

PRODUCT OUTLINE
INDIVIDUAL TAX-QUALIFIED LONG TERM CARE INSURANCE
NON-PARTNERSHIP
As of 8/1/03

Table of Contents

I.	Key References	1
II.	Cover Page	1
III.	Policy Schedule Page	2
IV.	Table of Contents	3
V.	Minimum Benefit Requirements for Long Term Care Insurance	3
VI.	Tax-Qualified Long Term Care Policy Provisions	4
VII.	Regulatory Rules relating to the Content of Forms for Individual Insurance that Must be Applied to Long Term Care Insurance.....	8
VIII.	Specific Regulatory Requirements for Long Term Care Insurance	8
IX.	Permissible Exclusions and Limitations on Coverage	10
X.	Prohibited Exclusions and Limitations for Long Term Care Coverage	11
XI.	Prohibition Against Post-Claims Underwriting in Long Term Care Coverage and Related Matters.....	12
XII.	Mandatory Standard Contract Provisions	13
XIII.	Optional Standard Provisions	14
XIV.	Other Provisions	14
XV.	Matters Affecting the Overall Content of Long Term Care Insurance Forms	17
XVI.	Applications	17
XVII.	Conditional Receipts / Interim Insurance Agreements.....	20
XVIII.	Interaction of Federal and New York State Requirements for Qualified Long Term Care Insurance Contracts	22
XIX.	Marketing of Individual Tax-Qualified Long Term Care Insurance in New York State Using Group Methods	23
XX.	Rating Procedures and Requirements	27

I. Key References

Key Federal Law Sections – Sections 213, 4980C and 7702B of the Internal Revenue Code (IRC) as amended by the Health Insurance Portability and Accountability Act (HIPAA)(and related NAIC models), Internal Revenue Service Notice 97-31 issued May 6, 1997, 26 CFR Part 1.

Key Insurance Law Sections – 1117, 3102, 3105, 3201 (Form Approval issues), 3216 especially 3216 (d)(1) and (2) (standard provisions), 3204 (contract/application issues).

Key Applicable Regulations – Regulation 62 (11 NYCRR 52) minimum standards for form, content and sale of health insurance including Sections 52.2, 52.12, 52.16, 52.17, 52.25 (long term care), 52.29 (replacement), 52.31, 52.33, 52.40, 52.41, 52.43, 52.44, 52.45 (minimum loss ratio standards), 52.47, 52.51 (applications), 52.53 (conditional receipts/interim insurance agreements), 52.54 and 52.65 (disclosure statement requirements), 52.70(a), (b) and (c) (special rules for franchise insurance); Regulation 169 (11 NYCRR 420) privacy of consumer financial and health information including Section 420.18

Key Circular Letters – Circular Letter No. 3 (1989), Circular Letter No. 5 (1997)

II. Cover Page

1. The cover page must prominently indicate the licensed New York insurer's name and full address. Full street address of the company's home office in prominent place (generally front and back of policy form) for disclosure purposes. No unlicensed entity in New York State should appear on the form. Section 3201(c)(1)
2. Include name of product as "Long Term Care Insurance" on the form within the defined category of Section 52.12 of Regulation 62
3. Include "free look" provision of 30 days within parameters of Section 3216(c)(10), Section 1117 and HIPAA.
4. Unique form identification number in lower left-hand corner of form. Section 52.31(d)
5. Renewability provisions of form must be placed on the front page of the policy form. Sections 52.17(a)(1) and (2)

The policy must be "Guaranteed Renewable" pursuant to Section 52.25(b)(1) of Regulation 62 and Section 7702B of the Internal Revenue Code as amended by the Health Insurance Portability and Accountability Act (HIPAA). The term "Guaranteed Renewable", under Section 52.25(b)(1), means that the insured has the right to continue the policy in force by the timely payment of premiums and the insurer has no unilateral right to make any change in any provision of the policy while the insurance is in force. The premium rates may be revised by the insurer on a class basis but the premium revision is subject to the approval of the Department. Section 52.25(b)(1) of Regulation 62 and Section 3201(c)(3) of the Insurance Law

Since the policy is intended to be "tax-qualified" and the policy is "guaranteed renewable", the renewability provision must also include a statement that if changes in federal or state laws or regulations affect the tax-qualification status of the policy, the insurer will offer such changes to the insured for acceptance or rejection. The renewability provision must also state that rejection of such changes when offered may cause the policy to lose its tax-qualified

status. Originates from Section 52.25(b)(1) of Regulation 62 and Section 4980C of the Internal Revenue Code.

6. Unless the policy is “guaranteed issue”, the following language, or language substantially similar shall be set out conspicuously on the long term care insurance policy at the time of delivery. Long term care insurance typically has some level of underwriting and is rarely “guaranteed issue”. Therefore, the following language, or language substantially similar, should appear on the cover page:

“Caution: The issuance of this long term care insurance policy is based upon your responses to the questions on your application. A copy of your application (is enclosed) (was retained by you when you applied). If your answers fail to include all material medical information requested, 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)”. Section 52.25(d)(3)(ii)

The Department will entertain reasonable alternatives to placement of all of this language on the cover page when space considerations and/or the requirement of conspicuous language do not allow placement of all of the language on the cover page. For example, the Department will allow a prominent cross-reference containing the substance of this cautionary language on the cover page. The prominent cover page cross reference must identify the page early in the policy language which conspicuously sets forth the language required by Section 52.25(d)(3)(ii) or substantially similar language.

7. As a “tax-qualified” policy, the cover page must contain a statement as required by HIPAA that the policy is intended to be tax-qualified under Section 7702B(b) of the Internal Revenue Code. Section 4980C(d) of IRC
8. If the policy will be issued to persons eligible for Medicare (due to age or disability), the policy must have a statement printed on or attached to the first page of the policy OR the first page of the disclosure statement required by Section 52.54 which notifies the buyer as follows:

“THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company”. Section 52.17(a)(33)(i) (The statement must appear in no less than 12-point type.)

9. The signature of one or more company officers should appear on the face page to execute the contract on behalf of the company.
10. If the policy is participating, the cover page must contain a statement to that effect. Section 3216(c)(1)

III. Policy Schedule Page

1. Complete with hypothetical data. Section 52.31(f)
2. Premium summary amounts should appear. Section 52.31(f) and Section 3216(c)(1)
3. Elimination period choices, maximum benefit period choices, daily benefit amounts, available overall maximum monetary amounts and similar optional choices made by the insured should be set forth. Section 52.31(f) and Section 3204(a)(1)

4. Name of insured space. Section 52.31(f) and Section 3216(c)(3)
5. Spaces for effective date of insurance, renewal dates and renewal terms. Section 52.31(f) and Section 3216(c)(2)
6. Optional choices of insured regarding certain benefits and/or riders should be set forth – originates from Section 52.31(f) and Section 3204(a)(1)

IV. Table of Contents

1. Table of Contents must be included when required. – Section 3102(c)(1)(G)

V. Minimum Benefit Requirements for Long Term Care Insurance

1. Section 52.12 of Regulation 62 defines long term care insurance as an insurance policy, rider, or certificate advertised, marketed, offered, or designed to provide coverage, subject to eligibility requirements, for not less than 24 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis and provides at least the benefits set forth below, or a combination of those benefits. The Regulation then proceeds to give three different options of minimum long term care benefits. The insurer must choose one option and follow the requirements. If the insurer intends to provide a combination of the three options, the Department must be given an opportunity to review and approve such combination. The three options are as follows:
 - a. Option I: (i) Coverage of all levels of care in a nursing home of at least \$100 per day; except that such \$100 may be reduced to at least \$70 per day for policies issued for delivery outside the “metropolitan area”, and (ii) Coverage of home care of at least 50 percent of the daily indemnity amount provided for care in a nursing home. “Metropolitan Area” is defined in Section 52.2(s) of Regulation 62 as that area within the corporate limits of the counties of the Bronx, Kings Nassau, New York, Queens, Richmond, Suffolk, Rockland and Westchester.
 - b. Option II: (i) Coverage of all levels of care in a nursing home at no less than 60% of reasonable charges, and (ii) Coverage of home care at no less than 60% of reasonable charges.
 - c. Option III: (i) Coverage of all levels of care in a nursing home which has contracted with an insurer to provide services to their policyholders, at no less than 75% of the negotiated rate. For non-contracting nursing homes, payment may be made at no less than 50% of the reasonable charge or \$55 per day, whichever is less, and (ii) Coverage of home care by a home care provider which has contracted with an insurer to provide services to their policyholders, at no less than 75% of the negotiated rate. For non-contracting home care providers, payment may be made at no less than 50% of the reasonable charge or \$30 per day, whichever is less.
2. The policy’s description of benefits must include a statement assuring the policyholder that the Nursing Home benefits and the Home Care benefits provided by the policy will never be less than the minimum benefits required by Section 52.12 of Regulation 62. Section 52.12
3. If the policy provides benefits in addition to those nursing home and home care benefits required by Section 52.12, the policy must identify the additional benefits, explain to the insured how the use of the unrequired benefits can reduce coverage limits beneath the minimum levels required by Section 52.12 and advise the insured that if he/she wishes to receive the minimum coverage amounts for benefits received, then he/she should manage their benefits accordingly.

The additional benefits discussed here are those that can deplete coverage benefit levels or maximums so that coverage benefit levels or maximums are left beneath required minimums for required Section 52.12 services. For example, a long term care policy may provide an assisted living facility benefit that counts against the 24 month benefit period for the required Section 52.12 nursing home benefit. Although the assisted living facility service is above the minimum services of Section 52.12, its use against the 24 month benefit period may reduce the benefit period to less than 24 months for a nursing home stay which followed an assisted living facility stay. Benefit designs of such a nature must be disclosed to the insured. The disclosure must indicate that the coverage allows the insured to use required benefits at required regulatory minimums, but he/she must manage benefit usage accordingly to achieve that possible result.

If the insurer provides additional benefits not required by Section 52.12 so the additional benefits never can result in payments beneath Section 52.12 levels for required Section 52.12 services, this disclosure is not necessary (e.g., assisted living facility stay has its own 12 month benefit period unrelated to the 24 month benefit period for a nursing home stay).

4. If the long term care policy under Section 52.12 contains any additional benefits which meet only Section 52.13 requirements (e.g., nursing home insurance only, home care insurance only, nursing home and home care insurance), those additional benefits are identified as Section 52.13 benefits within the Section 52.12 policy.

For example, although services outside the United States may be excluded, some insurers have chosen to offer international benefits. If international benefits are offered in a Section 52.12 policy, they must meet the minimum 52.12 benefits for the care provided. If the benefits are not provided at the Section 52.12 minimums, the nursing home and/or home care benefits must be at least the Section 52.13 minimums and those benefits must be identified as Section 52.13 benefits for nursing home insurance only, home care insurance only or nursing home and home care insurance.

VI. Tax-Qualified Long Term Care Policy Provisions

To qualify for favorable federal and New York State income tax treatment, the policy must meet or exceed all federal requirements for a tax-qualified policy*. Sections 7702B and 4980C of the Internal Revenue Code set forth the elements that must appear in a long term care policy for it to be considered “tax-qualified”. (This outline should not be used as a substitute for reading all federal statutes, regulations and guidelines relevant to tax-qualified long term care coverages.) Please also see XVIII below concerning the interaction of federal and New York State requirements and when federal law allows stricter state requirements to apply. The basic elements are as follows:

1. The Code defines “Qualified Long Term Care Services” as necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services and maintenance or personal care services which (A) are required by a “chronically ill individual” and (B) are provided pursuant to a plan of care prescribed by a “licensed health care practitioner”.
2. 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 2 out of the 6 “activities of daily living” for a period of at least 90 days due to a loss of functional capacity (the ADL trigger),
 - (ii) having a level of disability similar to the level of disability described in the ADL trigger as determined under regulations prescribed by the Secretary of the Treasury in

consultation with the Secretary of Health and Human Services (the Similar Level trigger), OR

- (iii) requiring “substantial supervision” to protect such individual from threats to health and safety due to “severe cognitive impairment” (the Cognitive Impairment trigger).

The term “chronically ill individual” shall not include any individual otherwise meeting the requirements of the preceding sentence unless, within the preceding 12-month period a licensed health care practitioner has certified that such individual meets such requirements.

3. “Activities of Daily Living” include only the following: eating, toileting, transferring, bathing dressing, and continence. A policy may not be considered “tax-qualified” unless the determination of whether an individual is a “chronically ill individual” takes into account at least five of such activities.
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).
5. The term “licensed health care practitioner” means any physician (as defined in section 1861(r)(1) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary acting within the scope of his/her New York State license.
6. It is advisable that the policy adhere to “safe harbor” definitions as set forth in federal regulations and IRS interim guidance of 1997 for favorable federal and New York State income tax treatment. If it does NOT adhere to the “safe harbor” definitions, the submission letter must explain how the policy is still tax-qualified. “Safe harbor” definitions relate to the following terms set forth in the IRC for determination of a chronically ill individual:
 - a. “Substantial assistance” means “hands-on assistance” and “standby assistance”.
 - b. “Hands-on” assistance means the physical assistance of another person without which the individual would be unable to perform the activity of daily living.
 - c. “Standby assistance” means the presence of another person within arm’s reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL (such as being ready to catch the individual if the individual falls while getting into or out of the bathtub or shower as part of bathing, or being ready to remove food from the individual’s throat if the individual chokes while eating.)
 - d. “Substantial supervision” means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the severely cognitively impaired individual from threats to his or her health or safety (such as may result from wandering).
 - e. “Severe cognitive impairment” means a loss or deterioration in intellectual capacity that is (a) comparable to (and includes) Alzheimer’s disease and similar forms of irreversible dementia, and (b) measured by clinical evidence and standardized tests that reliably measure impairment in the individual’s (i) short term or long-term memory, (ii) orientation as to people, places, or time, and (iii) deductive or abstract reasoning.

7. As tax-qualified, the policy identifies whether it is of an indemnity or expense nature within the meaning of HIPAA for favorable federal and New York State income tax treatment.
8. As tax-qualified, the policy cannot pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursed under Title XVIII of the Social Security Act or would be so reimbursed but for the application of a deductible or coinsurance amount.
9. As tax-qualified, the forms do not provide for cash surrender value or other money that can be paid, assigned or pledged as collateral for a loan or borrowed (except to reduce future premiums or increase future benefits or as otherwise specifically allowed by HIPAA).

10. Third Party Designation and Notice

- a. Notice before lapse or termination – No individual policy will be issued until the insurer has received from the applicant either a:

written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy for nonpayment of premium, or

written waiver dated and signed by the applicant electing not to designate additional persons to receive notice.

The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation will 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 will state:

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

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

- b. When the policyholder pays premium for a long-term care insurance policy through payroll or pension deduction plan, the above requirements need not be met until 60 days after the policyholder is no longer on such a payment plan. The application or enrollment form for such policies will clearly indicate the payment plan selected by the applicant.
- c. Lapse or termination for nonpayment of premium – No individual policy will be lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to the above requirements, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice will be given by first class mail, postage prepaid, and notice may not be given until 30 days after a premium is due and unpaid. Notice will be deemed to have been given as of 5 days after the date of mailing.

11. Reinstatement – A long term care insurance policy will include a provision for reinstatement of coverage, in the event of lapse if the insurer is provided proof of cognitive impairment or the loss of functional capacity. This option will be available to the insured if requested within 5 months after termination and will 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, if any, contained in the policy. The reinstatement provision required by Section 3216(d)(1)(D) of the Insurance Law must also be set forth in the policy. See XII, 4 on page 13.
12. If the filing contains any change to be issued to existing business where a policy was issued prior to January 1, 1997, the submission letter must address the effect of this change on the grandfathered tax-qualified status of the policy issued prior to January 1, 1997 (e.g., material changes to business issued prior to January 1, 1997 within the meaning of federal regulations and guidelines resulting in grandfathered tax-qualified status forfeiture).

Final federal regulations did provide that the following practices will not be treated as the issuance of a new contract for purposes of the grandfathering provision of Section 321(f)(2) of HIPAA:

- (1) A change in the mode of premium payment, such as from monthly premium payment to quarterly premium payment;
- (2) A classwide increase or decrease in premiums for contracts that have been issued on a guaranteed renewable basis;
- (3) A reduction in premiums due to the purchase of a long term care insurance policy by a member of the policyholder's family;
- (4) A reduction in coverage (with correspondingly lower premiums) made at the request of a policyholder;
- (5) A reduction in premiums that occurs because the policyholder becomes entitled to a discount under the issuer's pre-1997 premium rate structure (such as when a policyholder becomes a member of a group entitled to a group discount, or changes from smoker to non-smoker status);
- (6) The addition, without an increase in premiums, of alternative forms of benefits that may be selected by the policyholder;
- (7) The addition of a rider to increase benefits under a pre-1997 contract if the rider would constitute a qualified long term care insurance contract if it were a separate contract;
- (8) The deletion of a rider or provision of a contract that prohibited coordination of benefits with Medicare;
- (9) The effectuation of a continuation or conversion of coverage right under a group contract following an individual's ineligibility for continued coverage under the group contract;
- (10) The substitution of one insurer for another in an assumption reinsurance transaction.

* If the policy does not meet the express HIPAA definitions and all federal requirements for tax-qualified status, the insurer must explain its interpretation of HIPAA and federal requirements to make a tax-qualified submission.

VII. Regulatory Rules relating to the Content of Forms for Individual Insurance that Must be Applied to Long Term Care Insurance

1. If the insurer reduces benefits due to an age limit attainment, including any benefit period reduction, such reduction must be referenced on the first page or specification page of the policy – Section 52.17(a)(3).

If the insurer wishes to reduce benefits in excess of Section 52.12 minimums to the 52.12 minimums, the long term care insurance label may be retained. However, if the insurer wishes to reduce the benefits to a level below the minimums for long term care under Section 52.12 of Regulation 62, coverage equal to or in excess of Section 52.13 minimums may be used with prominent disclosure that the insured would only be receiving nursing home and home care insurance under Section 52.13. No such benefit design can leave any insured with less than the minimum benefits of Section 52.13 of Regulation 62. The procedure noted in this paragraph would apply when the insurer or insured desires to make the benefit structure one which complies with Section 52.13 rather than Section 52.12 (e.g. – insured reduces his/her benefits or insurer uses same policy to comply with Section 52.12 or Section 52.13 with use of variable material on a limited basis).

2. Insurer must comply with Section 52.17(a)(9) of Regulation 62 and Sections 3216(c)(13) and (14) of the Insurance Law for insureds entitled to suspend coverage during periods of military service. When the statute and regulation are read together, an insured is entitled to the right to resumption upon termination of military service of no longer than five years.
3. Family policies may provide a new contestable period for each new member added, but shall not provide for a new contestable period for the policy – Section 52.17(a)(10) of Regulation 62. For example, if a spouse is added as a dependent to an inforce long term care policy, a new contestable period for the spouse runs from the later spousal issuance date, but not a new contestable period for the primary insured previously issued coverage.
4. Insurer attaching any rider or endorsement that reduces or eliminates coverage after policy issuance shall provide for signed acceptance by the insured – Section 52.17(a)(12) of Regulation 62. See also Section 52.16(e)(2), however, for waivers issued as a condition of issuance, renewal or reinstatement.
5. Riders or endorsements providing a benefit for which a specific premium is charged shall show the premium on the application, rider or elsewhere in the policy – Section 52.17(a)(14) of Regulation 62.
6. Policies based upon attained age shall include the applicable schedule of rates – Section 52.17(a)(29) of Regulation 62.
7. No long term care insurer shall refuse to issue coverage, cancel coverage or decline to renew coverage because of the sex or marital status of the applicant or policyholder – Section 2607 of the Insurance Law.

VIII. Specific Regulatory Requirements for Long Term Care Insurance

1. The form must contain an “Extension of Benefits” provision pursuant to Section 52.25(b)(3) of Regulation 62. The insurer is reminded that the extension of benefits is

- provided for “total disability” as well as eligibility for benefits. In a tax-qualified policy, the term “total disability” may be defined in conformance with the federal benefit triggers.
2. If coverage is provided for dependents, the form must contain a provision that complies with Section 52.25(b)(4) of Regulation 62. Note: In New York State, a spouse’s right to conversion arises upon divorce or annulment, NOT legal separation.
 3. Section 52.25(c)(2) states that home care benefits may be substituted on a reasonable basis for other benefits provided in the policy in determining maximum coverage under the terms of the policy.
 4. Section 52.25(c)(3) requires insurers to offer to each applicant for long term care insurance at the time of purchase the option to purchase the policy with an inflation protection feature. The inflation protection feature offered by the insurer may not be any less favorable than one of the three options listed in Section 52.25(c)(3)(i) (ii) and (iii) and pertinent HIPAA and related federal requirements. The Section 52.25(c)(3) “make available” inflation protection features are:
 - (1) Increases benefit levels annually five percent or in proportion to the increase in the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics or its successor, in a manner so that increases are compounded annually;
 - (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 has not been declined for three consecutive times (accumulation of declined options is not required) and whenever the definition of the dollar amounts of Section 52.12 or 52.13 is increased for the amount of that increase only; or
 - (3) Covers a specified percentage of actual or reasonable charges.
 5. If the policy contains a return of premium on death provision permitted by Section 52.16(b) of Regulation 62, this benefit is not a non-forfeiture benefit under Section 52.16(b) and cannot be used to satisfy Section 52.25(c)(7). Any return of premium on death provision should be designed after consulting pertinent HIPAA provisions concerning cash surrender values, monies paid, assigned or pledged as loan collateral or monies borrowed, how premium refunds and policyholder dividends are to be applied and refunds on the death of an insured.
 6. Section 52.25(c)(5) states that inflation protection is not required to be offered of expense incurred long term care insurance policies without dollar maximums. However, this relates to Option II of Section 52.12(a)(1) and the Department is not aware any insurer offers this coverage presently in New York State.
 7. Section 52.25(c)(7) prohibits an insurer from offering a long term care insurance policy unless the policy, at the option of the insured, provides some type of nonforfeiture value, such as reduced paid up insurance. The reduced paid-up percentages may apply to the nursing home benefits only or to all benefits in the policy. These percentages must appear in the policy, and may change based upon experience, provided the policy or certificate states that such change will only be made in conjunction with an increase in premium. Pertinent HIPAA provisions should also be consulted.
 8. Section 52.25(c)(9) states that a “period of care” must be separated by at least 30 days of nonpayment of benefits to be considered two separate periods of care.

9. Any elimination period in the policy must be 180 days or less. If the insurer proposes an elimination period greater than 180 days, the submission letter contains a full explanation – Section 3201(c)(3).
10. If the filing provides that one spouse (or domestic partner meeting Department requirements), after depleting his/her policy benefits, can use the policy benefits of a “well” spouse, the “well” spouse’s benefits cannot be reduced to less than the minimum coverage requirements for a long term care policy. If the insurer wishes to reduce the benefits to a level below the minimums for long term care under Section 52.12 of Regulation 62, minimum coverage for a nursing home and home care policy may be used with prominent disclosure that the insured would only be receiving nursing home and home care insurance under Section 52.13. No such benefit design can leave any spouse with less than the minimum benefits of Section 52.13.
11. If this filing provides international coverage, the benefits must meet the minimum requirements of long term care. If the insurer wishes to provide benefits at a level below the minimums for long term care under Section 52.12 of Regulation 62, minimum coverage for a nursing home and home care policy may be used with prominent disclosure that the insured would only be receiving nursing home and home care insurance under Section 52.13.
12. The Department, as noted throughout this outline, is willing to allow certain limited benefits meeting Section 52.13 requirements in a Section 52.12 policy. However, the Department will not approve a policy design as long term care insurance under Section 52.12 that does not meet minimum Section 52.12 requirements.

IX. Permissible Exclusions and Limitations on Coverage

In general, the exclusionary or limiting language can be no less favorable than the various paragraphs of Section 52.25(b)(2) of Regulation 62.

1. If an insurer chooses to place a preexisting condition limitation in the coverage, must comply with Section 52.25(b)(2)(i) of Regulation 62. For the purposes of a long term care insurance policy, the only permissible preexisting condition limitation is one which excludes coverage, for no more than 6 months after the effective date of coverage for a condition for which medical advice was given or treatment was recommended by, or received from, a licensed health care provider within 6 months before the effective date of coverage.

Many insurers have chosen to rely solely upon medical underwriting in long term care coverage and not place any pre-existing condition limitations in policy language. The Department finds this approach acceptable.
2. If an insurer chooses to place an exclusion or limitation on coverage for mental or emotional disorders, it must comply with Section 52.25(b)(2)(ii) of Regulation 62, which does not permit exclusion or limitation of benefits on the basis of Alzheimer’s disease or demonstrable organic brain disease.
3. If an insurer chooses to place an exclusion or limitation on coverage for treatment arising out of alcoholism or drug addiction it must comply with Section 52.25 (b)(2)(iii) of Regulation 62 and Section 3216 (d)(2)(K) as pertinent.
4. If an insurer chooses to place an exclusion or limitation on coverage for illness, treatment, or medical condition arising out of the following situations, must comply with Section 52.25(b)(2)(iv) of Regulation 62:
 - 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, attempted suicide, or intentionally self-inflicted injury; or
 - e. aviation (this exclusion applies only to nonfare paying passengers).
5. If an insurer chooses to place an exclusion or limitation on coverage for benefits provided in a government facility, services for which benefits are provided under Medicare or other governmental program (except Medicaid), any state or Federal worker's compensation, employer's liability or occupational disease law, services provided by a member of the covered person's immediate family and services for which no charge is made in the absence of insurance, it must comply with Section 52.25(b)(2)(v) of Regulation 62.
 6. If an insurer chooses to place an exclusion or limitation on coverage related to territorial restrictions, must comply with Section 52.25(b)(2)(vi) of Regulation 62. It should be noted that this permissible territorial restriction limitation for long term care is specific to long term care coverage. For long term care coverage, the insurer must provide coverage while the insured is inside the United States and its possessions.
 7. For compliance with Sections 52.16(e)(2) and 52.2(i) of Regulation 62, insurers should note that Regulation 62 recognizes only aviation and its related activities and participation as a professional in sports as extra-hazardous activities that can be initially underwritten. Those extra-hazardous activities may be excluded from coverage by means of prominently disclosed waivers (see Section 52.16(e)(2)) at coverage issuance or extra premium ("rate up") may be charged for coverage of such extra-hazardous activities or standard coverage may be issued when an applicant indicates participation in such extra-hazardous activities or coverage may be declined based upon participation in such extra-hazardous activities. Sections 52.16(e)(2) and 52.2(i) do not recognize any other avocations, vocations or activities as extra-hazardous. Therefore, the insurer may only issue standard coverage or decline coverage for applicants participating in avocations, vocations or activities other than those defined in Section 52.2(i).
 8. Individual accident and health coverages, including long term care insurance, are not plans that can contain coordination of benefit provisions (Section 52.23(e)(3)(i)). Insurers have the ability to financially underwrite for other coverage before issuance and have statutory provisions (Sections 3216(d)(2)(C), (D) or (E)) for excess insurance situations after issuance.

X. Prohibited Exclusions and Limitations for Long Term Care Coverage

1. A long term care insurance policy may not limit or exclude benefits by requiring that the covered person have a prior hospitalization or a prior specified level of care in order for another level of care in a nursing home or home care benefits to be covered. 52.25(c)(1)(i)
2. A long term care insurance policy may not limit or exclude benefits by requiring that the insured/claimant first or simultaneously receive nursing and/or therapeutic services in a home or community setting before home care services are covered. 52.25(c)(1)(ii)
3. A long term care insurance policy may not limit or exclude benefits by limiting eligible services to services provided by registered nurses or licensed practical nurses. 52.25(c)(1)(iii)
4. A long term care insurance policy may not limit or exclude benefits 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/her license or certification. 52.25(c)(1)(iv)

5. A long term care insurance policy may not limit or exclude benefits by requiring that the insured/claimant have an acute condition before services covered under this policy are covered. Long term care policy designs that predicate benefits on “medically necessary” services or similar wording are viewed as a requirement of having an acute condition.

52.25(c)(1)(v)

6. A long term care insurance policy may not limit or exclude benefits by limiting benefits to services provided by Medicare-certified agencies or providers. 52.25(c)(1)(vi)

XI. Prohibition Against Post-Claims Underwriting in Long Term Care Coverage and Related Matters

1. Section 52.25(d)(1) states that insurers, whether or not they have obtained information concerning the applicant’s health condition prior to issuance of the policy, shall be prohibited from post-claims underwriting.
2. Section 52.25(d)(2) states that if an insurer requests information on an application concerning medications being taken by the applicant and the medications listed in such application were known by the insurer, or should have been known at the time of application to be directly related to a medical condition for which coverage would otherwise be denied, then the policy shall not be rescinded for that reason.
3. Section 52.25(d)(3)(i) sets forth cautionary language that must appear on an application for long term care coverage unless it is guaranteed issue.

“Caution: If your answers on this application fail to include all material medical information requested, (company) has the right to deny benefits or rescind your policy.”

4. Section 52.25(d)(3)(ii) sets forth a cautionary statement that must be placed conspicuously on the long term care insurance Policy at the time of delivery. It is recommended that this language appear on the cover page of the policy.

“Caution: The issuance of this long term care insurance policy is based upon your responses to the questions on your application. A copy of your application is enclosed. If your answers fail to include all material medical information requested, 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).”

5. Every insurer or other entity selling or issuing long term care insurance shall maintain a record of all policy rescissions, both state and countrywide, except those voluntarily effectuated by the insured, and shall annually furnish this information to the Superintendent in the format prescribed by the National Association of Insurance Commissioners (NAIC). Section 52.25(d)(6)
6. Long term care insurers are reminded of their obligations under Section 52.25(e) relating to permitted compensation arrangements for the sale of a long term care insurance policy. These obligations of the insurer may affect the rate materials submitted with long term care insurance filings.

XII. Mandatory Standard Contract Provisions

These provisions are required in each policy. The provision must be no less favorable to the insured than the following statutory provisions.

1. Must include a “Entire Contract; Changes” provision with no incorporation by reference to writings not part of the form – Section 3216 (d)(1)(A), Section 3204(a)(1).
2. As a tax-qualified long term care policy, the policy must include a “Time Limit on Certain Defenses” provision that conforms to the “three-tiered” incontestability provision required by Section 4980C of the Internal Revenue Code, which incorporates the language of the NAIC Long Term Care Insurance Model Act as of January 1993. The “three-tiered” incontestability language is as follows:

If a policy has been in force for less than six months, an insurer may rescind a long term care policy or deny an otherwise valid claim upon a showing of misrepresentation that is material to the acceptance for coverage.

If a policy has been in force for at least six months but less than two years, an insurer may rescind a long term care insurance policy or deny an otherwise valid claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits were sought.

After a policy has been in force for two (2) years it is not contestable upon the grounds of misrepresentation alone; such policy may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured’s health.

The Department interprets this language so that it is no less favorable than Section 3216(d)(1)(B)(i).

3. Must include a “Grace Period” provision for premium payment in accordance with the statutory options.
4. Must include “Reinstatement” provision in case of policy lapse in accordance with statutory options. Section 3216 (d)(1)(D) of the Insurance Law makes reference to a conditional receipt when premium is tendered with an application for reinstatement. Insurers are reminded that the conditional receipt used for reinstatement of policies has its own statutory requirements for use in the reinstatement situation. For example, Section 3216 (d)(1)(D) of the Insurance Law places a maximum 45-day time limit following the date of the conditional receipt for insurer action on a reinstatement application where the insurer or its agent issued a conditional receipt for premium tendered. The policy is reinstated on the 45th day following the conditional receipt date if the insurer has not approved or disapproved the reinstatement application in writing within that time period. - Section 3216 (d)(1)(D). (This reinstatement provision must be included in every policy along with the federal reinstatement language noted in VI. 11 on page 7. The Section 3216(d)(1)(D) reinstatement provision covers more than the loss of functional capacity and cognitive impairment situations.)
5. Must include “Notice of Claim” provision in accordance with statutory options – Section 3216 (d)(1)(E).
6. Must include “Claim Forms” provision – Section 3216 (d)(1)(F).
7. Must include “Proofs of Loss” provision – Section 3216 (d)(1)(G).

8. Must include “Time of Payment of Claims” provision in accordance with statutory options – Section 3216 (d)(1)(H).
9. Must include “Payment of Claims” provision in accordance with statutory options – Section 3216 (d)(1)(I). Section 3216(d)(1)(I) contains several scenarios and/or options for the insurer. Each scenario and/or option chosen must be as favorable or more favorable than Section 3216(d)(1)(I).
10. Must include “Physical Examinations and Autopsy” provision – Section 3216 (d)(1)(J).
11. Must include “Legal Actions” provision – Section 3216 (d)(1)(K).
12. When applicable, must include “Change of Beneficiary” provision in accordance with statutory options – Section 3216 (d)(1)(L).

XIII. Optional Standard Provisions

These provisions may be included, at the insurer’s option; but, if they are included, they must be no less favorable to the insured than the following statutory provisions.

1. If insurer chooses to place a “Misstatement of Age” provision in the coverage, must comply with Section 3216 (d)(2)(B).
2. If insurer chooses to place an “Other Insurance in this Insurer” provision in the coverage, must comply with Section 3216 (d)(2)(C).
3. If insurer chooses to place an “Insurance with Other Insurers” provision in the coverage, must comply with Section 3216 (d)(2)(D) or (E).
4. If insurer chooses to place an “Unpaid Premium” provision in the coverage, must comply with Section 3216 (d)(2)(G).
5. If insurer chooses to place a “Cancellation” provision in the coverage, must comply with Section 3216(d)(2)(H) of the Insurance Law.
6. If insurer chooses to place a “Conformity with State Statutes” provision in the coverage, must comply with Section 3216 (d)(2)(I).
7. If insurer chooses to place an “Illegal Occupation” provision in the coverage, must comply with Section 3216(d)(2)(J).
8. If insurer chooses to place an “Intoxicants and Narcotics” provision in the coverage, must comply with Section 3216 (d)(2)(K).

XIV. Other Provisions

1. Policy definitions of consumer price indexes and consumer price index factors sometimes used in non-partnership long term care insurance policies must be meaningful as used in a non-partnership long term care insurance policy, fair to the consumer and fully disclosed in the policy language. Insurers which reserve the right to change the consumer price index used to calculate policy adjustments in a policy should indicate in the policy language that any new index chosen by the insurer or change to a present index made by an insurer will be subject to the prior approval of the Superintendent of Insurance (or, as a more general alternative, subject to the approval of the insurance regulatory authority of the state where the policy was delivered or issued for delivery when required). An insurer that makes changes in

an index or chooses a new index is essentially reserving the right to materially affect future policy benefits for which an insured pays premiums based upon an index. This right of an insurer to change an index or choose a new index can make the benefit illusory if the insurer's action reduces or eliminates policy benefits in the future based upon the index. This would be contrary to Section 3201(c)(3) of the Insurance Law. In addition, future changes to a present index or choosing a new index in the future will vary the language of an approved policy, and this requires approval of the wording describing the new index or index changes under Section 3201(b)(1) of the Insurance Law. Changes to policy language must appear in the contract of insurance under Section 3204(a)(1) of the Insurance Law. -- Originates from Sections 3201(b)(1), 3201(c)(3), 3204(a)(1), 3217(b) of the Insurance Law and Sections 52.1(c), and 52.1(d) of Regulation 62.

The Department notes that insurers are constantly changing their non-partnership long term care insurance products to provide new innovations. While innovations in the long term care insurance market in New York State are encouraged, any such innovations must comply with relevant regulations and statutes.

As an example of such innovations, the Department is aware of an inflation protection design for long term care insurance coverages where the insurer modifies the level premium rating methodology. Briefly, the insurer charges less in the early years for this inflation protection design than it would charge for a level premium rating methodology. However, the insurer charges significantly more in the later years for this type of inflation protection rating methodology.

In sum, this inflation protection rating design (sometimes called "pay as you go") reduces the cost of inflation protection at time of sale with the insurer goal of increasing long term care insurance sales. However, the insurer fully intends to collect the same amount in premiums as with a level premium rating methodology by charging more in the later years than a level premium methodology would charge. This significant premium increase might not happen until 12 or 15 years from issuance of the inflation protection feature.

The Department is concerned that an applicant for the "pay as you go" design realizes he/she is purchasing an inflation protection feature whose cost increases significantly when he/she is older and likely on a fixed income. The "pay as you go" rating design can result in increased lapsation at older ages due to unaffordability of higher premiums at older ages. An insured who purchased such a "pay as you go" design without understanding its implications completely might believe the insurer engaged in "low ball" pricing tactics for the design. Insurers appear to differ on whether an insured can keep accumulated inflation protection increases already issued if the insured must lapse the inflation protection at older ages due to the higher premiums at older ages in the "pay as you go" design. The Department would view the forfeiture of accumulated inflation protection increases in the "pay as you go" design as not in compliance with Section 3201(c)(3) of the Insurance Law unless the insurer has a convincing explanation for its particular design.

The Department requests that any insurer proposing an innovation of this type or any other type in a long term care insurance submission explain it fully in the submission letter to the Department. The submission letter should give such innovation explanations prominence in the submission letter to the Department. The Department will consider such innovations according to statutory and regulatory parameters, including but not limited to, fairness to the consumer and full disclosure in the form language. Specific statutory and regulatory provisions dealing with long term care insurance will also be considered. ---Section 3201(c)(3) and Section 52.25(c)(3).

2. Policy definitions of “elimination period”, “waiting period”, or similar provisions which set a time period before benefits will be paid must be meaningful as used in a non-partnership long term care insurance policy, fair to the consumer and fully disclosed in the policy language – originates from Sections 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), and 52.1(d) of Regulation 62.
3. Policy definition of “hospital” as used in an individual long term care policy must comply with Section 52.2(m) of Regulation 62.
4. Policy definition of “pre-existing condition” must be meaningful as used in a long term care policy, fair to the consumer and fully disclosed in the policy language – originates from Sections 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d), 52.12, and 52.25(b)(2)(i) of Regulation 62. See also IX. 1 on page 10 above.
5. Policy definitions of “maximum benefit periods”, “benefit periods”, or similar provisions which set a maximum time period for payment of benefits must be meaningful as used in a long term care insurance policy, fair to the consumer and fully disclosed in the policy language. Reductions in benefit periods due to attainment of age limits must be prominently disclosed by placement on the policy face page or specification page – originates from Sections 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d), 52.17(a)(3) and 52.12 of Regulation 62. See also items in this outline regarding prominent disclosure of specific benefits with benefit periods or maximum benefit levels that differ from Section 52.12 and only comply with Section 52.13.
6. Policy definition of “mental disorders” must be meaningful as used in a long term care insurance policy, fair to the consumer, and fully disclosed in the policy language – originates from Sections 3201(c)(3), Sections 3217(b), 4224(b)(2) of the Insurance Law and Sections 52.1(c), 52.1(d), 52.12, and 52.25(b)(2)(ii) of Regulation 62.
7. Policy definitions of “physician”, “licensed health care practitioner” and similar terms cannot unduly limit access of the insured to benefits under the policy – originates from Sections 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d) and 52.12 of Regulation 62.
8. Section 3216(d)(1)(K) is governed by “lead in” wording present in Section 3216(d)(1). The “lead in” wording proscribes approval of language which would be less favorable in any respect to an insured than the wording in Section 3216(d)(1)(K). Section 3216(d)(1)(K) sets forth parameters to allow an insured to bring an action at law or equity in a non-partnership policy or any individual commercial accident and health insurance policy. Arbitration provisions set forth as a contractual right of an insurer generally preclude an insured from bringing an action at law or equity. Therefore, the Department is under a statutory constraint because arbitration provisions in a policy which preclude an insured from bringing an action at law or equity would be less favorable in many respects to an insured than the parameters set forth in Section 3216(d)(1)(K).

The Department addresses here its statutory inability to approve arbitration provisions in a non-partnership policy. The Department does not address in this product outline other reasonable and appropriate mechanisms which an insurer may be able to use in its ongoing relationship with an insured.

9. Insurers are reminded of their obligations under Section 3228 of the Insurance Law regarding refund of premium upon death of insured and/or any covered dependents.
10. No policy or form which contains the label "long term care insurance" for New York State minimum benefit standard purposes under Section 52.12 can provide benefits beneath the

minimums of Section 52.12. While a Section 52.13 policy or form can indicate it is "long term care insurance" solely for tax qualification purposes, the Section 52.13 coverage must indicate prominently that it is "nursing home and home care insurance", "nursing home insurance only" or "home care insurance only" for New York State minimum benefit standard purposes when the issued coverage contains minimum benefits beneath Section 52.12 and which only qualify under Section 52.13.

XV. Matters Affecting the Overall Content of Long Term Care Insurance Forms

1. Only benefits reasonably related to long term care may be added by rider or endorsement pursuant to Section 52.25(b)(5).
2. Due to regulatory requirements found in Sections 52.12 and 52.25(c)(1)(ii)(iv), long term care insurance policies in New York State provide custodial care in a nursing home and custodial home care services. In the limited instances where the Department may permit a limited benefit meeting Section 52.13 minimum standards as stated in this outline (e.g., international coverage benefit, spousal transfer benefit) in a Section 52.12 policy form, that limited benefit is subject to Section 52.13(c) and cannot be sold beneath Section 52.13 minimums.

XVI. Applications

1. If more than one application will be used, objective criteria is required to avoid unfair discrimination under Section 4224(b) of the Insurance Law. An example of unfair discrimination would be that, if two applications offer different levels of underwriting, two individuals would receive the same policy but undergo different levels of underwriting.

Insurers are reminded of their obligations under Section 4224(b)(1) as they pertain to the use of application forms with long term care insurance policies. Objective and rational criteria must be used by the long term care insurer to avoid unfair discrimination if the insurer is using multiple application forms with a long term care insurance form so different applicants are subjected to different medical and financial underwriting in attempting to obtain coverage. When a submission is made of multiple application forms to be used with long term care insurance where the Department could reasonably inquire about such obligations, the insurer should provide a detailed and prominent explanation in the submission letter about the use of multiple application forms with a long term care insurance product.

2. Section 52.51(a) of Regulation 62 requires that an application cannot contain questions as to race of the applicant.
3. Section 52.51(b) of Regulation 62 requires that questions regarding past or present health of any person that refers to a specific disease or general health must be asked to the best of the applicant's knowledge and belief. Questions regarding factual information, such as doctor's visits or hospital confinements, do not require this qualification.
4. Section 52.51(c) of Regulation 62 requires that no application will contain a provision that changes the terms of the policy to which it is attached.
5. Section 52.51(d) of Regulation 62 requires that no application will contain a statement that the applicant has not withheld any information or concealed any facts.
6. Section 52.51(e) of Regulation 62 requires that no application will contain an agreement that an untrue or false answer material to the risk shall render the contract void.

7. Section 52.51(f) of Regulation 62 requires that no application will contain an agreement that acceptance of any policy issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application, except in conformity with Section 3204 of the Insurance Law.
8. Section 52.51(g) of Regulation 62 requires that applications for conversion policies may not contain questions as to the health of the person or persons entitled to conversion.
9. Section 52.51(h) of Regulation 62 requires that applications for policies subject to Section 3216(d)(2)(D) or (E), "Insurance with Other Insurers", will contain a question or questions requiring information with respect to such other insurance.
10. Section 52.51(i) of Regulation 62 requires that if an insurer includes in a policy the optional standard provision under Section 3216(d)(2)(C), "Other Insurance in this Insurer", a statement describing the provision in the policy must be included in the application, or provided at the time of application by separate notice.
11. Section 52.51(j) of Regulation 62 requires that if a policy contains a provision with respect to "pre-existing conditions", a statement describing the policy provision must be included in the application OR provided at the time of application by delivery of the disclosure statement required by Section 52.54.
12. Section 52.25(d)(3)(i) of Regulation 62 requires that the following cautionary 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:

"Caution: If your answers on this application fail to include all material medical information requested, (company) has the right to deny benefits or rescind your policy".

Section 52.25(d)(3)(i) requires this one sentence caution using the language and placement indicated in this regulatory section.

13. Section 52.29(a) of Regulation 62 requires application forms for long term care insurance to include a question designed to elicit information as to whether the policy applied for is intended to replace any other accident and health insurance policy presently in force. The application must require a list of all existing accident and health insurance policies and require identification of those being replaced. The question, listing and replacement identification required by Section 52.29(a) pertain to all existing accident and health insurance of the applicant, and the insurer will not comply with Section 52.29(a) if it only views Section 52.29(a) as pertaining to long term care insurance, nursing home and home care insurance, nursing home insurance only or home care insurance only (long term care-type insurance).

The Department is concerned with an applicant unknowingly and inappropriately replacing any type of accident and health insurance with a long term care-type insurance when the long term care-type insurance will not cover the risk of the accident and health insurance being replaced. The Department is concerned that an agent knows and reviews all of the existing accident and health insurance of the applicant to provide proper advice as to the necessity for long term care-type insurance and to give proper advice to the applicant about the risks covered by the applicant's existing accident and health insurance which may not be covered by the long term care-type insurance. The agent must sign the statement required by Section 52.29(b) (see XVI. 14 below) and only a comprehensive review of the applicant's entire existing accident and health insurance portfolio will enable the agent to sign that statement. In addition, a comprehensive listing by the applicant of his/her entire accident and health insurance portfolio on the application form for long term care-type coverage will benefit the

applicant should questions arise in the future as to whether the long term care-type insurance was an appropriate replacement or an appropriate addition to his/her accident and health insurance portfolio at time of sale of the long term care-type product. A copy of the application is generally attached to issued long term care-type insurance so there will be a written record of the existing accident and health insurance at time of long term care-type insurance purchase years into the future should an inquiry arise.

14. Section 52.29(b) of Regulation 62 requires that the application for long term care insurance taken by an agent shall include, or have attached thereto, the following statement signed by the agent:

“I have reviewed the current accident and health insurance coverage of the applicant and find that the indicated replacement, or additional coverage of the type and amount applied for is appropriate for the applicant’s needs”.

15. Section 52.29(c) of Regulation 62 requires that, in situations where the a sale of a long term care insurance policy will involve replacement, an insurer, other than a direct response insurer, or its agent, shall furnish the applicant, PRIOR to the issuance or delivery of the policy, a notice regarding replacement of accident and health coverage. One copy of the notice must be provided to the applicant and the insurer shall retain an additional copy signed by the applicant. A direct response insurer must deliver the notice regarding replacement to the applicant at the time of the issuance of the policy.
 - a. Section 52.29(d) of Regulation 62 sets forth the format and language of the replacement notice that is to be used by an insurer other than a direct response insurer.
 - b. Section 52.29(e) of Regulation 62 sets forth the format and language of the replacement notice that is to be used by a direct response insurer.

Remember, accident and health policies include, but are not limited to, long term care insurance, nursing home insurance only, home care insurance only and nursing home and home care insurance policies. Please see XVI. 13 on page 18.

Replacements discussed here contemplate involvement of only non-partnership coverages. Replacements involving a partnership to partnership situation, a non-partnership to partnership situation or a partnership to non-partnership situation require a reading of more than Sections 52.29(c) and (d) of Regulation 62 and compliance with any additional requirements. The appropriate outlines, checklists, regulatory sections and Insurer Participation Agreement provisions (for partnership insurers) need to be consulted. All federal replacement requirements for tax-qualified long term care insurance should also be met.

16. Previous HIV test results are NOT questioned, sought or used per Sections 3217(b) and 52.1 of Regulation 62. Information regarding the diagnosis or treatment of AIDS or ARC may be sought and used. Also, the insurer has the right to conduct its own medical tests as part of the underwriting process
17. Individual long term care insurers are reminded of their obligations under Section 2611 of the Insurance Law and Section 2782 of the Public Health Law regarding written informed consent, authorization and disclosure of confidential information when the insurer uses an HIV antibody test in underwriting. Circular Letters No. 3 (1989) and No. 5 (1997) are relevant.
18. If this filing contains a reference to a telephone or in-person interview, the interview is conducted in the following manner:

Any questions raised during the interview are limited to those questions appearing on the application (i.e., questions over the phone would be no different than those being asked in the application).

The applicant will have an opportunity to review and make corrections to those statements that were attributed to him/her in the interview.

Any information obtained in the interview that will be used in the underwriting process will be reduced to writing, signed by the applicant and attached to the policy in compliance with Section 3204 of the Insurance Law.

19. If an Investigative Consumer Report will be prepared or procured, the insurer complies with Section 380-c of the General Business Law by providing notice in the application or in a separate form.
20. If a Medical Information Exchange Center (such as a Medical Information Bureau) will be used, the insurer complies with Section 321 of the Insurance Law.
21. Section 420.18(b) of Regulation 169 requires that an authorization to disclose nonpublic personal health information specifies the length of time the authorization will remain valid (maximum 24 months).
22. Section 403(d) of the Insurance Law requires a fraud warning on the application form.
23. Section 3204 of the Insurance Law contains requirements that apply to application forms for individual long term care insurance policies. An insurer may make insertions for administrative purposes only as long as the insertions are clearly not ascribed to the applicant. No other insertions or alterations of a written application will be made by anyone other than the applicant without his written consent.

XVII. Conditional Receipts / Interim Insurance Agreements

Section 52.53 of Regulation 62 requires that, if premium is paid prior to policy delivery and the insurer requires a determination of insurability as a condition precedent to the issuance of a policy, an insurer must issue either a conditional receipt or interim insurance agreement. In general, Section 52.53 sets forth two permissible methods for money to be accepted with an application – conditional receipt or interim insurance agreement. Section 52.53(c) defines a “determination of insurability” as a determination by the insurer as to whether the proposed insured is insurable under its underwriting rules and practices for the plan and amount of insurance applied for and at the insurer’s standard premium rate.

1. A conditional receipt sets an effective date for the policy if the applicant successfully completes the underwriting process. The conditional receipt shall contain an agreement to provide coverage subject to any reasonable limit regarding the amount of insurance specified in the receipt, contingent upon insurability, and provides that such insurability be determined as of a date no later than:

The date of completion of all parts of the application, including completion of the first medical examination if one is required by the company’s underwriting rules,
AND

The required premium has been paid.

Completion of a second medical examination may be required as a condition precedent to coverage if initially required by the company's underwriting rules because of the amount of insurance applied for or the age of the proposed insured.

If the proposed insured is insurable as of the above date, coverage under the issued policy begins not later than such date, except as provided in paragraph 4 below. Section 52.53(a) of Regulation 62.

2. Although the proposed insured dies, undergoes a change in health or otherwise becomes uninsurable according to the insurer's underwriting standards for the insurance plan for which application was made after the date provided in paragraph 1 above but before the application is approved or rejected and before the expiration of any time limit specified in the receipt, an insurer may determine that the proposed insured is not insurable only as of the date stated in paragraph 1 above. Information relating to an event or physical condition that is the subject of a question in any part of the application cannot be considered for underwriting purposes if the event or accident occurred or sickness first manifested itself after completion of that part of the application. Adverse changes in insurer underwriting rules after the date stated in paragraph 1 above cannot be taken into account when such adverse changes in underwriting rules take effect after the date stated in paragraph 1 above but before the application is approved or rejected and before the expiration of any time limit specified in the receipt. (In summary, policy underwriting can only be based on the insured's health status as of the date provided for in paragraph 1 above.) Section 52.53(e) of Regulation 62.

Suppose a long term care applicant pays premium with his/her application, and the insurer issues a conditional receipt to the applicant on December 1, 2002. The applicant completes all parts of the application truthfully on December 1, 2002, and the applicant awaits the insurer's underwriting decision. Then assume on December 8, 2002 (which is before the expiration of a 60 day time limit in the receipt), the applicant is diagnosed with a severe condition requiring home care services which would be covered under the long term care policy applied for (but not yet issued because the insurer is in the process of underwriting). The applicant begins to receive home care services on December 15, 2002. Then assume the applicant dies on January 27, 2003. The insurer would be using its underwriting rules in effect on December 1, 2002, and the insurer would be assessing the insured's health as of December 1, 2002 based upon a truthful application submitted by the applicant on December 1, 2002. The insurer would issue a long term care policy dated effective December 1, 2002. If the long term care policy issued had a 0-day waiting period for home care services, the insured would be obligated to pay for home care services received according to policy terms from December 15, 2002 until January 27, 2003. This might all occur retrospectively if the insurer used the full 60 day period mentioned in the conditional receipt and did not issue the long term care policy with a December 1, 2002 effective date until January 29, 2003.

3. An interim insurance agreement provides some type of immediate limited insurance coverage as of the application date. The agreement provides coverage in accordance with the policy and plan of insurance described in the application subject to any reasonable limit regarding the amount or duration of insurance specified in the agreement. Coverage is provided as of the application date and must provide at least 60 days coverage unless:

The policy applied for is issued prior to the end of the 60 days, OR

The applicant receives actual notice that coverage under the agreement is cancelled because the application has been declined. If notice is given by mail, it may be deemed received on the fifth day after mailing such notice to the applicant. Section 52.53(b) of Regulation 62.

4. An insurer may honor a written request from the applicant that coverage begins as of a specified date later than the date provided for in the conditional receipt or interim insurance agreement. In other than replacement situations, the applicant's written request for a later effective date must contain a statement signed by the applicant that he/she understands that he/she may be waiving certain rights and guarantees under the conditional receipt or interim insurance agreement. Section 52.53(f) of Regulation 62.
5. If coverage is provided under a conditional receipt or interim insurance agreement for two or more proposed insureds, the coverage must be determined separately for each proposed insured, except, however, all proposed insureds may be rejected in the event of fraud or material misrepresentations. Section 52.53(d) of Regulation 62.
6. If a policy is not issued within the time specified in the conditional receipt or interim insurance agreement, the application will be deemed rejected and all premiums will be refunded. Section 52.53(i) of Regulation 62.
7. In mail order cases only, an insurer may postpone the effective date of coverage to the date of issuance of the policy. Section 52.53(g) of Regulation 62.
8. In franchise cases, the coverage under the conditional receipt or interim insurance agreement may be made contingent upon meeting specified participation requirements. Section 52.53(h) of Regulation 62.

However, the Department views any insurer programs which have received a waiver under Section 1117 of the Insurance Law (sometimes called "marketing distribution" programs – see XIX. below) as individual sales and not franchise cases. Therefore, those programs must use conditional receipt and interim insurance agreements in the same manner as they would be used with individual long term care insurance sales.

The Department will entertain reasonable alternatives to Section 52.53 requirements, but any alternative must be as favorable for an insured as Section 52.53 requirements. The insurer cannot take the most favorable aspects of a conditional receipt and interim insurance agreement for an insurer and submit a hybrid form that is not as favorable for an insured as under Section 52.53.

XVIII. Interaction of Federal and New York State Requirements for Qualified Long Term Care Insurance Contracts

1. Insurers are reminded that individual tax qualified long term insurance contracts and related materials can be affected by both federal and New York State laws and regulations concerning tax qualified long term care insurance. The New York State Insurance Department reviews submissions in accordance with federal laws, federal regulations, New York State laws and New York State regulations. The New York State Insurance Department also reviews submissions with a view toward using the most stringent standards applicable when allowed (e.g., consumer protections) by the interaction of federal and New York State requirements. The New York State Insurance Department approves individual tax qualified long term care insurance contracts and related materials not only pursuant to Section 3201(b)(1) of the Insurance Law, but also pursuant to Section 1117(g) of the Insurance Law so favorable New York State income tax treatment can be obtained by an insured.

Insurers desiring to issue individual tax qualified long term care insurance contracts and related materials are reminded of their obligations to prepare submissions for approval in accordance with all federal and New York State requirements. Insurers desiring to issue individual tax qualified long term care insurance contracts and related materials must also prepare submissions in accordance with the interaction of federal and New York State requirements. These federal and New York State requirements pertain to contracts and

materials which require prior approval of the Department, and they also pertain to certain insurer documents and actions which may not need the prior approval of the Department.

As one example, the Department notes that both federal and New York State provisions require a disclosure statement which is referred to as an outline of coverage by Section 4980C of the Internal Revenue Code as added by Section 326 of HIPAA. Please see below for the New York State requirements. Section 4980C(c)(1)(A)(vi) of the Internal Revenue Code indicates certain outline of coverage requirements as well.

The disclosure statement/outline of coverage consumer protection required by the Internal Revenue Code as added by HIPAA is affected by Section 4980C(f) of the Internal Revenue Code as added by HIPAA. Section 4980C(f) essentially allows a state to impose a more stringent consumer protection than the NAIC Model Act or NAIC Model Regulation requirement adopted as of January, 1993 and used as a general standard for the long term care insurance consumer protection requirements of the Internal Revenue Code as added by HIPAA. Therefore, the insurer must develop a disclosure statement/outline of coverage complying with the more stringent of the New York State requirements set forth below and the requirements of the NAIC Model Regulation (containing the outline of coverage requirements).

Insurers are also reminded that Section 4980C imposes an excise tax on issuers of qualified long term care insurance contracts that do not provide for certain consumer protections. Failure to meet the disclosure statement /outline of coverage requirement as set forth in the Internal Revenue Code is subject to the excise tax penalty imposed by the Internal Revenue Code.

2. Sections 52.54 and 52.65 of Regulation 62 set forth the disclosure requirements for long term care insurance policies to accompany or be incorporated in the policy when delivered OR delivered to the applicant at the time application is made and receipt is acknowledged.
3. Section 52.25(c)(6) of the Regulation 62 requires that the following information be included in or with the disclosure statement:
 - a. A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period.
 - b. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases. An insurer may use a reasonable hypothetical or a graphic demonstration for the purposes of this disclosure.

XIX. Marketing of Individual Tax-Qualified Long Term Care Insurance in New York State Using Group Methods

This portion of the individual tax qualified long term care insurance product outline is devoted to how insurers offering these individual products in New York State currently market them using group or quasi-group methods. In the sale of individual accident and health insurance, including long term care insurance, it is generally recognized that individual sales on a "one to one" basis are the most time consuming and costly to administer. There is no ability to know beforehand the characteristics of the insureds who will purchase the individual product (as contrasted with the true group coverage where, as an example, one knows the type of employer or association purchasing--e.g., coal miners vs. librarians). True individual sales only occur by individual

solicitation where not many insureds are purchasing at a particular point of sale. The medical underwriting, if any, is generally detailed to obtain and process. Also, the individual sale is usually an adhesion contract situation where the insurer retains most of the bargaining leverage at point of sale, and the insurer retains that superior bargaining position concerning various issues such as claim processing after individual coverage is in force. This situation aids in explaining why many of the Insurance Law provisions pertaining to individual accident and health coverages (such as the standard provisions) are more detailed and protective of the individual insured. This same situation aids in explaining why many of the Regulation 62 provisions pertaining to individual accident and health coverage are also more detailed and protective of the individual insured.

With individual tax qualified long term care insurance, however, there are other factors to consider which may not apply to a usual individual accident and health insurance product. For example, individual tax qualified long term care insurance is very often sold to elderly applicants ages 65 and over. Also, the nature of the risk insured by the individual tax qualified long term care insurance product is skewed toward benefit payments and claims processing for insureds who are quite elderly and in their seventies, eighties or possibly even older. Therefore, consumer protections for these New York State insureds who are in their advanced years are very important. In addition, the federal government, with the enactment of HIPAA in 1996, has taken an active role in setting some standards for individual tax qualified long term care insurance products including benefit eligibility and consumer protection requirements. This is not generally the case with many other lines of individual accident and health insurance (except for Medicare supplement insurance also insuring persons in advanced years). The HIPAA enactment concerning tax qualified long term care insurance is regarded, in part, as a statement from the federal level that tax qualified long term care insurance is to be encouraged, but those purchasing it need some type of consumer protections due to the elderly population involved. We also note that New York State government has taken a more active role with individual tax qualified long term care insurance than with many other lines of individual accident and health insurance through specific long term care insurance enactments such as Section 1117 of the Insurance Law. Thus, the state has recognized the special needs of the population covered by individual tax qualified long term care insurance.

The Insurance Department has recognized the foregoing in the regulation of individual long term care insurance. When insurers have sought to market or offer the individual product using group or quasi-group methods, the Department desires to make certain that any savings or advantages of the group or quasi-group methods are passed on to the long term care insurance insureds who may be very vulnerable to misleading tactics. The Department wants to be certain that all statutory and regulatory requirements are met when insurers want to market individual products on a group or quasi-group basis so all long term care insureds, including the elderly, are not misled into believing an individual tax qualified long term care insurance product has some group product advantages which really do not exist. The Department has set regulatory requirements for individual tax-qualified long term care insurance products (including minimum loss ratios) keeping in mind the special characteristics of the individual tax qualified long term care insurance market.

The Department has also recognized the federal and New York State statutory enactments which encourage the sale of meaningful long term care insurance products in New York State. The Department is mindful that many excellent insurers offer comprehensive and detailed tax qualified long term care insurance products which provide meaningful protection for insureds of New York State when they need coverage for long term care services in their later years of life. The Department always seeks to balance the legitimate interests of long term care insurers with meaningful consumer protections for long term care insureds.

Based upon the foregoing, the Department will approve a payroll deduction arrangement for individual tax qualified long term care insurance products. When this arrangement is used for premium payments with no discounts at all and no other type of group or quasi-group methods, the individual tax qualified long term care insurance product remains subject to regulation as an individual product. No group or quasi-group savings or advantages to any significant degree are claimed by the insurer, and the individual insured has the convenience of payroll deduction as long as the employer is willing to provide that convenience. Here the insurer will accept premium payments directly from an insured should the insured lose the convenience of payroll deduction (such as when the insured retires from active employment and continues the long term care coverage into his/her retirement years when the coverage will most likely be needed). The insurer will also accept direct premium payments from an insured who desires not to choose payroll deduction to pay premiums.

Another group or quasi-group method is franchise insurance which an insurer offering individual tax qualified long term care insurance products in New York State can use. Sections 52.2 (k), 52.19 and 52.70 of Regulation 62 (11NYCRR52) should be consulted. Generally, the individual tax qualified long term insurance products are distributed on a mass merchandising basis, administered by group methods and may be provided with or without evidence of insurability (i.e.-with long term care insurance, there is always some type of evidence of insurability). Sponsorship by an employer or association occurs and exclusivity in the marketing of the individual products is granted to a particular insurer. The individual contract mechanism is retained. So the legal relationship is directly between the insurer and insured with no group policy being issued to a group policyholder. However, the insurer is generally able to know beforehand the characteristics of the insureds (e.g.-professional society, social group, etc.), and the insurer is generally able to obtain a significant number of insureds due to the sponsorship of the employer or association, exclusivity granted to the insurer in marketing the product and sizeable discounts for the insured. This method is just short of marketing the product as group under New York law, but the employer or association does not enter the direct legal relationship of the insurance contract and is not the group policyholder.

With franchise insurance, the agent or insurer representative usually does less work because of the sponsorship and exclusivity. The insurer achieves economies of acquisition and administration as well as knowing there is some affinity or relationship among all insureds purchasing the product. The Department recognizes the factors noted in this entire discussion of franchise individual tax qualified long term care insurance by allowing discounts for the franchise tax qualified long term care insurance arrangement when the product is initially sold. The Department also recognizes these factors in allowing the discounts to remain if the franchise arrangement ceases for any reason. The discounts may remain because the individual product was initially sold as part of a franchise method with the above factors present at time of sale. The usual individual product was not sold with these factors, and it can never have the discounts associated with a franchise product sale.

The Department has been approached by insurers whose marketing distribution channels were not necessarily ideally suited for the sale of individual tax qualified long term care insurance as franchise insurance or as only individual insurance. Often these insurers indicated to the Department that they desired to market their individual products at large places of employment or large association meetings, but the employer or association did not desire to be a group policyholder, grant exclusivity or be actively involved in the marketing process. These insurers indicated that long term care insurance is often a difficult sale with lower sales penetration rates, and these marketing opportunities at places of larger employment or large association gatherings provided opportunities for better sales penetration. Some of these insurers indicated that franchise insurance participation limits in Regulation 62 were too limiting for certain of their markets, and the sponsorship, exclusivity and mass marketing indicia contemplated by Regulation 62 for franchise insurance did not always exist for some of their markets.

The Department remained concerned with the obfuscation among individual insurance, franchise insurance and group insurance and their respective requirements. In sum, the insurer desired to solicit at places generally associated with group sales (and group long term care insurance has a 70% minimum loss ratio which is higher than the minimum loss ratio for individual or franchise long term care insurance). Solicitation at a group-type situs might confuse the insured into believing this was a group arrangement with group type savings (discounts, higher minimum loss ratio) and group-type protections (employer/association policyholder protecting its employees/members). Such a solicitation might confuse the insured into believing the employer/association endorsed or sponsored the program and the product had some type of franchise discount. Essentially, the insurers wanted to market an individual product in a quasi-group manner to obtain more sales.

The Department considers requests such as the foregoing on a "case by case" basis. Balancing the legitimate marketing needs of the insurer against consumer protections for the insured, the Department has entertained Section 1117 waiver (of certain franchise insurance requirements) requests from insurers which desire to market individual tax qualified long term care insurance products as noted.

The Department notes that marketing individual products at large places of employment or large association gatherings provides an agent or insurer representative with a larger population to solicit. This results in certain economies of acquisition and some easing of the burdens associated with a true "one by one" individual solicitation. Such group-type solicitations often result in better persistency because the insureds have a common employer or association nexus that results in fewer lapses and a longer compensation stream for the agent or insurer representative than from true "one by one" individual solicitation. Therefore, the Department often views lesser agent or insurer representative compensation as a viable and fair method to help achieve the higher expected loss ratio of at least 70% listed below.

To date, the Department has granted certain waiver requests where the insurer has explained its marketing plans in detail to us. This has resulted in another method to market individual tax qualified long term care insurance products which is set forth "case by case" in an approval letter from the Department to the insurer making the Section 1117 waiver request. In sum, existing Section 1117 waivers allow the marketing of individual tax qualified long term care insurance products as described above (i.e., other than as usual individual sales, franchise sales or group sales) when:

- (1) The expected loss ratio is at least 70%.
- (2) The maximum premium discount is 10% for issue ages 65 and over and 15% for issue ages 64 and under. Lesser premium discounts have also been filed by the Department. We stress that no discount amount is automatically placed on file by the Department. Each insurer must provide appropriate actuarial justification to the Department to obtain any premium discount. The percentages noted are to provide an idea of the premium discounts now allowed.
- (3) The policy form is NOT made generally available to the public.
- (4) The insurer does not require an exclusive endorsement or sponsorship from the employer or association.
- (5) The employer or association involvement is passive.
- (6) Where an employer or association may want to contribute toward premium payment, the employer/association contribution level does not exceed 50% of the premium due from any individual insured.
- (7) The product is not mass marketed.
- (8) The premium discount remains if the insured's relationship with the employer or association terminates for any reason.

XX. Rating Procedures and Requirements

1. Section 52.40 (a) of Regulation 62 sets forth general procedures and requirements that apply to the rating of long term insurance policies.
2. Section 52.40 (b) of Regulation 62 sets forth prohibited rating practices that may be applicable to long term care insurance policies.
3. Section 52.40 (c) of Regulation 62 sets forth requirements applicable to individual long term care insurance policies.
4. Section 52.40 (d) of Regulation 62 sets forth requirements applicable to individual long term care insurance policies.
5. Section 52.41 of Regulation 62 sets forth gross premium differentials based on sex, which apply to individual long term care insurance policies.
6. Section 52.43(a) and (c) of Regulation 62 sets forth standards for maintaining experience data that apply to long term care insurance policies.
7. Section 52.44(a) and (b) of Regulation 62 sets forth monitoring standards that apply to individual long term care insurance policies.
8. Section 52.45(h) of Regulation 62 sets forth minimum loss ratio standards that apply to individual long term care insurance policies.
9. Section 52.25(e) of Regulation 62 sets forth permitted compensation arrangements that apply to sale of long term care insurance products.

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