AUTHENTICATED,
OHIO LEGISLATIVE SERVICE
COMMISSION
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Ohio Administrative Code

Rule 3901-4-01 Long-term care insurance.

Effective: September 13, 2024

(A) Purpose

The purpose of this rule is to implement sections 3923.41 to 3923.49 of the Revised Code to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance.

(B) Authority

This regulation is promulgated pursuant to the authority vested in the superintendent under sections 3901.041, 3923.44 and 3923.47 of the Revised Code.

(C) Applicability

Except as otherwise specifically provided, this rule applies to all long-term care insurance policies, including qualified long-term care contracts and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in this state on or after the effective date by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations.

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

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

(2) The disability income policy is advertised, marketed, or offered as insurance for long-term care

services; or

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

(D) Definitions

For the purpose of this rule, the terms "long-term care insurance," "group long-term care insurance," "applicant," "policy" and "certificate" have the meanings set forth in section 3923.41 of the Revised Code. In addition, the following definitions apply.

(1) "Association" means any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if such association:

(a) Is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation; and

(b) Has been maintained in good faith for purposes other than obtaining insurance.

(2) "Exceptional increase" means:

(a) Only those increases filed by an insurer as exceptional for which the superintendent determines the need for the premium rate increase is justified:

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

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

(b) Except as provided in paragraph (T) of this rule, exceptional increases are subject to the same requirements as other premium rate schedule increases.

(c) The superintendent may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.

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

(3) "Incidental," as used in paragraph (T)(10) of this rule, means that the value of the long-term care benefits provided is less than ten per cent of the total value of the benefits provided over the life of the policy. These values are measured as of the date of issue.

(4) "Qualified actuary" means a member in good standing of the American academy of actuaries.

(5) "Similar policy forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in section 3923.41 of the Revised Code are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

(E) Policy definitions

No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

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

(2) "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

(3) "Adult day care" means a program of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

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

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

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

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

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

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

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

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

thereof," or words of similar import.

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

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

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

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

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

(17) All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "convalescent nursing home," "personal care facility," "specialized care providers," "assisted living facility" and "home care agency" are defined in relation to the services and facilities required to be available and the licensure, certification, registration or degree status of those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified or registered, it shall also state what requirements a provider must meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or when the state licenses, certifies or registers the provider of services under another name.

(F) Policy practices and provisions

(1) Renewability. The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of paragraph (I) of this rule.

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

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

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

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

(e) In addition to the other requirements of this paragraph, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

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

(a) Preexisting conditions or diseases;

(b) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of alzheimer's disease or other dementia;

(c) Alcoholism and drug addiction;

(d) Illness, treatment, or medical condition arising out of:

(i) War or act of war (whether declared or undeclared);

(ii) Participation in a felony, riot or insurrection;

(iii) Service in the armed forces or units auxiliary thereto;

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

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

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

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

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

(h)

(i) This paragraph is not intended to prohibit exclusions and limitations by type of provider. However, no long-term care issuer may deny a claim because services are provided in a state other then the state of policy issue under the following conditions:

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

(B) When the state other than the state of policy issue licenses, certifies or registers the provider

under another name.

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

(i) This paragraph is not intended to prohibit territorial limitations.

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

(4) Continuation or conversion

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

(b) For the purposes of this paragraph, a "basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate, and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to or contain incentives to use certain providers or facilities may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The superintendent may make a determination as to the substantial equivalency of benefits, and in doing so, may take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(c) For the purposes of this paragraph, a "basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group

policy which it replaced), for at least six months immediately prior to termination, is entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

(d) For the purposes of this paragraph, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the superintendent to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the superintendent, in making a determination as to the substantial equivalency of benefits, may take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

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

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

(g) Continuation of coverage or issuance of a converted policy is mandatory, except where:

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

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

(A) Providing benefits identical to or benefits determined by the superintendent to be substantially equivalent to or in excess of those provided by the terminating coverage; and

(B) The premium for which is calculated in a manner consistent with the requirements of paragraph (F)(4)(f) of this rule.

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

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

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

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

(5) Discontinuance and replacement

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

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

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

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

(6)

(a) The premium charged to an insured shall not increase due to either:

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

(ii) The duration the insured has been covered under the policy.

(b) The purchase of additional coverage is not considered a premium rate increase, but for purposes of the calculation required under paragraph (AA) of this rule, the portion of the premium attributable to the additional coverage is added to and considered part of the initial annual premium.

(c) A reduction in benefits is not considered a premium change, but for purpose of the calculation required under paragraph (AA) of this rule, the initial annual premium shall be based on the reduced benefits.

(7) Electronic enrollment for group polices

(a) In the case of a group defined in division (D) of section 3923.41 of the Revised Code, any requirement that a signature of an insured be obtained by an agent or insurer is deemed satisfied if:

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

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

(iii) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and "privileged information" as defined by division (U) of section 3904.01 of the Revised Code, is maintained.

(b) The insurer will make available, upon request of the superintendent, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

(G) Unintentional lapse

Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

(1)

(a) Notice before lapse or termination. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation does 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 shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for non-payment of premium. I understand that notice will not be given until thirty days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

The insurer will notify the insured of the right to change this written designation, no less often than

once every two years.

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

(c) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to paragraph (G)(1)(a) of this rule, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice is to be given by first class United Sates mail, postage prepaid; and notice may not be given until thirty days after a premium is due and unpaid. Notice is deemed to have been given as of five days after the date of mailing.

(2) Reinstatement. In addition to the requirement in paragraph (G)(1) of this rule, a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option is available to the insured if requested within five months after termination and allows for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

(H) Required disclosure provisions

(1) Renewability. Individual long-term care insurance policies shall contain a renewability provision.

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

reserved solely to the policyholder.

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

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

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

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

(5) Other limitations or conditions on eligibility for benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in divisions (E)(2) and (F) of section 3923.44 of the Revised Code shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

(6) Disclosure of tax consequences. With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy

or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This paragraph does not apply to qualified long-term care insurance contracts.

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

(8) A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in paragraph (DD)(5) of this rule that the policy is intended to be a qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended.

(9) A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in paragraph (DD)(5) of this rule that the policy is not intended to be a qualified long-term care insurance contract.

(I) Required disclosure of rating practices to consumers

(1) This paragraph applies as follows:

(a) Except as provided in paragraph (I)(1)(b) of this rule, this paragraph applies to any long-term care policy or certificate issued in this state on or after one hundred eighty days after the effective date of this rule.

(b) For certificates issued on or after the effective date of this amended rule under a group long-term care insurance policy as defined in division (D) of section 3923.41 of the Revised Code, which

policy was in force at the time this amended rule became effective, the provisions of this paragraph apply on the policy anniversary following three hundred sixty-five days after the effective date of this rule.

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

(a) A statement that the policy may be subject to rate increases in the future;

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

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

(d) A general explanation for applying premium rate or rate schedule adjustments that includes:

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

(ii) The right to a revised premium rate or rate schedule as provided in paragraph (I)(2) of this rule if the premium rate or rate schedule is changed;

(e)

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

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

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

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

(ii) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

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

(iv) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this paragraph or the end of a twenty-four-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with paragraph (I)(2)(e)(i) of this rule.

(v) If the acquiring insurer in paragraph (I)(2)(e)(iv) of this rule files for a subsequent rate increase, even within the twenty-four-month period, on the same policy form acquired from nonaffiliated insurers or block policy forms acquired from nonaffiliated insurers referenced in paragraph (I)(2)(e)(iv) of this rule, the acquiring insurer shall make all disclosures required by paragraph (I)(2) of this rule, including disclosure of the earlier rate increase referenced in paragraph (I)(2)(e)(iv) of this rule.

(3) An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under paragraphs (I)(2)(a) and (I)(2)(e) of this rule. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant will sign no later than at the time of delivery of the policy or certificate.

(4) An insurer shall use the forms in appendices B and F to this rule to comply with the requirements of paragraphs (I)(1) and (I)(2) of this rule.

(5) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least forty-five days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by paragraph (I)(2) of this rule when the rate increase is implemented.

(J) Initial filing requirements

(1) This paragraph applies to any long-term care policy issued in this state on or after one hundred eighty days after the effective date of this rule.

(2) An insurer shall provide the information listed in this paragraph to the superintendent thirty days prior to making a long-term care insurance form available for sale.

(a) A copy of the disclosure documents required in paragraph (I) of this rule; and

(b) An actuarial certification consisting of at least the following:

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

(ii) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(iii) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(iv) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

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

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

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

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

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

(ii) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the superintendent may request a demonstration under paragraph (J)(3) of this rule based on a standard age distribution; and

(v)

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

(B) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

(3)

(a) The superintendent may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on

similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

(b) In the event the superintendent asks for additional information under this provision, the period in paragraph (J)(2) of this rule does not include the period during which the insurer is preparing the requested information.

(K) Prohibition against post-claims underwriting

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

(2)

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

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

(3) Except for policies or certificates which are guaranteed issue:

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

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

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

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

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

(i) A report of a physical examination;

(ii) An assessment of functional capacity;

(iii) An attending physician's statement; or

(iv) Copies of medical records.

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

(5) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and shall annually furnish this information to the superintendent in the format prescribed by the national association of insurance commissioners in appendix A to this rule.

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

(1) A long-term care insurance policy or certificate shall not, if it provides benefits for home health

care or community care services, limit or exclude benefits:

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

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

(c) By limiting eligible services to services provided by registered nurses or licensed practical nurses;

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

(e) By excluding coverage for personal care services provided by a home health aide;

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

(g) By requiring that the insured or claimant have an acute condition before home health care services are covered;

(h) By limiting benefits to services provided by medicare-certified agencies or providers; or

(i) By excluding coverage for adult day care services.

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

retirement communities.

(3) Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

(M) Requirement to offer inflation protection

(1) No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(a) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five per cent;

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

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

(2) Where the policy is issued to a group, the required offer in paragraph (M)(1) of this rule will be made to the group policyholder; except, if the policy is issued to a group defined in division (D) of section 3923.41 of the Revised Code other than an employer, labor organization or trust established by one or more employers or labor organizations or a combination thereof, or an association group, and the group is not a continuing care retirement community, the offering will be made to each

proposed certificateholder.

(3) The offer in paragraph (M)(1) of this rule is not required of life insurance policies or riders containing accelerated long-term care benefits.

(4)

(a) Insurers shall include the following information in or with the outline of coverage:

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

(ii) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

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

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

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

(7)

(a) Inflation protection as provided in paragraph (M)(1)(a) of this rule shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this paragraph. The rejection may be either in the application or a on a

separate form.

(b) The rejection is considered a part of the application and shall state:

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

(N) Requirements for application forms and replacement coverage

(1) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing the questions may be used. With regard to a replacement policy issued to a group defined by division (D) of section 3923.41 of the Revised Code, the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement.

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

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

(i) If so, with which company?

(ii) If that policy lapsed, when did it lapse?

(c) Are you covered by medicaid?

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

(2) Agents shall list any other health insurance policies they have sold to the applicant.

(a) List policies sold that are still in force.

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

(3) Solicitations other than direct response. Upon determining that a sale will involve replacement, an insurer; other than an insurer using direct response solicitation methods, or its agent; shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided as shown in appendix I to this rule.

(4) Direct response solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided as shown in appendix I to this rule.

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

(6) Life insurance policies that accelerate benefits for long-term care shall comply with this paragraph if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer will comply with the replacement requirements of rule 3901-6-05 of the Administrative Code. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer will comply with both the long-term care and the life insurance replacement requirements.

(O) Reporting requirements

(1) Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a per cent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a per cent of the agent's total annual sales.

(2) Every insurer shall report annually by June thirtieth the ten per cent of its agents with the greatest percentages of lapses and replacements as measured by paragraph (O)(1) of this rule (appendix G to this rule).

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

(4) Every insurer shall report annually by June thirtieth the number of lapsed policies as a per cent of its total annual sales and as a per cent of its total number of policies in force as of the end of the preceding calendar year (appendix G to this rule).

(5) Every insurer shall report annually by June thirtieth the number of replacement policies sold as a per cent of its total annual sales and as a per cent of its total number of policies in force as of the preceding calendar year (appendix G to this rule).

(6) Every insurer shall report annually by June thirtieth, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied (appendix E to this rule).

(7) For purposes of this paragraph:

(a) "Policy" means only long-term care insurance;

(b) Subject to paragraph (O)(7)(c) of this rule, "claim" means a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms

or conditions of the policy have been met;

(c) "Denied" means the insurer refused to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

(d) "Report" means on a statewide basis.

(8) Reports required under this paragraph are to be filed with the superintendent.

(P) Licensing

A producer is not authorized to sell, solicit or negotiate with respect to long-term care insurance except as authorized by Chapter 3905. of the Revised Code.

(Q) Discretionary powers of superintendent

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

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

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

(3)

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

(b) The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

(c) The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

(R) Reserve standards

(1) When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with sections 3903.721 and 3903.728 of the Revised Code. Claim reserves shall also be established in the case when the policy or rider is in claim status.

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

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

(a) Definition of insured events;

(b) Covered long-term care facilities;

(c) Existence of home convalescence care coverage;

(d) Definition of facilities;

(e) Existence or absence of barriers to eligibility;

(f) Premium waiver provision;

(g) Renewability;

(h) Ability to raise premiums;

(i) Marketing method;

(j) Underwriting procedures;

(k) Claims adjustment procedures;

(l) Waiting period;

(m) Maximum benefit;

(n) Availability of eligible facilities;

(o) Margins in claim costs;

(p) Optional nature of benefit;

(q) Delay in eligibility for benefit;

(r) Inflation protection provisions; and

(s) Guaranteed insurability option.

Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the american academy of actuaries.

(2) When long-term care benefits are provided other than as in paragraph (R)(1) of this rule, reserves

are determined in accordance with rule 3901-3-13 of the Administrative Code.

(S) Loss ratio

(1) This paragraph applies to all long-term care insurance policies or certificates except those covered under paragraphs (J) and (T) of this rule.

(2) Benefits under long-term care insurance policies are deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty per cent, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration will be given to all relevant factors, including:

(a) Statistical credibility of incurred claims experience and earned premiums;

(b) The period for which rates are computed to provide coverage;

(c) Experienced and projected trends;

(d) Concentration of experience within early policy duration;

(e) Expected claim fluctuation;

(f) Experience refunds, adjustments or dividends;

(g) Renewability features;

(h) All appropriate expense factors;

(i) Interest;

(j) Experimental nature of the coverage;

(k) Policy reserves;

(l) Mix of business by risk classification; and

(m) Product features such as long elimination periods, high deductibles and high maximum limits.

(3) Paragraph (S)(2) of this rule does not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

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

(b) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of sections 3915.071 and 3915.072 of the Revised Code;

(c) The policy meets the disclosure requirements of divisions (K), (L), and (M) of section 3923.44 of the Revised Code.

(d) Any policy illustration that meets the applicable requirements of the rule 3901-6-04 of the Administrative Code; and

(e) An actuarial memorandum is filed with the insurance department that includes:

(i) A description of the basis on which the long-term care rates were determined;

(ii) A description of the basis for the reserves;

(iii) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(iv) A description and a table of each actuarial assumption used. For expenses, an insurer must

include per cent of premium dollars per policy and dollars per unit of benefits, if any;

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

(vi) The estimated average annual premium per policy and the average issue age;

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

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

(T) Premium rate schedule increases

(1) This paragraph applies as follows:

(a) Except as provided in paragraph (T)(1)(b) of this rule, this paragraph applies to any long-term care policy or certificate issued in this state on or after one hundred eighty days after the effective date of this rule.

(b) For certificates issued on or after the effective date of this amended rule under a group long-term care insurance policy as defined in division (D) of section 3923.41 of the Revised Code, which policy was in force at the time this amended rule became effective, the provisions of this paragraph apply on the policy anniversary following three hundred sixty-five days after the effective date of this rule.

(2) An insurer shall provide notice of a pending premium rate schedule increase for a group long-term care policy, including an exceptional increase, to the superintendent at least thirty days prior to

the notice to the policyholders. An insurer shall request approval of a pending premium rate schedule increase for an individual long-term care policy, including an exceptional increase, from the superintendent at least thirty days prior to the notice to the policyholders. The notice or request for approval includes:

(a) Information required by paragraph (I) of this rule;

(b) Certification by a qualified actuary that:

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

(ii) The premium rate filing is in compliance with the provisions of this paragraph;

(c) An actuarial memorandum justifying the rate schedule change request that includes:

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

(A) Annual values for each year preceding and following the valuation date shall be provided;

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

(C) The projections shall demonstrate compliance with paragraph (T)(3) of this rule; and

(D) For exceptional increases,

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

(ii) In the event the superintendent determines as provided in paragraph (D)(2)(d) of this rule that offsets may exist, the insurer shall use appropriate net projected experience;

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

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

(iv) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

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

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

(e) Sufficient information for review and approval of the premium rate schedule increase by the superintendent.

(3) All premium rate schedule increases shall be determined in accordance with the following requirements:

(a) Exceptional increases shall provide that seventy per cent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(b) Premium rate schedule increases are calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future

projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(i) The accumulated value of the initial earned premium times fifty-eight per cent;

(ii) Eighty-five per cent of the accumulated value of prior premium rate schedule increases on an earned basis;

(iii) The present value of future projected initial earned premiums times fifty-eight per cent; and

(iv) Eighty-five per cent of the present value of future projected premiums not in paragraph (T)(3)(c) of this rule on an earned basis;

(c) In the event that a policy form has both exceptional and other increases, the values in paragraphs (T)(3)(b)(ii) and (T)(3)(b)(iv) of this rule will also include seventy per cent for exceptional rate increase amounts; and

(d) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in rule 3901-3-13 of the Administrative Code. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

(4) For each rate increase that is implemented, the insurer will file with the superintendent updated projections, as defined in paragraph (T)(2)(c)(i) of this rule, annually for the next three years and include a comparison of actual results to projected values. The superintendent may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in paragraph (T)(11) of this rule, the projections required by this paragraph shall be provided to the policyholder in lieu of filing with the superintendent.

(5) If any premium rate in the revised premium rate schedule is greater than two hundred per cent of the comparable rate in the initial premium schedule, lifetime projections, as defined in paragraph (T)(2)(c)(i) of this rule, will be filed with the superintendent every five years following the end of the

required period in paragraph (T)(4) of this rule.

(6)

(a) If the superintendent has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in paragraph (T)(3) of this rule, the superintendent may require the insurer to implement any of the following:

(i) Premium rate schedule adjustments; or

(ii) Other measures to reduce the difference between the projected and actual experience.

(b) In determining whether the actual experience adequately matches the projected experience, consideration should be given to paragraph (T)(2)(c)(v) of this rule, if applicable.

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

(a) A plan, subject to superintendent approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise, the superintendent may impose the condition in paragraph (T)(8) of this rule; and

(b) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to paragraph (T)(3) of this rule had the greater of the original anticipated lifetime loss ratio or fifty-eight per cent been used in the calculations described in paragraphs (T)(3)(a) and (T)(3)(c) of this rule.

(8)

(a) For a rate increase filing that meets the following criteria, the superintendent shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(i) The rate increase is not the first rate increase requested for the specific policy form or forms;

(ii) The rate increase is not an exceptional increase; and

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

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

(i) The offer shall:

(A) Be subject to the approval of the superintendent;

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

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

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

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

(B) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten per cent.

(9) If the superintendent determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the superintendent may, in addition to the provisions of paragraph (T)(8) of this rule, prohibit the insurer from either of the following:

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

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

(10) Paragraphs (T)(1) to (T)(9) of this rule do not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in paragraph (D)(3) of this rule, if the policy complies with all of the following provisions:

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

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

(i) Sections 3915.071 and 3915.072 of the Revised Code, and

(ii) Section 3915.073 of the Revised Code;

(c) The policy meets the disclosure requirements of divisions (K), (L), and (M) of section 3923.44 of the Revised Code;

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

(i) Policy illustrations as required by rule 3901-6-04 of the Administrative Code;

(e) An actuarial memorandum is filed with the insurance department that includes:

(i) A description of the basis on which the long-term care rates were determined;

(ii) A description of the basis for the reserves;

(iii) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

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

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

(vi) The estimated average annual premium per policy and the average issue age;

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

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

(11) Paragraphs (T)(6) and (T)(8) of this rule do not apply to group insurance policies as defined in division (D) of section 3923.41 of the Revised Code, which are issued to an employer, labor organization or trust established by one or more employers or labor organizations or a combination

thereof where:

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

(b) The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than twenty per cent of the total premium for the group in the calendar year prior to the year a rate increase is filed.

(U) Filing requirements for advertising

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

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

(V) Standards for marketing

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

(a) Establish marketing procedures and agent training requirements to assure that:

(i) Any marketing activities, including any comparison of policies, by its agents or other producers will be fair and accurate; and

(ii) Excessive insurance is not sold or issued.

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

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

(c) Provide copies of the disclosure forms required in paragraph (I)(3) of this rule (appendices B and F to this rule) to the applicant.

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

(e) Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with paragraph (V)(1) of this rule.

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

(g) For long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to paragraph (F)(1)(c) of this rule.

(h) Provide an explanation of contingent benefit upon lapse provided for in paragraph (AA)(4)(c) of this rule and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in paragraph (AA)(4)(d) of this rule.

(2) In addition to the practices prohibited in sections 3901.20 and 3901.21 of the Revised Code, the following acts and practices are prohibited:

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

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

(c) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

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

(3)

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

(b) The insurer shall file with the insurance department the following material:

(i) The policy and certificate,

(ii) A corresponding outline of coverage, and

(iii) All advertisements requested by the insurance department.

(c) The association shall disclose in any long-term care insurance solicitation:

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

(ii) A brief description of the process under which the policies and the insurer issuing the policies were selected.

(d) If the association and the insurer have interlocking directorates or trustee arrangements, the association will disclose that fact to its members.

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

(f) The association shall also:

(i) At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change;

(ii) Actively monitor the marketing efforts of the insurer and its agents; and

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

(iv) Paragraphs (V)(3)(f)(i) to (V)(3)(f)(iii) of this rule shall not apply to qualified long-term care insurance contracts.

(g) No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the state insurance department the information required in this paragraph.

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

(i) Failure to comply with the filing and certification requirements of this paragraph constitutes an unfair trade practice.

(W) Suitability

(1) This paragraph does not apply to life insurance policies that accelerate benefits for long-term care.

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

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

(b) Train its agents in the use of its suitability standards; and

(c) Maintain a copy of its suitability standards and make them available for inspection upon request by the superintendent.

(3)

(a) To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take the following into consideration:

(i) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

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

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

(b) The issuer, and where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in paragraph (W)(3)(a) of this rule. The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in appendix B to this rule, in not less than twelve point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the superintendent.

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

(d) The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet in appendix B to this rule is prohibited.

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

(5) Agents shall use the suitability standards developed by the issuer in marketing long-term care insurance.

(6) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in appendix C to this rule, in not less than twelve point type.

(7) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to appendix D to this rule. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

(8) The issuer shall report annually to the superintendent the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards and the number of those who chose to confirm after receiving a suitability letter.

(X) Prohibition against preexisting conditions and probationary periods in replacement policies or certificates

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

(Y) Availability of new services or providers

(1) An insurer shall notify policyholders of the availability of a new long-term care policy series that providers coverage of new long-term care services or providers material in nature and not previously available through the insurer to the general public. The notice shall be provided within three hundred sixty-five days of the date the new policy series is made available for sale in this state.

(2) Notwithstanding paragraph (Y)(1) of this rule, notification is not required for any policy issued prior to the effective date of this rule or to any policyholder or certificateholder who is currently eligible for benefits, within an elimination period or on a claim, or who previously has been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

(3) The insurer shall make the new coverage available in one of the following ways:

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

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

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

(d) By an alternative program developed by the insurer that meets the intent of paragraph (Y) of this rule if the program is filed with and approved by the superintendent.

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

(5) Policies issued pursuant to this paragraph are considered exchanges and not replacements. These exchanges are not subject to paragraphs (N) and (W) of this rule, and the reporting requirements of paragraphs (O)(1) to (O)(5) of this rule.

(6) Where the policy is offered through an employer, labor organization, professional, trade or

occupational association, the required notification in paragraph (Y)(1) of this rule shall be made to the offering entity. However, if the policy is issued to a group defined in division (D)(4) of section 3923.41 of the Revised Code, the notification shall be made to each certificateholder.

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

(8) Paragraph (Y) of this rule does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(9) Paragraph (Y) of this rule becomes effective on or after three hundred sixty-five days after the effective date of this rule.

(Z) Right to reduce coverage and lower premiums

(1)

(a) Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways;

(i) Reducing the maximum benefit; or

(ii) Reducing the daily, weekly, or monthly benefit amount.

(b) The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier's administrative processes. An example of a policy design would be a partnership policy which maintains its partnership status by containing certain features as required by state or federal law.

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

(3) The age to determine the premium for the reduced coverage is based on the age used to determine the premiums for the coverage currently in force.

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

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

(6) Paragraph (Z) of this rule does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(7) The requirements of paragraph (Z) of this rule apply to any long-term care policy issued in this state on or after three hundred sixty-five days after the effective date of this rule.

(AA) Nonforfeiture benefit requirement

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

(2) A nonforfeiture benefit shall be offered that complies with the following:

(a) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer is the benefit described in paragraph (AA)(5) of this rule; and

(b) The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

(3) If the offer is rejected, the insurer shall provide the contingent benefit upon lapse described in this paragraph. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit upon lapse in paragraph (AA)(4)(d) of this rule still applies.

(4)

(a) After rejection of the offer, for individual and group policies without nonforfeiture benefits issued after the effective date of this paragraph, the insurer shall provide a contingent benefit upon lapse.

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

(c) A contingent benefit upon lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below stated on the insured's issue age, and the policy or certificate lapses within one hundred twenty days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty days prior to the due date of the premium reflecting the rate increase.

Triggers for a substantial premium increase	
Per cent increase over initial premium	Issue age
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%

63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

(d) A contingent benefit upon lapse shall also be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, the policy or certificate

lapses within one hundred twenty days of the due date of the premium so increased, and the ratio in paragraph (AA)(4)(f)(ii) of this rule is forty per cent or more. Unless otherwise required, policyholders shall be notified at least thirty days prior to the due date of the premium reflecting the rate increase.

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

This provision is in addition to the contingent benefit provided by paragraph (AA)(4)(c) of this rule and where both are triggered, the benefit provided is at the option of the insured.

(e) On or before the effective date of a substantial premium increase as defined in paragraph (AA)(4)(c) of this rule, the insurer shall:

(i) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(ii) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of paragraph (AA)(5) of this rule. This option may be elected at any time during the one hundred twenty-day period referenced in paragraph (AA)(4)(c) of this rule; and

(iii) Notify the policyholder or certificateholder that a default or lapse at any time during the one hundred twenty-day period referenced in paragraph (AA)(4)(c) of this rule shall be deemed to be the election of the offer to convert in paragraph (AA)(4)(e)(ii) of this rule unless the automatic option in paragraph (AA)(4)(f)(iii) of this rule applies.

(f) On or before the effective date of a substantial premium increase as defined in paragraph (AA)(4)(d) of this rule, the insurer shall:

(i) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(ii) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety per cent of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the one hundred twenty-day period referenced in paragraph (AA)(4)(d) of this rule; and

(iii) Notify the policyholder or certificateholder that a default or lapse at any time during the one hundred twenty-day period referenced in paragraph (AA)(4)(d) of this rule shall be deemed to be the election of the offer to convert in paragraph (AA)(4)(f)(ii) of this rule if the ratio is forty per cent or more.

(5) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with paragraph (AA)(4)(c) but not paragraph (AA)(4)(d) of this rule, are described in this paragraph:

(a) For purposes of paragraph (AA)(5)(a) of this rule, attained age rating is defined as a schedule of premiums starting from the issue date which increases with age at least one per cent per year prior to age fifty, and at least three per cent per year beyond age fifty.

(b) For purposes of this paragraph, the nonforfeiture benefit is a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits are determined as specified in paragraph (AA)(5)(c) of this rule.

(c) The standard nonforfeiture credit will be equal to one hundred per cent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of paragraph (AA)(6) of this rule.

(d)

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

(ii) Notwithstanding paragraph (AA)(5)(d)(i) of this rule, for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

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

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

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

(6) All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.

(7) There shall be no difference in the minimum nonforfeiture benefits as required under this paragraph for group and individual policies.

(8) The requirements set forth in this paragraph become effective three hundred sixty-five days after the effective date of this provision and shall apply as follows:

(a) Except as provided in paragraphs (AA)(8)(b) and (AA)(8)(c) of this rule, the provisions of paragraph (AA) of this rule apply to any long-term care policy issued in this state on or after the effective date of this rule.

(b) For certificates issued on or after the effective date of paragraph (AA) of this rule, under a group long-term care insurance policy as defined in division (D) of section 3923.41 of the Revised Code,

which policy was in force at the time this amended rule becomes effective, the provisions of paragraph (AA) of this rule do not apply.

(c) The last sentence in paragraph (AA)(3) and paragraphs (AA)(4)(d) and (AA)(4)(f) of this rule applies to any long-term care insurance policy or certificate issued in this state after one hundred eighty days after the effective date of this rule adopting those provisions, except new certificates on a group policy as defined in division (D)(1) of section 3923.41 of the Revised Code, three hundred sixty-five days after the effective date of this rule adopting those provisions.

(9) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit upon lapse are subject to the loss ratio requirements of paragraph (S) or (T) of this rule, whichever is applicable, treating the policy as a whole.

(10) To determine whether contingent nonforfeiture upon lapse provisions are triggered under paragraph (AA)(4)(c) or (AA)(4)(d) of this rule, a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

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

(a) The nonforfeiture provision is appropriately captioned;

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

(c) The nonforfeiture provision shall provide at least one of the following:

(i) Reduced paid-up insurance;

(ii) Extended term insurance;

(iii) Shortened benefit period; or

(iv) Other similar offerings approved by the superintendent.

(BB) Standards for benefit triggers

(1) A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

(2)

(a) Activities of daily living shall include at least the following as defined in paragraph (E) of this rule and in the policy:

(i) Bathing;

(ii) Continence;

(iii) Dressing;

(iv) Eating;

(v) Toileting; and

(vi) Transferring;

(b) Insurers may use activities of daily living to trigger covered benefits in addition to those

contained in paragraph (BB)(2)(a) of this rule as long as they are defined in the policy.

(3) An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in paragraphs (BB)(1) and (BB)(2) of this rule.

(4) For purposes of this paragraph the determination of a deficiency shall not be more restrictive than:

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

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

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

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

(7) The requirements set forth in this paragraph shall be effective three hundred sixty-five days after the effective date of this provision and applies as follows:

(a) Except as provided in paragraph (BB)(7)(b) of this rule, the provisions of this paragraph apply to a long-term care policy issued in this state on or after the effective date of this amended rule.

(b) For certificates issued on or after the effective date of paragraph (BB)(7) of this rule, under a group long-term care insurance policy as defined in division (D) of section 3923.41 of the Revised Code that was in force at the time this amended rule became effective, the provisions of this paragraph do not apply.

(CC) Additional standards for benefit triggers for qualified long-term care insurance contracts.

(1) For purposes of this paragraph the following definitions apply:

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

(b)

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

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

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

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

(c) "Licensed health care practitioner" means a physician, as defined in section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the secretary of the treasury.

(d) "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).

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

(3) A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least ninety days due to a loss of functional capacity or to severe cognitive impairment.

(4) Certifications regarding activities of daily living and cognitive impairment required pursuant to paragraph (CC)(3) of this rule shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the secretary of the treasury.

(5) Certifications required pursuant to paragraph (CC)(3) of this rule may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least ninety days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety-day period.

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

(DD) Standard format outline of coverage

This paragraph of the rule implements, interprets, and makes specific, the provisions of division (I) of section 3923.44 of the Revised Code in prescribing a standard format and the content of an outline of coverage.

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

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

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

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

(5) Format for outline of coverage is shown in appendix H to this rule.

(EE) Requirement to deliver shopper's guide

(1) A long-term care insurance shopper's guide in the format developed by the national association of insurance commissioners, or a guide developed or approved by the superintendent, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

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

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

(2) Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-reference guide, but shall furnish the policy summary required under division (K) of section 3923.44 of the Revised Code.

(FF) Penalties

In addition to any other penalties provided by the laws of this state any insurer and any agent found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three times the amount of any commissions paid for each policy involved in the violation or up to ten thousand dollars, whichever is greater.

(GG) Severability

If any portion of this rule or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the rule or related rules which can be given effect without the invalid portion or application, and to this end the provisions of this rule are severable.