2. For policies and certificates which provide actuarially equivalent benefits, no additional reserves need to be established.

3. Policy liens and policy loans, including accrued interest, represent assets of the company for statutory reporting purposes. For any policy on which the policy lien exceeds the policy's statutory reserve liability such excess must be held as a non-admitted asset.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:644.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1409 (December 1992).

§1523. Filing Requirement

A. The filing and prior approval of forms containing an accelerated benefit is required.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:644.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1409 (December 1992).

Chapter 17. Regulation 45—Filing of Affirmative Action Plans

§1701. Purpose

A. The purpose of this regulation is to implement R.S. 22:1923.A.(l), which requires an insurer to file an affirmative action plan upon the violation of a cease and desist order issued by the commissioner after hearing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1923.A.(1).
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1581 (December 1993).

§1703. Applicability and Scope

A. This regulation applies to any insurer that is called for hearing before the commissioner for violating Part X of the Insurance Code (Equal Opportunity In Insurance) and found to be in violation of a Cease and Desist Order issued in accordance with the provisions of R.S. 22:1923.A. It sets forth the minimum content and procedures for the filing of an affirmative action plan by an insurer who violates Part X of the Insurance Code, and who then violates a cease and desist order issued by the commissioner after hearing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1923.A.(1).
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1581 (December 1993).

§1705. Content and Procedure

A. The commissioner shall notify an insurer of its violation of a cease and desist order issued pursuant to Part X of the Insurance Code by Certified U.S. Mail, return receipt requested. Said notification shall also direct the insurer to file an affirmative action plan.

B. The notice shall require the insurer to file its plan within 20 days of receipt of the notice.

C. The insurer shall file its plan by means of the U.S. Mail, and it shall contain the minimum requirements stated in R.S. 22:1923.C(4)(a) and (b).

D. The insurer shall address the plan to the attention of the Office of Minority Affairs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1923.A.(1).
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1581 (December 1993).

§1707. Effective Date

A. This regulation shall become effective upon final promulgation in the *Louisiana Register*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1923.A.(1).
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1581 (December 1993).

Chapter 19. Regulation 46—Long-Term Care Insurance

§1901. Purpose

A. The purpose of this regulation is to implement R.S. 22:1181-1191, Long-Term Care Insurance Act, 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:462 (February 2005), LR 31:462 (February 2005), LR 43:1394 (July 2017) (effective January 1, 2018).

§1903. Applicability and Scope

A. Except as otherwise specifically provided, this regulation applies to all long-term care insurance policies, including qualified long-term care contracts and life insurance policies that accelerate benefits for long-term care delivered, or issued for delivery, in this state on or after February 20, 2005, by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations; and all similar organizations to the extent they are authorized to issue life or health insurance. Certain provisions of this regulation apply only to qualified long-term care insurance contracts as noted. Renewal policies shall comply with this regulation as amended.

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

1. the benefits of the disability income policy are

dependent upon or vary in amount based on the receipt of long-term care services;

2. the disability income policy is advertised, marketed or offered as insurance for long-term care services; or

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:462 (February 2005).

§1905. Definitions

A. For the purpose of this regulation, the terms *applicant*, *certificate*, *commissioner*, *group long-term care insurance*, *long-term care insurance*, *policy*, and *qualified long-term care insurance* shall have the meanings set forth in R.S. 22:1184. In addition, the following definitions will apply.

Benefit Trigger—for the purposes of independent review, a contractual provision in the insured's policy of long-term care insurance conditioning the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. For purposes of a tax-qualified long-term care insurance contract, as defined in section 7702B of the *Internal Revenue Code* of 1986, as amended, "benefit trigger" shall include a determination by a licensed health care practitioner that an insured is a chronically ill individual.

Exceptional Increase—

a. only those increases filed by an insurer as exceptional for which the commissioner determines the need for the premium rate increase is justified:

i. due to changes in laws or regulations applicable to long-term care coverage in this state; or

ii. due to increased and unexpected utilization that affects the majority of insurers of similar products;

b. except as provided in §1937, exceptional increases are subject to the same requirements as other premium rate schedule increases;

c. 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;

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

Incidental (as used in §1937.J)—that the value of the long-term care benefits provided is less than 10 percent 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.

Independent Review Organization—an organization that conducts independent reviews of long-term care benefit trigger decisions.

Licensed Health Care Professional—an individual qualified by education and experience in an appropriate field, to determine, by record review, an insured's actual functional or cognitive impairment.

Qualified Actuary—a member in good standing of the American Academy of Actuaries.

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 R.S. 22:1184(4)(a) are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:462 (February 2005), LR 43:1394 (July 2017) (effective January 1, 2018).

§1907. Policy Definitions

A.1. No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements.

Activities of Daily Living—at least bathing, continence, dressing, eating, toileting, and transferring.

Acute Condition—that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

Adult Day Care—a program for six or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting adults who are frail, impaired and elderly, or have other disabilities and 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.

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 any 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 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 in their residences to persons who are ill, have a disability, or have an infirmity. Such services may include homemaker services, assistance with activities of daily living, and respite care services.

Medicare—"the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted, and any later amendments or substitutes thereof," or words of similar import.

Mental or Nervous Disorder—shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

Personal Care—the provision of hands-on services to assist an individual with activities of daily living.

Skilled Nursing Care, Personal Care, Home Care, Specialized Care, Assisted Living Care, and *Other Services*—shall be defined in relation to the level of skill required, the nature of the care, and the setting in which care must be delivered.

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.

2. 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.

B. All providers of services including, but not limited to, skilled nursing facility, extended care facility, convalescent nursing home, personal care facility, specialized care providers, assisted living facility, and home care agency shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration, or degree status of those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified, or registered, it shall also state what requirements a provider must meet in lieu of licensure, certification, or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified, registered, or when the state licenses, certifies, or registers the provider of services under another name.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:976 (August 1997), LR 43:1394 (July 2017) (effective January 1, 2018), amended LR 45:279 (February 2019).

§1909. Policy Practices and Provisions

A. Renewability. The terms *guaranteed renewable* and *noncancellable* shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of §1913 of this regulation.

1. A policy issued to an individual shall 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 any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

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 any change in any 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 other requirements of §1909.A, a qualified long-term insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

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

1. preexisting conditions or diseases;

2. mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;

3. alcoholism and drug addiction;

4. illness, treatment, or medical condition arising out of:

a. war or act of war (whether declared or undeclared);

b. participation in a felony, riot, or insurrection;

c. service in the armed forces or units auxiliary thereto;

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

e. aviation (this exclusion applies only to non-fare paying passengers);

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

6. expenses for services or items available or paid under another long-term care insurance or health insurance policy;

7. 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 or would be so reimbursable but for the application of a deductible or coinsurance amount;

8. Subsection 1909.B is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

a. Subsection 1909.B is not intended to prohibit exclusions and limitations by type of provider. However, no long-term care issuer may deny a claim because services are provided in a state other than the state of policy issued under the following conditions:

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

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

b. For purposes of §1909.B.8:

i. *state of policy issue*—the state in which the individual policy or certificate was originally issued.

9. Subsection 1909.B is not intended to prohibit territorial limitations.

C. Extension of Benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization, if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

D. Continuation or Conversion

1. Group long-term care insurance issued in this state on or after the effective date of §1909 shall provide covered individuals with a basis for continuation or conversion of coverage.

2. For the purposes of §1909, a *basis for continuation of coverage* means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium, when due. Group policies which restrict provision of benefits and services to, or contain incentives to use certain providers and/or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans including, but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.

3. For the purposes of §1909, a *basis for conversion of coverage* means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

4. For the purposes of §1909, *converted policy* means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers and/or facilities, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans including, but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.

5. Written application for the converted policy shall be made, and the first premium due, if any, shall be paid as directed by the insurer not later than 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. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be

calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

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

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

b. the terminating coverage is replaced not later than 31 days after termination by group coverage effective on the day following the termination of coverage:

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

ii. the premium for which is calculated in a manner consistent with the requirements of §1909.D.6.

8. Notwithstanding any other provision of §1909, a converted policy issued to an individual who, at the time of conversion, is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. Such 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, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

10. Notwithstanding any other provision of §1909, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

11. For the purposes of §1909, 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:

1. shall not result in any exclusion for pre-existing conditions that would have been covered under the group policy being replaced; and

2. shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.

F.1. The premium charged to an insured shall not increase due to either:

a. the increasing age of the insured at ages beyond 65; or

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

2. The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under §1955, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

3. A reduction in benefits shall not be considered a premium change, but for purposes of the calculation required under §1955, 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 R.S. 22:1184(4)(a), any requirement that a signature of an insured be obtained by a producer or insurer shall be deemed satisfied if:

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

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

c. the telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and "privileged information" as defined by applicable state or federal law, 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:462 (February 2005), LR 43:1395 (July 2017) (effective January 1, 2018).

§1911. Unintentional Lapse

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

1. Notice before Lapse or Termination

a. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium or a written waiver, dated and signed by the

applicant, electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state:

> "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

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

c. When the policyholder or certificateholder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in §1911.A.1.a need not be met until 60 days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

d. Lapse or Termination for Nonpayment of Premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to §1911.A.1.a, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.

B. Reinstatement. In addition to the requirement in §1911.A.1, a long-term care insurance policy or certificate shall include a provision which provides for reinstatement of coverage, in the event of lapse, if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured, if requested within five months after termination, and shall allow for the collection of past due premium where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:978 (August 1997), LR 31:464 (February 2005).

§1913. 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 shall not apply to policies which 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 where 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 which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to, in writing and signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider, or endorsement.

C. Payment of Benefits. A long-term care insurance policy which 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 such terms and an explanation of such terms in its accompanying outline of coverage.

D. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to pre-existing conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Pre-Existing Condition Limitations."

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

F. Disclosure of Tax Consequences. With regard to life insurance policies which provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider, and at the time the accelerated benefit payment request is submitted, that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The

disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. §1913.F shall not apply to qualified long-term care insurance contracts.

G. 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 provision and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this provision. 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.

H. A qualified long-term care insurance contract shall include a disclosure statement in the policy, and in the outline of coverage as contained in §1963 that the policy is intended to be a qualified long-term care insurance contract under section 7702B(b) of the *Internal Revenue Code* of 1986, as amended.

I. A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in §1963 that the policy is not intended to be a qualified long-term care insurance contract.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:978 (August 1997), LR 31:465 (February 2005), LR 43:1395 (July 2017) (effective January 1, 2018).

§1915. Required Disclosure of Rating Practices to Consumers

A. This Section shall apply as follows.

1. Except as provided in §1915.A.2, §1915 applies to any long-term care policy or certificate issued in this state on or after August 19, 2005.

2. For certificates issued on or after the effective date of this amended regulation under a *group long-term care insurance policy* as defined in R.S. 22:1184(4), which policy was in force at the time this amended regulation became effective, the provisions of §1915 shall apply on the policy anniversary following February 19, 2006.

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 §1915.B 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 §1915 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:

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

b. the right to a revised premium rate or rate schedule as provided in §1915.B.3 if the premium rate or rate schedule is changed;

5.a. information regarding each premium rate increase on this policy form or similar policy forms over the past 10 years for this state or any other state that, at a minimum, identifies:

i. the policy forms for which premium rates have been increased;

ii. the calendar years when the form was available for purchase; and

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

b. the insurer may, in a fair manner, provide additional explanatory information related to the rate increases;

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

d. 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 the effective date of §1915 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 §1915.B.5.a of this Paragraph;

e. if the acquiring insurer in §1915.B.5.d above 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 §1915.B.5.d, the acquiring insurer shall make all disclosures required by §1915.B.5, including disclosure of the earlier rate increase referenced in §1915.B.5.d.

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 §1915.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 to comply with the requirements of §1915.B and §1915.C of this Section.

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. The notice shall include the information required by §1915.B when the rate increase is implemented.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:465 (February 2005), amended LR 43:1395 (July 2017) (effective January 1, 2018).

§1917. Initial Filing Requirements

A. This Section applies to any long-term care policy issued in this state on or after August 19, 2005, except that §1917.B.2.d and §1917.B.3 apply to any long-term care policy issued in this state on or after January 1, 2018.

B. An insurer shall provide the information listed in §1917.B to the commissioner 45 days prior to making a long-term care insurance form available for sale:

1. a copy of the disclosure documents required in §1915; and

2. an actuarial certification consisting of at least the following:

a. 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;

b. a statement that the policy design and coverage provided have been reviewed and taken into consideration;

c. a statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

d. a statement that the premiums contain at least the minimum margin for moderately adverse experience defined in §1917.B.2.d.i or the specification of and justification for a lower margin as required by §1917.B.2.d.ii:

i. a composite margin shall not be less than 10 percent of lifetime claims;

ii. a composite margin that is less than 10 percent may be justified in uncommon circumstances. The proposed amount, full justification of the proposed amount, and methods to monitor developing experience that would be the basis for withdrawal of approval for such lower margins must be submitted;

iii. a composite margin lower than otherwise considered appropriate for the stand-alone long-term care policy may be justified for long-term care benefits provided through a life policy or an annuity contract. Such lower composite margin, if utilized, shall be justified by appropriate actuarial demonstration addressing margins and volatility when considering the entirety of the product;

iv. a greater margin may be appropriate in circumstances where the company has less credible experience to support its assumptions used to determine the premium rates;

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

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

f. a statement that reserve requirements have been reviewed and considered. Support for this statement shall include:

i. sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; and

ii. a statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship.

3. An actuarial memorandum prepared, dated, and signed by a member of the Academy of Actuaries shall be included and shall address and support each specific item required as part of the actuarial certification and provide at least the following information:

a. an explanation of the review performed by the actuary prior to marking the statements in §1917.B.2.b and §1917.B.2.c;

b. a complete description of pricing assumptions;

c. sources and levels of margins incorporated into the gross premiums that are the basis for the statement in §1917.B.2.a of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. Deviations in margins between ages, sexes, plans, or states shall be clearly described. Deviations in margins required to be described are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating gross premium scales; and

d. a demonstration that the gross premiums include the minimum composite margin specified in §1917.B.2.d.

C. In any review of the actuarial certification and actuarial memorandum, the commissioner may request review by an actuary with experience in long-term care

pricing who is independent of the company. In the event the commissioner asks for additional information as a result of any review, the period in §1917.B does not include the period during which the insurer is preparing the requested information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:466 (February 2005), amended LR 43:1395 (July 2017) (effective January 1, 2018).

§1919. Requirements 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 any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

1. increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than 5 percent;

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 shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5 percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

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

B. Where the policy is issued to a group, the required offer in §1919.A shall be made to the group policyholder; except, if the policy is issued to a group defined in R.S. 22:1184(4)(d), other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

C. The offer in §1919.A shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

D.1. Insurers shall include the following information in or with the outline of coverage:

a. a graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period;

b. any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

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

E. Inflation protection benefit increases, under a policy which contains such 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 which provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. Such offer shall disclose, in a conspicuous manner, that the premium may change in the future, unless the premium is guaranteed to remain constant.

G.1. Inflation protection, as provided in §1919.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 §1919.G.1. The rejection may be either in the application or on a separate form.

2. The rejection shall be considered a part of the application and shall state:

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1156 (September 1993), amended LR 23:975 (August 1997), LR 31:467 (February 2005), LR 43:1396 (July 2017) (effective January 1, 2018).

§1921. Prohibition against Post-Claim Underwriting (Formerly §1915)

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

B.1. If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

2. If the medications listed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall 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 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];

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

a. a report of a physical examination;

b. an assessment of functional capacity;

c. an attending physician's statement; or

d. copies of medical records.

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 which 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 §1969, Appendix A.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:467 (February 2005), LR 43:1396 (July 2017) (effective January 1, 2018).

§1923. Minimum Standards for Home Health and Community Care Benefits in Long-Term Care Insurance Policies (Formerly §1917)

A. A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits:

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

2. by requiring that the insured or claimant first, or simultaneously, receive nursing or therapeutic services, or both, in a home, community, or institutional setting before home health care services are covered;

3. by limiting eligible services to services provided by registered nurses or licensed practical nurses;

4. by requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

5. by excluding coverage for personal care services provided by a home health aide;

6. by requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

7. by requiring that the insured or claimant have an acute condition before home health care services are covered;

8. by limiting benefits to services provided by Medicare-certified agencies or providers;

9. by 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 one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1158 (September 1993), amended LR 23:982 (August 1997), repromulgated LR 31:467 (February 2005), amended LR 43:1396 (July 2017) (effective January 1, 2018).

§1925. Requirements for Application Forms and Replacement Coverage (Formerly §1921)

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 any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer, except where the coverage is sold without a producer, containing such questions may be used. With regard to a replacement policy issued to a group defined by R.S. 22:1184(4)(a), 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, health maintenance organization contract)?

2. Did you have another long-term care insurance

policy or certificate in force during the last 12 months?

a. If so, with which company?

b. If that policy lapsed, when did it lapse?

3. Are you covered by Medicaid?

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

B. Producers shall list any other health insurance policies they have sold to the applicant.

1. List policies sold which are still in force.

2. List policies sold in the past five years which are no longer in force.

C. Solicitations Other than Direct Response. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its producer, 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 such 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 [company name] Insurance Company. Your new policy provides thirty (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 PRODUCER
[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 which you may presently have (pre-existing 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. State law provides that your replacement policy or certificate may not contain new pre-existing conditions or probationary periods. The insurer will waive any time periods applicable to pre-existing 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 producer 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 your sign it, reread it carefully to be certain that all information has been properly recorded.

_____
(Signature of Producer, Broker or Other Representative)
[Typed Name and Address of Producer or Broker]

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

_____ _____
(Applicant's Signature) (Date)

D. Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the 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 [company name] Insurance Company. Your new policy provides thirty (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 (pre-existing 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. State law provides that your replacement policy or certificate may not contain new pre-existing conditions or probationary periods. Your insurer will waive any time periods applicable to pre-existing 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 producer 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 thirty (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, name of the insured, and policy number or address, including zip code. Such notice shall be made within five working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

F. Life Insurance policies that accelerate benefits for long-term care shall comply with this Section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of Regulation 70. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:468 (February 2005), LR 43:1396 (July 2017) (effective January 1, 2018).

§1927. Reporting Requirements (Formerly §1923)

A. Every insurer shall maintain records for each producer of that producer's amount of replacement sales as a percentage of the producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the producer as a percentage of the producer's total annual sales.

B. Each insurer shall report annually, by June 30, the 10 percent of its producers with the greatest percentages of lapses and replacements, as measured by §1927.A (§1969, Appendix G).

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 producer activities regarding the sale of long-term care insurance.

D. Every insurer shall report annually, by June 30, the number of lapsed policies as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the end of the preceding calendar year (§1969, Appendix G).

E. Every insurer shall report annually, by June 30, the number of replacement policies sold as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the preceding calendar year (§1969, Appendix G).

F. Every insurer shall report annually, by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied (§1969, Appendix E).

G. For purposes of §1927:

1. *policy* means only long-term care insurance; and

2. subject to §1927.G.3, *claim* means a request for a payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

3. *denied* means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

4. *report* means on a statewide basis.

H. Reports required under this Section shall be filed with the commissioner.

I. Annual rate certification requirements

1. Section 1927.I applies to any long-term care policy issued in this state on or after January 1, 2018.

2. The following annual submission requirements apply subsequent to initial rate filings for individual long-term care insurance policies made under §1927:

a. an actuarial certification prepared, dated, and signed by a member of the American Academy of Actuaries who provides the information shall be included and shall provide at least the following information:

i. a statement of the sufficiency of the current premium rate schedule including:

(a). for the rate schedules currently marketed:

(i). the premium rate schedule continues to be 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; or

(ii). if the above statement cannot be made, a statement that margins for moderately adverse experience may no longer be sufficient. In this situation, the insurer shall provide to the commissioner, within 60 days of the date the actuarial certification is submitted to the commissioner, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience so that the ultimate premium rate schedule would be reasonably expected to be sustainable over the future life of the form with no future premium increases anticipated. Failure to submit a plan of action to the commissioner within 60 days or to comply with the time frame stated in the plan of action constitutes grounds for the commissioner to withdraw or modify approval of the form for future sales pursuant to R.S. 22:972;

(b). for the rate schedules that are no longer marketed:

(i). that premium rate schedule continues to be sufficient to cover anticipated costs under best estimate

assumptions; or

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

ii. a description of the review performed that led to the statement;

b. an actuarial memorandum dated and signed by a member of the American Academy of Actuaries who prepares the information shall be prepared to support the actuarial certification and provide at least the following information:

i. a detailed explanation of the data sources and review performed by the actuary prior to making the statement in §1927.I.2.a;

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

iii. a description of the credibility of the experience data;

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

c. the actuarial certification required pursuant to §1927.I.2.a must be based on calendar year data and submitted annually no later than May 1 of each year starting in the second year following the year in which the initial rate schedules are first used. The actuarial memorandum required pursuant to §1927.I.2.b must be submitted at least once every three years with the certification.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:469 (February 2005), LR 43:1397 (July 2017) (effective January 1, 2018).

§1929. Licensing (Formerly §1925)

A. A producer is not authorized to market, sell, solicit, or negotiate with respect to long-term care except as authorized by R.S. 22:1543 and R.S. 22:1547(A)(1) and (2).

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:470 (February 2005), LR 43:1397 (July 2017) (effective January 1, 2018).

§1931. Discretionary Powers of Commissioner (Formerly §1927)

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

1. the modification or suspension would be in the best interest of the insureds;

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

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

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

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:470 (February 2005).

§1933. Reserve Standards (Formerly §1929)

A. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with R.S. 22:751, R.S. 22:752, and R.S. 22:753. Claim reserves shall also be established in the case when the policy or rider is in claim status.

B. Reserves for policies and riders subject to §1933.B should be based on the multiple decrement model, utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit, assuming no long-term care benefit.

C.1. In the development and calculation of reserves for policies and riders subject to §1933.C, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures, and all other considerations which have an impact on projected claim costs including, but not limited to, the following:

a. definition of insured events;

b. covered long-term care facilities;

c. existence of home convalescence care coverage;

d. definition of facilities;

e. existence or absence of barriers to eligibility;

f. premium waiver provision;

g. renewability;

h. ability to raise premiums;

i. marketing method;

j. underwriting procedures;

k. claims adjustment procedures;

l. waiting period;

m. maximum benefit;

n. availability of eligible facilities;

o. margins in claim costs;

p. optional nature of benefit;

q. delay in eligibility for benefit;

r. inflation protection provisions; and

s. guaranteed insurability option.

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

D. When long-term care benefits are provided other than as in §1933.A, reserves shall be determined in accordance with prevailing NAIC actuarial standards.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:470 (February 2005), LR 43:1397 (July 2017) (effective January 1, 2018).

§1935. Loss Ratio
(Formerly §1931)

A. This Section shall apply to all long-term care insurance policies or certificates except those covered under §1917, §1937, and §1939.

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 percent, 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:

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; and

13. product features such as long elimination periods, high deductibles, and high maximum limits.

C. Section 1935.B shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

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

2. the portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of R.S. 22:936;

3. the policy meets the disclosure requirements of R.S. 22:1186(H), (I) and (J);

4. any policy illustration that meets the applicable requirements of Regulation 55; and

5. an actuarial memorandum is filed with the insurance department that includes:

a. a description of the basis on which the long-term care rates were determined;

b. a description of the basis for the reserves;

c. a summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

d. a description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

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

f. the estimated average annual premium per policy and the average issue age;

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

h. a description of the effect of the long-term care policy provision on the required premiums, nonforfeiture

values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:470 (February 2005), LR 43:1398 (July 2017) (effective January 1, 2018).

§1937. Premium Rate Schedule Increases

A. This Section shall apply as follows.

1. Except as provided in §1937.A.2, §1937 applies to any long-term care policy or certificate issued in this state on or after August 19, 2005 and prior to January 1, 2018.

2. For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in R.S. 22:1184(4)(a), which policy was in force at the time this amended regulation became effective, the provisions of §1937 shall apply on the policy anniversary following February 19, 2006.

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

1. information required by §1915;

2. certification by a qualified actuary that:

a. 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;

b. the premium rate filing is in compliance with the provisions of §1937;

c. the insurer may request a premium rate schedule increase less than what is required under §1937, and the commissioner may approve such premium rate schedule increase, without submissions of the certification in §1937.B.2.a, if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required under §1937.B.2.a, the premium rate schedule increase filing satisfies all other requirements of §1937 and is, in the opinion of the commissioner, in the best interest of policyholders;

3. an actuarial memorandum justifying the rate schedule change request that includes:

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

i. annual values for the five years preceding and the three years following the valuation date shall be provided separately;

ii. the projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

iii. the projections shall demonstrate compliance with §1937.C; and

iv. for exceptional increases:

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

(b). in the event the commissioner determines as provided in §1905 that offsets may exist, the insurer shall use appropriate net projected experience;

b. disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

c. 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;

d. a statement that policy design, underwriting and claims adjudication practices have been taken into consideration;

e. 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; and

f. a demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin specified in §1917.B.2.d is projected to be exhausted;

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; and

5. sufficient information for review and approval of the premium rate schedule increase by the commissioner.

C. All premium rate schedule increases shall be determined in accordance with the following requirements:

1. exceptional increases shall provide that 70 percent 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 such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

a. the accumulated value of the initial earned premium times 58 percent;

b. 85 percent of the accumulated value of prior premium rate schedule increases on an earned basis;

c. the present value of future projected initial earned premiums times 58 percent; and

d. 85 percent of the present value of future projected premiums not in §1937.C.2.c on an earned basis;

3. in the event that a policy form has both exceptional and other increases, the values in §1937.C.2.b and d will also include 70 percent for exceptional rate increase amounts; and

4. all present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as defined annually under R.S. 22:753. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

D. For each rate increase that is implemented, the insurer shall file for approval by the commissioner updated projections, as defined in §1937.B.3.a, annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in §1937.K, the projections required by §1937.D shall be provided to the policyholder in lieu of filing with the commissioner.

E. If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in §1937.B.3.a, shall be filed for approval by the commissioner every five years following the end of the required period in §1937.D. For group insurance policies that meet the conditions in §1937.K, the projections required by §1937.E shall be provided to the policyholder in lieu of filing with the commissioner.

F.1. 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 §1937.C, the commissioner may require the insurer to implement any of the following:

a. premium rate schedule adjustments; or

b. other measures to reduce the difference between the projected and actual experience.

2. In determining whether the actual experience adequately matches the projected experience, consideration should be given to §1937.B.3.e, 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:

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 §1937.H; and

2. the original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to §1937.C had the greater of the original anticipated lifetime loss ratio or 58 percent been used in the calculations described in §1937.C.2.a and c.

H.1. For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

a. the rate increase is not the first rate increase requested for the specific policy form or forms;

b. the rate increase is not an exceptional increase; and

c. the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

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

a. The offer shall:

i. be subject to the approval of the commissioner;

ii. be based on actuarially sound principles, but not be based on attained age; and

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

b. 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; and

ii. the maximum rate increase determined based only on the experience of the insureds originally issued the form plus 10 percent.

I. 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 §1937.H of this Section, prohibit the insurer from either of the following:

1. filing and marketing comparable coverage for a period of up to five years; or

2. offering all other similar coverages and limiting

marketing of new applications to the products subject to recent premium rate schedule increases.

J. Section 1937.A through I shall not apply to policies for which the long-term care benefits provided by the policy are *incidental*, as defined in §1905, if the policy complies with all of the following provisions:

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

2. the portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

a. R.S. 22:936;

b. R.S. 22:952; and

c. R.S. 22:914;

3. the policy meets the disclosure requirements of R.S. 22:1186(H), (I), and (J);

4. the portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

a. policy illustrations as required by Regulation 55;

b. disclosure requirements in Regulation 28;

5. an actuarial memorandum is filed with the insurance department that includes:

a. a description of the basis on which the long-term care rates were determined;

b. a description of the basis for the reserves;

c. a summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

d. a description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

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

f. the estimated average annual premium per policy and the average issue age;

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

h. 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.

K. Section 1937.F and §1937.H shall not apply to group insurance policies as defined in R.S. 22:1184(4)(a) where:

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

2. the policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than 20 percent of the total premium for the group in the calendar year prior to the year a rate increase is filed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:471 (February 2005), amended LR 43:1398 (July 2017) (effective January 1, 2018).

§1939. Premium Rate Schedule Increases for Policies Subject to Loss Ratio Limits Related to Original Filings

A. Section 1939 shall apply as follows.

1. Except as provided in §1939.A.2, §1939 applies to any long-term care policy or certificate issued in this state on or after January 1, 2018.

2. For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in R.S. 22:1184(4)(a), which policy was in force at the time this amended regulation became effective, the provisions of §1939 shall apply on the policy anniversary following January 1, 2018.

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

1. information required by §1915;

2. certification by a qualified actuary that:

a. 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;

b. the premium rate filing is in compliance with the provisions of §1939;

c. the insurer may request a premium rate schedule increase less than what is required under §1939 and the commissioner may approve such premium rate schedule increase, without submissions of the certification in §1939.B.2.a, if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required under §1939.B.2.a, the premium rate schedule increase filing satisfies all other requirements of §1939 and is, in the opinion of the commissioner, in the best interest of policyholders;

3. an actuarial memorandum justifying the rate

schedule change request that includes:

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

i. annual values for the five years preceding and the three years following the valuation date shall be provided separately;

ii. the projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

iii. the projections shall demonstrate compliance with §1939.C; and

iv. for exceptional increases:

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

(b). in the event the commissioner determines as provided in §1905 that offsets may exist, the insurer shall use appropriate net projected experience;

b. disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

c. 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;

d. a statement that policy design, underwriting, and claims adjudication practices have been taken into consideration;

e. 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; and

f. a demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin specified in §1917.B.2.d is projected to be exhausted;

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; and

5. sufficient information for review and approval of the premium rate schedule increase by the commissioner.

C. All premium rate schedule increases shall be determined in accordance with the following requirements:

1. exceptional increases shall provide that 70 percent 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 such that the sum of the lesser of the accumulated value of incurred claims, without the inclusion of active life reserves, or the accumulated value of historic expected claims, without the inclusion of active life reserves, plus the present value of the future expected incurred claims, projected without the inclusion of active life reserves, will not be less than the sum of the following:

a. the accumulated value of the initial earned premium times the greater of 58 percent and the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience;

b. 85 percent of the accumulated value of prior premium rate schedule increases on an earned basis;

c. the present value of future projected initial earned premiums times the greater of 58 percent and the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience; and

d. 85 percent of the present value of future projected premiums not in §1939.C.2.c on an earned basis;

3. expected claims shall be calculated based on the original filing assumptions assumed until new assumptions are filed as part of a rate increase. New assumptions shall be used for all periods beyond each requested effective date of a rate increase. Expected claims are calculated for each calendar year based on the in-force at the beginning of the calendar year. Expected claims shall include margins for moderately adverse experience; either amounts included in the claims that were used to determine the lifetime loss ratio consistent with the original filing or as modified in any rate increase filing;

4. in the event that a policy form has both exceptional and other increases, the values in §1939.C.2.b and d will also include 70 percent for exceptional rate increase amounts; and

5. all present and accumulated values used to determine rate increases, including the lifetime loss ratio consistent with the original filing reflecting margins for moderately adverse experience, shall use the maximum valuation interest rate for contract reserves as defined annually under R.S. 22:753. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

D. For each rate increase that is implemented, the insurer shall file for approval by the commissioner updated projections, as defined in §1939.B.3.a, annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in §1939.K, the projections required by §1939.D shall be provided to the policyholder in lieu of filing with the commissioner.

E. If any premium rate in the revised premium rate

schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in §1939.B.3.a, shall be filed for approval by the commissioner every five years following the end of the required period in §1939.D. For group insurance policies that meet the conditions in §1939.K, the projections required by §1939.E shall be provided to the policyholder in lieu of filing with the commissioner.

F.1. 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 §1939.C, the commissioner may require the insurer to implement any of the following:

a. premium rate schedule adjustments; or

b. other measures to reduce the difference between the projected and actual experience.

2. In determining whether the actual experience adequately matches the projected experience, consideration should be given to §1939.B.3.e, 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 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 §1939.H.1-2.

H.1. For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

a. the rate increase is not the first rate increase requested for the specific policy form or forms;

b. the rate increase is not an exceptional increase; and

c. the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

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

a. The offer shall:

i. be subject to the approval of the commissioner;

ii. be based on actuarially sound principles, but not be based on attained age; and

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

b. 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; and

ii. the maximum rate increase determined based only on the experience of the insureds originally issued the form plus 10 percent.

I. 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 §1939.H.1-2, prohibit the insurer from either of the following:

1. filing and marketing comparable coverage for a period of up to five years; or

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

J. Section 1939.A through I shall not apply to policies for which the long-term care benefits provided by the policy are *incidental*, as defined in §1905, if the policy complies with all of the following provisions:

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

2. the portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

a. R.S. 22:936;

b. R.S. 22:952; and

c. R.S. 22:914;

3. the policy meets the disclosure requirements of R.S. 22:1186(H), (I), and (J);

4. the portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

a. policy illustrations as required by Regulation 55;

b. disclosure requirements in Regulation 28;

5. an actuarial memorandum is filed with the

insurance department that includes:

a. a description of the basis on which the long-term care rates were determined;

b. a description of the basis for the reserves;

c. a summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

d. a description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

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

f. the estimated average annual premium per policy and the average issue age;

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

h. 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.

K. Section 1939.F and H shall not apply to group insurance policies as defined in R.S. 22:1184(4)(a) where:

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

2. the policyholder, and not the certificate holders, pays a material portion of the premium, which shall not be less than 20 percent of the total premium for the group in the calendar year prior to the year a rate increase is filed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22: 1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 43:1398 (July 2017) (effective January 1, 2018).

§1941. Filing Requirement (Formerly §1939)

A. Prior to a long-term care insurer or other similar organization offering group long-term care insurance to a resident of this state, pursuant to R.S. 22:1185, it shall file with the commissioner evidence that the group meets the requirements of R.S. 22:1184(4)(d); and such insurers shall file for approval any group policy or certificate to be offered to residents of this state, regardless of from where it was issued or delivered.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:473 (February 2005), LR 43:1401 (July 2017) (effective January 1, 2018).

§1943. Filing Requirements for Advertising (Formerly §1941)

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

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), repromulgated LR 31:473 (February 2005), amended LR 43:1401 (July 2017) (effective January 1, 2018).

§1945. Standards for Marketing (Formerly §1943)

A. Every insurer, health care service plan, or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

1. establish marketing procedures and producer training requirements to assure that:

a. any marketing activities, including any comparison of policies by its producers or other producers will be fair and accurate; and

b. 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 §1915.D (Appendices B and F) 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 any such 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. establish auditable procedures for verifying compliance with §1945.A;

6. if the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program, approved by the commissioner, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificateholder that such a program 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 §1909.A.3 of this regulation;

8. provide an explanation of contingent benefit upon lapse provided in §1955.D.3 and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in §1955.D.4.

B. In addition to the practices prohibited in R.S. 22:1961 et seq., the following acts and practices are prohibited.

Cold Lead Advertising—making use directly, or indirectly, of any method of marketing which fails to disclose, in a conspicuous manner, that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.

High Pressure Tactics—employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

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

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

C.1. With respect to the obligations set forth in §1945.C.1, the primary responsibility of an association, as defined in R.S. 22:1184(4)(b), 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. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

2. The insurer shall file with the insurance department the following material:

a. the policy and certificate;

b. a corresponding outline of coverage; and

c. all advertisements requested by the insurance department.

3. The association shall disclose in any long-term care insurance solicitation:

a. the specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and

b. a brief description of the process under which the policies, and the insurer issuing the policies, were selected.

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.a. The association shall also:

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 producers; and

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

b. Clauses 1945.C.6.a.i-iii shall not apply to qualified long-term care insurance contracts.

7. No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the state insurance department the information required in §1945.C.

8. The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in §1945.C.

9. Failure to comply with the filing and certification requirements of §1943 constitutes an unfair trade practice in violation of R.S. 22:1961 et seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:475 (February 2005), LR 43:1402 (July 2017) (effective January 1, 2018), repromulgated LR 44:784 (April 2018).

§1947. Suitability
(Formerly §1945)

A. Section 1947 shall not apply to life insurance policies that accelerate benefits for long-term care.

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

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 producers in the use of its suitability standards; and

3. maintain a copy of its suitability standards and make them available for inspection, upon request, by the commissioner.

C.1. To determine whether the applicant meets the standards developed by the issuer, the producer and issuer shall develop procedures that take the following into consideration:

a. the ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

b. the applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

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

2. The issuer, and where a producer is involved, the producer shall make reasonable efforts to obtain the information set out in §1947.C.1. The efforts shall include presentation to the applicant at, or prior to, application the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in §1969.B, Appendix B, in not less than 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 producer of information obtained through the personal worksheet in §1969.B, Appendix B, is prohibited.

D. The issuer shall use the suitability standards it has developed, pursuant to §1947, in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

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

F. 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 §1969.C, Appendix C, in not less than 12-point type.

G. 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 §1969.D, Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:475 (February 2005), LR 43:1402 (July 2017) (effective January 1, 2018).

§1949. Prohibition against Pre-Existing Conditions and Probationary Periods in Replacement Policies or Certificates
(Formerly §1947)

A. If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to pre-existing 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), repromulgated LR 31:475 (February 2005), LR 43:1403 (July 2017) (effective January 1, 2018).

§1951. Availability of New Services or Providers

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

B. Notwithstanding §1951.A above, notification is not required for any policy issued prior to the effective date of §1951 or to any policyholder or certificateholder who is currently eligible for benefits, within an elimination period or on a claim, or who previously had been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

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

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

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

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

4. by an alternative program developed by the insurer that meets the intent of §1951 if the program is filed with and approved by the commissioner.

D. An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of §1951.D, "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders that purchased such a new proprietary policy shall be notified when a new long-term care policy series that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel.

E. Policies issued pursuant to §1951 shall be considered exchanges and not replacements. These exchanges shall not be subject to §1925 and §1947 and the reporting requirements of §1927.A through E.

F. Where the policy is offered through an employer, labor organization, professional, trade, or occupational association, the required notification in §1951.A above shall be made to the offering entity. However, if the policy is issued to a group defined in R.S. 22:1184(4)(d), the notification shall be made to each certificateholder.

G. Nothing in §1951 shall prohibit an insurer from offering any policy, rider, certificate, or coverage change to any policyholder or certificateholder. However, upon request, any policyholder may apply for currently available coverage that includes the new services or providers. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

H. Section 1951 does not apply to life insurance policies or riders containing accelerated long-term care benefits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22: 1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 43:1403 (July 2017) (effective January 1, 2018).

§1953. Right to Reduce Coverage and Lower Premiums

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

a. reducing the maximum benefits; or

b. reducing the daily, weekly or monthly benefit amount.

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

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

B. The provision shall include a description of the process for requesting and implementing a reduction in coverage.

C. The premium for the reduced coverage shall:

1. be based on the same age and underwriting class used to determine the premium for the coverage currently in force; and

2. be consistent with the approved rate table.

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

E. If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by §1911.A.l.d.

F. Section 1953 does not apply to life insurance policies or riders containing accelerated long-term care benefits.

G. The requirements of §1953.A through F shall apply to any long-term care policy issued in this state on or after January 1, 2018.

H. A premium increase notice required by §1915.E shall include:

1. an offer to reduce policy benefits provided by the

current coverage consistent with the requirements of §1953;

2. a disclosure stating that all options available to the policyholder or certificateholder may not be of equal value; and

3. in the case of a partnership policy or certificate, a disclosure that some benefit reduction options may result in a loss in partnership status that may reduce policyholder or certificateholder protections.

I. The requirements of §1953.H shall apply to any rate increase implemented in this state on or after January 1, 2018.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22: 1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 43:1404 (July 2017) (effective January 1, 2018).

§1955. Nonforfeiture Benefit Requirement (Formerly §1949)

A. Section 1955 does not apply to life insurance policies or riders containing accelerated long-term care benefits.

B. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of R.S. 22:1188:

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 §1955.E; and

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.

C. If the offer required to be made under R.S. 22:1188 is rejected, the insurer shall provide the contingent benefit upon lapse described in §1955. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in §1955.D.4 shall still apply.

D.1. After rejection of the offer required under R.S. 22:1188, for individual and group policies without nonforfeiture benefits issued after the effective date of §1955, the insurer shall provide a contingent benefit upon lapse.

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

3. A contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least 45 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%
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%

4.a. A contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio in §1955.D.6.b is 40 percent or more. Unless otherwise required, policyholders shall be notified at least 45 days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase	
Issue Age	Percent Increase over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

b. This provision shall be in addition to the contingent benefit provided by §1955.D.3 above and, where both are triggered, the benefit provided shall be at the option of the insured.

5. On or before the effective date of a substantial premium increase as defined in §1955.D.3, the insurer shall:

a. offer to reduce policy benefits provided by the current coverage consistent with the requirements of §1953 so that required premium payments are not increased;

b. offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of §1955.E. This option may be elected at any time during the 120-day period referenced in §1955.D.3; and

c. notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in §1955.D.3 shall be deemed to be the election of the offer to convert in §1955.D.5.b above unless the automatic option in §1955.D.6.c applies.

6. On or before the effective date of a substantial premium increase as defined in §1955.D.4 above, the insurer shall:

a. offer to reduce policy benefits provided by the current coverage consistent with the requirements of §1953 so that required premium payments are not increased;

b. offer to convert the coverage to a paid-up status where the amount payable for each benefit is 90 percent of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period reference in §1955.D.4; and

c. notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in §1955.D.4 shall be deemed to be the election of the offer to convert in §1955.D.6.b above if the ratio is 40 percent or more.

7. For any long-term care policy issued in this state on or after January 1, 2018:

a. in the event the policy or certificate was issued at least 20 years prior to the effective date of the increase, a value of 0 percent shall be used in place of all values in the above table; and

b. values above 100 percent in the table in §1955.D.3 above shall be reduced to 100 percent.

E. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with §1955.D.3 but not §1955.D.4, are described in §1955.E.

1. For purposes of §1955.E, *attained age rating* is defined as a schedule of premiums, starting from the issue date, which increases with increasing age at least 1 percent per year prior to age 50, and at least 3 percent per year beyond age 50.

2. For purposes of §1955.E, the nonforfeiture benefit shall be 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 §1955.E.3.

3. The standard nonforfeiture credit will be equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of §1955.F.

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

b. Notwithstanding §1955.E.4.a, for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

i. the end of the tenth year following the policy or certificate issue date; or

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

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

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

G. There shall be no difference in the minimum nonforfeiture benefits, as required under §1955, for group and individual policies.

H. The requirements set forth in §1955 shall be effective January 1, 1999 and shall apply as follows.

1. Except as provided in §1955.H.2 and §1955.H.3 below, the provisions of §1955 apply to any long-term care policy issued in this state on or after the effective date of this amended regulation.

2. For certificates issued on or after the effective date of §1955, under a group long-term care insurance policy, as defined in R.S. 22:1184(4)(a), which policy was in force at the time this amended regulation became effective, the provisions of §1955 shall not apply.

3. The last sentence in §1955.C and §1955.D.4 and §1955.D.6 shall apply to any long-term care insurance policy or certificate issued in this state after January 1, 2018, except new certificates on a group policy as defined in R.S. 22:1184(4)(a) after July 1, 2018.

I. 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 §1935,

§1937, or §1939, whichever is applicable, treating the policy as a whole.

J. To determine whether contingent nonforfeiture upon lapse provisions are triggered under §1955.D.3 or §1955.D.4, a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

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

1. the nonforfeiture provision shall be appropriately captioned;

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

3. the nonforfeiture provision shall provide at least one of the following:

a. reduced paid-up insurance;

b. extended term insurance;

c. shortened benefit period; or

d. other similar offerings approved by the commissioner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:475 (February 2005), LR 43:1404 (July 2017) (effective January 1, 2018).

§1957. Standards for Benefit Triggers (Formerly §1951)

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 shall 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.1. Activities of daily living shall include at least the following as defined in §1907 and in the policy:

a. bathing;

b. continence;

c. dressing;

d. eating;

e. toileting; and

f. transferring.

2. Insurers may use activities of daily living to trigger covered benefits in addition to those contained in §1957.B.1, as long as they are defined in the policy.

C. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in §1957.A-B.

D. For purposes of §1957, the determination of a deficiency shall not be more restrictive than:

1. requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

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

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 set forth in §1957 shall be effective January 1, 1999 and shall apply as follows.

1. Except as provided in §1957.G.2, the provisions of §1957 apply to a long-term care policy issued in this state on or after the effective date of the amended regulation.

2. For certificates issued on or after the effective date of §1957, under a group long-term care insurance policy, as defined in R.S. 22:1184(4)(a) that was in force at the time this amended regulation became effective, the provisions of §1957 shall not apply.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), repromulgated LR 31:477 (February 2005), amended LR 43:1406 (July 2017) (effective January 1, 2018).

§1959. Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts (Formerly §1953)

A. For purposes of this Section the following definitions apply.

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

2.a. Chronically ill individual has the meaning prescribed for this term by Section 7702B(c)(2) of the

Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

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

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

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

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

4. Maintenance or personal care services means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

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

C. A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's ability 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 pursuant to §1959.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 treasury.

E. Certifications required pursuant to §1959.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 contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:477 (February 2005), LR 43:1406 (July 2017) (effective January 1, 2018).

§1961. Appealing an Insurer's Determination That the Benefit Trigger is Not Met

A. For purposes of §1961, "authorized representative" is authorized to act as the covered person's personal representative within the meaning of 45 CFR 164.502(g) promulgated by the secretary of the U.S. Department of Health and Human Services under the administrative simplification provisions of the Health Insurance Portability and Accountability Act and means the following:

1. a person to whom a covered person has given express written consent to represent the covered person in an external review;

2. a person authorized by law to provide substituted consent for a covered person; or

3. a family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent.

B. If an insurer determines that the benefit trigger of a long-term care insurance policy has not been met, it shall provide a clear, written notice to the insured and the insured's authorized representation, if applicable, of all of the following:

1. the reason that the insurer determined that the insured's benefit trigger has not been met;

2. the insured's right to internal appeal in accordance with §1961.C, and the right to submit new or additional information relating to the benefit trigger denial with the appeal request; and

3. the insured's right, after exhaustion of the insurer's internal appeal process, to have the benefit trigger determination reviewed under the independent review process in accordance with §1961.D.

C. Internal Appeal. The insured or the insured's authorized representative may appeal the insurer's adverse benefit trigger determination by sending a written request to the insurer, along with any additional supporting information, within 120 calendar days after the insured and the insured's authorized representative, if applicable, receives the insurer's benefit determination notice. The internal appeal shall be considered by an individual or group of individuals designated by the insurer, provided that the individual or individuals making the internal appeal decision may not be the same individual or individuals who made the initial benefit determination. The internal appeal shall be completed and written notice of the internal appeal decision shall be sent to the insured and the insured's authorized representative, if applicable, within 30 calendar days of the insurer's receipt of all necessary information upon which a final determination can be made.

1. If the insurer's original determination is upheld

upon internal appeal, the notice of the internal appeal decision shall describe any additional internal appeal rights offered by the insurer. Nothing herein shall require the insurer to offer any internal appeal rights other than those described in §1961.C.

2. If the insurer's original determination is upheld after the internal appeal process has been exhausted, and new or additional information has not been provided to the insurer, the insurer shall provide a written description of the insured's right to request an independent review of the benefit determination as described in §1961.D to the insured and the insured's authorized representative, if applicable.

3. As part of the written description of the insured's right to request an independent review, an insurer shall include the following, or substantially equivalent, language: "We have determined that the benefit eligibility criteria ("benefit trigger") of your [policy] [certificate] has not been met. You may have the right to an independent review of our decision conducted by long-term care professionals who are not associated with us. Please send a written request for independent review to us at [address]. You must inform us, in writing, of your election to have this decision reviewed within 120 days of receipt of this letter. Listed below are the names and contact information of the independent review organizations approved by your state insurance commissioner's office to conduct long-term care insurance benefit eligibility reviews. If you wish to request an independent review, please choose one of the listed organizations and include its name with your request for independent review. If you elect independent review but do not choose an independent review organization with your request, we will choose one of the independent review organizations for you and refer the request for independent review to it."

4. If the insurer does not believe the benefit trigger decision is eligible for independent review, the insurer shall inform the insured and the insured's authorized representative, if applicable, and include in the notice the reasons for its determination of independent review ineligibility.

5. The appeal process described in §1961.C is not deemed to be a "new service or provider" as referenced in §1951, Availability of New Services or Providers, and therefore does not trigger the notice requirements of §1951.

D. Independent Review of Benefit Trigger Determination

1. Request. The insured or the insured's authorized representative may request an independent review of the insured's benefit trigger determination after the internal appeal process outlined in §1961.C has been exhausted. A written request for independent review may be made by the insured or the insured's authorized representative to the insurer within 120 calendar days after the insurer's written notice of the final internal appeal decision is received by the insured and the insured's authorized representative, if applicable.

2. Cost. The cost of the independent review shall be borne by the insurer.

3. Independent Review Process

a. Within five business days of reviewing a written request for independent review, the insurer shall refer the request to the independent review organization that the insured or the insured's authorized representative has chosen from the list of approved organizations the insurer has provided to the insured. If the insured or the insured's authorized representative does not choose an approved independent review organization to perform the review, the insurer shall choose an independent review organization approved by the state. The insurer shall vary its selection of authorized independent review organizations on a rotating basis.

b. The insurer shall refer the request for independent review of a benefit trigger determination to an independent review organization subject to the following:

i. the independent review organization shall be on a list of approved independent review organizations that satisfy the requirements of a qualified long-term care insurance independent review organization contained in §1961;

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

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

c. If the insured or the insured's authorized representative has new or additional information not previously provided to the insurer, whether submitted to the insurer or the independent review organization, such information shall first be considered in the internal review process, as set forth in §1961.C.

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

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

iii. If the insurer maintains its denial after such review, the independent review organization shall continue its review and render its decision within the time period specified in §1961.D.3.i below. If the insurer overturns its decision following its review, the independent review request shall be considered withdrawn.

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

and address of the independent review organization.

e. Within five business days of receipt of the request for independent review, the independent review organization assigned pursuant to §1961.D.3 shall notify the insured and the insured's authorized representative, if applicable, and the insurer that it has accepted the independent review request and identify the type of licensed health care professional assigned to the review. The assigned independent review organization shall include in the notice a statement that the insured or the insured's authorized representative may submit in writing to the independent review organization within seven days following the date of receipt of the notice of additional information and supporting documentation that the independent review organization should consider when conducting its review.

f. The independent review organization shall review all of the information and documents received pursuant to §1961.D.3.e that has been provided to the independent review organization. The independent review organization shall provide copies of any documentation or information provided by the insured or the insured's authorized representative to the insurer for its review, if it is not part of the information or documentation submitted by the insurer to the independent review organization. The insurer shall review the information and provide its analysis of the new information in accordance with the §1961.D.3.h.

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

h. If the insurer overturns its benefit trigger determination:

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

ii. the independent review process shall immediately cease.

i. The independent review organization shall provide to the insured and the insured's authorized representative, if applicable, and the insurer written notice of its decision, within 30 calendar days from receipt of the referral referenced in §1961.D.3.b. If the independent review organization overturns the insurer's decision, it shall:

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

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

iii. for tax-qualified long-term care insurance contracts, provide a certification (made only by a licensed health care practitioner as defined in section 7702B(c)(4) of the *Internal Revenue Code*) that the insured is a chronically ill individual.

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

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

l. Nothing in §1961 shall restrict the insured's right to submit a new request for benefit trigger determination after the independent review decision, should the independent review organization uphold the insurer's decision.

m. The insurance department shall utilize the criteria set forth in §1969.H, Appendix H, Guidelines for Long-Term Care Independent Review Entities, in certifying or approving entities to review long-term care insurance benefit trigger decisions.

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

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

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

2. Neither it nor any of its licensed health care professionals may, in any manner, be related to or affiliated with an entity that previously provided medical care to the insured.

3. Utilize a licensed health care professional who is not an employee of the insurer or related in any manner to the insured.

4. Neither it nor its licensed health care professional who conducts the reviews may receive compensation of any type that is dependent on the outcome of the review.

5. Be state approved to conduct such reviews if the state requires such approvals.

6. Provide a description of the fees to be charged by it for independent reviews of a long-term care insurance benefit trigger decision. Such fees shall be reasonable and customary for the type of long-term care insurance benefit

trigger decision under review.

7. Provide the name of the medical director or health care professional responsible for the supervision and oversight of the independent review procedure.

8. Have on staff, or contract with, a licensed health care practitioner, as defined by Section 7702B(c)(4) of the *Internal Revenue Code* of 1986, as amended, who is qualified to certify that an individual is chronically ill for purposes of a qualified long-term care insurance contract.

F. Maintenance of Records and Reporting Obligations by Independent Review Organizations. Each approved independent review organization shall comply with the following:

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

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

3. report annually to the commissioner, by June 30, in the aggregate and for each long-term care insurer all of the following:

a. the total number of requests received for independent review of long-term care benefit trigger decisions;

b. the total number of reviews conducted and the resolution of such reviews (i.e., the number of reviews which upheld or overturned the long-term care insurer's determination that the benefit trigger was not met);

c. the number of reviews withdrawn prior to review;

d. the percentage of reviews conducted within the prescribed timeframe set forth in §1961.D.3.i; and

e. such other information the commissioner may require.

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

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

1. an insured's misrepresentation;

2. changes in the insured's benefit eligibility; and

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

H. Applicability. The requirements of §1961 apply to a benefit trigger request made under a long-term care insurance policy on or after July 1, 2018.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 43:1407 (July 2017) (effective January 1, 2018).

§1963. Standard Format Outline of Coverage (Formerly §1955)

A. Section 1963 of the regulation implements, interprets, and makes specific the provisions of R.S. 22:1186(G) in prescribing a standard format and the content of an outline of coverage.

B. The outline of coverage shall be a free-standing document, using no smaller than 10-point type.

C. The outline of coverage shall contain no material of an advertising nature.

D. 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.

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

F. Format for outline of coverage:

[COMPANY NAME]
[ADDRESS—CITY AND 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.**
   (a) 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

(b) 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 producers] Neither [insert company name] nor its producers 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 deductible(s), waiting periods, elimination periods and benefit maximums.]

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

(c) [Noninstitutional 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) Pre-existing conditions;

(b) Noneligible facilities and provider;

(c) Noneligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:478 (February

2005), LR 43:1410 (July 2017) (effective January 1, 2018).

§1965. Requirement to Deliver Shopper's Guide (Formerly §1957)

A. A long-term care insurance shopper's guide in the format developed by the NAIC, 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 producer solicitations, a producer must 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 must be presented in conjunction with any application or enrollment form.

B. Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under R.S. 22:1186(I).

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190..

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:480 (February 2005), LR 43:1411 (July 2017) (effective January 1, 2018).

§1967. Penalties (Formerly §1959)

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:480 (February 2005), LR 43:1411 (July 2017) (effective January 1, 2018).

§1969. Appendices (Formerly 1961)

A. Appendix A

RESCISSION REPORTING FORM FOR LONG-TERM CARE POLICIES FOR THE STATE OF LOUISIANA 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 Number	Policy and Certificate Number	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

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

PREMIUM INFORMATION

Policy Form Numbers

_____

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

Type of Policy (noncancellable/guaranteed renewable):

_____

The Company's Right to Increase Premiums:

_____

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

Rate Increase History

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

Questions Related to Your Income

How will you pay each year's premiums?

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

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

percent of your income.

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

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

☐ From my Income ☐ From my Savings/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.

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

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

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 producer (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:_____ _____

(Producer) (Date)

Producer'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 producer 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.

C. 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 nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

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

Counseling

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

Facilities

- Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

D. 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, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

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

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

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

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

Please check one box and return in the enclosed envelope.

- ☐ Yes, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.
- ☐ No. I have decided not to buy a policy at this time.

_____ _____
Applicant Signature Date

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

E. 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. Indicate the manner of reporting by checking one of the boxes below:

- ☐ Per claimant – counts each individual who makes one or a series of claim requests.
- ☐ Per transaction – counts each claim payment request.

"Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition. It does not include a request for payment that is in excess of the applicable contractual limits.

Inforce Data

		State Data	Nationwide Data[1]
	Total Number of Inforce Policies [Certificates] as of December 31s		

Claims and Denial Data

		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.

F. Appendix F

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 (e.g., next anniversary date, next billing date, etc.) (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 poliy 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: 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 (i.e., 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 any more premiums).
- Your "paid-up" policy benefits are $10,000 (provided you have a least $10,000 of benefits remaining under your policy.)

Turn the Page

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%

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
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

[The following contingent nonforfeiture disclosure need only be included for those limited pay policies to which §1955.D.4 and §1955.D.6 are applicable.

In addition to the contingent nonforfeiture benefits described above, the following reduced "paid-up" contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced "paid-up" benefit AND the contingent benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced "paid-up" contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below;

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect; AND
3. The ration of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

a. The total lifetime amount of benefits your reduced paid up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.
b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable

ratio.

Example:

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy.

G. Appendix G

LONG-TERM CARE INSURANCE REPLACEMENT AND LAPSE REPORTING FORM

For the State of _____ For the Reporting Year of _____
Company Name: _____ Due: June 30 annually
Company Address: _____ Company NAIC Number: _____
Contact Person: _____ Phone Number: (____)_____

Instructions

The purpose of this form is to report on a statewide basis information regarding long-term care insurance policy replacements and lapses. Specifically, every insurer shall maintain records for each producer on that producer's amount of long-term care insurance replacement sales as a percent of the producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the producer as a percent of the producer's total annual sales. The tables below should be used to report the ten percent (10%) of the insurer's producers with the greatest percentages of replacements and lapses.

Listing of the 10% of Producers with the Greatest Percentage of Replacements

Producer's Name	Number of Policies Sold By This Producer	Number of Policies Replaced By This Producer	Number of Replacements As % of Number Sold By This Producer

Listing of the 10% of Producers with the Greatest Percentage of Lapses

Producer's Name	Number of Policies Sold By This Producer	Number of Policies Lapsed By This Producer	Number of Lapses As % of Number Sold By This Producer

Company Totals

Percentage of Replacement Policies Sold to Total Annual Sales ____%
Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year) ____%
Percentage of Lapsed Policies to Total Annual Sales ____%
Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) ____%

H. Appendix H

GUIDELINE FOR LONG-TERM CARE INDEPENDENT REVIEW ENTITIES

In order for an organization to qualify as an independent review organization for long-term care insurance benefit trigger decisions, it shall comply with all of the following:

a. The independent review organization shall ensure that all health care professionals on its staff and with whom it contracts to provide benefit trigger determination reviews hold a current unrestricted license or certification to practice a health care profession in the United States.

b. The independent review organization shall ensure that any health care professional on its staff with whom it contracts to provide benefit trigger determination reviews who is a physician holds a current certification by a recognized American medical specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

c. The independent review organization shall ensure that any health care professional on its staff with whom it contracts to provide benefit trigger determination reviews who is not a physician holds a current certification in the specialty in which that person is licensed, by a recognized American specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

d. The independent review organization shall ensure that all health care professionals on its staff and with whom it contracts to provide benefit trigger determination reviews have no history of disciplinary actions or sanctions including, but not limited to, the loss of staff privileges or any participation restriction taken or pending by any hospital or state or federal government regulatory agency.

e. The independent review organization shall ensure that neither it, nor any of its employees, agents, or licensed health care professionals utilized for benefit trigger determination reviews receives compensation of any type that is dependent on the outcome of the review.

f. The independent review organization shall ensure that neither it, nor any of its employees, agents, or licensed health care professionals it utilized for benefit trigger determination reviews are in any manner related to, employed by, or affiliated with the insurer, insured, or with a person who previously provided medical care or long-term care services to the insured.

g. The independent review organization shall provide a description of the qualifications of the reviewers retained to conduct independent review of long-term care insurance benefit trigger decisions, including the reviewer's current and past employment history, practice affiliations, and a description of past experience with decisions relating to long-term care, functional capacity, dependency in activities of daily living, or in assessing cognitive impairment. Specifically, with regard to reviews of tax qualified long-term care insurance contracts, it must demonstrate the ability to assess the severity of cognitive impairment requiring substantial supervision to protect the individual from harm or with assessing deficits in the ability to perform without substantial assistance from another person at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity.

h. This independent review organization shall provide a description of the procedures employed to ensure that reviewers conducting independent reviews are appropriately licensed or registered; trained in the principles, procedures, and standards of the independent review organization; and knowledgeable about the functional or cognitive impairments associated with the diagnosis and disease staging processes, including expected duration of such impairment, which is the subject of the independent review.

i. The independent review organization shall provide the number of reviewers retained by the independent review organization and a description of the areas of expertise available from such reviewers and the types of cases such reviewers are qualified to review (e.g. assessment of cognitive impairment or inability to perform activities of daily living due to a loss of functional capacity).

j. The independent review organizations shall provide a description of the policies and procedures employed to protect confidentiality of protected health information, in accordance

with federal and state law.

k. The independent review organization shall provide a description of its quality assurance program.

l. The independent review organization shall provide the names of all corporations and organizations owned or controlled by the independent review organization or which own or control the organization, and the nature and extent of any such ownership or control. The independent review organization shall ensure that neither it, nor any of its employees, agents, or licensed health care professionals utilized are not a subsidiary of, or owned or controlled by, an insurer or by a trade association of insurers of which the insured is a member.

m. The independent review organization shall provide the names and résumés of all directors, officers, and executives of the independent review organization.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1186(A), 22:1186(E), 22:1188(C), 22:1189, and 22:1190.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:480 (February 2005), amended LR 43:1412 (July 2017) (effective January 1, 2018).

Chapter 21. Regulation 47—Actuarial Opinion and Memorandum Regulation

§2101. Purpose

A. The purpose of this regulation is to prescribe:

1. requirements for statements of actuarial opinion that are to be submitted in accordance with R.S. 22:162.1, and for memoranda in support thereof;

2. rules applicable to the appointment of an appointed actuary; and

3. guidance as to the meaning of "adequacy of reserves."

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:162.1 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2543 (October 2005).

§2103. Authority

A. This regulation is issued pursuant to the authority vested in the commissioner of insurance of the State of Louisiana under R.S. 22:162.1. This regulation will take effect for annual statements for the year 2005.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:162.1 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2543 (October 2005).

§2105. Scope

A. This regulation shall apply to all life insurance companies and fraternal benefit societies doing business in this state and to all life insurance companies and fraternal benefit societies that are authorized to reinsure life insurance, annuities or accident and health insurance business in this state. This regulation shall be applied in a manner that allows the appointed actuary to utilize his or her professional judgment in performing the asset analysis and developing the actuarial opinion and supporting memoranda, consistent with relevant actuarial standards of practice. However, the commissioner shall have the authority to specify methods of actuarial analysis particular to a company's business profile and may include specific actuarial methods and assumptions including, where appropriate, simplified actuarial methods and assumptions, when, in the commissioner's judgment, such specifications are necessary, or sufficient, to meet the objective of rendering an acceptable opinion as to the adequacy of the reserves and related items.

B. This regulation shall be applicable to all annual statements filed with the office of the commissioner after the effective date of this regulation. A statement of opinion on the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with §2111 of this regulation, and a memorandum in support thereof in accordance with §2113 of this regulation, shall be required each year.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:162.1 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2543 (October 2005).

§2107. Definitions

Actuarial Opinion—the opinion of an appointed actuary regarding the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with §2111 of this regulation and with applicable Actuarial Standards of Practice.

Actuarial Standards Board—the board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice.

Annual Statement—that statement required by Section R.S. 22:1451 of the Insurance Law to be filed by the company with the office of the commissioner annually.

Appointed Actuary—an individual who is appointed or retained in accordance with the requirements set forth in §2109.C. of this regulation to provide the actuarial opinion and supporting memorandum as required by R.S. 22:162.1.

Asset Adequacy Analysis—an analysis that meets the standards and other requirements referred to in §2109.D. of this regulation.

Commissioner—the insurance commissioner of this state.

Company—a life insurance company, fraternal benefit society or reinsurer subject to the provisions of this regulation.

Qualified Actuary—an individual who meets the requirements set forth in §2109.B. of this regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:162.1 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of