IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

Market Oversight

18.04.11 – Long-term Care Insurance Minimum Standards

Who does this rule apply to?
This rule applies to all long-term care insurance policies delivered or issued for delivery in Idaho. This includes qualified long-term care insurance contracts and life insurance policies that accelerate benefits for long-term care and policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance Certain provisions of this chapter apply only to qualified long-term care insurance.

What is the purpose of this rule?
The purpose of this rule is to promote the public interest and availability of long-term care insurance coverage. The intent is to protect applicants from unfair sales and enrollment practices and facilitate public understanding, comparison, flexibility, and innovation in the development of long-term care insurance.

What is the legal authority for the agency to promulgate this rule?
This rule implements the following statutes passed by the Idaho Legislature:

- 41-02, et seq., Idaho Code – The Department of Insurance
- 41-46, et seq., Idaho Code – Long-term Care Insurance Act

Who do I contact for more information on this rule?

Department of Insurance
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Boise, ID 83720-0043

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Boise, ID 83720-0043
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18.04.11 – Long-Term Care Insurance Minimum Standards

000. LEGAL AUTHORITY.
Title 41, Chapters 2 and 46, Idaho Code. (7-1-21)T

001. TITLE AND SCOPE.

01. Title. IDAPA 18.04.11, "Long-Term Care Insurance Minimum Standards." (7-1-21)T

02. Purpose. The purpose of this chapter is 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. (7-1-21)T

03. Scope and Applicability. Except as specifically provided, this chapter applies to all long-term care insurance policies including qualified long-term care insurance contracts and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in this state; certain provisions of this chapter apply only to qualified long-term care insurance. Additionally, this chapter is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if: (7-1-21)T

a. The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services; (7-1-21)T

b. The disability income policy is advertised, marketed or offered as insurance for long-term care services; or (7-1-21)T

c. 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. (7-1-21)T

002. INCORPORATION OF DOCUMENTS BY REFERENCE.

01. Forms. Documents incorporated by reference may be obtained from the Idaho Department of Insurance website. (7-1-21)T

02. Documents Incorporated by Reference. This chapter incorporates by reference the following documents, appendices, and attachments of the National Association of Insurance Commissioners (NAIC) Long-Term Care Model Regulation. The Model Regulation is available from the NAIC and from the Idaho Department of Insurance. (7-1-21)T

a. Rescission Reporting Form for Long-Term Care, Appendix A. (7-1-21)T

b. Personal Worksheet, Appendix B. (7-1-21)T

c. Things You Should Know Before You Buy Long-Term Care Insurance, Appendix C. (7-1-21)T

d. Suitability Letter, Appendix D. (7-1-21)T

e. Claims Denial Reporting Form, Appendix E. (7-1-21)T

f. Instructions, Appendix F. (7-1-21)T

g. Replacement and Lapse Reporting Form, Appendix G. (7-1-21)T

h. Outline of Coverage. (7-1-21)T

i. Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance, Attachment I. (7-1-21)T

j. Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance, Attachment II. (7-1-21)T

003. -- 009. (RESERVED)

010. DEFINITIONS.
For the purpose of this rule, the following definitions apply in addition to those found in Title 41, Chapter 46, Idaho Code. (7-1-21)T

01. Exceptional Increase. Means only those increases filed by an insurer as exceptional for which the director determines the need for the premium rate increase is justified due to changes in Idaho laws or rules applicable to long-term care coverage, or due to increased and unexpected utilization that affects the majority of insurers of similar products. (7-1-21)T

a. Except as provided in Section 025, Premium Rate Schedule Increases, exceptional increases are subject to the same requirements as other premium rate schedule increases. (7-1-21)T

b. The director 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. (7-1-21)T

c. The director, in determining that the necessary basis for an exceptional increase exists, will determine any potential offsets to higher claims costs. (7-1-21)T

02. Incidental. As used in Subsection 025.10, the value of the long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy. These values are measured as of the date of issue. (7-1-21)T

03. Qualified Actuary. Means a member in good standing of the American Academy of Actuaries. (7-1-21)T

011. POLICY DEFINITIONS.
For the purpose of this rule, no long-term care insurance policy delivered or issued for delivery in this state may use the terms set forth below, unless the terms are defined in the policy. In relation to the Qualified Long-Term Care plans, such definitions are to satisfy definitions as amended by the U.S. Treasury Department and the following requirements. (7-1-21)T

01. Activities of Daily Living. At least bathing, continence, dressing, eating, toileting, and transferring. (7-1-21)T

02. Acute Condition. The individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, to maintain the individual's health status. (7-1-21)T

03. Adult Day Care. A program for six (6) or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home. (7-1-21)T

04. 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. (7-1-21)T

05. 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. (7-1-21)T

06. 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). (7-1-21)T

07. Dressing. Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs. (7-1-21)T

08. Eating. Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or

table) or by a feeding tube or intravenously. (7-1-21)T

09. Hands-On Assistance. Physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living. (7-1-21)T

10. Home Health Care Services. Medical and non-medical 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. (7-1-21)T

11. Mental or Nervous Disorder. Limited to neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder. (7-1-21)T

12. Personal Care. The provision of hands-on services to assist an individual with activities of daily living. (7-1-21)T

13. Similar Policy Forms. Means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in Section 41-4603(4)(a), Idaho Code, are not considered similar to certificates or policies 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: (7-1-21)T

a. Institutional long-term care benefits only; (7-1-21)T

b. Non-institutional long-term care benefits only; or (7-1-21)T

c. Comprehensive long-term care benefits. (7-1-21)T

14. Skilled Nursing Care, Personal Care, Home Care, Specialized Care, Assisted Living Care and Other Services. Defined in relation to the level of skill prescribed, the nature of the care and the setting in which care need be delivered. (7-1-21)T

15. Toileting. Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene. (7-1-21)T

16. Transferring. Moving into or out of a bed, chair, or wheelchair. (7-1-21)T

17. All Providers of Services. 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 is defined in relation to the services and facilities prescribed 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 also states what requirements a provider need meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or when the state licenses, certifies or registers the provider of services under another name. (7-1-21)T

012. POLICY PRACTICES AND PROVISIONS.

01. Renewability. The terms “guaranteed renewable” and “noncancellable” cannot be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 014 of this rule. (7-1-21)T

a. A policy issued to an individual cannot contain renewal provisions other than “guaranteed renewable” or “noncancellable.” (7-1-21)T

b. 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. (7-1-21)T

c. 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. (7-1-21)T

d. The term "level premium" may only be used when the insurer does not have the right to change the premium for a specified period for the life of the policy. (7-1-21)T

e. In addition to the other requirements of Subsection 011.01, a qualified long-term care insurance contract is guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986 as amended. (7-1-21)T

02. Limitations and Exclusions. A policy cannot be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows: (7-1-21)T

a. Preexisting conditions or diseases; (7-1-21)T

b. Mental or nervous disorders; however, this does not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease; (7-1-21)T

c. Alcoholism and drug addiction; (7-1-21)T

d. Illness, treatment, or medical condition arising out of: (7-1-21)T

i. War or act of war (whether declared or undeclared); (7-1-21)T

ii. Participation in a felony, riot, or insurrection; (7-1-21)T

iii. Service in the armed forces or units auxiliary thereto; (7-1-21)T

iv. Suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or (7-1-21)T

v. Aviation (this exclusion applies only to non-fare-paying passengers). (7-1-21)T

e. Treatment provided in a government facility (unless prescribed 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; (7-1-21)T

f. Expenses for services or items available or paid under another long-term care insurance or health insurance policy; or (7-1-21)T

g. 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. (7-1-21)T

h. Subsection 011.02 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 issue under the following conditions: (7-1-21)T

i. When the state other than the state of policy issue does not have the provider licensing, certification or registration prescribed in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration; or (7-1-21)T

ii When the state other than the state of policy issue licenses, certifies or registers the provider under another name. For purposes of this Subsection 011.02.h. "state of policy issue" means the state in which the individual policy or certificate was originally issued. (7-1-21)T

iii. Subsection 011.02 is not intended to prohibit territorial limitations. (7-1-21)T

03. Extension of Benefits. Termination of long-term care insurance is without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy. (7-1-21)T

04. Continuation or Conversion. (7-1-21)T

a. Group long-term care insurance issued in this state on or after the effective date of Section 011 provides covered individuals with a basis for continuation or conversion of coverage. (7-1-21)T

b. For the purposes of Section 011, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities, may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The director makes a determination as to the substantial equivalency of benefits, and in doing so, takes 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. (7-1-21)T

c. For the purposes of Section 011, "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, is entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability. (7-1-21)T

d. For the purposes of Section 011, "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 or facilities, the director, in making a determination as to the substantial equivalency of benefits, takes 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. (7-1-21)T

e. Written application for the converted policy is made and the first premium due, if any, is paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy is issued effective on the day following the termination of coverage under the group policy and is renewable annually. (7-1-21)T

f. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy is 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 is calculated on the basis of the insured's age at inception of coverage under the group policy replaced. (7-1-21)T

g. Continuation of coverage or issuance of a converted policy is mandatory, except where: (7-1-21)T

i. Termination of group coverage resulted from an individual's failure to make any prescribed payment of premium or contribution when due; or (7-1-21)T

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: (7-1-21)T

(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 (7-1-21)T

(2) The premium for which is calculated in a manner consistent with the requirements of Subsection 011.04.f. (7-1-21)T

h. Notwithstanding any other provision of Section 011, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than one hundred percent (100%) of incurred expenses. The provision is only included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable. (7-1-21)T

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, cannot exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect. (7-1-21)T

j. Notwithstanding any other provision of Section 011, an insured individual whose eligibility for group long-term care coverage is based upon the individual's relationship to another person is entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage. (7-1-21)T

k. For the purposes of Section 011 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. (7-1-21)T

05. 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 offers 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: (7-1-21)T

a. Will not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and (7-1-21)T

b. Cannot vary or depend on the individual's health or disability status, claim experience or use of long-term care services. (7-1-21)T

06. Premium Changes. (7-1-21)T

a. The premium charged to an insured cannot increase due to either: (7-1-21)T

i. The increasing age of the insured at ages beyond sixty-five (65); or (7-1-21)T

ii. The duration the insured has been covered under the policy. (7-1-21)T

b. The purchase of additional coverage is not considered a premium rate increase, but for purposes of the calculation prescribed under Section 032, the portion of the premium attributable to the additional coverage is added to and considered part of the initial annual premium. (7-1-21)T

c. A reduction in benefits is not considered a premium change, but for purpose of the calculation prescribed under Section 032, the initial annual premium is based on the reduced benefits. (7-1-21)T

07. Electronic Enrollment for Group Policies. (7-1-21)T

a. In the case of a group defined in Section 41-4603(4)(a), Idaho Code, any requirement that a signature of an insured be obtained by a producer or insurer is satisfied if: (7-1-21)T

i. The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information is provided to the enrollee; (7-1-21)T

ii. The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention, and prompt retrieval of records; and (7-1-21)T

iii. The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information, "privileged information," is maintained. (7-1-21)T

b. The insurer makes available, upon request of the director, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts. (7-1-21)T

013. UNINTENTIONAL LAPSE.

01. Notice Before Lapse or Termination. Each insurer offering long-term care insurance, as a protection against unintentional lapse, complies with the following: (7-1-21)T

a. No individual long-term care policy or certificate is issued until the insurer has received from the applicant either a written designation of at least one (1) 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 (1) person who is to receive the notice of termination, in addition to the insured. Designation cannot constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation will provide space clearly designated for listing at least one (1) person. The designation includes each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver states: "Protection against unintended lapse. I understand that I have the right to designate at least one (1) 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 thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice." The insurer notifies the insured of the right to change this written designation, no less often than once every two (2) years. (7-1-21)T

b. When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in Subsection 013.01.a. need not be met until sixty (60) days after the policyholder or certificate holder is no longer on such a payment plan. The application or enrollment form for such policies or certificates clearly indicates the payment plan selected by the applicant. (7-1-21)T

c. Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate can lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to Subsection 013.01.a., at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice is given by first class United States mail, postage prepaid; and notice cannot be given until thirty (30) days after a premium is due and unpaid. Notice is deemed to have been given as of five (5) days after the date of mailing. (7-1-21)T

02. Reinstatement. In addition to the requirement in Subsection 013.01, a long-term care insurance policy or certificate includes a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option is available to the insured if requested within five (5) months after termination and allows for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity cannot be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy

and certificate. (7-1-21)T

014. REQUISITE DISCLOSURE PROVISIONS.

01. Renewability. Individual long-term care insurance policies will contain a renewability provision. (7-1-21)T

a. The provision is appropriately captioned, appears on the first page of the policy, and clearly states that the coverage is guaranteed renewable or noncancellable. This provision cannot apply to policies that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder. (7-1-21)T

b. A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, includes a statement that the premium rates may change. (7-1-21)T

02. Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy requires signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term is agreed to in writing signed by the insured, except if the increased benefits or coverage are prescribed by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge is set forth in the policy, rider or endorsement. (7-1-21)T

03. Payment of Benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import includes a definition of these terms and an explanation of the terms in its accompanying outline of coverage. (7-1-21)T

04. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations appears as a separate paragraph of the policy or certificate and is labeled as "Preexisting Condition Limitations." (7-1-21)T

05. 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 banned in Section 41-4605(4)(b)(i), Idaho Code, sets forth a description of the limitations or conditions, including any prescribed number of days of confinement, in a separate paragraph of the policy or certificate and labels such paragraph "Limitations or Conditions on Eligibility for Benefits." (7-1-21)T

06. Disclosure of Tax Consequences. With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is prescribed 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 is prominently displayed on the first page of the policy or rider and any other related documents. Subsection 014.06 cannot apply to qualified long-term care insurance contracts. (7-1-21)T

07. Benefit Triggers. Activities of daily living and cognitive impairment is used to measure an insured's need for long-term care and is described in the policy or certificate in a separate paragraph and is labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers need to be explained. If these triggers differ for different benefits, explanation of the trigger accompanies each benefit description. If an attending physician or other specified person needs to certify a certain level of functional dependency to be eligible for benefits, this too needs to be specified. (7-1-21)T

08. Qualified Contracts. A qualified long-term care insurance contract includes a disclosure statement in the policy and in the outline of coverage as contained in Section 035 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. (7-1-21)T

09. Non-Qualified Contracts. A non-qualified long-term care insurance contract includes a disclosure statement in the policy and in the outline of coverage as contained in Section 035 that the policy is not intended to be a qualified long-term care insurance contract. (7-1-21)T

10. Requisite Disclosure of Rating Practices to Consumers. (7-1-21)T

a. Subsection 014.10 applies as follows: (7-1-21)T

i. Except as provided in Subsection 014.10.a.ii., Subsection 014.10 applies to any long-term care policy or certificate issued in this state on or after July 1, 2001. (7-1-21)T

ii. For certificates issued on or after the effective date of this amended rule under a group long-term care insurance policy as defined in Section 41-4603(4)(a), Idaho Code, which policy was in force at the time this amended rule became effective, the provisions of Subsection 014.10 applies on the policy anniversary following January 1, 2002. (7-1-21)T

b. Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers provide all of the information listed in Subsection 014.10.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 provides all information listed in Subsection 014.10.b. to the applicant no later than at the time of delivery of the policy or certificate. (7-1-21)T

i. A statement that the policy may be subject to rate increases in the future; (7-1-21)T

ii. An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision; (7-1-21)T

iii. The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase; and (7-1-21)T

iv. A general explanation for applying premium rate or rate schedule adjustments that includes a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and the right to a revised premium rate or rate schedule as provided in Subsection 014.10.b.ii., if the premium rate or rate schedule is changed. (7-1-21)T

c. Information regarding each premium rate increase on this policy form or similar forms over the past ten (10) years for this state or any other state that, at a minimum, identifies: (7-1-21)T

i. The policy forms for which premium rates have been increased; (7-1-21)T

ii. The calendar years when the form was available for purchase; and (7-1-21)T

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. (7-1-21)T

d. The insurer may, in a fair manner, provide additional explanatory information related to the rate increases. (7-1-21)T

e. An insurer has 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 acquisition. (7-1-21)T

f. 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 Subsection 014.10 or the end of a twenty-four (24) month period following the acquisition of the

block of policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company includes the disclosure of that rate increase in accordance with Subsection 014.10.c. (7-1-21)T

g. If the acquiring insurer in Subsection 014.10.f. above files for a subsequent rate increase, even within the twenty-four (24) month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from insurers referenced in Subsection 014.10.f., the acquiring insurer will make all disclosures prescribed by Subsection 014,10.c., including disclosure of the earlier rate increase referenced in Subsection 014.10.f. (7-1-21)T

h. An applicant signs an acknowledgment at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure prescribed under Subsections 014.10.b. and 014.10.c. If because of the method of application the applicant cannot sign an acknowledgment at the time of application, the applicant signs no later than at the time of delivery of the policy or certificate. (7-1-21)T

i. An insurer uses the forms in Appendices B and F to comply with the disclosure requirements of Subsection 014.10.b. and Subsection 014.10.h. (7-1-21)T

j. An insurer provides notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least thirty (30) days prior to the implementation of the premium rate schedule increase by the insurer. The notice includes the information prescribed by Subsection 014.10.b., when the increase is implemented. (7-1-21)T

015. PROHIBITION AGAINST POST-CLAIMS UNDERWRITING.

01. Health Conditions. All applications for long-term care insurance policies or certificates except those that are guaranteed issue contains clear and unambiguous questions designed to ascertain the health condition of the applicant. (7-1-21)T

02. Medication. If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it will also ask the applicant to list the medication that has been prescribed. If the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would be denied, then the policy or certificate cannot be rescinded for that condition. (7-1-21)T

03. Non-Guaranteed Issue. Except for policies or certificates which are guaranteed issue: (7-1-21)T

a. The following language is 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. (7-1-21)T

b. The following language, or language substantially similar to the following, is 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)." (7-1-21)T

c. Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the insurer obtains one (1) of the following: (7-1-21)T

i. A report of a physical examination; (7-1-21)T

ii. An assessment of functional capacity; (7-1-21)T

iii. An attending physician's statement; or (7-1-21)T

iv. Copies of medical records. (7-1-21)T

04. Delivery of Application or Enrollment and Form. A copy of the completed application or enrollment form (whichever is applicable) is 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. (7-1-21)T

05. Record of Rescissions. Every insurer or other entity selling or issuing long-term care insurance benefits maintains a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and annually furnishes this information to the insurance director in the format prescribed by the National Association of Insurance Commissioners in Appendix A. (7-1-21)T

016. MINIMUM STANDARDS FOR HOME HEALTH AND COMMUNITY CARE BENEFITS IN LONG-TERM CARE INSURANCE POLICIES.

01. Limitations or Exclusions. A long-term care insurance policy or certificate cannot, if it provides benefits for home health care or community care services, limit or exclude benefits: (7-1-21)T

a. By requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided; (7-1-21)T

b. By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community, or institutional setting before home health care services are covered; (7-1-21)T

c. By limiting eligible services to services provided by registered nurses or licensed practical nurses; (7-1-21)T

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 their licensure or certification; (7-1-21)T

e. By excluding coverage for personal care services provided by a home health aide; (7-1-21)T

f. By requiring that the provision of home health care services be at a level of certification or licensure greater than that prescribed by the eligible service; (7-1-21)T

g. By requiring that the insured or claimant have an acute condition before home health care services are covered; (7-1-21)T

h. By limiting benefits to services provided by Medicare-certified agencies or providers; or (7-1-21)T

i. By excluding coverage for adult day care services. (7-1-21)T

02. Coverage Equivalency. A long-term care insurance policy or certificate, if it provides for home health or community care services, provides total home health or community care coverage that is a dollar amount equivalent to at least one-half (1/2) of one (1) year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement cannot apply to policies or certificates issued to residents of continuing care retirement communities. (7-1-21)T

03. Maximum Coverage. 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. (7-1-21)T

017. REQUIREMENT TO OFFER INFLATION PROTECTION.

01. Inflation Protection Offer. 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 will 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 (1) of the following: (7-1-21)T

a. Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%); (7-1-21)T

b. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status as long as the option for the previous period has not been declined. The amount of the additional benefit is no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or (7-1-21)T

c. Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit. (7-1-21)T

d. With respect to inflation protection for a Partnership policy only: (7-1-21)T

i. If the policy is sold to an individual who has not attained age sixty-one (61) as of the date of purchase, the policy will provide some level of automatic compound annual inflation protection; (7-1-21)T

ii. If the policy is sold to an individual who has attained age sixty-one (61) but has not attained age 76 as of the date of purchase, the policy will provide some level of automatic annual inflation protection; and (7-1-21)T

iii. If the policy is sold to an individual who has attained age seventy-six (76) as of the date of purchase, the policy may (but is not prescribed to) provide some level of inflation protection. (7-1-21)T

02. Group Offer. Where the policy is issued to a group, the prescribed offer in Subsection 017.01 is 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 is made to each proposed certificateholder. (7-1-21)T

03. Requirements for Life Insurance Policies. The offer in Subsection 017.01 above is not prescribed of life insurance policies or riders containing accelerated long-term care benefits. (7-1-21)T

04. Outline of Coverage. Insurers include the following information in or with the outline of coverage: (7-1-21)T

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 shows benefit levels over at least a twenty (20) year period. (7-1-21)T

b. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. (7-1-21)T

c. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure. (7-1-21)T

05. Continuation of Inflation Protection. Inflation protection benefit increases under a policy which contains these benefits 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. (7-1-21)T

06. Premium Disclosures. An offer of inflation protection that provides for automatic benefit increases includes an offer of a premium which the insurer expects to remain constant. The offer discloses in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant . (7-1-21)T

07. Rejection of Offer. Inflation protection as provided in Subsection 017.01 is included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as prescribed in Subsection 017.07. The rejection may be either in the application or on a separate form. The rejection is considered a part of the application and states: "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 (signature line: _____)." (7-1-21)T

018. REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE.

01. Application Forms. Application forms 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 the questions may be used. With regard to a replacement policy issued to a group defined by Section 41-4603(a), Idaho Code, 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. (7-1-21)T

a. Do you have another long-term care insurance policy or certificate in force (including insurance, Fraternal Benefit Societies, Managed Care Organization) or other similar organizations? (7-1-21)T

b. Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months? (7-1-21)T

i. If so, with which company? (7-1-21)T

ii. If that policy lapsed, when did it lapse? (7-1-21)T

c. Are you covered by Medicaid? (7-1-21)T

d. Do you intend to replace any of your medical or health insurance coverage with this policy (certificate)? (7-1-21)T

02. Other Policy Disclosures. Producers list any other health insurance policies they have sold to the applicant. (7-1-21)T

a. List policies sold that are still in force. (7-1-21)T

b. List policies sold in the past five (5) years that are no longer in force. (7-1-21)T

03. 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 furnishes 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 (1) copy of the notice is retained by the applicant and an additional copy signed by the applicant is retained by the insurer. The prescribed notice is in a form based on the NAIC Model Regulation Attachment I. (7-1-21)T

04. Direct Response Solicitations. Insurers using direct response solicitation methods deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The prescribed notice is in a form based on the NAIC Model Regulation Attachment II. (7-1-21)T

05. Notice of Replacement. Where replacement is intended, the replacing insurer notifies, in writing, the existing insurer of the proposed replacement. The existing policy is identified by the insurer, name of the insured and policy number or address including zip code. Notice is made within five (5) working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner. (7-1-21)T

06. Life Insurance Policy Replacement. Life insurance policies that accelerate benefits for long-term care comply with Section 018 if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer complies with the replacement requirements of IDAPA 18.03.04, "Replacement of Life Insurance and Annuities." If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer complies with both the long-term care and the life insurance replacement requirements. (7-1-21)T

019. REPORTING REQUIREMENTS.

01. Maintenance of Producer Records. Every insurer maintains records for each producer of that producer's amount of replacement sales as a percent of the producer's total annual sales and the number of lapses of long-term care insurance policies sold by the producer as a percent of the producer's total annual sales, in the format of Appendix G. (7-1-21)T

02. Producers Experiencing Lapses and Replacements. Every insurer reports annually by June 30 the ten percent (10%) of its producers with the greatest percentages of lapses and replacements as measured by Subsection 019.01. (7-1-21)T

03. Purpose of Reports. 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. (7-1-21)T

04. Lapsed Policies. Every insurer reports annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year. (7-1-21)T

05. Replacement Policies. Every insurer reports annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year. (7-1-21)T

06. Claims Denied. Every insurer reports 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, other than claims denied for failure to meet the waiting period or because of an applicable preexisting condition, in the format of Appendix E. (7-1-21)T

07. Policies and Reports. For purposes of Section 019, "policy" means only long-term care insurance and "report" means on a statewide basis. (7-1-21)T

a. Policy means only long-term care insurance; (7-1-21)T

b. Claim means any request for payment of benefits under a policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met; (7-1-21)T

c. Denied means the insurer refused to pay a claim for any reason; and (7-1-21)T

d. Report means on a statewide basis. (7-1-21)T

08. Filing. Reports prescribed under Section 019 are filed with the Director. (7-1-21)T

020. LICENSING.
No producer is authorized to sell, solicit, or negotiate with respect to long-term care insurance except as authorized by Title 41, Chapter 10, Producer Licensing. (7-1-21)T

021. DISCRETIONARY POWERS OF DIRECTOR.
The director may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this rule with respect to a specific long-term care insurance policy or certificate

upon a written finding that: (7-1-21)T

01. General Requirement. The modification or suspension would be in the best interest of the insureds; the purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and the modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or (7-1-21)T

02. Residential Care Community. 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 (7-1-21)T

03. Other Insurance Products. 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. (7-1-21)T

022. RESERVE STANDARDS.

01. Acceleration of Benefits Under Life Policies. 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 are determined in accordance with Section 41-612, Idaho Code, Standard Valuation Law – Life Insurance. Claim reserves will also be established in the case when the policy or rider is in claim status. (7-1-21)T

02. Decrement Models. Reserves for policies and riders subject to Section 022 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 can 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. (7-1-21)T

03. Considerations Impacting Projected Claim Costs. Any applicable valuation morbidity table is certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries. In the development and calculation of reserves for policies and riders subject to Section 022, due regard is 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: (7-1-21)T

a. Definition of insured events; (7-1-21)T

b. Covered long-term care facilities; (7-1-21)T

c. Existence of home convalescence care coverage; (7-1-21)T

d. Definition of facilities; (7-1-21)T

e. Existence or absence of barriers to eligibility; (7-1-21)T

f. Premium waiver provision; (7-1-21)T

g. Renewability; (7-1-21)T

h. Ability to raise premiums; (7-1-21)T

i. Marketing method; (7-1-21)T

j. Underwriting procedures; (7-1-21)T

k. Claims adjustment procedures; (7-1-21)T

l. Waiting period; (7-1-21)T

m. Maximum benefit; (7-1-21)T

n. Availability of eligible facilities; (7-1-21)T

o. Margins in claim costs; (7-1-21)T

p. Optional nature of benefit; (7-1-21)T

q. Delay in eligibility for benefit; (7-1-21)T

r. Inflation protection provisions; and (7-1-21)T

s. Guaranteed insurability option. (7-1-21)T

04. Benefits Not Covered in Section 022. When long-term care benefits are provided other than as in Subsection 022.01 above, reserves are determined in accordance with Section 41-608, Idaho Code, "Reserve for Disability Insurance." (7-1-21)T

023. LOSS RATIO.
Section 023 applies to all (group and individual) long-term care insurance policies or certificates except those covered under Sections 024 and 025 of this chapter. (7-1-21)T

01. Expected Loss Ratios. Benefits under long-term care insurance policies are 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 is given to all relevant factors, including: (7-1-21)T

a. Statistical credibility of incurred claims experience and earned premiums; (7-1-21)T

b. The period for which rates are computed to provide coverage; (7-1-21)T

c. Experienced and projected trends; (7-1-21)T

d. Concentration of experience within early policy duration; (7-1-21)T

e. Expected claim fluctuation; (7-1-21)T

f. Experience refunds, adjustments or dividends; (7-1-21)T

g. Renewability features; (7-1-21)T

h. All appropriate expense factors; (7-1-21)T

i. Interest; (7-1-21)T

j. Experimental nature of the coverage; (7-1-21)T

k. Policy reserves; (7-1-21)T

l. Mix of business by risk classification; and (7-1-21)T

m. Product features such as long elimination periods, high deductibles and high maximum limits. (7-1-21)T

02. Policies That Accelerate Benefits. Subsection 023.01 cannot 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: (7-1-21)T

a. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy; (7-1-21)T

b. The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of Section 41-1927, Idaho Code, Standard Nonforfeiture Law – Life Insurance. (7-1-21)T

c. The policy meets the disclosure requirements of Sections 41-4605(9), 41-4605(10), and 41-4605(11), Idaho Code. (7-1-21)T

i. Any policy illustration that meets the applicable requirements of the NAIC Life Insurance Illustrations Model Regulation. (7-1-21)T

d. An actuarial memorandum is filed with the insurance department that includes: (7-1-21)T

i. A description of the basis on which the long-term care rates were determined; (7-1-21)T

ii. A description of the basis for the reserves; (7-1-21)T

iii. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance; (7-1-21)T

iv. A description and a table of each actuarial assumption used. For expenses, an insurer will include percent of premium dollars per policy and dollars per unit of benefits, if any; (7-1-21)T

v. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives; (7-1-21)T

vi. The estimated average annual premium per policy and the average issue age; (7-1-21)T

vii. A statement as to whether underwriting is performed at the time of application. The statement indicates whether underwriting is used and, if used, the statement includes a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement indicates whether the enrollee or any dependent will be underwritten and when underwriting occurs; and (7-1-21)T

viii. A description of the effect of the long-term care policy provision on the prescribed premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status. (7-1-21)T

024. FILING REQUIREMENT.

Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state pursuant to Section 41-4604, Idaho Code, Extraterritorial Jurisdiction – Group Long-Term Care Insurance, it files 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. (7-1-21)T

01. Initial Filing Requirements. (7-1-21)T

a. Subsection 024.01 applies to any long-term care policy issued in this state on or after July 1, 2001. (7-1-21)T

b. An insurer will provide the information listed in Subsection 024.01 to the director thirty (30) days prior to making the long-term care insurance form available for sale. (7-1-21)T

c. A copy of the disclosure documents prescribed in Section 014. (7-1-21)T

d. An actuarial certification consisting of at least the following: (7-1-21)T

i. A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated; (7-1-21)T

ii. A statement that the policy design and coverage provided have been reviewed and taken into consideration; (7-1-21)T

iii. A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration. (7-1-21)T

e. A complete description of the basis for contract reserves that are anticipated to be held under the form, to include: (7-1-21)T

i. Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; (7-1-21)T

ii. A statement that the assumptions used for reserves contain reasonable margins for adverse experience; (7-1-21)T

iii. A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted; and (7-1-21)T

iv. 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; (7-1-21)T

v. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship; (7-1-21)T

vi. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the director may request a demonstration under Subsection 024.02 based on a standard age distribution; and (7-1-21)T

vii. 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, (7-1-21)T

viii. A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences. (7-1-21)T

02. Actuarial Demonstration. The director may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration includes either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both. (7-1-21)T

a. In the event the director requests additional information under this provision, the period referred to in Subsection 024.01.b. of this section does not include the period of time during which the insurer is preparing the requested information. (7-1-21)T

025. PREMIUM RATE SCHEDULE INCREASES.

01. Premium Rate Increase Notice. An insurer provides notice of a pending premium rate schedule increase, including an exceptional increase, to the director at least thirty (30) days prior to the notice to the

policyholders and includes: (7-1-21)T

a. Information prescribed by Section 014. (7-1-21)T

b. Certification by a qualified actuary that: (7-1-21)T

i. If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated; and (7-1-21)T

ii. The premium rate filing is in compliance with the provisions of this Section 025. (7-1-21)T

02. Actuarial Memorandum. The actuarial memorandum justifying the rate schedule change request includes: (7-1-21)T

a. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method of 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: (7-1-21)T

i. Annual values for the past five (5) years preceding and the three (3) years following the valuation date are provided separately; (7-1-21)T

ii. The projections include the development of the lifetime loss ratio, unless the rate of increase is an exceptional increase; (7-1-21)T

iii. The projections demonstrate compliance with Subsection 025.03; and (7-1-21)T

iv. For exceptional increases; (7-1-21)T

(1) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and (7-1-21)T

(2) In the event the director determines as provided in Subsection 010.09.c. that offsets may exist, the insurer uses appropriate net projected experience. (7-1-21)T

b. Disclosure of how reserves have been incorporated in this rate increase will trigger contingent benefit upon lapse. (7-1-21)T

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. (7-1-21)T

d. A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and 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. (7-1-21)T

e. 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 director; and sufficient information for review of the premium rate schedule increase by the director. (7-1-21)T

03. Premium Rate Schedule Increases. All premium rate schedule increases are determined in accordance with the following requirements: (7-1-21)T

a. Exceptional increases provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits. (7-1-21)T

b. Premium rate schedule increases are 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: (7-1-21)T

i. The accumulated value of the initial earned premium times fifty eight percent (58%); (7-1-21)T

ii. Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis; (7-1-21)T

iii. The present value of future projected initial earned premiums times fifty-eight percent (58%); and (7-1-21)T

iv. Eighty-five percent (85%) of the present value of future projected premiums not in Subsection 025.03.b.iii. on an earned basis. (7-1-21)T

c. In the event that a policy form has both exceptional and other increases, the values in Subsections 025.03.b.ii. and 025.03.b.iv., will also include seventy percent (70%) for exceptional rate increase amounts. (7-1-21)T

d. All present and accumulated values used to determine rate increases use the maximum valuation interest rate for contract reserves as specified in IDAPA 18.07.07, "Minimum Reserve Standards For Individual And Group Health Insurance Contracts," Appendix A, IIA. The actuary discloses as part of the actuarial memorandum the use of any appropriate averages. (7-1-21)T

04. Projections Filed for Review. For each rate increase that is implemented, the insurer files for review by the director updated projections, as defined in Subsection 025.02.a., annually for the following three (3) years and include a comparison of actual results to projected values. The director may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Subsection 025.13, the projections prescribed by this Subsection 025.04 are provided to the policyholder in lieu of filing with the director. (7-1-21)T

05. Revised Premium Rate. If any premium rate in the revised premium rate schedule is greater than 200 percent (200%) of the comparable rate in the initial premium schedule, lifetime projections, as defined in Subsection 025.02.a., are filed for review by the director every five (5) years following the end of the prescribed period in Subsection 025.04. For group insurance policies that meet the conditions in Subsection 025.13, the projections prescribed by Subsection 025.05 are provided to the policyholder in lieu of filing with the director. (7-1-21)T

06. Actual and Projected Experience. If the director 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 the premium specified in Subsection 025.03, the director may require the insurer to implement any of the following: (7-1-21)T

a. Premium rate schedule adjustments; or (7-1-21)T

i. Other measures to reduce the difference between the projected and actual experience. (7-1-21)T

b. In determining whether the actual experience adequately matches the projected experience, consideration should be given to Subsection 025.02.d. and 025.02.e., if applicable. (7-1-21)T

07. Contingent Benefit upon Lapse. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer files: (7-1-21)T

a. A plan, subject to director 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. If the director should determine that such appropriate administration and claims processing functions have not

been addressed, provisions of Subsection 025.08 may be applied; and (7-1-21)T

b. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to Subsection 025.03 had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculations described in Subsections 025.03.b.i. and 025.03.b.iii. (7-1-21)T

08. Additional Rate Increase Filings. For a rate increase filing that meets the following criteria, the director reviews, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapse has occurred or is anticipated: (7-1-21)T

a. The rate increase is not the first rate increase requested for the specific policy form or forms; (7-1-21)T

b. The rate increase is not an exceptional increase; and (7-1-21)T

c. The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse. (7-1-21)T

d. In the event significant adverse lapse 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 director may determine that a rate spiral exists. Following the determination that a rate spiral exists, the director may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates. The offer will; (7-1-21)T

i. Be subject to the approval of the director; (7-1-21)T

ii. Be based on actuarially sound principles, but not be based on attained age; and (7-1-21)T

iii. Provide that the maximum benefits under any new policy accepted by an insured is reduced by comparable benefits already paid under the existing policy. (7-1-21)T

e. The insurer maintains 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 is limited to the lesser of: (7-1-21)T

i. The maximum rate increase determined based on the combined experience; and (7-1-21)T

ii. The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%). (7-1-21)T

09. Persistent Practice of Inadequate Rate Filings. If the director determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the director may, in addition to the provisions of Subsection 025.08 of this section, prohibit the insurer from either of the following: (7-1-21)T

a. Filing and marketing comparable coverage for a period of up to five (5) years; or (7-1-21)T

b. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases. (7-1-21)T

10. Exceptions. Subsection 025.01 and 025.09 does not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in Subsection 010.12, if the policy complies with all of the following provisions: (7-1-21)T

a. The interest credited internally to determine cash value accumulations, including long-term care, if

any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy; (7-1-21)T

b. The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following: (7-1-21)T

i. Section 41-1927, Idaho Code, Standard Nonforfeiture Law-Life Insurance; (7-1-21)T

ii. Section 41-1927A, Idaho Code, Standard Nonforfeiture Law for Individual Deferred Annuities; (7-1-21)T

iii. IDAPA 18.03.03, Subsection 018.02, "Variable Contracts." (7-1-21)T

11. Exceptions for Disclosure and Performance Standards. The policy meets the disclosure requirements of Sections 41-4605(9), 41-4605(10) and 41-4605(11), Idaho Code, pertaining to the Disclosure and Performance Standards for Long-term Care Coverage. (7-1-21)T

12. Exception If Actuarial Memorandum Filed Which Includes Defined Information. An actuarial memorandum is filed with the Department of Insurance that includes: (7-1-21)T

a. A description of the basis on which the long-term care rates were determined; (7-1-21)T

b. A description of the basis for the reserves; (7-1-21)T

c. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance; (7-1-21)T

d. A description and a table of each actuarial assumption used. For expenses, an insurer will include percent of premium dollars per policy and dollars per unit of benefits, if any; (7-1-21)T

e. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives; (7-1-21)T

f. The estimated average annual premium per policy and the average issue age; (7-1-21)T

g. A statement as to whether underwriting is performed at the time of application. The statement indicates whether underwriting is used and, if used, the statement includes a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement indicates whether the enrollee or any dependent will be underwritten and when underwriting occurs; and (7-1-21)T

h. A description of the effect of the long-term care policy provision on the prescribed premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claims status. (7-1-21)T

13. Exceptions for Association Plans. Premium Rate Schedule Increases Subsections 025.06 and 025.08 cannot apply to group insurance policies as defined in Section 41-4603(4)(a), Idaho Code, where: (7-1-21)T

a. The policies insure two hundred fifty (250) or more persons and the policyholder has five thousand (5,000) or more eligible employees of a single employer; or (7-1-21)T

b. The policyholder, and not the certificateholders, pay a material portion of the premium, which cannot be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed. (7-1-21)T

026. FILING REQUIREMENTS FOR ADVERTISING.

01. Filing and Retention. Every Insurer, Fraternal Benefit Society, Managed Care Organization, or other similar organization providing long-term care insurance or benefits in this state provides a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio, or television medium to the Director of Insurance of this state for review and approval by the Director. In addition, all advertisements are retained by the insurer or other entity for at least five (5) years from the date the advertisement was first used; or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time. (7-1-21)T

02. Exemptions. The director may exempt from these requirements any advertising form or material when, in the director's opinion, this requirement cannot be reasonably applied. (7-1-21)T

027. STANDARDS FOR MARKETING AND PRODUCER TRAINING.

01. General Provisions. Every Insurer, Fraternal Benefit Society, Managed Care Organization or other similar organization marketing long-term care insurance coverage in this state, directly or through its producers, will: (7-1-21)T

a. Establish marketing procedures and producer training requirements to assure that any marketing activities, including any comparison of policies by its producers will be fair and accurate. (7-1-21)T

b. Establish marketing procedures to assure excessive insurance is not sold or issued. (7-1-21)T

c. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following: "Notice to buyer: This policy cannot 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." (7-1-21)T

d. Provide copies of the disclosure forms prescribed in Subsection 014.10. (7-1-21)T

e. Provide an explanation of contingent benefit upon lapse as provided for in Subsection 032.04.b. and if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying period in Subsection 032.04.c. (7-1-21)T

f. Inquire and 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 prescribed. (7-1-21)T

g. Establish auditable procedures for verifying compliance with Subsection 027.01. (7-1-21)T

h. At solicitation, provide written notice to the prospective policyholder and certificateholder that Senior Health Insurance Benefits Advisors/SHIBA the program is available and the name, address and telephone number of the program. (7-1-21)T

i. For long-term care insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to Subsection 011.01.c. of this chapter. (7-1-21)T

02. Banned Practices. In addition to the practices banned in Title 41, Chapter 13, Idaho Code, Trade Practices and Frauds, the following acts and practices are banned: (7-1-21)T

a. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy, or to take out a policy of insurance with another insurer. (7-1-21)T

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

purchase or recommend the purchase of insurance. (7-1-21)T

c. Cold Lead Advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company. (7-1-21)T

d. Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy. (7-1-21)T

03. Associations. With respect to the obligations set forth in Subsection 027.03, the primary responsibility of an association, as defined in Section 41-4603(4)(b), Idaho Code, when endorsing or selling long-term care insurance is to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations 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. (7-1-21)T

a. The insurer files with the insurance department the following material: (7-1-21)T

i. The policy and certificate; (7-1-21)T

ii. A corresponding outline of coverage; and (7-1-21)T

iii. All advertisements to be utilized. (7-1-21)T

b. The association discloses in any long-term care insurance solicitation: (7-1-21)T

i. 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 (7-1-21)T

ii. A brief description of the process under which the policies and the insurer issuing the policies were selected. (7-1-21)T

c. If the association and the insurer have interlocking directorates or trustee arrangements, the association discloses that fact to its members. (7-1-21)T

d. The board of directors of associations selling or endorsing long-term care insurance policies or certificates reviews and approves the insurance policies as well as the compensation arrangements made with the insurer. (7-1-21)T

e. The association also will: (7-1-21)T

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; (7-1-21)T

ii. Actively monitor the marketing efforts of the insurer and its producers; and (7-1-21)T

iii. Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates. (7-1-21)T

iv. Subsections 027.03.e.i. through 027.03.e.iii. cannot apply to qualified long-term care insurance contracts. (7-1-21)T

f. 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 prescribed in Section 027. (7-1-21)T

g. The insurer cannot 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 Section 027. (7-1-21)T

h. Failure to comply with the filing and certification requirements of Section 027 constitutes an unfair trade practice in violation of Title 41, Chapter 13, Idaho Code, Trade Practices and Frauds. (7-1-21)T

04. Producer Training Requirements. An individual cannot sell, solicit or negotiate long-term care insurance unless the individual is licensed as an insurance producer for life and disability (accident and health insurance) and has completed a one-time training course and ongoing training every twenty-four (24) months thereafter. The training meets the requirements set forth in this Subsection 027.04. Such training requirements may be approved as continuing education course under IDAPA 18.06.04, "Continuing Education." (7-1-21)T

a. The one-time training course prescribed by this section is no less than eight (8) hours. In addition to the one-time training course, an individual who sells, solicits, or negotiates long-term care insurance completes the ongoing training prescribed by this Subsection 027.04, which is no less than four (4) hours every twenty four (24) months. (7-1-21)T

b. The training prescribed under Subsection 027.04.a. consists of topics related to long-term care insurance, long-term care services and qualified state long-term care insurance partnership program, including, but not limited to: (7-1-21)T

i. State and federal regulations and requirements and the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services, including Medicaid; (7-1-21)T

ii. Available long-term care services and providers; (7-1-21)T

iii. Changes or improvements in long-term care services or providers; (7-1-21)T

iv. Alternatives to the purchase of private long-term care insurance; (7-1-21)T

v. The effect of inflation on benefits and the importance of inflation protection; and (7-1-21)T

vi. Consumer suitability standards and guidelines. (7-1-21)T

c. The training prescribed by Subsection 027.04. cannot include any sales or marketing information, materials, or training, other than those prescribed by state and federal law. (7-1-21)T

d. Insurers subject to this rule obtain verification that a producer receives training prescribed by Subsection 027.04 before a producer is permitted to sell, solicit or negotiate the insurer's long-term care insurance products, maintain records subject to the state's record retention requirements, and make that verification available to the director upon request. An insurer maintains records with respect to the training of its producers concerning the distribution of its long-term care Partnership policies that will allow the Department of Insurance to provide assurance to the Division of Medicaid that the producers have received the training as prescribed by Subsection 027.04 and that producers have demonstrated an understanding of the Partnership policies and their relationship to public and private coverage of long-term care including Medicaid in this state. These records are maintained in accordance with the state's record retention requirements and made available to the director upon request. (7-1-21)T

e. The satisfaction of these training requirements in any state satisfy the training requirements of this state. (7-1-21)T

028. SUITABILITY.

01. Life Insurance Policies That Accelerate Benefits. Section 028 cannot apply to life insurance policies that accelerate benefits for long-term care. (7-1-21)T

02. General Provisions. Every Insurer, Fraternal Benefit Society, Managed Care Organization or other similar organization marketing long-term care insurance (the "issuer") will: (7-1-21)T

a. Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant; (7-1-21)T

b. Train its producers in the use of its suitability standards; and (7-1-21)T

c. Maintain a copy of its suitability standards and make them available for inspection upon request by the director. (7-1-21)T

03. Determination of Standards. To determine whether the applicant meets the standards developed by the issuer; (7-1-21)T

a. The producer and issuer develop procedures that take the following into consideration: (7-1-21)T

i. The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage; (7-1-21)T

ii. The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and (7-1-21)T

iii. The values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement. (7-1-21)T

b. The issuer and producer, if involved, make reasonable efforts to obtain the information set out in Subsection 028.03. The efforts include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer contains, at a minimum, the information in the format contained in the NAIC Model Regulations in Appendix B, in not less than twelve (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 is filed with the director. (7-1-21)T

i. Copies of NAIC Model Regulations for Long-Term Care Insurance Minimum Standards Appendixes B, C, and D can be found at the Idaho Department of Insurance website. (7-1-21)T

c. A completed personal worksheet is 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. (7-1-21)T

d. The sale or dissemination outside the company or agency by the issuer or producer of information obtained through the personal worksheet in the NAIC Model Regulations, Appendix B is banned. (7-1-21)T

04. Appropriateness. The issuer uses the suitability standards it has developed pursuant to Section 028 in determining whether issuing long-term care insurance coverage to an applicant is appropriate. (7-1-21)T

05. Use of Standards. Producers use the suitability standards developed by the issuer in marketing long-term care insurance. (7-1-21)T

06. Disclosure Form. 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" is provided. The form is in the format contained in the NAIC Model Regulations, Appendix C, in not less than twelve (12) point type. (7-1-21)T

07. Rejection and Alternatives. 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 sends the applicant a letter similar to the NAIC Model Regulations, 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 is made part of the applicant's file. (7-1-21)T

08. Reporting. The issuer reports annually to the director 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. (7-1-21)T

029. PROHIBITION AGAINST PREEXISTING CONDITIONS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES.

If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer waives any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy. (7-1-21)T

030. AVAILABILITY OF NEW SERVICES OR PROVIDERS.

01. Notification to Policyholder. An insurer notifies the policyholder of the availability of a new long-term care policy 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 is provided within twelve (12) months of the date the new policy is made available for sale in this state. (7-1-21)T

02. Exceptions to Notification Requirements. Notwithstanding Subsection 030.01, notification is not prescribed for any policy issued prior to the effective date of this Section 030 or to any policyholder who is currently eligible for benefits, within an elimination period or on claim, or who previously has 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 prescribed premium to add such new services or providers. (7-1-21)T

03. New Coverage. The insurer makes the new coverage available in one of the following ways: (7-1-21)T

a. By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age; (7-1-21)T

b. By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits are based on premiums paid or reserves held for the prior policy or certificate. (7-1-21)T

c. By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status is recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost of the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or (7-1-21)T

d. By an alternative program developed by the insurer that meets the intent of Section 030 if the program is filed with and approved by the Director. (7-1-21)T

04. Proprietary Policy. An insurer is not prescribed to notify policyholders of a new proprietary policy created and filed for use in a limited distribution channel. For purposes of this Subsection 030.04, "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 proprietary policy are notified when a new long-term care policy that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel. (7-1-21)T

05. Exchanges and Not Replacements. Policies issued pursuant to this Section 030 are considered

exchanges and not replacements. These exchanges are not subject to Section 018, and Section 028, and the reporting requirements of Section 019.01. through 019.05. of this rule. (7-1-21)T

06. Employer Sponsored Plan. Where the policy is offered through an employer, labor organization, professional, trade or occupational association, the prescribed notification in Subsection 030.01 is made to the offering entity. However, if the policy is issued to a group defined in Section 41-4603 (04) (d), Idaho Code, Long Term Care Insurance Act, the notification is made to each certificateholder. (7-1-21)T

07. Nothing Prohibits an Insurer From Offering Coverage. Nothing in this Section 030 prohibits an insurer from offering any policy, rider, certificate or coverage change to any policyholder or certificate-holder. 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 eligibility requirements, including underwriting and payment of the prescribed premium to add such new services or providers. (7-1-21)T

08. Not Applicable to Life Insurance Policies. This Section 030 does not apply to life insurance policies or riders containing accelerated long-term care benefits. (7-1-21)T

031. RIGHT TO REDUCE COVERAGE AND LOWER PREMIUMS.

01. Reduction of Coverage. Every long-term care insurance policy and certificate includes 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: (7-1-21)T

a. Reducing the maximum benefit; or (7-1-21)T

b. Reducing the daily, weekly or monthly benefit amount. (7-1-21)T

c. The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier's administrative processes. (7-1-21)T

02. Implementing a Reduction in Coverage. The provision includes a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage. (7-1-21)T

03. Determination of Premium for Reduced Coverage. The age to determine the premium for the reduced coverage is based on the age used to determine the premiums for the coverage currently in force. (7-1-21)T

04. Limitations for the Reduction of Coverage. The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable. (7-1-21)T

05. Notification in Regard to the Possible Lapse of Policy. If a policy or certificate is about to lapse, the insurer provides a written reminder to the policyholder or certificateholder of their right to reduce coverage and premiums in the notice prescribed by Subsection 013.01.c. of this rule. (7-1-21)T

06. Not Applicable to Life Insurance Policies or Riders Containing Accelerated Benefits. This Section 031 does not apply to life insurance policies or riders containing accelerated long-term care benefits. (7-1-21)T

07. Compliance Requirements. The requirements of this Section 031 apply to any long-term care policy issued in this state on or after November 1, 2007. Compliance with this Section 031 may be accomplished by policy replacement, exchange or by adding the prescribed provision via amendment or endorsement to the policy. (7-1-21)T

032. NONFORFEITURE BENEFIT REQUIREMENT.

01. Life Insurance Policies That Accelerate Benefits. Section 032 does not apply to life insurance policies or riders containing accelerated long-term care benefits. (7-1-21)T

02. Nonforfeiture Benefits. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of Section 41-4607, Idaho Code, every Insurer, Fraternal Benefit Society, Managed Care Organization, or other similar organization marketing long-term care insurance coverage in this state satisfies the following: (7-1-21)T

a. A policy or certificate offered with nonforfeiture benefits will 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 is the benefit described in Subsection 032.04.e. (7-1-21)T

b. The offer is in writing if the nonforfeiture benefit is not described in the Outline of Coverage or other materials given to the prospective policyholder. (7-1-21)T

03. Contingent Benefit. If the offer prescribed under Section 41-4607, Idaho Code, is rejected, the insurer provides the contingent benefit upon lapse described in Section 032. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in Subsection 032.04.b.i. still applies. (7-1-21)T

04. Rejection of Offer. After rejection of the offer prescribed under Section 41-4607, Idaho Code, as it pertains to nonforfeiture benefits, for individual and group policies without nonforfeiture benefits issued after the effective date of Section 032, the insurer provides a contingent benefit upon lapse. (7-1-21)T

a. In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate provides either the nonforfeiture benefit or the contingent benefit upon lapse. (7-1-21)T

b. A contingent benefit on lapse is 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 within Subsection 032.04 based on the insured's issue age, and the policy or certificate lapses within one hundred twenty (120) days of the due date of the premium so increased. Unless otherwise prescribed, policyholders are notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Table: Issue Age - Percent Increase Over Initial Premium				
Issue Age	**Percent Increase Over Initial Premium**		**Issue Age**	**Percent Increase Over Initial Premium**
29 and under	200%		72	36%
30-34	190%		73	34%
35-39	170%		74	32%
40-44	150%		75	30%
45-49	130%		76	28%
50-54	110%		77	26%
55-59	90%		78	24%
60	70%		79	22%
61	66%		80	20%
62	62%		81	19%
63	58%		82	18%
64	54%		83	17%
65	50%		84	16%
66	48%		85	15%
67	46%		86	14%
68	44%		87	13%
69	42%		88	12%
70	40%		89	11%
71	38%		90 and over	10%

(7-1-21)T

i. A contingent benefit on lapse is also 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 one hundred twenty (120) days of the due date of the premium so increased, and the ratio in Subsection 032.04.d.ii. is forty percent (40%) or more. Unless otherwise prescribed, policyholders are notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers For A Substantial Premium Increase

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

This provision is in addition to the contingent benefit provided by Subsection 032.04.b. and where both are triggered, the benefit provided is at the option of the insured. (7-1-21)T

c. On or before the effective date of a substantial premium increase as defined in Subsection 032.04.b., the insurer: (7-1-21)T

i. Offers to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that premium payments are not increased; (7-1-21)T

ii. Offers to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Subsection 032.04.e. This option may be elected at any time during the one hundred twenty (120) day period referenced in Subsection 032.04.b.; and (7-1-21)T

iii. Notifies the policyholder or certificate holder that a default or lapse at any time during the one hundred twenty (120) day period referenced in Subsection 032.04.b. is the election of the offer to convert in Subsection 032.04.c.ii. unless the automatic option in Subsection 032.04.d.iii. applies. (7-1-21)T

d. On or before the effective date of a substantial premium increase as defined in Subsection 032.04.b.i., the insurer: (7-1-21)T

i. Offers to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that premium payments are not increased; (7-1-21)T

ii. Offers to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent (90%) 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 one hundred twenty (120) day period referenced in Subsection 032.04.b.i.; and (7-1-21)T

iii. Notifies the policyholder or certificateholder that a default or lapse at any time during the one hundred twenty (120) day period referenced in Subsection 032.04.b.i. is the election of the offer to convert in Subsection 032.04.d.ii. above if the ratio is forty percent (40%) or more. (7-1-21)T

e. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, in accordance with Subsection 032.04.b. but not Subsection 032.04.b.i. are described in Subsection 032.04.e. (7-1-21)T

i. For purposes of this Subsection 032.04.e., attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one percent (1%) per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (50); (7-1-21)T

ii. For purposes of Subsection 032.04.e., the nonforfeiture benefit is of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits are determined as specified in Subsection 032.04.e.iii.; (7-1-21)T

iii. The standard nonforfeiture credit will be equal to one hundred percent (100%) of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional

shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit cannot be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Subsection 032.04.f.; (7-1-21)T

iv. The nonforfeiture benefit begins not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse is effective during the first three (3) years as well as thereafter. (7-1-21)T

v. Notwithstanding Subsection 032.04.e.iv. for a policy or certificate with attained age rating, the nonforfeiture benefit begins on the earlier of: (7-1-21)T

(1) The end of the tenth year following the policy or certificate issue date; or (7-1-21)T

(2) The end of the second year following the date the policy or certificate is no longer subject to attained age rating. (7-1-21)T

vi. 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. (7-1-21)T

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 be payable if the policy or certificate had remained in premium paying status. (7-1-21)T

g. There is no difference in the minimum nonforfeiture benefits as prescribed under Section 032 for group and individual policies. (7-1-21)T

h. For certificates issued on or after the effective date of this Section 032, under a group long-term care insurance policy as defined in Section 41-4603(4)(a), Idaho Code, which policy was in force at the time this rule became effective, the provisions of Section 032 cannot apply. (7-1-21)T

i. The last sentence Subsection 032.03 and Subsection 032.04.b. and Subsection 032.04.d. applies to any long-term care insurance policy defined in Section 41-4603(4)(a), Idaho Code one (1) year after adoption. (7-1-21)T

i. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse are subject to the loss ratio requirements of Section 023 or Section 025, whichever is applicable, treating the policy as a whole. (7-1-21)T

j. To determine whether contingent nonforfeiture upon lapse provisions are triggered under Subsection 032.04.b. or 032.04.b.i., a replacing insurer that purchased or assumed a block or blocks of long-term care insurance policies from another insurer calculates the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer. (7-1-21)T

k. A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts is offered that meets the following requirements: (7-1-21)T

i. The nonforfeiture provision is appropriately captioned; (7-1-21)T

ii. The nonforfeiture provision provides a benefit available in the event of a default on the payment of any premiums and states that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying contracts filed for review with the Director for the same contract form; and (7-1-21)T

iii. The nonforfeiture provision provides at least one (1) of the following: (7-1-21)T

(1) Reduced paid-up insurance; (7-1-21)T

(2) Extended term insurance; (7-1-21)T

(3) Shortened benefit period; or (7-1-21)T

(4) Other similar offerings approved by the Director. (7-1-21)T

033. STANDARDS FOR BENEFIT TRIGGERS.

01. Conditions of Benefits Payment. A long-term care insurance policy conditions 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 is not more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment. (7-1-21)T

02. Activities of Daily Living. Insurers may use activities of daily living to trigger covered benefits in addition to those contained in Subsection 033.02 as long as they are defined in the policy. Activities of daily living includes at least the following as defined in Section 010 and in the policy. (7-1-21)T

a. Bathing; (7-1-21)T

b. Continence; (7-1-21)T

c. Dressing; (7-1-21)T

d. Eating; (7-1-21)T

e. Toileting; and (7-1-21)T

f. Transferring. (7-1-21)T

03. Additional Provisions. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions cannot restrict, and are not in lieu of, the requirements contained in Subsections 033.01 and 033.02. (7-1-21)T

04. Determinations of Deficiency. For purposes of Section 033 the determination of a deficiency cannot be more restrictive than: (7-1-21)T

a. Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or (7-1-21)T

b. If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed to protect the insured or others. (7-1-21)T

05. Assessments. Assessments of activities of daily living and cognitive impairment are performed by licensed or certified professionals, such as physicians, nurses or social workers. (7-1-21)T

06. Appeals. Long-term care insurance policies include a clear description of the process for appealing and resolving benefit determinations. (7-1-21)T

07. Effective Date. The requirements set forth in Section 033 are effective within twelve (12) months of the effective date of the rule and apply as follows: (7-1-21)T

a. Except as provided in Subsection 033.07.b. the provisions of Section 033 apply to a long-term care policy issued in this state on or after the effective date of the rule. (7-1-21)T

b. For certificates issued on or after the effective date of Section 033, under a group long-term care insurance policy as defined in Section 41-4603(4)(a), Idaho Code, which was in force at the time this rule became

effective, the provisions of Section 033 do not apply. (7-1-21)T

034. ADDITIONAL STANDARDS FOR BENEFIT TRIGGERS FOR QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

01. Definitions. For purposes of Section 034 the following definitions apply: (7-1-21)T

a. Qualified long-term care services means services that meet the requirements of Section 7702B(a)(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 prescribed by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner. (7-1-21)T

b. 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: (7-1-21)T

i. Being unable to perform (without substantial assistance from another individual) at least two (2) activities of daily living for a period of at least ninety (90) days due to a loss of functional capacity; or (7-1-21)T

ii. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment. (7-1-21)T

c. The term chronically ill individual cannot include an individual meeting these requirements unless within the preceding twelve (12) month period a licensed health care practitioner has certified that the individual meets these requirements. (7-1-21)T

d. Licensed health care practitioner means a physician, as defined in Section 1861(r)(1) of the Social Security Act, and a registered professional nurse, licensed social worker, or other individual who meets requirements prescribed by the Secretary of the Treasury. (7-1-21)T

e. Maintenance or personal care services means any care, the primary purpose of which is the provision of needed assistance with any of the disabilities, the existence of which leads to the conclusion that the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment). (7-1-21)T

02. The Chronically Ill. A qualified long-term care insurance contract pays 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. (7-1-21)T

03. Payments and Conditions. A qualified long-term care insurance contract conditions the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity; or to severe cognitive impairment. (7-1-21)T

04. Certifications by Professionals. Certifications regarding activities of daily living and cognitive impairment prescribed pursuant to Subsection 034.03 are performed by licensed or certified professionals, such as physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury. (7-1-21)T

05. Certifications by Carrier. Certification prescribed pursuant to Subsection 034.03 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 ninety (90) days due to a loss of functional capacity and the insured is in claim status, the certification cannot be rescinded and additional certifications cannot be performed until after the expiration of the ninety (90) day period. (7-1-21)T

06. Appeals. Qualified long-term care contracts include a clear description of the process for appealing

and resolving benefit determinations. (7-1-21)T

035. STANDARD FORMAT OUTLINE OF COVERAGE.
Section 035 of the rule implements, interprets and makes specific, the provisions of Section 41-4605(7)(a), Idaho Code, in prescribing a standard format and the content of an outline of coverage. (7-1-21)T

01. Format. The outline of coverage is a freestanding document, using no smaller than ten (10) point type. 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. (7-1-21)T

02. Content. The outline of coverage contains no material of an advertising nature. (7-1-21)T

03. Standard Form. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated. Format for the outline of coverage is published on the Department of Insurance website. (7-1-21)T

036. REQUIREMENT TO DELIVER SHOPPER'S GUIDE.

01. Approved Format. A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the director, is provided to all prospective applicants of a long-term care insurance policy or certificate. (7-1-21)T

a. In the case of producer solicitations, a producer will deliver the shopper's guide prior to the presentation of an application or enrollment form. (7-1-21)T

b. In the case of direct response solicitations, the shopper's guide will be presented in conjunction with any application or enrollment form. (7-1-21)T

02. Exceptions. Life insurance policies or riders containing accelerated long-term care benefits are not obligated to furnish the above-referenced guide, but furnish the policy summary prescribed under Section 41-4605(9), Idaho Code, Disclosure and Performance Standards for Long-Term Care Insurance. (7-1-21)T

037. PENALTIES.
In addition to any other penalties provided by the laws of this state any insurer and any producer found to have violated any requirement of this state relating to the marketing of such insurance or of IDAPA 18.04.11, "Long-Term Care Insurance Minimum Standards," is subject to an administrative penalty of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to ten thousand dollars ($10,000), whichever is greater. (7-1-21)T

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