits.* A long-term care insurance policy or certificate containing limitations or conditions for eligibility other than those prohibited in sections 1105 and 1108 of the act (40 P. S. §§ 991.1105 and 991.1108) shall set forth a description of the limitations or conditions, including the required number of days of confinement, in a separate paragraph of the policy or certificate and shall label this paragraph "Limitations or Conditions on Eligibility for Benefits."

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

(g) *Disclosure statement—qualified.* A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in § 89a.126(e)(3) (relating to standard format 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 (26 U.S.C.A. § 7702B(b)).

(h) *Disclosure statement—nonqualified.* A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in § 89a.126(e)(3) that the policy is not intended to be a qualified long-term care insurance contract.

§ 89a.108. Required disclosure of rating practices to consumers.

(a) This section shall apply as follows:

(1) Except as provided in paragraph (2), this section applies to a long-term care policy or certificate issued in this Commonwealth on or after _____ (*Editor's Note*: The blank refers to a date 6 months after the effective date of adoption of this proposal.).

(2) For certificates issued on or after _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposal.) under a group long-term care insurance policy as defined in section 1103 of the act (40 P. S. § 991.1103), which policy was in force on _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposal.) this section shall apply on the policy anniversary following _____ (*Editor's Note*: The blank refers to a date 12 months after the effective date of adoption of this proposal.).

(b) 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.

(1) A statement that the policy may be subject to rate increases in the future.

(2) An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision.

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

(4) A general explanation for applying premium rate or rate schedule adjustments that shall include both of the following:

(i) A description of when premium rate or rate schedule adjustments will be effective (for example, next anniversary date, next billing date).

(ii) The right to a revised premium rate or rate schedule as provided in paragraph (2) if the premium rate or rate schedule is changed.

(5) The following information:

(i) Information regarding each premium rate increase on this policy form or similar policy forms over the past 10 years for this Commonwealth or any other state that, at a minimum, identifies all of the following:

(A) The policy forms for which premium rates have been increased.

(B) The calendar years when the form was available for purchase.

(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, 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 nonaffiliated insurers or the long-term care policies acquired from 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 later of _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposal.) 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 subparagraph (i).

(v) If the acquiring insurer in subparagraph (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 subparagraph (iv), the acquiring insurer shall make all disclosures required by this paragraph, including disclosure of the earlier rate increase referenced in subparagraph (iv).

(c) 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 (b)(1) and (5). 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.

(d) An insurer shall use the forms in Appendices B and F (relating to long term care insurance personal worksheet; and rate information) to comply with the requirements of subsections (a) and (b).

(e) 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 for the policyholder or certificateholder. The notice shall include the information required by subsection (b) when the rate increase is implemented.

§ 89a.109. Initial filing requirements.

(a) This section applies to a long-term care policy issued in this Commonwealth on or after _____ (*Editor's Note*: The blank refers to a date 6 months after the effective date of adoption of this proposal.).

(b) An insurer shall provide the information listed in this subsection to the Commissioner prior to making a long-term care insurance form available for sale subject to the Accident and Health Filing Reform Act (40 P. S. §§ 3801—3815).

(1) A copy of the disclosure documents required in § 89a.108 (relating to required disclosure of rating practices to consumer).

(2) 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 the following:

(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).

(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 this statement cannot be made, a complete description of the situations where this does not occur.

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

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

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

(c) 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 premium or benefit differences; relevant and credible data from other studies, or both. In the event the Commissioner asks for additional information under this

provision, the period in subsection (a) does not include the period during which the insurer is preparing the requested information.

§ 89a.110. Prohibition against postclaims underwriting.

(a) Applications for 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.

(b) If an application for 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. 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, the policy or certificate may not be rescinded for that condition.

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

(1) 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.

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

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

(i) A report of a physical examination.

(ii) An assessment of functional capacity.

(iii) An attending physician's statement.

(iv) Copies of medical records.

(d) 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.

(e) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both State and countrywide, except those that the insured voluntarily effectuated and shall annually furnish this information to the Insurance Commissioner in the format prescribed by the National Association of Insurance Commissioners in Appendix A (relating to rescission reporting form for long-term care policies).

§ 89a.111. Minimum standards for home health and community care benefits in long-term care insurance policies.

(a) A long-term care insurance policy or certificate may not, if it provides benefits for home health care or community care services, limit or exclude benefits by requiring any of the following:

(1) That the insured or claimant would need care in a skilled nursing facility if home health or community care services were not provided.

(2) That the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before home health care services are covered.

(3) Limiting eligible services to services provided by registered nurses or licensed practical nurses.

(4) Requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or licensed or certified home care worker acting within the scope of the person licensure or certification.

(5) Excluding coverage for personal care services provided by a home health aide.

(6) Requiring that the provision of home health or community care services be at a level of certification or licensure greater than that required by the eligible service.

(7) Requiring that the insured or claimant have an acute condition before home health or community care services are covered.

(8) Limiting benefits to services provided by Medicare-certified agencies or providers.

(9) Excluding coverage for adult day care services.

(b) 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 1 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 does not apply to policies or certificates issued to residents of continuing care retirement communities.

(c) Home health or community care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

§ 89a.112. Requirement to offer inflation protection.

(a) No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder in addition to 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 shall 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:

(1) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate of at least 5%.

(2) 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 may not be 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.

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

(b) When the policy is issued to a group, the required offer in subsection (a) shall be made to the group policyholder; except, if the policy is issued to a group defined in section 1103 of the act (40 P. S. § 991.1103) other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

(c) The offer in subsection (a) is not required of life insurance policies or riders containing accelerated long-term care benefits.

(d) Insurers shall include all of the information listed in this subsection or with the outline of coverage. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure. The information is as follows:

(1) 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.

(2) Expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(e) Inflation protection benefit increases under a policy which 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.

(f) An offer of inflation protection that 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.

(g) Inflation protection as provided in subsection (a)(1) 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. 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 policy(ies), and I reject inflation protection.

§ 89a.113. Requirements for application forms and replacement coverage.

(a) 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 another accident and sickness or long-term care policy or certificate presently in force. A supplementary application or form to be signed by the applicant and agent, except when the coverage is sold without an agent, containing the questions may be used. With regard to a replacement policy issued to a group defined by section 1103 of the act (40 P. S. § 991.1103), 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 that the certificateholder has been notified of the replacement.

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

(2) 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?

(3) Are you covered by Medicaid? If you are eligible or covered by Medicaid, you may not need to purchase the policy since it may provide duplicate benefits.

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

(b) Agents shall list health insurance policies they have sold to the applicant.

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

(2) List policies sold in the past 5 years that are no longer in force.

(c) 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 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 following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [insurance company name]. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

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

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]:

(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

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

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

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

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

_____

(Signature of Agent, Broker or Other Representative)

[Typed Name and Address of Agent or Broker]

The above "Notice to Applicant" was delivered to me on:

_____ _____

(Applicant's Signature) (Date)

(d) 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 following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [insurance company name]. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

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

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

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

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

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within 30 days if any information is not correct and complete, or if any past medical history has been left out of the application.

[Company Name]

(e) 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, the name of the insured and policy number or address including zip code. Notice shall be made within 5 working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

(f) The insurer shall maintain records demonstrating delivery date of policies so that this date can be used to determine the commencement of the 30-day policy examination period. Delivery date shall be deemed the date the policy is received by the policyholder.

§ 89a.114. Reporting requirements.

(a) 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.

(b) Every insurer shall report annually to the Department by June 30 the 10% of its agents with the greatest percentages of lapses and replacements as measured by subsection (a).

(c) 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.

(d) Every insurer shall report annually to the Department 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.

(e) Every insurer shall report annually to the Department 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.

(f) Every insurer shall report annually to the Department by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. (Appendix E) (relating to claims denial reporting form long term care insurance).

(g) For purposes of this section:

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

(2) Subject to paragraph (3), "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 terms or conditions of the policy have been met.

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

(4) "Report" means on a Statewide basis.

(h) Reports required under this section shall be filed with the Commissioner.

§ 89a.115. Licensing.

A producer is not authorized to sell, solicit or negotiate with respect to long-term care insurance except as authorized by sections 601 and 621 of the act (40 P. S. §§ 231 and 251).

§ 89a.116. Reserve standards.

When long-term care benefits are provided, reserves shall be determined in accordance with sections 301.1 and 311.1 of the act (40 P. S. §§ 71.1 and 93) and Chapter 84a (relating to minimum reserve standards for individual and group health and accident insurance contracts).

§ 89a.117. Loss ratio.

(a) This section shall apply to all long-term care insurance policies or certificates except those covered under §§ 89a.109 and 89.118 (relating to initial filing requirements; and premium rate schedule increases).

(b) Benefits under 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. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including the following:

(1) Statistical credibility of incurred claims experience and earned premiums.

(2) The period for which rates are computed to provide coverage.

(3) Experienced and projected trends.

(4) Concentration of experience within early policy duration.

(5) Expected claim fluctuation.

(6) Experience refunds, adjustments or dividends.

(7) Renewability features.

(8) All appropriate expense factors.

(9) Interest.

(10) Experimental nature of the coverage.

(11) Policy reserves.

(12) Mix of business by risk classification.

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

§ 89a.118. Premium rate schedule increases.

(a) This section shall apply as follows:

(1) Except as provided in paragraph (2), this section applies to a long-term care policy or certificate issued in this Commonwealth on or after _____ (*Editor's Note*: The blank refers to a date 6 months from the effective date of adoption of this proposal.).

(2) For certificates issued on or after _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposal.) under a group long-term care insurance policy as defined in section 1103 of the act (40 P. S. § 991.1103), which policy was in force on _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposal.), this section shall apply on the policy anniversary following _____ (*Editor's Note*: The blank refers to a date 12 months after the effective date of adoption of this proposal.).

(b) An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the Commissioner subject to the requirements of The Accident and Health Filing Reform Act (40 P. S. §§ 3801—3815) prior to the notice to the policyholders and shall include all of the following:

(1) Information required by § 89a.108 (relating to required disclosure of rating practices to consumers).

(2) 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.

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

(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 assumptions that deviate from those used for pricing other forms currently available for sale.

(A) Annual values for the 5 years preceding and the 3 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 (c).

(D) For exceptional increases, the projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase. If the Commissioner determines as provided in § 89a.103 (relating to definitions) 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.

(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.

(4) 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.

(5) Sufficient information for review subject to The Accident and Health Filing Reform Act (40 P. S. §§ 3801—3815) of the premium rate schedule increase by the Commissioner.

(c) Premium rate schedule increases shall be determined in accordance with the following requirements:

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

(2) Premium rate schedule increases shall be calculated so 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) Eighty-five 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%.

(iv) Eighty-five percent of the present value of future projected premiums not in this subsection on an earned basis.

(3) If a policy form has both exceptional and other increases, the values in paragraph (2)(ii) and (iv) will also include 70% for exceptional rate increase amounts.

(4) The present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in Chapter 84a (relating to minimum reserve standards for individual and group health and accident insurance contracts). The actuary shall disclose as part of the actuarial memorandum the use of appropriate averages.

(d) For each rate increase that is implemented, the insurer shall file for review subject to The Accident and Health Filing Reform Act (40 P. S. §§ 3801—3815) by the Commissioner, updated projections, as defined in subsection (b)(3)(i), annually for the next 3 years and include a comparison of actual results to projected values. The Commissioner may extend the period to greater than 3 years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection (k), the projections required by this subsection shall be provided to the policyholder in lieu of filing with the Commissioner.

(e) If a 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 (b)(3)(i), shall be filed for review subject to The Accident and Health Filing Reform Act (40 P. S. §§ 3801—3815) by the Commissioner every 5 years following the end of the required period in subsection (d). For group insurance policies that meet the conditions in subsection (k), the projections required by this subsection shall be provided to the policyholder in lieu of filing with the Commissioner.

(f) 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 (c), the Commissioner may require the insurer to implement premium rate schedule adjustments, or other measures to reduce the difference between the projected and actual experience. In determining whether the actual experience adequately matches the projected experience, consideration should be given to subsection (b)(3)(v), if applicable.

(g) 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 the following:

(1) 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 (h).

(2) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection (c) had the greater of the original anticipated lifetime loss ratio or 58% been used in the calculations described in subsection (c)(1)(i) and (iii)

(h) For a rate increase filing that meets the following criteria, the Commissioner will 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:

(1) The rate increase is not the first rate increase requested for the specific policy form.

(2) The rate increase is not an exceptional increase.

(3) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(i) If significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the Commissioner may determine that a rate spiral exists.

Following the determination that a rate spiral exists, the Commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(1) The offer shall:

(i) Be subject to the approval of the Commissioner.

(ii) Be based on actuarially sound principles, but not be based on attained age.

(iii) Provide that maximum benefits under a new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

(2) 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:

(i) The maximum rate increase determined based on the combined experience.

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

(j) 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 (h), prohibit the insurer from either of the following:

(1) Filing and marketing comparable coverage for up to 5 years.

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

(k) Subsections (a)—(j) do not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in § 89a.103 (relating to definitions), if the policy complies with the following conditions:

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

(2) An actuarial memorandum is filed with the Department that includes the following:

(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 shall include percent of premium dollars per policy and dollars per unit of benefits.

(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 types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or a dependent will be underwritten and when underwriting occurs.

(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.

(l) Subsections (f) and (h) do not apply to group insurance policies as defined in section 1103 of the act (40 P. S. § 991.1103) when either:

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

(2) The policyholder, and not the certificateholders, pays a material portion of the premium, which may 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.

§ 89a.119. Filing requirement.

Prior to an insurer or similar organization offering group long-term care insurance to a resident of this Commonwealth under section 621.2 of the act (40 P. S. § 756.2), 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 Commonwealth.

§ 89a.120. Standards for marketing.

(a) Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this Commonwealth, directly or through its producers, shall:

(1) Establish marketing procedures and agent training requirements to assure that marketing activities, including a comparison of policies, by its agents or producers will be fair and accurate and excessive insurance is not sold or issued.

(2) 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."

(3) Provide copies of the disclosure forms required in § 89a.108(c) (Appendices B and F) (relating to long term care insurance personal worksheet; and rate information) to the applicant.

(4) 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 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.

(5) Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this subsection.

(6) Provide written notice to the prospective policyholder or certificateholder at solicitation that a senior insurance counseling program approved by the Commonwealth is available and the name, address and telephone number of the program.

(7) For long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to § 89a.105(a)(3) (relating to policy practices and provisions).

(8) Provide an explanation of contingent benefit upon lapse provided for in § 89a.123(d)(3) (relating to nonforfeiture benefit requirement).

(b) The following acts and practices are prohibited:

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

(2) *High pressure tactics.* Employing a 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.

(3) *Cold lead advertising.* Making use directly or indirectly of a 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.

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

(5) *Other prohibited practices.* Other practices prohibited by The Unfair Insurance Practices Act (40 P. S. §§ 1171.1—1171.15).

(c) With respect to the obligations in this subsection, the primary responsibility of an association, as defined in paragraph (2) of the "group long-term care insurance" definition in section 1103 of the act (40 P. S. § 991.1103), when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions.

(1) Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by the associations to ensure that members of the associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

(2) The insurer shall file with the Department the following material:

(i) The policy and certificate.

(ii) A corresponding outline of coverage.

(iii) Advertisements requested by the Department.

(3) The association shall disclose the following in a long-term care insurance solicitation:

(i) The specific nature and amount of the compensation arrangements (including the 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.

(ii) A brief description of the process under which the policies and the insurer issuing the policies were selected.

(4) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

(5) The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

(6) The association shall do the following except that this does not apply to qualified long-term care insurance contracts:

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

(ii) Actively monitor the marketing efforts of the insurer and its agents.

(iii) Review and approve all marketing materials or insurance communications used to promote sales or sent to members regarding the policies or certificates.

(7) Group long-term care insurance policies or certificates may not be issued to an association unless the insurer files with the Department the information required in this subsection.

(8) The insurer may not issue a long-term care policy or certificate to an association or continue to market that policy or certificate unless the insurer certifies annually that the association has complied with this subsection.

(9) Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of The Unfair Insurance Practices Act.

§ 89a.121. Suitability.

(a) Every insurer, nonprofit hospital plan and professional health services plan corporation or other entity marketing long-term care insurance (the issuer) shall meet the following conditions:

(1) 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.

(2) Train its agents in the use of its suitability standards.

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

(b) To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take the items in paragraph (1) into consideration.

(1) The agent and issuer shall 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.

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

(2) The issuer, and when an agent is involved, the agent shall make reasonable efforts to obtain the information in paragraph (1). The efforts shall include presentation to the applicant, at or prior to application of the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix B (relating to long-term care insurance personal worksheet), in at least 12 point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the Commissioner.

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

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

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

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

(e) 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 (relating to things you should know before you buy long-term care insurance), in at least 12 point type.

(f) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to the one presented in Appendix D (relating to long-term care insurance suitability letter). 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.

(g) The issuer shall report annually to the Commissioner the total number of applications received from residents of this Commonwealth, 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.

§ 89a.122. Prohibition against preexisting conditions and probationary periods in replacement policies or certificates.

If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive 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.

§ 89a.123. Nonforfeiture benefit requirement.

(a) Nonforfeiture benefits shall be offered under the following:

(1) 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 (e).

(2) 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.

(b) If the offer made for nonforfeiture benefits is rejected, the insurer shall provide the contingent benefit upon lapse described in this section.

(c) After rejection of the offer for nonforfeiture benefits for individual and group policies without nonforfeiture benefits issued after _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposal.), the insurer shall provide a contingent benefit upon lapse.

(1) If 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.

(2) 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 in this paragraph 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.

Triggers for a Substantial Premium Increase

Issue Age	*Percent Increase Over Initial Premium*
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%

Triggers for a Substantial Premium Increase

Issue Age	*Percent Increase Over Initial Premium*
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

(3) On or before the effective date of a substantial premium increase as defined in paragraph (2), the insurer shall meet the following conditions:

(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 (e). This option may be elected during the 120-day period referenced in subsection (d)(3).

(iii) Notify the policyholder or certificateholder that a default or lapse during the 120-day period referenced in subsection (d)(3) shall be deemed to be the election of the offer to convert in subsection (d)(4).

(d) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in this subsection as follows:

(1) For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least 1% per year prior to age 50, and at least 3% per year beyond age 50.

(2) For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in paragraph (3).

(3) The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to 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 be at least 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 (f).

(4) The nonforfeiture benefit shall begin by the end of the 3rd year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first 3 years as well as thereafter. For a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of either the end of the 10th year following the policy or certificate issue date or the end of the 2nd year following the date the policy or certificate is no longer subject to attained age rating.

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

(e) The 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.

(f) There may not be a difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

(g) The requirements in this section are effective _____ (*Editor's Note*: The blank refers to a date 12 months after the effective date of adoption of this proposal.) and apply as follows:

(1) Except as provided in paragraph (2), this section applies to a long-term care policy issued in this Commonwealth on or after _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposal.).

(2) For certificates issued on or after _____ (*Editor's Note:* The blank refers to the effective date of adoption of this proposal.) under a group long-term care insurance policy as defined in section 1103 of the act (40 P. S. § 991.1103), which policy was in force on _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposal.), this section does not apply.

(h) 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 § 89a.117 (relating to loss ratio) treating the policy as a whole.

(i) To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection (d)(3), a replacing insurer that purchased or otherwise assumed 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.

(j) A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets all of the following requirements:

(1) The nonforfeiture provision shall be appropriately captioned.

(2) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of 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.

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

(i) Reduced paid-up insurance.

(ii) Extended term insurance.

(iii) Shortened benefit period.

(iv) Other similar offerings approved by the Commissioner.

§ 89a.124. Standards for benefit triggers.

(a) 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 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.

(b) Insurers may use activities of daily living to trigger covered benefits in addition to those contained in paragraphs (1)—(6) as long as they are defined in the policy. Activities of daily living shall include at least the following as defined in § 89a.104 (relating to policy definitions) and in the policy:

(1) Bathing.

(2) Continence.

(3) Dressing.

(4) Eating.

(5) Toileting.

(6) Transferring.

(c) An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate. The provisions may not restrict, and are not in lieu of, the requirements in subsections (a) and (b).

(d) For purposes of this section, the determination of a deficiency may not be more restrictive than either of the following:

(1) Requiring the supervisory or hands-on assistance of another person to perform the prescribed activities of daily living.

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

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

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

(g) The requirements in this section become effective _____ (*Editor's Note*: The blank refers to a date 12 months from the effective date of adoption of this proposal.) and apply as follows:

(1) Except as provided in paragraph (2), this section applies to a long-term care policy issued in this Commonwealth on or after _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposal.).

(2) For certificates issued on or after _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposal.), under a group long-term care insurance policy as defined in section 1103 of the act (40. P. S. § 991.1103) that was in force on _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposal.) this section does not apply.

§ 89a.125. Additional standards for benefit triggers for qualified long-term care insurance contracts.

(a) For purposes of this section the following definitions apply:

Qualified long-term care services—Means services that meet the requirements of section 7702(c)(1) of the Internal Revenue Code of 1986 (26 U.S.C.A. § 7702(c)(1)) 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 uner a plan of care prescribed by a licensed health care practitioner.

Chronically ill individual—Has the meaning prescribed for this term by section 7702B(c)(2) of the Internal Revenue Code of 1986 (26 U.S.C.A. § 7702B(c)(2)).

(i) Under this provision, a chronically ill individual means an individual who has been certified by a licensed health care practitioner as either of the following:

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

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

(ii) The term does 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.

Licensed health care practitioner—A physician, as defined in section 1861(r)(1) of the Social Security Act (42 U.S.C.A. § 1395x(r)(1)), a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the Secretary of the United States Treasury.

(4) *Maintenance or personal care services*—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).

(b) 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.

(c) 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.

(d) Certifications regarding activities of daily living and cognitive impairment required under subsection (c) 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 United States Treasury.

(e) Certifications required under subsection (c) 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.

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

§ 89a.126. Standard format outline of coverage.

(a) This section implements, interprets and makes specific section 1111 of the act (40 P. S. § 911.1111) in prescribing a standard format and the content of an outline of coverage.

(b) The outline of coverage shall:

(1) Be a free-standing document, using no smaller than 10-point type.

(2) Contain no material of an advertising nature.

(c) 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.

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

(e) The standard format for outline of coverage is as follows:

[COMPANY NAME]

[ADDRESS—CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. 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]

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

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

3. FEDERAL TAX CONSEQUENCES.

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

OR

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

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:

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

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

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

(c) [Describe waiver of premium provisions or state that there are not such provisions.]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

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

6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

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

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home. This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductibles, waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Non-institutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.]

[Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions.

(b) Non-eligible facilities and provider.

(c) Non-eligible levels of care (for example, unlicensed providers, care or treatment provided by a family member, and the like).

(d) Exclusions and exceptions.

(e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 9 above.]

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

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

(a) That the benefit level will not increase over time.

(b) Any automatic benefit adjustment provisions.

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

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

(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

13. PREMIUM.

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

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

14. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used.

(b) Describe other important features.]

15. CONTACT THE COMMONWEALTH HEALTH INSURANCE ASSISTANCE PROGRAM (APPRISE-1-800-783-7067) IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY (INSERT INSURANCE COMPANY NAME AND PHONE NUMBER) IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

§ 89a.127. Requirement to deliver shopper's guide.

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.

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

(2) In the case of direct response solicitations, the shopper's guide shall be presented in conjunction with an application or enrollment form.

§ 89a.128. Penalties.

In addition to other penalties provided by the laws of this Commonwealth, an insurer or producer found to have violated requirements relating to the regulations of long-term care insurance or the marketing of long-term care

insurance shall be subject to penalties under section 1114 of the act (40 P. S. § 991.1114).

§ 89a.129. Permitted compensation arrangements.

(a) An insurer or other entity may provide commission or other compensation to an agent or broker for the sale of a long-term care insurance policy or certificate only if the first year commission or other compensation is not greater than 50% of the first year premium.

(b) The commission or other compensation provided for a minimum of 5 subsequent (renewal) years may not exceed 10% of the renewal premium.

(c) When there is a replacement of an existing policy or duplication of coverage, an entity may not provide compensation to its agents or brokers and an agent or broker may not receive compensation greater than the renewal compensation payable by the replacing or duplicative insurer.

(d) For purposes of this section, "compensation" includes pecuniary or nonpecuniary remuneration relating to the sale or renewal of the policy or certificate, including bonuses, gifts, prizes, awards and finders fees.

(e) Subsections (a) and (b) apply solely to agents and brokers who directly solicit applicants and insureds and who effect the sale of a policy or certificate and not to general agents or other entities who contract with or are otherwise employed by insurers.

APPENDIX A

RESCISSION REPORTING FORM FOR LONG-TERM CARE POLICIES FOR THE STATE OF _____ FOR THE REPORTING YEAR 20[__]

Company Name:

Address:

Phone Number:

Due: March 1 annually

Instructions:

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

Policy Form #	*Policy and Certificate #*	*Name of Insured*	*Date of Policy Issuance*	*Date/s Claim/s Submitted*	*Date of Rescission*

Detailed reason for rescission:

Signature

Name and Title (please type)

Date

APPENDIX B

LONG TERM CARE INSURANCE PERSONAL WORKSHEET

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

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

Premium Information

Policy Form Numbers _____

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

Type of Policy (noncancellable/guaranteed renewable):

The Company's Right to Increase Premiums: _____

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

Rate Increase History

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

Questions Related to Your Income

How will you pay each year's premium?

☐ From my Income ☐ From my Savings/Investments
☐ My Family will Pay

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

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

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

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

Will you buy inflation protection? (check one)
☐ Yes ☐ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

☐ From my Income ☐ From my Savings/Investments
☐ My Family will Pay

The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually. Contact your area Agency on Aging for information on the range of costs for Long Term Care Services in your area. The Area Agency on Aging phone number can be found in the blue pages of the phone book or on the Pennsylvania Department of Aging web site at www.aging.state.pa.us.

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

How are you planning to pay for your care during the elimination period? (check one)

☐ From my Income ☐ From my Savings/Investments
☐ My Family will Pay

Questions Related to Your Savings and Investments

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

☐ Under $20,000 ☐ $20,000-$30,000
☐ $30,000-$50,000 ☐ Over $50,000

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

☐ Stay about the same ☐ Increase ☐ Decrease

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

Disclosure Statement

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

Signed: _____
(Applicant) (Date)

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

Signed: _____
(Agent) (Date)

Agent's Printed Name:]

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

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____]
(Applicant) (Date)

The company may contact you to verify your answers.

APPENDIX C

THINGS YOU SHOULD KNOW BEFORE YOU BUY LONG-TERM CARE INSURANCE

Long-Term Care Insurance

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

Medicare

- Medicare does not pay for most long-term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's healthcare service bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back premium you have paid if you are dissatisfied for a reason or choose not to purchase the policy.

Counseling • Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

APPENDIX D

LONG-TERM CARE INSURANCE SUITABILITY LETTER

Dear [Applicant]:

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

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

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

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

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

Please check one box and return in the enclosed envelope.

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

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

_____

APPLICANT'S SIGNATURE DATE

Please return to [issuer] at [address] by [date].

APPENDIX E

CLAIMS DENIAL REPORTING FORM LONG-TERM CARE INSURANCE

For the State of _____

For the Reporting Year of _____

Company Name: _____
Due: June 30 annually

Company Address:

_____

_____

_____

Company NAIC Number:

_____

_____

Contact Person: _____ Phone Number: _____

Line of Business: Individual Group

Instructions

The purpose of this form is to report all long-term care claim denials under in force long-term care insurance policies. "Denied" means a claim that is not paid for a reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

		State Data	***Nationwide Data[1]***
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Long-Term Care Claim Denied due to:		
8	• Long-Term Care Services Not Covered under the Policy[2]		
9	• Provider/Facility Not Qualified under the Policy[3]		
10	• Benefit Eligibility Criteria Not Met[4]		
11	• Other		

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.

2. Example—home health care claim filed under a nursing home only policy.

3. Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.

4. Examples—a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

APPENDIX F

RATE INFORMATION

Instructions:

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Insurers shall provide all of the following information to the applicant:

Long Term Care Insurance

Potential Rate Increase Disclosure Form

1. **[Premium Rate] [Premium Rate Schedules]:]** [Premium rate] [Premium rate schedules] that [is] [are] applicable to you and that will be in effect until a request is made and [filed] [approved] for an increase [is] [are] [on the application] [$ _____])

2. **The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.**

3. **Rate Schedule Adjustments:**

The company will provide a description of when premium rate or rate schedule adjustments will be effective (for example, next anniversary date, next billing date, and the like) (fill in the blank): _____.

4. **Potential Rate Revisions:**

This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

• Pay the increased premium and continue your policy in force as is.

• Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)

• Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)

• Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

Turn the Page

*** Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

• Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table and

• You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (that is, new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

• You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.

• In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay more premiums).

• Your "paid-up" policy benefits are $10,000 (provided you have a least $10,000 of benefits remaining under your policy.)

Contingent Nonforfeiture

Cumulative Premium Increase over Initial Premium

That qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%

Contingent Nonforfeiture Cumulative Premium Increase over Initial Premium That qualifies for Contingent Nonforfeiture (Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)	
Issue Age	Percent Increase Over Initial Premium
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

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