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18.01.60 - LONG-TERM CARE INSURANCE MINIMUM STANDARDS

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000. LEGAL AUTHORITY.
This rule is issued pursuant to the authority vested in the Director under Chapter 46, Title 41, Idaho Code, and Chapter 52, Title 67, Idaho Code. (7-1-93)

001. TITLE AND SCOPE.

01. Purpose. The purpose of this rule is to implement Chapter 46, Title 41, Idaho Code, 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. (7-1-93)

02. Applicability. Except as otherwise specifically provided, this rule applies to all long-term insurance policies and certificates delivered or issued for delivery in this state on or after July 15, 1990, by insurers, fraternal benefit societies, nonprofit health, hospital and medical service corporations, prepaid health plans, health maintenance organizations and all similar organizations. (7-1-93)

002. -- 003. (RESERVED).

004. DEFINITIONS.
For the purpose of this rule: (7-1-93)

01. Applicant. "Applicant" means: (7-1-93)

a. In the case of an individual long-term care policy, the person who seeks to contract for benefits; and (7-1-93)

b. In the case of a group long-term care insurance policy, the proposed certificate holder. (7-1-93)

02. Certificate. "Certificate" means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state. (7-1-93)

03. Director. "Director" means the Director of the Idaho Department of Insurance. (7-1-93)

04. Group Long-Term Care Insurance. "Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this state and issued to: (7-1-93)

a. One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations; or (7-1-93)

b. Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association: (7-1-93)

i. Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and (7-1-93)

ii. Has been maintained in good faith for purposes other than obtaining insurance; or (7-1-93)

c. An association or a trust or the trustee(s) of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this state, the

association or associations, or the insurer of the association or associations, shall file evidence with the Director that the association or associations have at the outset a minimum of one hundred (100) persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one (1) year; and have a constitution and by-laws which provide that: (7-1-93)

i. The association or associations hold regular meetings not less than annually to further purposes of the members; (7-1-93)

ii. Except for credit unions, the association or associations collect dues or solicit contributions from members; and (7-1-93)

iii. The members have voting privileges and representation on the governing board and committees. Sixty (60) days after such filing the association or associations will be deemed to satisfy such organizational requirements, unless the Director makes a finding that the association or associations do not satisfy those organizational requirements. (7-1-93)

d. A group other than as described in Subsections 004.04.a. through 004.04.c., subject to a finding by the director that: (7-1-93)

i. The issuance of the group policy is not contrary to the best interest of the public; (7-1-93)

ii. The issuance of the group policy would result in economies of acquisition or administration; and (7-1-93)

iii. The benefits are reasonable in relation to the premiums charged. (7-1-93)

05. Long-term Care Insurance. "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; 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 term includes group and individual policies or riders whether issued by insurers, fraternal benefit societies, nonprofit health, hospital and medical service corporations, prepaid health plans, health maintenance organizations or any similar organization. Such term also includes a policy or rider which provides for payment of benefits based on cognitive impairment or the loss of functional capacity. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. (7-1-93)

06. Policy. "Policy" means any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this state by an insurer, fraternal benefit society, nonprofit health, hospital, or medical service corporation, prepaid health plans, health maintenance organization or any similar organization. (7-1-93)

005. POLICY DEFINITIONS AND TERMS.

No long-term care insurance policy or subscriber contract advertised, solicited, delivered or issued for delivery in this state shall use the terms set forth below, unless these terms are defined in the policy or subscriber contract and the definitions satisfy the following requirements: (7-1-93)

01. Medicare. "Medicare" shall be defined as "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. (7-1-93)

02. Mental or Nervous Disorder. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder. (7-1-93)

03. Skilled Nursing Care, Immediate Care, Personal Care, Home Care and Other Services. "Skilled nursing care," "intermediate care," "personal care," "home care," and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered. (7-1-93)

04. Accident, Accidental Injury or Accidental Means. "Accident," "accidental injury," or "accidental means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization. (7-1-93)

a. The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force." (7-1-93)

b. Such definition may provide that injuries shall not include injuries for which benefits are provided under any workers' compensation, employer's liability or similar law, motor vehicle no-fault plan, unless prohibited by law, or injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit. (7-1-93)

05. Acute Condition. "Acute condition" shall be defined to mean 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 their health status. (7-1-93)

06. Home Health Care Services. "Home health care services" shall be defined to mean medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services. (7-1-93)

07. Convalescent Nursing Home, Extended Care Facility or Skilled Nursing Facility. "Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" shall be defined in relation to its status, facilities and available services. (7-1-93)

a. A definition of such home or facility shall not be more restrictive than one requiring that it: (7-1-93)

i. Be operated pursuant to law; (7-1-93)

ii. Be approved for payment of medicare benefits or be qualified to receive such approval, if so requested; (7-1-93)

iii. Be primarily engaged in providing, in addition to room and board accommodation, skilled nursing care under the supervision of a duly licensed physician; (7-1-93)

iv. Provide continuous twenty-four (24) hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and (7-1-93)

v. Maintain a daily medical record of each patient. (7-1-93)

b. The definition of such home or facility may provide that such term shall not be inclusive of: (7-1-93)

i. Any home, facility or part thereof used primarily for rest; (7-1-93)

ii. A home or facility for the aged or for the care of drug addicts or alcoholics; or (7-1-93)

iii. A home or facility primarily used for the care and treatment of mental diseases or disorders, or educational care. (7-1-93)

08. Hospital. "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals. (7-1-93)

a. The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital: (7-1-93)

i. Be an institution operated pursuant to law; (7-1-93)

ii. Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and (7-1-93)

iii. Provide twenty-four (24) hour nursing service by or under the supervision of registered graduate professional nurses (R.N.'s). (7-1-93)

b. The definition of the term "hospital" may state that such term shall not be inclusive of: (7-1-93)

i. Convalescent homes, convalescent, rest, or nursing facilities; or (7-1-93)

ii. Facilities primarily affording custodial or educational care; or (7-1-93)

iii. Facilities for the aged, drug addicts or alcoholics; or (7-1-93)

iv. Any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services. (7-1-93)

09. Preexisting Conditions. Preexisting conditions may not be defined more restrictive than a condition for which medical advice or treatment was recommended by, or received from a provider of health care services within six (6) months preceding the effective date of coverage of an insured person. No long-term care policy or certificate other than a policy or certificate issued to a group as defined in Subsection 004.04.a. of this chapter may exclude coverage for loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six (6) months following the effective date of coverage of an insured person. (7-1-93)

10. Providers of Services. 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. (7-1-93)

006. -- 010 (RESERVED).

011. POLICY PRACTICES AND PROVISIONS.

01. Renewability. The terms "guaranteed renewable" and "noncancelable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 012 of this chapter. (7-1-93)

02. Conditions for Nonrenewal. No such policy issued to an individual shall contain renewal provisions less favorable to the insured than "guaranteed renewable." However, the Director may authorize nonrenewal on a state-wide basis, on terms and conditions deemed necessary by the Director, to best protect the interests of the insureds, if the insurer demonstrates: (7-1-93)

a. That renewal will jeopardize the insurer's solvency; or (7-1-93)

b. That: (7-1-93)

i. The actual paid claims and expenses have substantially exceeded the premium and investment income associated with the policies; and (7-1-93)

ii. The policies will continue to experience substantial and unexpected losses over their lifetime; and (7-1-93)

iii. The projected loss experience of the policies cannot be significantly improved or mitigated through reasonable rate adjustments or other reasonable methods; and (7-1-93)

iv. The insurer has made repeated and good faith attempts to stabilize loss experience of the policies, including the timely filing for rate adjustments. (7-1-93)

03. Guaranteed Renewable. 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. (7-1-93)

04. Noncancellable. 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. (7-1-93)

05. Limitations and Exclusions. No policy may 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: (7-1-93)

a. Preexisting conditions or diseases; (7-1-93)

b. Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease; (7-1-93)

c. Alcoholism and drug addiction; (7-1-93)

d. Illness, treatment or medical condition arising out of: (7-1-93)

i. War or act of war (whether declared or undeclared); (7-1-93)

ii. Participation in a felony, riot or insurrection; (7-1-93)

iii. Service in the armed forces or units auxiliary thereto; (7-1-93)

iv. Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or (7-1-93)

v. Aviation (this exclusion applies only to non-fare paying passengers). (7-1-93)

e. 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. (7-1-93)

f. No long-term care insurance policy may: (7-1-93)

i. Be cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deteriorating of the mental or physical health of the insured individual or certificate holder; or (7-1-93)

ii. Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder. (7-1-93)

g. Subsection 011.05 is not intended to prohibit exclusions and limitations by type of provider or territorial limitations. (7-1-93)

06. 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. (7-1-93)

07. Continuation or Conversion. (7-1-93)

a. Group long-term care insurance issued in this state on or after the effective date of this rule shall provide covered individuals with a basis for continuation or conversion of coverage. (7-1-93)

b. For the purposes of this section, "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 Director 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. (7-1-93)

c. For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six (6) 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. (7-1-93)

d. For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the Director 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 Director, 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, benefits levels and administrative complexity. (7-1-93)

e. Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy and shall be renewable annually. (7-1-93)

f. 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. (7-1-93)

g. Continuation of coverage or issuance of a converted policy shall be mandatory, except where: (7-1-93)

i. Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or (7-1-93)

ii. The terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage: (7-1-93)

(1) Providing benefits identical to or benefits determined by the Director to be substantially equivalent to or in excess of those provided by the terminating coverage; and (7-1-93)

(2) The premium for which is calculated in a manner consistent with the requirements of Subsection 011.07.f of this chapter. (7-1-93)

h. Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than one hundred percent (100%) 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. (7-1-93)

i. 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. (7-1-93)

j. Notwithstanding any other provision of this section, 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. (7-1-93)

k. For the purpose of this section: a "Managed-Care Plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks. (7-1-93)

012. REQUIRED DISCLOSURE PROVISIONS.

01. Renewability. Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. This provision 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.

DRAFTING NOTE: The last sentence of this rule is intended to apply to long-term care policies which are part of or combined with life insurance policies, since life insurance policies generally do not contain renewability provisions. (7-1-93)

02. Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured or exercises a specifically reserved right under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement. (7-1-93)

03. 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. (7-1-93)

04. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations." (7-1-93)

05. Persons Eligible for Medicare. Any individual policy, subscriber contract, or certificate for long-term care issued or issued for delivery in this state to persons eligible for Medicare shall contain a notice to the insureds that the policy, subscriber contract or certificate is not a Medicare supplement policy. Such notice shall be printed on the first page of the individual policy, subscriber contract or certificate. This same notice shall be printed on the first page of the outline of coverage. Such notice shall be in no less than twelve (12) point type and shall contain the following language: "This (policy, subscriber contract or certificate) is not a Medicare supplement (policy or certificate). If you are eligible for Medicare, review the Medicare supplement buyer's guide available from the company. (7-1-93)

06. Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in Section 41-4605, Idaho Code, shall set forth a description of such limitations or conditions, including any required number of days or confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits." (7-1-93)

07. Right to Return -- Free Look. (7-1-93)

a. Individual long-term care insurance policyholders shall have the right to return the policy within the period of time provided in Idaho Code Section 41-4605(6)(a) and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. Individual long-term care insurance policies shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within the number of days of its delivery as specified in Idaho Code Section 41-4605(6)(a) and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. (7-1-93)

b. A person insured under a long-term care insurance policy issued pursuant to a direct response solicitation shall have the right to return the policy within the period of time provided in Idaho Code Section 41-4605(6)(b) and to have the premium refunded if, after examination, the insured person is not satisfied for any reason. Long-term care insurance policies issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page or attached thereto stating in substance that the insured person shall have the right to return the policy within the number of days of its delivery as specified in Idaho Code Section 41-4605(6)(b) and to have the premium refunded if after examination the insured person is not satisfied for any reason. (7-1-93)

08. Standard Format and Outline of Coverage. This section of the rule implements, interprets and makes specific, the provisions of Idaho Code Section 41-4605(7) in prescribing a standard format and the content of an outline of coverage. (7-1-93)

a. The outline of coverage shall be a free-standing document, using no smaller than ten (10) point type. (7-1-93)

b. The outline of coverage shall contain no material of an advertising nature. (7-1-93)

c. Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring. (7-1-93)

d. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated. (7-1-93)

e. Format for outline of coverage: (See Appendix A at the end of this chapter.)

013. PROHIBITION AGAINST POST-CLAIMS UNDERWRITING.

01. Clear and Unambiguous Questioning in Application. 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. (7-1-93)

02. Questions on Medication. (7-1-93)

a. If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed. (7-1-93)

b. 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. (7-1-93)

03. Required Language. Except for policies or certificates which are guaranteed issue: (7-1-93)

a. The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate: (7-1-93)

Caution: If your answers on this application are incorrect or untrue, (company) has the right to deny benefits or rescind your policy. (7-1-93)

b. The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery. (7-1-93)

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) (7-1-93)

c. A physician's statement of the mental and physical condition of the proposed insured shall accompany the application of any person over seventy-five (75) years of age. (7-1-93)

04. Delivery of Completed Application form Required. A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application. (7-1-93)

05. Record of Policy or Certificate Rescissions Required. 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 furnish within their annual report this information to the Department of Insurance in the format prescribed in Section 41-335, Idaho Code. (7-1-93)

06. Reporting of Cancellation, Nonrenewal, Termination Required. Every insurer or other entity selling or issuing long-term care insurance benefits in the state of Idaho shall annually, on or before March 1, report to the Department of Insurance any cancellation, nonrenewal or termination of such policy within the state of Idaho, stating the reasons therefore. (7-1-93)

014. MINIMUM STANDARDS FOR HOME HEALTH CARE BENEFITS IN LONG-TERM CARE INSURANCE POLICIES.

01. Restrictions on Limitations and Exclusions of Benefits. A long-term care insurance policy or certificate may not limit or exclude benefits: (7-1-93)

a. By requiring that the insured/claimant would need skilled care in a skilled nursing facility if home

health care services were not provided; (7-1-93)

b. By requiring that the insured/claimant first or simultaneously receive nursing and/or therapeutic services in a home or community setting before home health care services are covered; (7-1-93)

c. By limiting eligible services to services provided by registered nurses or licensed practical nurses; (7-1-93)

d. By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification; (7-1-93)

e. By requiring that the insured/claimant have an acute condition before home health care services are covered; (7-1-93)

f. By limiting benefits to services provided by Medicare-certified agencies or providers. (7-1-93)

02. Home health Care Coverage. Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate. (7-1-93)

DRAFTING NOTE: Subsection 014.01.b. above permits the home health care benefits to be counted toward the maximum length of long-term care coverage under the policy. This subsection is not intended to restrict home health care to a period of time which would make the benefit illusory. It is suggested that fewer than forty (40) visits amount to an illusory home health care benefit. (7-1-93)

015. REQUIREMENT TO OFFER INFLATION PROTECTION.

01. Option to Purchase Inflation Protection Required. No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder 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: (7-1-93)

a. Increases benefit levels annually, in a manner so that the increases are compounded annually; (7-1-93)

b. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined; or (7-1-93)

c. Covers a specified percentage of actual or reasonable charges. (7-1-93)

02. Inflation Protection, Group Policy. Where the policy is issued to a group, the required offer in subsection "a" above shall be made to the group policyholder; except, if the policy is issued to a group defined in Section 41-4603 (4)(d), Idaho Code, other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder. (7-1-93)

03. Exemptions to Inflating Protection Requirement. The offer in Subsection 015.01 above shall not be required of: (7-1-93)

a. Life insurance policies or riders containing accelerated long-term care benefits, or (7-1-93)

b. Expense incurred long-term care insurance policies. (7-1-93)

04. Benefit Level Comparisons, Premium Increase Expectations Information Required. Insurers shall

include the following information in or with the outline of coverage: (7-1-93)

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 twenty (20) year period. (7-1-93)

b. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages seventy-five (75), and eighty-five (85) for benefit increases. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure. (7-1-93)

DRAFTING NOTE: It is intended that meaningful inflation protection be provided. It is suggested that a minimum of five percent (5%) (compounded) annual cost increase be used as a base for determining future costs and premiums. Meaningful benefit minimums or durations could include providing increases to attained age, or for a period such as at least twenty (20) years, or for some multiple of the policy's maximum benefit, or throughout the period of coverage. (7-1-93)

016. REQUIREMENTS FOR REPLACEMENT.

01. Question Concerning Replacement. Individual and direct response solicited long-term care insurance application forms shall include a question designed to elicit information as to whether the proposed insurance policy is intended to replace any other accident and sickness, disability or long-term care insurance policy presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used. (7-1-93)

02. Solicitations Other than Direct Response. Upon determining that a sale will involve replacement and prior to issuance or delivery of the individual long-term care insurance policy, an insurer, (other than an insurer using direct response solicitation methods), or its agent, shall furnish the applicant a notice regarding replacement of accident and sickness or long-term care coverage. One (1) 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 manner shown in Appendix B at the end of this chapter. (7-1-93)

017. DISCRETIONARY POWERS OF DIRECTOR.
The Director may, to the extent allowed by statue and upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this rule with respect to a specific long-term care insurance policy or certificate upon a written finding that: (7-1-93)

01. Modification or Suspension. The modification or suspension would be in the best interest of the insureds; and (7-1-93)

02. Achievability of Purposes. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and (7-1-93)

03. Other Reasons for Modifying or Suspending. (7-1-93)

a. The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or (7-1-93)

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 (7-1-93)

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. (7-1-93)

018. RESERVE STANDARDS.

01. Determination of Reserves When Benefits Provided Through Acceleration of Benefits. 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 such benefits shall be determined in accordance with Section 41-612, Idaho Code. Claim reserves must also be established in the case when such policy or rider is in claim status. Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event 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 benefits. In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following: (7-1-93)

a. Definition of insured events; (7-1-93)

b. Covered long-term care facilities; (7-1-93)

c. Existence of home convalescence care coverage; (7-1-93)

d. Definition of facilities; (7-1-93)

e. Existence or absence of barriers to eligibility; (7-1-93)

f. Premium waiver provision; (7-1-93)

g. Renewability; (7-1-93)

h. Ability to raise premiums; (7-1-93)

i. Marketing method; (7-1-93)

j. Underwriting procedures; (7-1-93)

k. Claims adjustment procedures; (7-1-93)

l. Waiting period; (7-1-93)

m. Maximum benefit; (7-1-93)

n. Availability of eligible facilities; (7-1-93)

o. Margins in claim costs; (7-1-93)

p. Optional nature of benefit; (7-1-93)

q. Delay in eligibility for benefit; (7-1-93)

r. Inflation protection provisions; and (7-1-93)

s. Guaranteed insurability option. Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries. (7-1-93)

02. Determination of Reserves in Other Cases. When long-term care benefits are provided other than as in Subsection 018.01 above, reserves shall be determined in compliance with Section 41-608, Idaho Code. (7-1-93)

019. LOSS RATIO.
Benefits under individual long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including: (7-1-93)

01. Statistical Credibility of Incurred Claims Experience and Earned Premiums. (7-1-93)

02. The Period for Which Rates Are Computed to Provide Coverage. (7-1-93)

03. Experienced and Projected Trends. (7-1-93)

04. Concentration of Experience Within Early Policy Duration. (7-1-93)

05. Expected Claim Fluctuation. (7-1-93)

06. Experience Refunds, Adjustments or Dividends. (7-1-93)

07. Renewability Features. (7-1-93)

08. All Appropriate Expense Factors. (7-1-93)

09. Interest. (7-1-93)

10. Experimental Nature of the Coverage. (7-1-93)

11. Policy Reserves. (7-1-93)

12. Mix of Business by Risk Classification. (7-1-93)

13. Product Features Such As Long Elimination Periods, High Deductibles and High Maximum Limits. (7-1-93)

020. FILING REQUIREMENTS.
Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state pursuant to Section 41-4604, Chapter 46, Title 41, Idaho Code, it shall file with the Director evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state. (7-1-93)

021. SEVERABILITY
If any provision of this rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby. (7-1-93)

022. -- 999. (RESERVED).

APPENDIX A

(COMPANY NAME)
(ADDRESS - CITY & STATE)
(TELEPHONE NUMBER)
LONG-TERM CARE INSURANCE
OUTLINE OF COVERAGE

(Policy Number of 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. 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.)

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

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

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

5. 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.)

6. 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) (Non-institutional benefits, by skill level.)

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

7. LIMITATIONS AND EXCLUSIONS. Describe:

(a) (Preexisting conditions);

(b) (Non-eligible facilities/provider);

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

(d) (Exclusions/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 (6) above.)

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

8. 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.

9. TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) Describe the policy renewability provisions;

(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;

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

10. 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.)

11. 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.

12. ADDITIONAL FEATURES:

(a) Indicate if medical underwriting is used;

(b) Describe other important features.

APPENDIX B

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

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing disability 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 ten (10) 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.

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

ii. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

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

_____
(Date)

_____
(Applicant's Signature)"

iii. 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

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.

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

ii. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage

iii. (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)