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TITLE 230 – DEPARTMENT OF BUSINESS REGULATION

CHAPTER 20 – INSURANCE

SUBCHAPTER 35 – LONG TERM CARE INSURANCE

PART 1 – Long Term Care Insurance

1.1 Purpose

The purpose of this Part is to implement R.I. Gen. Laws Chapter 27-34.2, 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. This Part is not intended to interfere with the qualification of long-term care policies or certificates as provided for in Chapter 97, SEC. 7702B(b) of the U.S. Internal Revenue Code of 1986 (26 U.S.C. § 7702B(b)), as added by the Health Insurance Portability and Accountability Act of 1996, Pub.L. No. 104-191, as now constituted or later amended.

1.2 Authority

This Part is issued pursuant to the authority vested in the Director under R.I. Gen. Laws § 27-34.2-6(a).

1.3 Applicability and Scope

A. Except as otherwise specifically provided, this Part applies to all long-term care insurance as defined in R.I. Gen. Laws § 27-34.2-4, including qualified long-term care contracts subject to the requirements of Section 7702B(b) of the Internal Revenue Code of 1986 (26 U.S.C. § 7702B(b)), as amended and life insurance policies that accelerate benefits for long- term care delivered or issued for delivery in this state on or after the effective date of the 2008 amendments to this Part by issuers, as defined in R.I. Gen. Laws § 27-34.2-4.

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

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

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

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

1.4 Definitions

A. For the purpose of this Part, the terms "long-term care insurance," "qualified long-term care insurance," "group long term care insurance," "applicant," "policy" and "certificate" shall have the meanings set forth in R.I. Gen. Laws § 27-34.2-4. In addition, the following definitions shall apply:

1. "Benefit trigger," for the purposes of independent review, means a contractual provision in the insured's policy of long-term care insurance conditioning the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. For purposes of a tax-qualified long-term care insurance contract, as defined in Section 7702B of the Internal Revenue Code of 1986 (26 U.S.C. § 7702B), as amended, "benefit trigger" shall include a determination by a licensed health care practitioner that an insured is a chronically ill individual.

2. "Director" means the Director of the Department of Business Regulation or his or her designee.

3. "Exceptional increase" means

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

      (1) Due to changes in laws or regulations applicable to long-term care coverage in this state; or

      (2) Due to increased and unexpected utilization that affects the majority of issuers of similar products.

   b. Except as provided in §§ 1.20 and 1.20.1 of this Part, exceptional increases are subject to the same requirements as other premium rate schedule increase

c. 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.

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

4. "Incidental," as used in §§ 1.20(J) and 1.20.1(J) of this Part, means that 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 shall be measured as of the date of issue.

5. "Licensed health care professional" means an individual qualified by education and experience in an appropriate field, to determine, by record review, an insured's actual functional or cognitive impairment.

6. "Qualified actuary" means a member in good standing of the American Academy of Actuaries.

7. "Similar policy forms" means all of the long-term care insurance policies and certificates issued by an issuer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in R.I. Gen. Laws § 27-34.2-4(4)(i) are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

1.5 Policy Definitions

A. No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements, except that, when and if the U.S. Treasury Department may develop additional or different policy definitions intended to satisfy the requirements of Section 7702B(b) of the Internal Revenue Code of 1986 (26 U.S.C. § 7702B(b)), as amended, such definitions may be used in policies and certificates intended to be tax qualified, instead of and/or in addition to the following definitions:

1. "Activities of daily living" means at least bathing, continence, dressing, eating, toileting and transferring.

2. "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as

physicians and registered nurses, in order to maintain his or her health status.

3. "Adult day care" means a 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.

4. "Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

5. "Cognitive impairment" means a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

6. "Continence" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

7. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

8. "Eating" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

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

10. "Home health care services" means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

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

12. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

13. "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

14. "Skilled nursing care," "personal care," "home care," “specialized care,” “assisted living care” and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

15. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

16. "Transferring" means moving into or out of a bed, chair or wheelchair.

B. All providers of services, including but not limited to services licensed under R.I. Gen. Laws Chapters 23-17.1, 23-17.3, 23-17.4, and 23-17.7.1, and consumer or self-directed services provided under the same guidelines as R.I. Gen. Laws Chapter 40-8.1 and similar services licensed under the laws of other jurisdictions. Such services shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration or degree status of those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified or registered, it shall also state what requirements a provider must meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or when the state licenses, certifies or registers the provider of services under another name.

1.6 Policy Practices and Provisions

A. Renewability. The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of § 1.8 of this Part.

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

2. The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the issuer 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 issuer on a class basis.

3. The term "noncancellable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the issuer has no right to

unilaterally make any change in any provision of the insurance or in the premium rate.

4. The term “level premium” may only be used when the issuer does not have the right to change the premium.

5. In addition to the other requirements of this subsection, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986 (26 U.S.C. § 7702B(b)(1)(C)), as amended.

B. Limitations and Exclusions. A policy may not be delivered or issued for delivery in this state as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows, and, with respect to tax qualified policies to any additional extent necessary to qualify under federal law:

1. Preexisting conditions or diseases;

2. Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease, other dementias nor organic brain disorder;

3. Alcoholism and drug addiction;

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

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

b. Participation in a felony, riot or insurrection;

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

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

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

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

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

7. In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.

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

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

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

   c. For purposes of this paragraph, “state of policy issue” means the state in which the individual policy or certificate was originally issued.

9. This Subsection is not intended to prohibit territorial limitations.

C. Extension of Benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if 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.

D. Continuation or Conversion

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

2. For the purposes of this section, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities may provide continuation benefits that are substantially equivalent to the benefits of the existing

group policy. The director shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non- managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

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

4. For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the 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, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

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

6. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

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

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

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

(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

(2) The premium for which is calculated in a manner consistent with the requirements of § 1.6(D)(6) of this Part.

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

9. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

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

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

E. Discontinuance and Replacement

1. If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the previous group policy on

its date of termination. Coverage provided or offered to individuals by the issuer and premiums charged to persons under the new group policy:

a. Shall not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

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

F. Premium Changes

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

a. The increasing age of the insured at ages beyond sixty-five (65); or

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

2. The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under § 1.28 of this Part, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

3. A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under § 1.28 of this Part, the initial annual premium shall be based on the reduced benefits.

G. Electronic Enrollment for Group Policies

1. In the case of a group defined in R.I. Gen. Laws § 27-34.2-4(4)(i), any requirement that a signature of an insured be obtained by a producer or issuer shall be deemed satisfied if:

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

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

c. The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that confidentiality is maintained with respect to individually identifiable information, including individually identifiable information that relates to a claim for insurance benefits or a civil or criminal proceeding involving an individual and is collected in connection with or in reasonable anticipation of a claim for insurance benefits or civil or criminal proceeding involving an individual.

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

1.7 Unintentional Lapse

Provisions regarding Unintentional Lapse are contained in R.I. Gen. Laws § 27-34.2-12.

1.8 Required Disclosure Provisions

A. Renewability. Individual long-term care insurance policies shall contain a renewability provision.

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

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

B. Riders and Endorsements. Except for riders or endorsements by which the issuer 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 policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider or endorsement.

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

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

E. Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility, other than those prohibited in R.I. Gen. Laws § 27-34.2-6-(e)(2), shall set forth a description of such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

F. Disclosure of Tax Consequences. With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This subsection shall not apply to qualified long-term care insurance contracts.

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

H. A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in § 1.31(F)(3) of this Part that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986 (26 U.S.C. § 7702B(b)), as amended.

I. A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in § 1.31(F)(3) of this Part that the policy is not intended to be a qualified long-term care insurance contract.

1.9 Required Disclosure of Rating Practices to Consumers

A. This section shall apply as follows:

1. Except as provided in § 1.9(A)(2) of this Part, this section applies to any long-term care policy or certificate issued in this state on or after December 1, 2008.

2. For certificates issued on or after the effective date of this amended Part under a group long-term care insurance policy as defined in R.I. Gen.

Laws § 27-34.2-4(4)(i), which policy was in force at the time this amended Part became effective, the provisions of this section shall apply on the policy anniversary following June 1, 2009.

B. Other than policies for which no applicable premium rate or rate schedule increases can be made, issuers shall provide all of the information listed in this subsection to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an issuer shall provide all of the information listed in this section to the applicant no later than at the time of delivery of the policy or certificate.

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

2. An explanation of potential future premium rate revisions, and the policyholder's or certificate holder's option in the event of a premium rate revision;

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

4. A general explanation for applying premium rate or rate schedule adjustments that shall include:

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

   b. The right to a revised premium rate or rate schedule as provided in § 1.9(B)(3) of this Part if the premium rate or rate schedule is changed;

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

   a. The policy forms for which premium rates have been increased;

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

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

6. The issuer may, in a fair manner, provide additional explanatory information related to the rate increases.

7. An issuer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated issuers or the long-term care policies acquired from other nonaffiliated issuers when those increases occurred prior to the acquisition.

8. If an acquiring issuer files for a rate increase on a long-term care policy form acquired from nonaffiliated issuers or a block of policy forms acquired from nonaffiliated issuers on or before the later of the effective date of this section or the end of a twenty-four-month period following the acquisition of the block or policies, the acquiring issuer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with § 1.9(B)(5) of this Part.

9. If the acquiring issuer in § 1.9(B)(8) of this Part files for a subsequent rate increase, even within the twenty-four- month period, on the same policy form acquired from nonaffiliated issuers or block of policy forms acquired from nonaffiliated issuers referenced in § 1.9(B)(8) of this Part, the acquiring issuer shall make all disclosures required by §§ 1.9(B)(5), (6), (7) and (8) of this Part, including disclosure of the earlier rate increase referenced in § 1.9(B)(8) of this Part.

C. An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the issuer made the disclosure required under §§ 1.9(B)(1), (5), (6), (7), (8) and (9) of this Part. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

D. An issuer shall use the forms in Appendices B and F provided in Bulletins issued for the purpose of designating the forms required to be used by this Part to comply with the requirements of §§ 1.9(B) and (C) of this Part.

E. An issuer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, if applicable, at least forty-five (45) days prior to the implementation of the premium rate schedule increase by the issuer. The notice shall include the information required by § 1.9(B) of this Part when the rate increase is implemented.

1.10 Initial Filing Requirements

A. This section applies to any long-term care policy issued in this state on or after December 1, 2008 except that §§ 1.10(B)(2)(d) and (B)(3) apply to any long-term care policy issued in this state on or after January 1, 2019.

B. An insurer shall provide the information listed in this subsection to the Director (60) days prior to making a long-term care insurance form available for sale.

1. A copy of the disclosure documents required in § 1.9 of this Part; and

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

a. A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

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

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

d. A statement that the premiums contain at least the minimum margin for moderately adverse experience defined in § 1.10(B)(2)(d)((1)) of this Part or the specification of and justification for a lower margin as required by § 1.10(B)(2)(d)((2)) of this Part.

(1) A composite margin shall not be less than 10% of lifetime claims.

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

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

(4) A greater margin may be appropriate in circumstances where the company has less credible experience to support its assumptions used to determine the premium rates.

e. A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also

available from the issuer except for reasonable differences attributable to benefits; or

f. A comparison of the premium schedules for similar policy forms that are currently available from the issuer with an explanation of the differences.

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

(1) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; and

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

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

a. An explanation of the review performed by the actuary prior to making the statements in §§ 1.10(B)(2)(b) and (c) of this Part,

b. A complete description of pricing assumptions; and

c. Sources and levels of margins incorporated into the gross premiums that are the basis for the statement in § 1.10(B)(2)(a) of this Part the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. Deviations in margins between ages, sexes, plans or states shall be clearly described. Deviations in margins required to be described are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating gross premium scales.

d. A demonstration that the gross premiums include the minimum composite margin specified in § 1.10(B)(2)(d) of this Part.

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

care pricing who is independent of the company. In the event the director asks for additional information as a result of any review, the period in § 1.10(B) of this Part does not include the period during which the insurer is preparing the requested information.

1.11 Prohibition Against Post-Claims Underwriting

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

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

1. If the medications listed in such application were known by the issuer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

C. Except for policies or certificates which are guaranteed issue:

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

a. Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy.

2. The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

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

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

a. A report of physical examination;

b. An assessment of functional capacity;

c. An attending physician's statement; or

d. Copies of medical records.

D. A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

E. Every issuer selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated and shall annually furnish this information to the Director in the format in Appendix A provided in a Bulletin issued for the purpose of designating the forms required to be used by this Part.

1.12 Minimum Standards for Home Health Care Benefits in Long-Term Care Insurance Policies

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

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

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

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

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

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

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

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

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

9. By excluding coverage for adult day care services.

B. A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

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

1.13 Requirement to Offer Inflation Protection

A. No issuer may offer a long-term care insurance policy unless the issuer 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. Issuers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

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

2. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence or insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 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

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

B. Where the policy is issued to a group, the required offer in § 1.13(A) of this Part shall be made to the group policyholder; except, if the policy is issued to a group defined in R.I. Gen. Laws § 27-34.2-4(4)(v) other than to a continuing care retirement community, the offering shall be made to each proposed certificate-holder.

C. The offer in § 1.13(A) of this Part shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

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

1. A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period.

2. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

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

E. Inflation protection benefit increases under a policy which contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

F. An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the issuer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

G. Inflation protection as provided in § 1.13(A)(1) of this Part shall be included in a long-term care insurance policy unless an issuer obtains a rejection of inflation protection signed by the policyholder as required in this subsection. The rejection may be either in the application or on a separate form.

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

a. 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.

1.14 Requirements for Application Forms and Replacement Coverage

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace 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 R.I. Gen. Laws § 27-34.2-4(4)(i), 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 certificate-holder has been notified of the replacement.

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

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

   a. If so, with which company?

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

3. Are you covered by Medicaid?

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

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

1. List policies sold that are still in force.

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

C. Solicitations Other Than Direct Response. Upon determining that a sale will involve replacement, an issuer; other than an issuer using direct response solicitation methods, or its producer; shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long- term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the issuer. The required notice shall be provided in the following manner:

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

[Insurance company's name and address]

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

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

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

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

(Use additional sheets, as necessary.)

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

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

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

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

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

(Signature of Producer, Broker or Other Representative)

[Typed Name and Address of Producer or Broker]

The above “Notice to Applicant” was delivered to me on:

_____

(Applicant’s Signature) (Date)

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

NOTICE TO APPLICANT REGARDING REPLACEMENT

OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company’s name and address]

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

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

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

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

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

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

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

[Company Name]

E. Where replacement is intended, the replacing issuer shall notify, in writing, the existing issuer of the proposed replacement. The existing policy shall be identified by the issuer, name of the insured and policy number or address including zip code. Notice shall be made within five (5) working days from the date the application is received by the issuer or the date the policy is issued, whichever is sooner.

F. Life insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the issuer shall comply with the requirements of Life Insurance and Annuities Replacement (Subchapter 25 Part 4 of this Chapter). If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing issuer shall comply with both the long-term care and the life insurance replacement requirements.

1.15 Reporting Requirements

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

B. Every issuer shall report annually by June 30 the ten percent (10%) of its producers with the greatest percentages of lapses and replacements as measured by § 1.15(A) of this Part. (Appendix G provided in a Bulletin issued for the purpose of designating the forms required to be used by this Part)

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

D. Every issuer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year. (Appendix G provided in a Bulletin issued for the purpose of designating the forms required to be used by this Part)

E. Every issuer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year. (Appendix G provided in a Bulletin issued for the purpose of designating the forms required to be used by this Part)

F. Every issuer shall report annually by June 30 for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. (Appendix E provided in a Bulletin issued for the purpose of designating the forms required to be used by this Part)

G. For purposes of this section:

1. “Policy” means only long-term care insurance;

2. Subject to § 1.15(G)(3) of this Part, “Claim” means a request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

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

4. “Report” means on a statewide basis.

H. Reports required under this section shall be filed with the Director.

I. Annual rate certification requirements.

1. This Subsection applies to any long-term care policy issued in this state on or after January 1, 2019.

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

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

(1) A statement of the sufficiency of the current premium rate schedule including:

(AA) For the rate schedules currently marketed,

(i) The premium rate schedule continues to be sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated; or

(ii) If the above statement cannot be made, a statement that margins for moderately adverse experience may no longer be sufficient. In this situation, the insurer shall provide to the commissioner, within sixty (60) days of the date the actuarial certification is submitted to the commissioner, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience so that the ultimate premium rate schedule would be reasonably expected to be sustainable over the future life of the form with no future premium increases anticipated. Failure to submit a plan of action to the commissioner within sixty (60) days or to comply with the time frame stated in the plan of action constitutes grounds for the commissioner to withdraw or modify its approval of the form for future sales pursuant to R.I. Gen. Laws § 27-34.2-6(a)(2) and R.I. Gen. Laws Chapter 42-35.

(BB) For the rate schedules that are no longer marketed,

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

(ii) That the premium rate schedule may no longer be sufficient. In this situation, the insurer shall

provide to the director, within sixty (60) days of the date the actuarial certification is submitted to the commissioner, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience.

(2) A description of the review performed that led to the statement.

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

(1) A detailed explanation of the data sources and review performed by the actuary prior to making the statement in § 1.15(I)(2) of this Part.

(2) A complete description of experience assumptions and their relationship to the initial pricing assumptions.

(3) A description of the credibility of the experience data.

(4) An explanation of the analysis and testing performed in determining the current presence of margins.

c. The actuarial certification required pursuant to § 1.15(I)(2)(a) of this Part must be based on calendar year data and submitted annually no later than May 1st of each year starting in the second year following the year in which the initial rate schedules are first used. The actuarial memorandum required pursuant to § 1.15(I)(2)(b) of this Part must be submitted at least once every three (3) years with the certification.

1.16 Licensing

A producer is not authorized to sell, solicit or negotiate with respect to long-term care insurance except as authorized by R.I. Gen. Laws Chapter 27-2.4.

1.17 Discretionary Powers of Commissioner

A. 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 Part with respect to a specific long- term care insurance policy or certificate upon a written finding that:

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

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

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

4. 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

5. 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.

1.18 Reserve Standards

A. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with R.I. Gen. Laws Chapter 27-4.5.

B. Claim reserves shall also be established in the case when the policy or rider is in claim status.

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

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

1. Definition of insured events;

2. Covered long-term care facilities;

3. Existence of home convalescence care coverage;

4. Definition of facilities;

5. Existence or absence of barriers to eligibility;

6. Premium waiver provision;

7. Renewability;

8. Ability to raise premiums;

9. Marketing method;

10. Underwriting procedures;

11. Claims adjustment procedures;

12. Waiting period;

13. Maximum benefit;

14. Availability of eligible facilities;

15. Margins in claim costs;

16. Optional nature of benefit;

17. Delay in eligibility for benefit;

18. Inflation protection provisions; and

19. Guaranteed insurability option.

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

F. When long-term care benefits are provided other than as in § 1.18(A) of this Part, reserves shall be determined in accordance with R.I. Gen. Laws § 27-4.5-10 and regulations promulgated thereunder.

1.19 Loss Ratio

A. This section shall apply to all long-term care insurance policies or certificates except those covered under §§ 1.10, 1.20 and 1.21 of this Part.

B. Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides for adequate reserving of the long-

term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

1. Statistical credibility of incurred claims experience and earned premiums;

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

3. Experienced and projected trends;

4. Concentration of experience within early policy duration;

5. Expected claim fluctuation;

6. Experience refunds, adjustments or dividends;

7. Renewability features;

8. All appropriate expense factors;

9. Interest;

10. Experimental nature of the coverage;

11. Policy reserves;

12. Mix of business by risk classification; and

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

C. § 1.19(B) of this Part shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

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

2. The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of R.I. Gen. Laws Chapter 27-4.5.

3. The policy meets the disclosure requirements of R.I. Gen. Laws §§ 27-34.2-6(i)(4), (j) and (k):

4. An actuarial memorandum is filed with the director that includes:

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

b. A description of the basis for the reserves;

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

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

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

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

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

h. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

1.20 Premium Rate Schedule Increases

A. This section shall apply as follows:

1. Except as provided in § 1.20(A)(2) of this Part below, this section applies to any long-term care policy or certificate issued in this state on or after December 1, 2008 and prior to January 1, 2019.

2. For certificates issued on or after the effective date of this amended Part under a group long-term care insurance policy as defined in R.I. Gen. Laws § 27-34.2-4(4)(i), which policy was in force at the time this amended Part became effective, the provisions of this section shall apply on the policy anniversary following June 1, 2009.

B. An issuer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the Director at least 60 days prior to the notice to the policyholders and shall include:

1. Information required by § 1.9 of this Part;

2. Certification by a qualified actuary that:

   a. If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

   b. The premium rate filing is in compliance with the provisions of this section;

   c. The insurer may request a premium rate schedule increase less than what is required under this section and the director may approve such premium rate schedule increase, without submission of the certification in § 1.20(B)(2)(a) of this Part, if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required under § 1.20(B)(2)(a) of this Part, the premium rate schedule increase filing satisfies all other requirements of this section, and is, in the opinion of the commissioner, in the best interest of policyholders.

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

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

      (1) Annual values for the five (5) years preceding and the three (3) years following the valuation date shall be provided separately;

      (2) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

      (3) The projections shall demonstrate compliance with § 1.20(C) of this Part; and

      (4) For exceptional increases,

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

(BB) In the event the Director determines as provided in § 1.4(A)(4) of this Part that offsets may exist, the issuer shall use appropriate net projected experience;

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

c. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

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

e. In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the issuer will need to file composite rates reflecting projections of new certificates; and

f. A demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin specified in § 1.10(B)(2)(d) of this Part is projected to be exhausted.

4. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the Director; and

5. Sufficient information for review [and approval] of the premium rate schedule increase by the Director.

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

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

2. Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

a. The accumulated value of the initial earned premium times fifty-eight percent (58%);

b. Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;

c. The present value of future projected initial earned premiums times fifty-eight percent (58%); and

d. Eighty-five percent (85%) of the present value of future projected premiums not in § 1.20(C)(2)(c) of this Part on an earned basis;

3. In the event that a policy form has both exceptional and other increases, the values in §§ 1.20(C)(2)(b) and (d) of this Part will also include seventy percent (70%) for exceptional rate increase amounts; and

4. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in § 30-3.8(B)(1) of this Chapter. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

D. For each rate increase that is implemented, the issuer shall file for approval by the Director updated projections, as defined in § 1.20(B)(3)(a) of this Part, annually for the next 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 § 1.20(K) of this Part, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the Director.

E. 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 § 1.20(B)(3)(a) of this Part, shall be filed for approval by the Director every five (5) years following the end of the required period in § 1.20(D) of this Part. For group insurance policies that meet the conditions in § 1.20(K) of this Part, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the Director.

F. 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 premiums specified in § 1.20(C) of this Part, the Director may require the issuer to implement any of the following:

1. Premium rate schedule adjustments; or

2. Other measures to reduce the difference between the projected and actual experience.

3. In determining whether the actual experience adequately matches the projected experience, consideration should be given to § 1.20(B)(3)(e) of this Part, if applicable.

G. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the issuer shall file:

1. 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; otherwise the Director may impose the condition in § 1.20(H) of this Part; and

2. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to § 1.20(C) of this Part had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculations described in §§ 1.20(C)(2)(a) and (c) of this Part.

H. For a rate increase filing that meets the following criteria, the Director shall review, 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 lapsation has occurred or is anticipated:

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

2. The rate increase is not an exceptional increase; and

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

I. In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the issuer 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 issuer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the issuer or its affiliates.

1. The offer shall:

a. Be subject to the approval of the Director;

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

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

2. The issuer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

a. The maximum rate increase determined based on the combined experience; and

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

J. If the Director determines that the issuer 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 § 1.20(H) of this Part, prohibit the issuer from either of the following:

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

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

K. §§ 1.20(F) and (H) of this Part shall not apply to policies for which the long-term care benefits provided by the policy are incidental if the policy complies with all of the following provisions:

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

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

a. R.I. Gen. Laws Chapter 27-4.3 and

b. R.I. Gen. Laws Chapter 27-4.4

3. The policy meets the disclosure requirements of R.I. Gen. Laws. §§ 27-34.2-6(i)(4)(j) and (k);

4. The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the policy illustrations as required by R.I. Gen. Laws Chapter 27-62;

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

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

   b. A description of the basis for the reserves;

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

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

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

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

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

   h. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

L. §§ 1.20(F) and (H) of this Part, shall not apply to group insurance policies as defined in R.I. Gen. Laws § 27-34.2-4 (4)(i) where:

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

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

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

A. This section shall apply as follows:

1. Except as provided in § 1.20.1(A)(2) of this Part below, this section applies to any long-term care policy or certificate issued in this state on or after January 1, 2019.

2. For certificates issued on or after the effective date of this amended Part under a group long term care insurance policy as defined in R.I. Gen. Laws § 27-34.2-4(E)(1), which policy was in force at the time this amended Part became effective, the provisions of this section shall apply on the policy anniversary following January 1, 2019.

B. An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least [30] days prior to the notice to the policyholders and shall include:

1. Information required by § 1.9 of this Part;

2. Certification by a qualified actuary that:

a. If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

b. The premium rate filing is in compliance with the provisions of this section;

c. The insurer may request a premium rate schedule increase less than what is required under this section and the commissioner may approve such premium rate schedule increase, without submission of the certification in § 1.20.1(B)(2)(a) of this Part, if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required under § 1.20.1(B)(2)(a) of this Part, the premium rate schedule increase filing satisfies all other requirements of this section, and is, in the opinion of the commissioner, in the best interest of policyholders.

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

a. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including

reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

(1) Annual values for the five (5) years preceding and the three (3) years following the valuation date shall be provided separately;

(2) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(3) The projections shall demonstrate compliance with § 1.20(C) of this Part; and

(4) For exceptional increases,

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

(BB) In the event the commissioner determines as provided in § 1.4(A)(3)(e) of this Part that offsets may exist, the insurer shall use appropriate net projected experience;

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

c. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

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

e. In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates; and

f. A demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin specified in § 1.10(B)(2)(d) of this Part is projected to be exhausted.

4. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the director; and

5. Sufficient information for review and approval of the premium rate schedule increase by the director.

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

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

2. Premium rate schedule increases shall be calculated such that the sum of the lesser of:

a. the accumulated value of actual incurred claims, without the inclusion of active life reserves, or

b. the accumulated value of historic expected claims, without the inclusion of active life reserves, plus the present value of the future expected incurred claims, projected without the inclusion of active life reserves, will not be less than the sum of the following:

(1) The accumulated value of the initial earned premium times the greater of:

(AA) fifty-eight percent (58%) and

(BB) the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience;

(2) Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;

(3) The present value of future projected initial earned premiums times the greater of:

(AA) fifty-eight percent (58%) and

(BB) the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience; and

(4) Eighty-five percent (85%) of the present value of future projected premiums not in § 1.20(C)(2)(b)((3)) of this Part on an earned basis;

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

4. In the event that a policy form has both exceptional and other increases, the values in §§ 1.20.1(C)(2)(b) and (d) of this Part will also include seventy percent (70%) for exceptional rate increase amounts; and

5. All present and accumulated values used to determine rate increases, including the lifetime loss ratio consistent with the original filing reflecting margins for moderately adverse experience, shall use the maximum valuation interest rate for contract reserves as specified in Subchapter 30 Part 3 of this Chapter. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

D. For each rate increase that is implemented, the insurer shall file for review and approval by the director updated projections, as defined in § 1.20.1(B)(3)(a) of this Part, annually for the next 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 § 1.20.1(K) of this Part, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the director.

E. If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in § 1.20.1(B)(3)(a) of this Part, shall be filed for review and approval by the director every five (5) years following the end of the required period in § 1.20.1(D) of this Part. For group insurance policies that meet the conditions in § 1.20.1(K) of this Part, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

F. 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 premiums specified in § 1.20.1(C) of this Part, the director may require the insurer to implement any of the following:

1. Premium rate schedule adjustments; or

2. Other measures to reduce the difference between the projected and actual experience.

3. In determining whether the actual experience adequately matches the projected experience, consideration should be given to § 1.20.1(B)(3)(e) of this Part, if applicable.

G. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file a plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the director may impose the condition in § 1.20.1(H) of this Part.

H. Lapse Rates

1. For a rate increase filing that meets the following criteria, the director shall review, 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 lapsation has occurred or is anticipated:

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

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

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

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

   a. The offer shall:

      (1) Be subject to the approval of the director;

      (2) Be based on actuarially sound principles, but not be based on attained age; and

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

b. The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

(1) The maximum rate increase determined based on the combined experience; and

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

I. If the director determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of § 1.20.1(H) of this Part, prohibit the insurer from either of the following:

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

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

J. §§ 1.20(A) through (I) of this Part shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in § 1.4(A)(4) of this Part, if the policy complies with all of the following provisions:

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

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

a. R.I. Gen. Laws Chapter 27-4.3 and

b. R.I. Gen. Laws Chapter 27-4.4.

3. The policy meets the disclosure requirements of R.I. Gen. Laws §§ 27-34.2-6(i)(4)(j) and (k);

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

   a. Policy illustrations as required by Life Insurance Illustrations (Subchapter 25 Part 14 of this Chapter); and

   b. Disclosure requirements in INSURANCE REGULATION 41 ANNUITY DISCLOSURE, Subchapter 25 Part 6 of this Chapter;

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

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

   b. A description of the basis for the reserves;

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

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

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

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

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

   h. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

K. §§ 1.20.1(F) and (H) of this Part shall not apply to group insurance policies as defined in R.I. Gen. Laws § 27-34.2-4(4)(i) where:

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

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

1.21 Filing Requirements

Prior to an issuer offering group long-term care insurance to a resident of this state pursuant to R.I. Gen. Laws § 27-34.2-5, it shall file with the Director a copy of the certificate and the outline of coverage, along with 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.

1.22 Filing Requirements for Advertising

A. Every issuer providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio or television medium to the director for review or approval by the director to the extent it may be required under state law. In addition, all advertisements shall be retained by the issuer for at least three (3) years from the date the advertisement was first used.

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

1.23 Standards for Marketing

A. Every issuer marketing long-term care insurance coverage in this state, directly or through its producers, shall:

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

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

   b. Excessive insurance is not sold or issued.

2. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following:

   a. "Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

3. Provide copies of the disclosure forms required in § 1.9(C) of this Part (Appendices B and F provided in a Bulletin issued for the purpose of designating the forms required to be used by this Part) to the applicant.

4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long- term care insurance has accident and sickness insurance is not required.

5. Every issuer marketing long-term care insurance shall establish auditable procedures for verifying compliance with this § 1.23(A) of this Part.

6. If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the Director, the issuer shall, at solicitation, provide written notice to the prospective policyholder and certificate holder that the program is available and the name, address and telephone number of the program.

7. For long-term care health insurance policies and certificates, use the terms “noncancellable” or “level premium” only when the policy or certificate conforms to §§ 1.6(A)(3) and (4) of this Part.

8. Provide an explanation of contingent benefit upon lapse provided for in § 1.28(D)(3) of this Part and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in § 1.28(D)(4) of this Part.

B. In addition to the practices prohibited in R.I. Gen. Laws Chapter 27-29-1, the following acts and practices are prohibited:

1. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or issuers 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 issuer.

2. 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.

3. 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.

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

C. With respect to the obligations set forth in this subsection, the primary responsibility of an association, as defined in R.I. Gen. Laws § 27-34.2-4(4)(ii), when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

1. The issuer shall file with the insurance department the following material:

   a. The policy and certificate,

   b. A corresponding outline of coverage, and

   c. All advertisements requested by the insurance department.

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

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

   b. A brief description of the process under which the policies and the issuer issuing the policies were selected.

3. If the association and the issuer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

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

5. The association shall also:

   a. 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 issuer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change;

   b. Actively monitor the marketing efforts of the issuer and its producers; and

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

d. §§ 1.24(C)(5)(a) through (c) of this Part above shall not apply to qualified long-term care insurance contracts.

6. No group long-term care insurance policy or certificate may be issued to an association unless the issuer files with the state insurance department the information required in this subsection.

7. The issuer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the issuer certifies annually that the association has complied with the requirements set forth in this subsection.

8. Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of R.I. Gen. Laws Chapter 27-29-8.

1.24 Suitability

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

B. Every issuer marketing long-term care insurance shall:

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

2. Train its producers in the use of its suitability standards; and

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

C. To determine whether the applicant meets the standards developed by the issuer

1. The producer and issuer shall develop procedures that take the following into consideration:

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

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

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

2. The issuer, and where a producer is involved, the producer shall make reasonable efforts to obtain the information set out in § 1.24(C)(1) of this Part above. The efforts shall include presentation to the applicant, at or prior to application, of the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix B provided in a Bulletin issued for the purpose of designating the forms required to be used by this Part, in not less than twelve (12) point type. The issuer may request the applicant to provide additional information to comply with its suitability standards.

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

4. The sale or dissemination outside the company or agency by the issuer or producer of information obtained through the personal worksheet in Appendix B provided in a Bulletin issued for the purpose of designating the forms required to be used by this Part is prohibited.

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

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

F. At the same tune as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix C provided in a Bulletin issued for the purpose of designating the forms required to be used by this Part, in not less than twelve (12) point type.

G. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to Appendix D provided in a Bulletin issued for the purpose of designating the forms required to be used by this Part. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

H. The issuer shall report annually to the 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.

1.25 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 issuer shall waive 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.

1.26 Availability of New Services or Providers

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

B. Notwithstanding § 1.26(A) of this Part above, notification is not required for any policy issued prior to the effective date of this Section or to any policyholder or certificate holder who is currently eligible for benefits, within an elimination period or on a claim, or who previously had been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The issuer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

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

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

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

3. By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the

new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or

4. By an alternative program developed by the issuer that meets the intent of this Section if the program is filed with and approved by the Director.

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

E. Policies issued pursuant to this Section shall be considered exchanges and not replacements. These exchanges shall not be subject to §§ 1.14 and 1.24 of this Part, and the reporting requirements of §§ 1.15(A) through (E) of this Part.

F. Where the policy is offered through an employer, labor organization, professional, trade or occupational association, the required notification in § 1.26(A) of this Part shall be made to the offering entity. However, if the policy is issued to a group defined in R.I. Gen. Laws § 27-34.2-4(4)(v), the notification shall be made to each certificate holder.

G. Nothing in this Section shall prohibit an issuer 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 issuer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

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

I. This Section shall become effective on or after June 1, 2009.

1.27 Right to Reduce Coverage and Lower Premiums

A. Every long-term care insurance policy and certificate shall include a provision that

1. allows the policyholder or certificate holder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:

a. Reducing the maximum benefit; or

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

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

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

B. The provision shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

C. The premium for the reduced coverage shall:

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

2. Be consistent with the approved rate table.

D. The issuer 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.

E. If a policy or certificate is about to lapse, the issuer shall provide a written reminder to the policyholder or certificate holder of his or her right to reduce coverage and premiums in the notice required by R.I. Gen. Laws § 27-34.2-12(a)(3).

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

G. The requirements of this §§ 1.27(A) through (F) of this Part shall apply to any long-term care policy issued in this state on or after December 1, 2008.

H. A premium increase notice required by § 1.9(E) of this Part shall include:

1. An offer to reduce policy benefits provided by the current coverage consistent with the requirements of this section;

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

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

I. The requirements of § 1.27(H) of this Part shall apply to any rate increase implemented in this state on or after July 1, 2019.

1.28 Nonforfeiture Benefit Requirement

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

B. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of R.I. Gen. Laws § 27-34.2-19:

1. A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in § 1.28(E) of this Part; and

2. The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.

C. If the offer required to be made under R.I. Gen. Laws § 27-34.2-19 is rejected, the issuer shall provide the contingent benefit upon lapse described in this section. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in § 1.28(D)(4) of this Part shall still apply.

D. After rejection of the offer required under R.I. Gen. Laws § 27-34.2-19, for individual and group policies without nonforfeiture benefits, the issuer shall provide a contingent benefit upon lapse.

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

2. The contingent benefit on lapse shall be triggered every time an issuer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within one hundred twenty (120) days of the due date of the premium so increased. Unless otherwise required, policyholders shall be 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

29 and Under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%

73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and Over	10%

3. A contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period every time an issuer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial

annual premium set forth below based on the insured's issue age, the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio in § 1.28(D)(5)(b) of this Part is forty percent (40%) or more. Unless otherwise required, policyholders shall be 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	Percentage Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

4. On or before the effective date of a substantial premium increase as defined in § 1.28(D)(2) of this Part, the issuer shall:

   a. Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased:

   b. Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of § 1.28(E) of this Part. This option may be elected at any time during the one hundred twenty (120) day period referenced in § 1.28(D)(2) of this Part; and

   c. Notify the policyholder or certificate holder that a default or lapse at any time during the one hundred twenty (120) day period referenced in § 1.28(D)(2) of this Part shall be deemed to be the election of the offer to convert in § 1.28(D)(4)(b) of this Part above unless the automatic option in § 1.28(D)(5)(c) of this Part applies.

5. On or before the effective date of a substantial premium increase as defined in § 1.28(D)(3) of this Part above, the issuer shall:

   a. Offer to reduce policy benefits provided by the current coverage consistent with the requirements of § 1.27 of this Part so that required premium payments are not increased;

   b. Offer to convert the coverage to a paid-up status where the amount payable for each benefit is 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 120-day period referenced in § 1.28(D)(3) of this Part; and

c. Notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in § 1.28(D)(3) of this Part shall be deemed to be the election of the offer to convert in § 1.28(D)(5)(b) of this Part above if the ratio is forth percent (40%) or more.

6. For any long-term care policy issued in this state on or after January 1, 2019.

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

b. Values above 100% in the table in § 1.28(D)(3) of this Part above shall be reduced to 100%.

E. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with § 1.28(D)(2) of this Part but not § 1.28(D)(3) of this Part, are described in this subsection:

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

2. For purposes of this subsection, the nonforfeiture benefit shall be a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in § 1.28(D)(3) of this Part.

3. The standard nonforfeiture credit will be equal to 100 percent (100%) of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The issuer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than 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 § 1.28(F) of this Part.

4. The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit on

lapse shall be effective during the first three (3) years as well as thereafter.

a. Notwithstanding § 1.28(E)(4) of this Part for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

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

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

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

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

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

H. The requirements set forth in this section shall become effective as provided in Section 31 of the former Insurance Regulation 44 that this Part has replaced, and shall apply as follows:

1. Except as provided in § 1.28(H)(2) of this Part below, the provisions of this section apply to any long-term care policy issued in this state on or after September 8, 1998.

2. For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in R.I. Gen. Laws § 27-34.2-4(4)(i), which policy was in force on September 8, 1998, the provisions of this section shall not apply.

3. The last sentence in §§ 1.28(C), (D)(3) and (D)(5) of this Part shall apply to any long-term care insurance policy or certificate issued in this state after six (6) months after their adoption, except new certificates on a group policy one (1) year after their adoption.

I. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of §§ 1.19, 1.20 and 1.20.1 of this Part treating the policy as a whole.

J. To determine whether contingent nonforfeiture upon lapse provisions are triggered under §§ 1.28(D)(2) or (D)(3) of this Part, a replacing issuer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another issuer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original issuer.

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

1. The nonforfeiture provision shall be appropriately captioned;

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

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

a. Reduced paid-up insurance;

b. Extended term insurance;

c. Shortened benefit period; or

d. Other similar offerings approved by the Director.

1.29 Standards for Benefit Triggers

A. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be 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.

B. Activities of daily living shall include at least the following as defined in § 1.5 of this Part and in the policy:

1. Bathing;

2. Continence;

3. Dressing;

4. Eating;

5. Toileting; and

6. Transferring.

C. Issuers may use activities of daily living to trigger covered benefits in addition to those contained in §§ 1.29(B)(1) through (6) of this Part above as long as they are defined in the policy.

D. An issuer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in §§ 1.29(A) and (B) of this Part.

E. For purposes of this section the determination of a deficiency shall not be more restrictive than:

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

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

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

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

H. A long-term care insurance policy that is intended to be tax qualified may contain benefit trigger provisions that are less favorable to the policyholder or beneficiary than the standards in this section only to the extent necessary to qualify under federal tax standards.

1.30 Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts

A. For purposes of this section the following definitions apply:

1. "Qualified long-term care services" means services that meet the requirements of Section 7702(c)(1) of the Internal Revenue Code of 1986 (26 U.S.C. § 7702(c)(1)), as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

2. "Chronically ill individual" has the meaning prescribed for this term by section 7702B(c)(2) of the Internal Revenue Code of 1986 (26 U.S.C. § 7702B(c)(2)), as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

   (a) 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

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

   (c) The term "chronically ill individual" shall not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner has certified that the individual meets these requirements.

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

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

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

C. A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's 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.

D. Certifications regarding activities of daily living and cognitive impairment required pursuant to § 1.30(C) of this Part shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury.

E. Certifications required pursuant to § 1.30(C) of this Part 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 may not be rescinded and additional certifications may not be performed until after the expiration of the ninety-day period.

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

1.31 Standard Format Outline of Coverage

A. This section of the Part implements, interprets and makes specific, the provisions of R.I. Gen. Laws § 27-34.2-6(H) in prescribing a standard format and the content of an outline of coverage.

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

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

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

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

F. Format for outline of coverage:

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

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

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

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

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

3. FEDERAL TAX CONSEQUENCES.

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

OR

Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified long-term care

insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986 as amended. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. BENEFITS PROVIDED BY THIS POLICY.

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

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

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

(d) Eligibility for Payment of Benefits

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

[Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must

certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities/provider;

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

(d) Exclusions/exceptions;

(e) Limitations.]

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

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

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

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

(b) Any automatic benefit adjustment provisions;

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

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

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

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

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease, other dementias or organic brain disorder. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

13. PREMIUM

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

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

14. ADDITIONAL FEATURES

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

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

1.32 Prompt Payment of Clean Claims

A. For purposes of this section:

1. “Claim” means a request for payment of benefits under an in-force policy, regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.

2. “Clean claim” means a claim that has no defect or impropriety, including any lack of required substantiating documentation, such as satisfactory evidence of expenses incurred, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

B. Within thirty (30) business days after receipt of a claim for benefits under a long-term care insurance policy or certificate, an insurer shall pay such claim if it is a clean claim, or send a written notice acknowledging the date of receipt of the claim and one of the following:

1. The insurer is declining to pay all or part of the claim and the specific reason(s) for denial; or

2. That additional information is necessary to determine if all or any part of the claim is payable and the specific additional information that is necessary.

C. Within thirty (30) business days after receipt of all the requested additional information, an insurer shall pay a claim for benefits under a long-term care insurance policy or certificate if it is a clean claim, or send a written notice that the insurer is declining to pay all or part of the claim, and the specific reason or reasons for denial.

D. If an insurer fails to comply with §§ 1.32(B) or (C) of this Part, such insurer shall pay interest at the rate of 1% per month on the amount of the claim that should have been paid but that remains unpaid forty-five (45) business days after the receipt of the claim with respect to § 1.32(B) of this Part or all requested additional information with respect to § 1.32(C) of this Part. The interest payable pursuant to this subsection shall be included in any late reimbursement without requiring the person who filed the original claim to make any additional claim for such interest.

E. The provisions of § 1.32 of this Part shall not apply where the insurer has a reasonable basis supported by specific information that such claim was fraudulently submitted.

F. Any violation of this Part by an insurer if committed flagrantly and in conscious disregard of the provisions of this regulation or with such frequency as to constitute a general business practice shall be considered a violation of the R.I. Gen. Laws Chapter 27-29

G. The provisions of § 1.32 of this Part supersedes any other claim payment requirement found in R.I. Gen. Laws § 27-18-61.

1.33 Requirement to Deliver Shoppers Guide

A. 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, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

1. In the case of producer solicitations, a producer must deliver the shopper's guide prior to the presentation of an application or enrollment form.

2. In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

B. Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under R.I. Gen. Laws § 27-34.2-6.

1.34 Rhode Island Long-Term Care Partnership Program

A. In order to provide for the offering and sale of policies (including certificates) under the Rhode Island State Long-term Care Insurance Partnership Program, in accordance with Section 1917(b)(1)(C) of the Social Security Act [42 U.S.C. 1396p(b)(1)(C), as amended by Pub. L. No. 109-171, Sec. 6021], and R.I. Gen. Laws § 40-8-22, the following provisions in § 1.34(B) of this Part shall apply:

B. A "qualified state long-term care partnership policy" or "partnership policy" must meet the following conditions:

1. The person insured under the policy is Rhode Island resident at the time the coverage becomes effective.

2. The policy is a qualified long-term care insurance policy as defined in Sec. 7702B(b) of the Internal Revenue Code of 1986, as amended. (26 U.S.C. 7702B(b)).

3. The policy provides the following inflation protection:

a. If the person insured has not attained the age of 61 as of the date of purchase, the policy provides:

(1) automatic annual compounded inflation increases at a rate not less than be no less favorable than three percent (3%) compound annual inflation protection; or

(2) automatic annual compounded inflation increases at a rate based on changes in the consumer price index. "Consumer price index" means consumer price index for all urban consumers, U.S. city average, all items, as determined by the Bureau of Labor Statistics of the United States Department of Labor; or

(3) annual compounded inflation increases at a rate not less than three percent which meets all of the following requirements:

(4) the benefit increases occur automatically, unless the insured specifically rejects an increase;

(5) the increases must be provided until the insured has at least attained age 76 and each increase up to and including the increase that takes effect at age 76 must not be rejected in

order to retain partnership policy status – the insurer must notify the insured that rejection of an increase will cause the policy's partnership status to end;

(6) increases may end when the insured has attained age 76 or if the insured becomes eligible for benefits on or after age 76;

(7) the additional premium for each increase under this feature may be based on the premium rates that apply to the insured's attained age at the time of the increase; and rejection of an increase may not operate to prevent the insured from receiving future increases.

b. If the person insured has attained age 61 but has not attained age 76 as of the date of purchase, the policy provides some level of inflation protection

c. If the person insured has attained age 76 as of the date of purchase, the policy may, but is not required to, provide some level of inflation protection.

4. An issuer may offer the exchange of one policy for a qualified partnership policy, in accordance with the rules for exchange applicable to new services or providers contained in § 1.26 of this Part. In making an offer to exchange policies that were in effect prior to the effective date of the 2008 amendments to this Part, the issuer shall determine conditions of the offer in a uniform and nondiscriminatory manner. For purposes of applying the Medicaid rules relating to the Partnership program, the addition of a rider, endorsement, or change in schedule page for a policy may be treated as giving rise to an exchange." When the addition of a rider, endorsement, or change in the schedule page for a policy is used to give the coverage a new effective date to qualify for Partnership (and no other coverage changes are made), the policyholder shall not lose any benefits built up from the original effective date of the coverage.

C. Certification of Qualified Long-term Care Insurance Policies

1. In keeping with 42 U.S.C. § 1396p(b)(5)(B)(iii), the Director shall certify policies to be in compliance with §§ 1.34(A) and (B) of this Part. An issuer may apply for certification of a policy that has been previously approved, or it may request certification when the form is filed for approval.

a. The director's certification shall be based on certification on the form in Appendix H provided in a Bulletin issued for the purpose of designating the forms required to be used by this Part by an officer of the issuer that;

(1) The policy is designed and intended to be a qualified long-term care policy, as described in § 1.34(B)(2) of this Part, and

(2) The policy complies with all sections of this Part [Required for Partnership].

b. The Director may also consider such other information pertaining to the policy's certification, as he may deem appropriate.

c. The issuer shall notify the Director within ten (10) business days following any time that it should become aware that a certified policy shall have its status as a tax qualified long-term care policy challenged by the United States Department of the Treasury.

D. An insurer or its agent, soliciting or offering to sell a policy that is intended to qualify as a partnership policy, shall provide to each prospective applicant a Partnership Program Notice (Appendix I provided in a Bulletin issued for the purpose of designating the forms required to be used by this Part), outlining the requirements and benefits of a partnership policy. A similar notice may be used for this purpose if filed and approved by the commissioner. The Partnership Program Notice shall be provided with the required Outline of Coverage.

E. A partnership policy issued or issued for delivery in Rhode Island shall be accompanied by a Partnership Disclosure Notice (Appendix J provided in a Bulletin issued for the purpose of designating the forms required to be used by this Part) explaining the benefits associated with a partnership policy and indicating that at the time issued, the policy is a qualified state long-term care insurance partnership policy. A similar notice may be used if filed and approved by the commission. The Partnership Disclosure Notice shall also include a statement indicating that by purchasing this partnership policy, the insured does not automatically qualify for Medicaid.

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TITLE 230 - DEPARTMENT OF BUSINESS REGULATION (INCLUDES THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER)

CHAPTER 20 - INSURANCE

SUBCHAPTER 35 - LONG TERM CARE INSURANCE

PART 1 - LONG TERM CARE INSURANCE (FORMERLY INSURANCE REGULATION 44) (230-RICR-20-35-01)

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