Rules of
Department of Commerce and Insurance
Division 400—Life, Annuities and Health
Chapter 4—Long-Term Care

Title 20—DEPARTMENT OF COMMERCE AND INSURANCE
Division 400—Life, Annuities and Health
Chapter 4—Long-Term Care

20 CSR 400-4.050 General Instructions

PURPOSE: This rule prescribes the general filing requirements for the rules in this chapter.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Filing and Report Forms. The following forms have been adopted and approved for use in this state and are incorporated by reference:

(A) The Rescission Reporting Form for Long-Term Care Policies (Form LTC-A), approved as Appendix A to the Long-Term Care Model Regulation adopted by the National Association of Insurance Commissioners and printed as model #641 in October 2007, or any form which substantially comports with the specified form;

(B) The Long-Term Care Insurance Personal Worksheet Form (Form LTC-B), approved as Appendix B to the Long-Term Care Model Regulation adopted by the National Association of Insurance Commissioners and printed as model #641 in October 2007, or any form which substantially comports with the specified form;

(C) The Things You Should Know Before You Buy Long-Term Care Insurance Form (Form LTC-C), approved as Appendix C to the Long-Term Care Model Regulation adopted by the National Association of Insurance Commissioners and printed as model #641 in October 2007, or any form which substantially comports with the specified form;

(D) The Long-Term Care Insurance Suitability Letter Form (Form LTC-D), approved as Appendix D to the Long-Term Care Model Regulation adopted by the National Association of Insurance Commissioners and printed as model #641 in October 2007, or any form which substantially comports with the specified form;

(E) The Claims Denial Reporting Form (Form LTC-E), approved as Appendix E to the Long-Term Care Model Regulation adopted by the National Association of Insurance Commissioners and printed as model #641 in October 2007, or any form which substantially comports with the specified form;

(F) The Potential Rate Increase Disclosure Form (Form LTC-F), approved as Appendix F to the Long-Term Care Model Regulation adopted by the National Association of Insurance Commissioners and printed as model #641 in October 2007, or any form which substantially comports with the specified form;

(G) The Replacement and Lapse Reporting Form (Form LTC-G), approved as Appendix G to the Long-Term Care Model Regulation adopted by the National Association of Insurance Commissioners and printed as model #641 in October 2007, or any form which substantially comports with the specified form;

(H) The Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance (Form LTC-1), approved in Section 14 of the Long-Term Care Model Regulation adopted by the National Association of Insurance Commissioners and printed as model #641 in October 2007, or any form which substantially comports with the specified form;

(I) The Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance (Form LTC-2), approved in Section 14 of the Long-Term Care Model Regulation adopted by the National Association of Insurance Commissioners and printed as model #641 in October 2007, or any form which substantially comports with the specified form;

(J) The Outline of Coverage Form (Form LTC-3), approved in Section 31 of the Long-Term Care Model Regulation adopted by the National Association of Insurance Commissioners and printed as model #641 in October 2007, or any form which substantially comports with the specified form;

(K) The Long-Term Care Partnership Exchange Notification Form (Form LTC-4), revised on March 10, 2008, or any form which substantially comports with the specified form;

(L) The Partnership Program Policy Certification Form (Form LTC-5), revised on March 10, 2008, or any form which substantially comports with the specified form;

(M) The Missouri's Long-Term Care Insurance Partnership Disclosure Notice Form (Form LTC-6), revised on March 10, 2008, or any form which substantially comports with the specified form; and

(N) The Missouri's Long-Term Care Insurance Partnership Delivery Notice Form (Form LTC-7), revised on March 10, 2008, or any form which substantially comports with the specified form.

(2) Availability. The above forms are published by the Missouri Department of Commerce and Insurance, PO Box 690, Jefferson City, MO 65102. The forms do not include any amendments or additions. The forms are available at the department's office in Jefferson City, Missouri, on the department website, www.insurance.mo.gov, or by mailing a written request to the Missouri Department of Commerce and Insurance, PO Box 690, Jefferson City, Missouri 65102.

(3) Filing Fees. All reports, filings, or amendments to reports required to be filed by insurers under this chapter shall be accompanied by a filing fee of fifty dollars ($50) as required by section 374.230(5), RSMo.

AUTHORITY: section 374.045, RSMo 2000 and section 381.042, RSMo Supp. 2007. Original rule filed Nov. 15, 2007, effective July 30, 2008. Non-substantive change filed Sept. 11, 2019, published Oct. 31, 2019.*

**Original authority: 374.045, RSMo 1967, amended 1993, 1995 and 381.042, RSMo 2000, amended 2007.*

20 CSR 400-4.100 Long-Term Care Insurance

PURPOSE: This rule implements sections 376.1100–376.1130, RSMo, 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.

(1) Applicability and Scope. This regulation is based upon the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners (NAIC), Model #641, published October 2007 ("2007 LTC Model").

(A) Except as otherwise specifically provided, this regulation applies to all long-term

care insurance policies, including qualified long-term care contracts and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in this state on or after January 1, 2004, by insurers, fraternal benefit societies, nonprofit health, hospital and medical service corporations, prepaid health plans, health maintenance organizations and all similar organizations. Certain provisions of this regulation apply only to qualified long-term care insurance contracts as noted.

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

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

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

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

(2) Definitions. For the purpose of this regulation, the terms "long-term care insurance," "qualified long-term care insurance," "group long-term care insurance," "director," "applicant," "policy" and "certificate" shall have the meanings set forth in section 376.1100.2, RSMo. In addition, the following definitions apply:

(A) "Exceptional increase."

1. Exceptional increase means only those increases filed by an insurer as exceptional for which the director determines the need for the premium rate increase is justified:

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

B. Due to increased and unexpected utilization that affects the majority of insurers of similar products.

2. Except as provided in section (18) of this regulation, exceptional increases are subject to the same requirements as other premium rate schedule increases.

3. 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.

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

(B) "Incidental," as used in subsection (18)(J) of this regulation, 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.

(C) "Qualified actuary" means a member in good standing of the American Academy of Actuaries (AAA).

(D) "Similar policy forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in section 376.1100.2(4)(a), RSMo, 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:

1. Institutional long-term care benefits only;

2. Non-institutional long-term care benefits only; or

3. Comprehensive long-term care benefits.

(3) Policy Definitions. 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:

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

(B) "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.

(C) "Adult day care" means a program for five (5) 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.

(D) "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.

(E) "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.

(F) "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).

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

(H) "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.

(I) "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.

(J) "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.

(K) "Medicare" means "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.

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

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

(N) "Skilled nursing care," "intermediate care," "personal care," "home care" and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

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

(P) "Transferring" means moving into or out of a bed, chair or wheelchair.

(Q) All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal care facility," and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition

may require that the provider be appropriately licensed or certified.

(4) 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 section (7) of this regulation.

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

2. The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

3. The term "noncancellable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

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

5. In addition to the other requirements of this subsection, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of *Internal Revenue Code* (IRC), section 7702B(b)(1)(C), as referenced herein.

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

1. Preexisting conditions or diseases;

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

3. Alcoholism and drug addiction;

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

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

B. Participation in a felony, riot or insurrection;

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

D. Suicide or attempted suicide while sane or intentionally self-inflicted injury; or

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

5. Treatment provided in a government facility (unless otherwise required by law), services to the extent that benefits are available under Title XVIII of the Social Security Act (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 Medicare 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 or territorial limitations. However, no long-term care issuer may deny a claim because services were provided in a state other than the state of policy issue under the following circumstances:

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

(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 on or after January 1, 2004 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 (6) months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

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 insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

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:

(I) 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

(II) The premium for which is calculated in a manner consistent with the requirements of paragraph (4)(D)6. of this rule.

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 one hundred percent (100%) of incurred expenses. The provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

9. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, 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. If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

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

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

(F) Premium.

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 section (24) of this regulation, 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 section (24) of this regulation, the initial annual premium shall be based on the reduced benefits.

(G) Electronic Enrollment for Group Policies.

1. In the case of a group defined in section 376.1100.2(4)(a), RSMo, any requirement that a signature of an insured be obtained by a producer or insurer shall be deemed satisfied if:

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

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

C. The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of personally identifiable financial information as defined by 20 CSR 100-6.100, is maintained.

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

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

(A) Notice Before Lapse or Termination.

1. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one (1) person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one (1) person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one (1) person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state:

"Protection against unintended lapse. I understand that I have the right to designate at least one (1) person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

2. The insurer shall notify the insured of the right to change this written designation, no less often than once every two (2) years.

3. When the policyholder or certificateholder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in paragraph (5)(A)1. of this rule need not be met until sixty (60) days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

4. Lapse or termination for nonpayment

of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to paragraph (5)(A)1. of this regulation, at the address provided by the insured for purposes of receiving notice of lapse or termination.

A. Notice shall be given by first class United States mail, postage prepaid.

B. Notice may not be given until thirty (30) days after a premium is due and unpaid.

C. Notice shall be deemed to have been given as of five (5) days after the date of mailing.

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

(6) 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 that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder, including long-term care policies that are part of or combined with life insurance policies, since life insurance policies do not contain renewability provisions.

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

(B) Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that 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 these terms and an explanation of the terms in its accompanying outline of coverage.

(D) Limitations. If a long-term care insurance policy or certificate contains 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 section 376.1109, RSMo, shall set forth a description of the 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 the provision of paragraph (29)(E)3. of this regulation, that the policy is intended to be a qualified long-term care insurance contract under IRC, section 7702B(b), as referenced herein.

(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 the provisions of paragraph (29)(E)3. of this regulation, that the policy is not intended to be a qualified long-term care insurance contract.

(7) Required Disclosure of Rating Practices to Consumers.

(A) This section shall apply as follows:

1. Except as provided in paragraph (7)(A)2., below, this section applies to any long-term care policy or certificate issued in this state six (6) months following the effective date of this regulation.

2. For certificates issued on or after the effective date of this regulation under a group long-term care insurance policy as defined in section 376.1100.2(4)(a), RSMo, which policy was in force at the time this regulation became effective, the provisions of this section shall apply on the policy anniversary following July 1 of the year following the year in which this regulation becomes effective.

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

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

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

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

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

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 paragraph (7)(B)3. of this rule if the premium rate or rate schedule is changed;

5. Information relating to premium rate increases.

A. 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:

(I) The policy forms for which premium rates have been increased;

(II) The calendar years when the form was available for purchase; and

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

B. The insurer may, in a manner that is not misleading to the applicant, provide additional explanatory information related to the rate increases.

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

D. If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of either the effective date of this regulation or the end of a twenty-four (24)-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with subparagraph (7)(B)5.A. of this rule.

E. If the acquiring insurer in the provisions of subparagraph (7)(B)5.D. of this regulation, above, files for a subsequent rate increase, even within the twenty-four (24)-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in provisions of subparagraph (7)(B)5.D. of this regulation, above, the acquiring insurer shall make all disclosures required by paragraph (7)(B)5. above, including disclosure of the earlier rate increase referenced in the provisions of subparagraph (7)(B)5.D. of this regulation.

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

(D) An insurer shall use the Long-Term Care Personal Worksheet (Form LTC-B) and the Potential Rate Increase Disclosure Form (Form LTC-F) to comply with the requirements of subsections (7)(B) and (D) of this rule.

(E) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least forty-five (45) days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by subsection (7)(B) when the rate increase is implemented.

(8) Initial Filing Requirements.

(A) This section applies to any long-term care policy issued in this state six (6) months following the effective date of this regulation.

(B) An insurer shall provide the information listed in this subsection to the director thirty (30) days prior to making a long-term care insurance form available for sale.

1. A copy of the disclosure documents required in section (7) of this regulation; 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 complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

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

(II) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(III) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted);

(IV) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur;

(V) When the difference between the gross premium and the renewal net valuation premiums is not sufficient to cover expected renewal expenses, the description provided could demonstrate the type and level of change in the reserve assumptions that would be necessary for the difference to be sufficient.

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

(b) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the director may request a demonstration under subsection (8)(C) of this regulation based on a standard age distribution; and

E. Premium rate schedule.

(I) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(II) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences. At a minimum, the insurer must provide that a broad range of expected combinations in a manner designed to provide a fair presentation for review by the director.

(C) The director may request additional information to be provided.

1. The director may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

2. In the event the director asks for

additional information under this provision, the period in subsection (8)(B) of this regulation does not include the period during which the insurer is preparing the requested information.

(9) Prohibition Against Post-Claims Underwriting.

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

(B) Medication.

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

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

(C) Except for policies or certificates that are guaranteed issue:

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

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

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

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

3. Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the insurer shall obtain one (1) of the following:

A. A report of a physical examination;

B. An assessment of functional capacity;

C. An attending physician's statement; or

D. Copies of medical records.

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

(E) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and shall annually furnish this information to the insurance director on the Rescission Reporting Form for Long-Term Care Policies (Form LTC-A).

(10) Minimum standards for home health and community care benefits in long-term care insurance policies.

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

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

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

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

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

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

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

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

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

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 (1/2) of one (1) year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement 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. This subsection is not intended to restrict home health care to a period of time which would make the benefit illusory. Fewer than three hundred sixty-five (365) benefit days and less than a twenty-five dollar ($25) daily maximum benefit constitute illusory home health care benefits.

(11) Requirement to Offer Inflation Protection.

(A) No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one (1) 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 of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 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 subsection (11)(A) of this rule, above, shall be made to the group policyholder; except, if the policy is issued to a group defined in section 376.1100.2(4)(a), RSMo, other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

(C) The offer in subsection (11)(A) of this rule, above, shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

(D) Information Required in or with the Outline of Coverage.

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

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

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

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

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

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

(G) Rejection of Inflation Protection.

1. Inflation protection as provided in paragraph (11)(A)1. of this rule, above, shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection.

2. The rejection may be either in the application or on a separate form.

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

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

(12) 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 section 376.1100.2(4)(a), RSMo, the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement:

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

2. "Did you have another long-term care insurance policy or certificate in force during the last 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, including the following:

1. All policies sold that are still in force.

2. All 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 insurer, other than an insurer using direct response solicitation methods, or its producer, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage.

1. One (1) copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer.

2. The required notice shall be provided in the manner set forth in the Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance Form (Form LTC-1).

(D) Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the manner set forth in the Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance Form (Form LTC-2).

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

(F) Life insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of 20 CSR 400-5.400. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

(13) Reporting Requirements.

(A) For purposes of this section:

1. "Policy" means only long-term care insurance;

2. Subject to subsection (13)(G), below, "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 insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

4. "Report" means on a statewide basis.

(B) Every insurer 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.

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

(D) Every insurer shall report, annually by June 30, the ten percent (10%) of its producers

with the greatest percentages of lapses and replacements as measured by subsection (A) of this section, above. The required report is the Replacement and Lapse Reporting Form (Form LTC-G).

(E) Every insurer shall report annually by June 30, by completing Form LTC-G, 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.

(F) Every insurer shall report annually by June 30, by completing Form LTC-G, 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.

(G) Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. The required report is the Claims Denial Reporting Form (Form LTC-E).

(H) Reports required under this section shall be filed with the director.

(14) Licensing. A producer is not authorized to sell, solicit or negotiate with respect to long-term care insurance except as authorized by section 375.018, RSMo.

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

(A) The modification or suspension would be in the best interest of the insureds;

(B) The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

(C) One of the following:

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

2. 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

3. 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.

(16) 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 section 376.380, RSMo. Claim reserves shall also be established in the case when the policy or rider is in claim status.

(B) Reserves for policies and riders subject to 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.

(C) 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.
20. Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the AAA.

(D) When long-term care benefits are provided other than as in subsections (A) through (C) of this section, above, reserves shall be determined in accordance with section 376.410, RSMo, and 20 CSR 200-1.140.

(17) Loss Ratio.

(A) This section shall apply to all long-term care insurance policies or certificates except those covered under sections (8) and (18) of this regulation.

(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 that 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) Subsection (B) of this section, above, 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 section 376.670, RSMo;

3. The policy meets the disclosure requirements of section 376.1109, RSMo;

4. Any policy illustration that meets the applicable requirements of sections 375.1500–375.1527, RSMo; and

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

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

B. A description of the basis for the reserves;

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

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

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

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

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

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

(18) Premium Rate Schedule Increases.

(A) This section shall apply as follows:

1. Except as provided in paragraph (18)(A)2., below, this section applies to any long-term care policy or certificate issued in this state six (6) months following the effective date of this regulation.

2. For certificates issued on or after the effective date of this proposed rule under a group long-term care insurance policy as defined in section 376.1100.2(4)(a), RSMo, which policy was in force at the time this proposed rule became effective, the provisions of this section shall apply on the policy anniversary following twelve (12) months after the effective date of this regulation.

(B) An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the director at least thirty (30) days prior to the notice to the policyholders and shall include:

1. Information required by section (7) of this regulation, above;

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; and

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

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

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

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

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

(III) The projections shall demonstrate compliance with subsection (18)(C), below; and

(IV) For exceptional increases:

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

(b) In the event the director determines, as provided in the provisions of paragraph (2)(A)4. of this regulation, 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; and

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

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

5. Sufficient information for review 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 subparagraph (18)(C)2.C., above, on an earned basis;

3. In the event that a policy form has both exceptional and other increases, the values in the provisions of subparagraphs (18)(C)2.B. and D., above, 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 20 CSR 200-1.140. 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 by the director updated projections, as defined in the provisions of subparagraph (18)(B)3.A. of this rule, above, 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 subsection (K) of this section, below, 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 two hundred percent (200%) of the comparable rate in the initial premium schedule, lifetime projections, as defined in the provisions of subparagraph (18)(B)3.A., above, shall be filed for review by the director every five (5) years following the end of the required period in subsection (D) of this section, above. For group insurance policies that meet the conditions in subsection (K) of this section, below, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the director.

(F) Director may request additional steps be taken by the insurer.

1. 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 subsection (C) of this section, above, the director may require the insurer to implement any of the following:

A. Premium rate schedule adjustments; or

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

2. In determining whether the actual experience adequately matches the projected experience, consideration should be given to the provisions of subparagraph (18)(B)3.E. of this regulation, if applicable.

(G) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file the following documents:

1. A plan, subject to the director's 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 subsection (H) of this section, below; and

2. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection (C) of this section, above, had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculations described in the provisions of subparagraphs (18)(C)2.A. and C., above.

(H) Significant Adverse Lapsation.

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 director may determine that a rate spiral exists. If it is determined 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 (1) or more reasonably comparable products being offered by the insurer or its affiliates.

A. The offer shall:

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

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

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

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

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

(II) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus 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 director may, in addition to the provisions of subsection (H) of this section, above, 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) Subsections (A) through (I) of this section shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in subsection (2)(B), above, 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. Section 376.669, RSMo;

B. Section 376.670, RSMo;

C. Section 376.671, RSMo;

3. The policy meets the disclosure requirements of section 376.1109, RSMo;

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 sections 375.1500–375.1527, RSMo;

B. Disclosure requirements in 20 CSR 400-1.020; and

5. An actuarial memorandum is filed with the 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) Subsections (F) and (H) of this section, above, shall not apply to group insurance policies as defined in section 376.1100.2(4)(a), RSMo, where:

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

2. The policyholder, and not the certificateholders, 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.

(19) Filing Requirement. Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state pursuant to section 376.1103, RSMo, it shall file with the director evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

(20) Filing Requirements for Advertising.

(A) Every insurer, health care service plan, or other entity providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio or television medium to the director for review by the director to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer, health care service plan, or other entity for at least three (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, that requirement may not be reasonably applied.

(21) Standards for Marketing.

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

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

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

B. Excessive insurance is not sold or issued.

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

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

3. Provide copies of the disclosure forms required in subsection (7)(C) of this regulation (Form LTC-B and Form LTC-F) to the applicant.

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

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

6. If the state in which the policy or certificate is to be delivered or issued for delivery has a state senior health insurance assistance program approved by the director, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificateholder 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 the provisions of (4)(A)3. of this regulation.

8. Provide an explanation of contingent benefit upon lapse provided for in the provisions of paragraph (24)(D)3. and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in paragraph (24)(D)4.

(B) In addition to the practices prohibited in sections 376.930 to 376.948, RSMo, the following acts and practices are prohibited:

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

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) Association Responsibility.

1. With respect to the obligations set forth in this subsection, the primary responsibility of an association, as defined in section 376.1100.2(4)(b), RSMo, when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

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

A. The policy and certificate;

B. A corresponding outline of coverage; and

C. All advertisements requested by the department.

3. The association shall disclose in any long-term care insurance solicitation, the following information:

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

B. A brief description of the process under which the policies and the insurer issuing the policies were selected.

4. If the association and the insurer have

interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

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

6. The association shall also do the following:

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

B. Actively monitor the marketing efforts of the insurer and its producers;

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. The provisions of subparagraphs (21)(C)6.A. through C. of this regulation shall not apply to qualified long-term care insurance contracts.

7. The materials specified for filing in this section shall be filed in accordance with this state's filing due dates and procedures.

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

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

10. Knowingly failing to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of section 375.936(5), RSMo.

(22) Suitability.

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

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

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) Requirement to Develop Procedures.

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

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

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

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

2. The issuer, and where a producer is involved, the producer shall make reasonable efforts to obtain the information set out in paragraph (22)(C)1. above. The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Form LTC-B, in not less than twelve (12)-point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the director.

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

4. The sale or dissemination outside the company or business entity by the issuer or producer of information obtained through the personal worksheet in Form LTC-B 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 time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" (Form LTC-C) shall be provided. The form shall be in the format as approved by the director in Form LTC-C 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 the format outlined in the Long-Term Care Insurance Suitability Letter (Form LTC-D). However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

(H) The issuer shall report annually by June 30 to the director the following information:

1. The total number of applications received from residents of this state;

2. The number of those who declined to provide information on the personal worksheet;

3. The number of applicants who did not meet the suitability standards; and

4. The number of those who chose to confirm after receiving a suitability letter.

(23) Prohibition against preexisting conditions and probationary periods in replacement policies or certificates. If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive 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.

(24) 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 section 376.1127, RSMo:

1. A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection (E) of this section, below; 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 section 376.1127, RSMo, is rejected, the insurer shall provide the contingent benefit upon lapse described in this section.

(D) Actions Required after Rejection.

1. After rejection of the offer required under section 376.1127, RSMo, for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the insurer shall provide a contingent benefit upon lapse.

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

3. The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium 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%

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

4. On or before the effective date of a substantial premium increase as defined in the provisions of (24)(D)3. of this regulation, above, the insurer 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. The insured's right to reduce policy benefits in the event of the premium increase does not affect any other right to elect a reduction in benefits provided under the policy;

B. Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection (E) of this section, below. This option may be elected at any time during the one hundred twenty (120)-day period referenced in paragraph (24)(D)3. of this rule, above; and

C. Notify the policyholder or certificateholder that a default or lapse at any time during the one hundred twenty (120)-day period referenced in the paragraph (24)(D)3. of this rule, above, shall be deemed to be the election of the offer to convert as provided for by the provisions of (24)(D)4.B. of this regulation, above.

(E) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse.

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 (1%) 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 of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in the provisions of paragraph (24)(E)3. of this rule, below.

3. The standard nonforfeiture credit will be equal to one hundred percent (100%) of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit 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 subsection (F) of this section, below.

4. Timing of nonforfeiture benefit.

A. The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three (3) years as well as thereafter.

B. Notwithstanding the provisions of (24)(E)4.A., above, for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

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

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

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

(F) All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid-up status will not exceed the maximum benefits which would be 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 twelve (12) months after the effective date of this regulation and shall apply as follows:

1. Except as provided in the provisions of paragraph (24)(H)2., below, the provisions of this section apply to any long-term care policy issued in this state on or after the effective date of this proposed rule.

2. The provisions of this section shall not apply to certificates issued on or after the effective date of this regulation, under a group long-term care insurance policy as

defined in section 376.1100.2(4)(a), RSMo, which policy was in force at the time this regulation became effective.

(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 section (17) of this regulation treating the policy as a whole.

(J) To determine whether contingent nonforfeiture upon lapse provisions are triggered under paragraph (24)(D)3., of this rule, above, a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

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

1. The nonforfeiture provision shall be appropriately captioned;

2. The nonforfeiture provision shall provide 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 (1) 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.

(25) Availability of New Services or Providers.

(A) An insurer shall notify policyholders of the availability of a new long-term care policy series, except for those stated in 20 CSR 400-4.110, that provides coverage for new long-term care services or providers material in nature and not previously available through the insurer to the general public. The notice shall be provided within twelve (12) months of the date the new policy series is made available for sale in this state.

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

(C) The insurer shall make the new coverage available in one (1) 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 of the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; and

4. By an alternative program developed by the insurer that meets the intent of this section if the program is filed with and approved by the director.

(D) An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of 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 section (12) and the reporting requirements of subsections (13)(A) to (E) of this regulation.

(F) Where the policy is offered through an employer, labor organization, professional trade or occupational association, the required notification in subsection (A) above shall be made to the offering entity. However, if the policy is issued to a group defined in section 376.1100(4)(d), RSMo, the notification shall be made to each certificateholder.

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

(H) 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 the effective date of this regulation.

(26) Right to Reduce Coverage and Lower Premium.

(A) Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium.

1. The provision provides for the reduction in at least one (1) of the following ways:

A. Reducing the maximum benefit; or

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

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

3. 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.

4. The age to determine the premium for the reduced coverage shall be based on the age used to determine premium for the coverage currently in force.

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

(B) If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by paragraph (5)(A)1. of this regulation.

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

(D) The requirements of this section shall apply to any long-term care policy issued in this state on or after the effective date of this regulation.

(27) 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.

1. Activities of daily living shall include at least the following as defined in section (3) of this regulation and in the policy:

A. Bathing;
B. Continence;
C. Dressing;
D. Eating;
E. Toileting; and
F. Transferring;

2. Insurers may use activities of daily living to trigger covered benefits in addition to those contained in paragraph (27)(B)1., of this rule, above, as long as they are defined in the policy.

(C) An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate. However, the provisions shall not restrict, and are not in lieu of, the requirements contained in subsections (A) and (B) of this section, above.

(D) 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.

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

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

(G) The requirements set forth in this section shall be effective one (1) year from the date that this regulation becomes effective and shall apply as follows:

1. Except as provided by paragraph (27)(G)2., of this rule, below, the provisions of this section apply to a long-term care policy issued in this state on or after the effective date of this regulation.

2. The provisions of this section shall not apply to certificates issued on or after the effective date of this regulation, under a group long-term care insurance policy as defined in section 376.1100.2(4)(a), RSMo, that was in force at the time this regulation became effective.

(28) 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 IRC, section 7702(c)(1) as referenced herein, 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."

A. Chronically ill individual has the meaning prescribed for this term by IRC, section 7702B(c)(2) as referenced herein. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

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

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

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

3. "Licensed health care practitioner" means a physician, as defined in section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the United States 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 subsection (C) of this section, above, 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 United States Secretary of the Treasury.

(E) Certifications required pursuant to subsection (C) of this section, above, 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 (90)-day period.

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

(29) Standard Format Outline of Coverage. This section implements, interprets and makes specific, the provisions of section 376.1115, RSMo, in prescribing a standard format and the content of an outline of coverage.

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

(B) The outline of coverage shall contain no material of an advertising nature.

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

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

(E) The format for the outline of coverage shall conform to the Outline of Coverage form (Form LTC-3).

(30) Requirement to Deliver Shopper's Guide.

(A) A long-term care insurance shopper's

guide in the format developed by the NAIC, 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 section 376.1115, RSMo.

AUTHORITY: sections 374.045 and 536.016, RSMo 2000 and sections 376.1109, 376.1127, and 376.1130, RSMo Supp. 2006. Original rule filed Jan. 28, 1991, effective Sept. 30, 1991. Amended: Filed July 12, 2002, effective Jan. 30, 2003. Rescinded and readopted: Filed March 17, 2003, effective Jan. 1, 2004. Amended: Filed Nov. 15, 2007, effective July 30, 2008.*

**Original authority: 374.045, RSMo 1967, amended 1993, 1995; 376.1109, RSMo 1990, amended 2002; 376.1127, RSMo 2002; 376.1130, RSMo 2002; and 536.016, RSMo 1997, amended 1999.*

20 CSR 400-4.110 Qualified Long-Term Care Partnership Program

PURPOSE: This rule prescribes the additional requirements for Qualified Long-Term Care Partnership Plans.

(1) Requirements. For the purposes of this section, "Qualified Long-Term Care Partnership coverage" shall mean any long-term care coverage that is intended to be marketed as part of a long-term care partnership program, as outlined in sections 208.690 to 208.698, known as the "Missouri Long-Term Care Partnership Program Act."

(A) Coverage Requirements. Coverage will be considered meeting the requirements of the Missouri Long-Term Care Partnership Program if the following requirements are met:

1. The insured was a resident of this state when coverage first became effective;

2. The coverage is a qualified long-term care insurance policy (as defined in section 7702B(b) of the *Internal Revenue Code* of 1986);

3. The coverage meets the requirements of the Deficit Reduction Act of 2005, except for Subchapter B, Section 6021(a)(1)(iii)(IV) as stated in section 208.696.1(2), RSMo; and

4. The coverage includes inflation protection no less favorable than the following:

A. For a person who is less than sixty-one (61) years of age as of the date of purchase, the coverage provides compound annual inflation protection; and

B. For a person who is at least sixty-one (61) years of age but less than seventy-six (76) years of age, the policy provides some level of inflation protection; and

C. For any person who has attained the age of seventy-six (76), inflation protection may be provided but is not required.

D. In order for coverage to meet the requirements of subparagraph (1)(A)4.A., if the required inflation protection offer of five percent (5%) compound annual inflation protection referenced in 20 CSR 400-4.100(11) is rejected, the inflation protection included shall:

(I) Provide automatic annual compounded inflation increases at a rate not less than three percent (3%); or

(II) Provide automatic annual compound 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

(III) The director may approve an alternative inflation protection method so long as such method is submitted to the director with an explanation and demonstration as to how the alternative method provides for meaningful benefits which are in the best interest of the consumer and provides assurances that the policy or certificate will remain a partnership plan.

(B) Offers of Exchange. In addition to complying with the requirements of 20 CSR 400-4.100(25), where applicable—

1. Within one hundred eighty (180) days of the date that an insurer begins to advertise, market, offer, sell or issue policies that qualify under the state long-term care partnership program, the insurer shall offer, on a one (1)-time basis, in writing, to all existing policyholders and certificateholders that were issued long-term care coverage by the insurer on or after February 8, 2006, the option to exchange their existing long-term care coverage for coverage that is intended to qualify under the Missouri Long-Term Care Partnership Program (Partnership Plan). The written offer of exchange shall include the Long-Term Care Partnership Program Exchange Notification letter (Form LTC-4);

2. An exchange occurs when an insurer offers a policyholder or certificateholder (hereinafter "insured") the option to replace an existing long-term care insurance policy with a policy that qualifies as a Partnership Plan, and the insured accepts the offer to terminate the existing policy and accepts the new policy. In making an offer to exchange, an insurer shall comply with all of the following requirements:

A. The offer shall be made on a nondiscriminatory basis without regard to the age or health status of the insured;

B. The offer shall remain open for a minimum of one hundred eighty (180) days from the date of mailing by the insurer to the insured's last known address; and

C. At the time the offer is made, the insurer shall provide the insured a copy of Form LTC-4;

3. Notwithstanding paragraphs (1)(B)1. and 2., above:

A. An offer to exchange may be deferred for any insured who is currently eligible for benefits under an existing policy or who is subject to an elimination period on a claim, but such deferral shall continue only as long as such eligibility or elimination period exists, or the insured is no longer in claims status;

B. An offer to exchange does not have to be made if the insured would be required to purchase additional benefits to qualify for the state long-term care partnership program and the insured is not eligible to purchase the additional benefits under the insurer's new business, long-term care, underwriting guidelines;

4. If the new policy has an actuarial value of benefits equal to or lesser than the actuarial value of benefits of the existing policy, then all of the following apply:

A. The new policy shall not be underwritten; and

B. The rate charged for the new policy shall be determined using the original issue age and risk class of the insured that was used to determine the rate of the existing policy;

5. If the new policy has an actuarial value of benefits exceeding the actuarial value of the benefits of the existing policy, then all of the following apply:

A. The insurer shall apply its new business, long-term care, underwriting guidelines to the increased benefits only; and

B. The rate charged for the new policy shall be determined using the method set forth in subparagraph (1)(B)4.B., above, for the existing benefits, increased by the rate for

the increased benefits using the then current attained age and risk class of the insured for the increased benefits only;

6. The new policy offered in an exchange shall be on a form that is currently offered for sale by the insurer in the general market and the effective date of the Partnership Plan policy shall be the same as the new policy;

7. In the event of an exchange, the insured shall not lose any rights, benefits or built-up value that has accrued under the original policy with respect to the benefits provided under the original policy, including, but not limited to, rights established because of the lapse of time related to pre-existing condition exclusions, elimination periods, or incontestability clauses;

8. Insurers may complete an exchange by issuing a new policy with an effective date no earlier than the effective date of Missouri's State Plan Amendment;

9. For those insureds with long-term care policies issued before February 8, 2006, any insurer may offer any insured an option to exchange an existing policy for a policy that qualifies as a Partnership Plan. The requirements set forth in paragraphs (1)(B)2. through 9. shall apply to any such exchange; and

10. Policies or certificates issued pursuant to this section shall be considered exchanges and not replacements. These exchanges shall not be subject to 20 CSR 400-4.100(12) and the reporting requirements of subsections (13)(B) through (F), in accordance with subsection (25)(E) of regulation 20 CSR 400-4.100.

(C) Filing Requirements.

1. Any policy that is intended to qualify as a Partnership Plan must be filed for approval with the director prior to use, and such filing shall include a separate partnership certification for each form, signed by an officer, which shall include:

A. Certification that the form includes all consumer protection requirements set forth in section 1917(b)(5)A of the Social Security Act (42 U.S.C. 1396p(b)(5)(A)) and that it contains specified provisions of the Deficit Reduction Act of 2005 and the appropriate provisions included in this regulation and sections 376.1100 through 376.1130, RSMo;

B. General information, including:

(I) Name, address and telephone number of the issuer;

(II) Policy form(s) covered by this certificate, including the form number and approval date; and

(III) Specimen copies of each form if they have not been previously approved by the department;

C. Identification and location in the form of each of the required provisions indicated in the Deficit Reduction Act of 2005 and this regulation; and

D. A statement that the form complies with the partnership program inflation protection requirements of paragraph (1)(A)4. of this regulation.

2. Insurers intending to make use of a previously filed policy as a qualifying partnership policy shall submit to the director the Partnership Program Policy Certification Form (Form LTC-5) signed by an officer of the company with respect to each such policy form filed. For each policy form, the partnership program certification shall identify the policy by the original form number and approval date.

3. If an insurer intends to amend a previously approved policy with an endorsement or rider in order to bring the policy into compliance with the partnership program, the insurer shall file the endorsement or rider for approval by the director prior to use, and the filing shall include a partnership program certification signed by an officer of the company for each policy to be amended by the endorsement or rider, which shall include the original form number and filing date of the previously filed policy.

4. Insurers using Form LTC-4 do not have to file the form with the director before use.

(D) Partnership Plan Disclosure Form.

1. For policies intended to qualify under the partnership program, the producer or insurer shall give the consumer a partnership disclosure notice using the Long-Term Care Partnership Program Disclosure Notice (Form LTC-6), either—

A. Along with the outline of coverage required by regulation at the time of solicitation;

B. In the case of a policy issued to a group where an outline of coverage is not delivered, along with the enrollment forms; or

C. In the case of a life insurance policy that offers long-term care insurance as a term of the policy or in a rider, along with the policy summary at the time of solicitation.

2. A partnership policy or certificate issued or issued for delivery in Missouri shall be accompanied by a Long-Term Care Partnership Delivery Notice (Form LTC-7) explaining the benefits associated with a partnership policy and indicating that at the time issued, the policy is intended to be a qualified state long-term care insurance partnership policy. A similar notice may be used if filed and approved by the director.

(E) Data Reporting.

1. Each insurer offering partnership program policies in this state shall make regular reports to the United States Secretary of Health and Human Services that include such information as required by law or as the secretary determines is appropriate for the administration of the partnership program.

2. If requested, the regular reports required by United States Secretary of Health and Human Services shall also be submitted to the director.

AUTHORITY: sections 208.696, 376.1109, 376.1127, and 376.1130, RSMo Supp. 2007 and sections 374.045 and 536.016, RSMo 2000. Original rule filed Nov. 15, 2007, effective July 30, 2008.*

**Original authority: 208.696, RSMo 2007; 374.045, RSMo 1967, amended 1993, 1995; 376.1109, RSMo 1990, amended 2002; 376.1127, RSMo 2002; 376.1130, RSMo 2002; and 536.016, RSMo 1997, amended 1999.*

20 CSR 400-4.120 Producer Training and Continuing Education

PURPOSE: This rule prescribes the producer training requirements for long-term care insurance generally and for Qualified Long-Term Care Partnership Plans.

(1) Licensing. Pursuant to section 208.696.1(1), RSMo, a producer shall not sell, solicit or negotiate long-term care insurance, unless licensed under section 375.018, RSMo, 20 CSR 400.4-100(14) and this rule and the individual has been qualified for both the life and health lines of authority.

(2) Initial Training.

(A) Prior to selling a Qualified Long-Term Care Partnership Plan, a producer shall complete an initial training course no less than eight (8) hours in duration, which has been approved by the director under section 375.020.9(2), RSMo.

(B) In addition to the requirements in section 375.020, RSMo, the curriculum for an initial training course shall consist of topics related to long-term care insurance, long-term care services and, if applicable, Qualified Long-Term Care Partnership Programs, including, but not limited to:

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

2. Available long-term services and providers;

3. Changes of improvements in long-term care services or providers;

4. Alternatives to the purchase of private long-term care insurance;

5. The effect of inflation protection on benefits and the importance of inflation protection; and

6. Consumer suitability standards and guidelines, including 20 CSR 700-1.152.

(C) The training required by this section shall not include training that is insurer or company product specific or that includes sales or marketing information, materials or training, other than those required by state or federal law.

(3) Ongoing Duty to Obtain Training.

(A) A producer shall not sell, solicit or negotiate a Qualified Long-Term Care Partnership Plan after renewal unless prior to each biennial license renewal under section 375.018, RSMo, the producer has completed four (4) hours of training, which has been approved by the director under section 375.020.9(2), RSMo, and includes the content required in subsection (2)(B).

(4) Producer Competence. The failure of a producer to meet the qualifications required shall constitute a violation of the rule, subjecting the producer to enforcement action by the director. Failure to comply with the requirements also demonstrates incompetence, subjecting a producer to discipline or disqualification under the provisions of 375.141, RSMo.

(5) Insurer Supervision. Insurers subject to this regulation shall obtain verification that a producer receives training required in this rule before a producer is permitted to sell, solicit or negotiate the insurer's Qualified Long-Term Care Partnership Plans. The insurer shall maintain records of this verification subject to the state's record retention requirements, and make that verification available to the director upon request.

(6) Assurance of Training. Insurers subject to this rule shall maintain records with respect to the training of all producers soliciting, offering for sale or selling its partnership policies, which will allow the director to provide assurance to the state Medicaid agency that producers have received the training required in this rule and that producers have demonstrated an understanding of the partnership policies and their relationship to the public and private coverage of long-term care, including Medicaid, in this state. These records shall be maintained in accordance with the state's record retention requirements and shall be made available to the director upon request.

(7) The satisfaction of these training requirements in any state shall be deemed to satisfy the training requirements of this state.

AUTHORITY: sections 208.696 and 375.143, RSMo Supp. 2007 and section 374.045, RSMo 2000. Original rule filed Nov. 15, 2007, effective July 30, 2008.*

**Original authority: 208.696, RSMo 2007; 374.045, RSMo 1967, amended 1993, 1995; and 375.143, RSMo 2007.*