

**POLICY IN FORCE STANDARDIZED DATA REQUEST**  
**Property & Casualty Line of Business**  
**Farmowners**

Contents: This file should be downloaded from company system(s) and contain one record for each property insured under a Farmowners policy issued in [applicable state] which was in force at any time during the examination period.

For multiple dwellings, non-dwelling structures, and scheduled farm property, please repeat records as necessary.

Uses: Data will be used to determine if the company follows appropriate procedures with respect to the issuance and/or termination of Farmowners policies in [applicable state] within the scope of the examination.

- Cross-reference with the claims data file to validate the completeness of the in force file; and
- Cross-reference to state (s) licensing information to ensure proper producer licensure.

Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A		NAIC company code
PolPre	6	3	A		Policy prefix ( <b>Blank if NONE</b> )
PolNo	9	20	A		Policy number
PolSuf	29	3	A		Policy suffix ( <b>Blank if NONE</b> )
PolStTyp	32	3	A		Policy status type for the record (i.e., new or renewal) <b>Please provide a list to explain any codes used</b>
PolTyp	35	5	A		Type of policy (i.e., FO-1, FO-2, etc.) <b>Please provide a list to explain any codes used</b>
PolForm	40	10	A		Policy form number as filed with the insurance department
FormTyp	50	10	A		Basic, Broad, Specified
PrCode	60	6	A		Company internal producer, CSR, or business entity producer identification code <b>Please provide a list to explain any codes used</b>
NPN	66	6	A		National producer number
InsFirst	72	15	A		First name of the first named insured
InsMid	87	15	A		Middle name of the first named insured
InsLast	102	20	A		Last name of the first named insured
CovLmtA	122	11	N	0	Coverage A limit (Dwelling)
CovPremA	133	11	N	2	Coverage A premium amount (Dwelling)
CovLmtB	144	11	N	0	Coverage B limit (Personal property, if coverage allocated by Dwelling)
CovPremB	155	11	N	2	Coverage B premium amount (Personal property)
InsAddr	166	25	A		Dwelling street address (location)
InsCity	191	20	A		Dwelling city (location)
InsSt	211	2	A		Dwelling state (location)
InsZip	213	5	A		Dwelling ZIP code (location)

Field Name	Start	Length	Type	Decimals	Description
StrYr	218	4	A		Year the structure was built
StrTyp	222	15	A		Type of structure (i.e. frame, masonry, etc.) <b>Please provide a list to explain any codes used.</b>
StrSqFt	237	4	A		Structure square footage
ProtCl	241	3	A		Protection class (if protection class is utilized)
CovLmtC	244	11	N	0	Coverage C limit (Loss of use)
CovPremC	255	11	N	2	Coverage C premium amount (Loss of use)
CovLmtD	266	11	N	0	Coverage D limit (Other Farm Structures) (Barns, Farm Buildings, Silos)
CovPremD	277	11	N	2	Coverage D premium amount (Other Farm Structures) (Barns, Farm Buildings, Silos)
SchStr	288	64	A		List all scheduled structures not Dwellings (on separate line)
CovLmtE	352	11	N	0	Coverage E limit (Blanket Farm Personal Property)
CovPremE	363	11	N	2	Coverage E premium amount Blanket Farm Personal Property)
CovLmtF	374	11	N	0	Coverage F limit (Scheduled Farm Personal Property)
CovPremF	385	11	N	2	Coverage F premium amount (Scheduled Farm Personal Property)
SchProp	396	64	A		List all scheduled property not Dwellings or Structures (on separate line)
CovLmtG	460	11	N	0	Coverage G limit (Farm Personal Liability)
CovPremG	471	11	N	2	Coverage G premium amount (Farm Personal Liability)
RemLoc	482	64	A		List all secondary locations with no structures (on separate line)
CovLmtH	546	11	N	0	Coverage H limit (Medical payments)
CovPremH	557	11	N	2	Coverage H premium amount (Medical payments)
PolDisc	568	20	A		Policy discounts (i.e. alarm, multi policy) <b>If codes are used, provide a list of codes along with their meanings</b>
SurTyp	588	15	A		Surcharge type, if applicable <b>Please provide a list to explain any codes used</b>
SurAmt	603	11	N	2	Surcharge amount (Do not use commas or dollar signs)
PolPrem	614	11	N	2	Total policy premium amount (sum of all premium for the policy, involving all premium, fees, etc.)
EndorLst	625	20	A		List endorsements attached to the policy <b>Please provide a list to explain any codes used</b>
RateTerr	645	5	A		Code specifying rating territory (please provide list of codes)
DedTyp	650	10	A		Deductible type <b>If codes are used, provide a list of codes along with their meanings</b>
DedAmt	660	11	N	0	Deductible amount or percentage, if any
UWTier	671	25	A		Underwriting tier, if tier rating is utilized <b>Please provide a list to explain any codes used</b>
InsVal	696	11	N	2	Insurance to value amount
InsValDt	707	10	D		Date of last insurance to value completed [MM/DD/YYYY]
FeeTyp	717	20	A		Type of fees applied, if applicable <b>Please provide a list to explain any codes used</b>
FeeAmt	737	11	N	2	Amount of fee applied <b>Repeat field for each fee applied</b>
AppRecDt	748	10	D		Date application received [MM/DD/YYYY]
AppProDt	758	10	D		Date application processed [MM/DD/YYYY]

Field Name	Start	Length	Type	Decimals	Description
InceptDt	768	10	D		Inception date of the policy [MM/DD/YYYY]
EffDt	778	10	D		Policy effective date [MM/DD/YYYY]
ExpDt	788	10	D		Policy expiration date [MM/DD/YYYY]
PdDt	798	10	D		Date policy was paid to before cancellation [MM/DD/YYYY]
CanTerDt	808	10	D		Date policy cancelled/terminated [MM/DD/YYYY]
CanReqDt	818	10	D		Date cancellation requested, if applicable [MM/DD/YYYY]
<del>CanTer</del>	<del>828</del>	<del>1</del>	<del>A</del>		<del>Who cancelled the coverage C=Consumer or I=Insurer</del>
CanTerRs	<del>828</del> 29	64	A		Reason for cancellation/termination of coverage (i.e., <del>lapse, insured request, company cancellation lapse, underwriting reasons, change of risk, non-payment</del> ) <b>If codes are used, provide a list of codes along with their meanings</b>
<del>CanTer</del>	<del>892</del>	<del>1</del>	<del>A</del>		<del>Who cancelled the coverage C=Consumer or I=Insurer</del>
CanTerNt	893	10	D		Date the cancellation/termination notice was mailed [MM/DD/YYYY]
PremRef	903	11	N	2	Amount of premium refunded to the insured
RfndDt	914	10	D		Date premium refund mailed [MM/DD/YYYY]
RefMthd	924	25	A		Refund method (i.e., 90%, pro rata, etc.) <b>If codes are used, provide a list of codes along with their meanings</b>
EndRec	949	1	A		End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.

G:\MKTREG\DATA\D Working Groups\D WG 2019 MCES (PCW)\Docs\_WG Calls 2019\SDRs\Current Drafts\FO In Force 12-11-19.docx

**CLAIMS STANDARDIZED DATA REQUEST**  
**Property & Casualty Line of Business**  
**Farmowners**

**Contents:** This file should be downloaded from company system(s) and contain one record for each claim transaction (i.e. paid/denied/pending/closed w/o payment) that the company processed within the scope of the examination. Include all claims open during the examination period. Do not include expense payments to vendors.

**Uses:** Data will be used to determine if the company follows appropriate procedures with respect to the handling of Farmowners claims within the scope of the examination.

- Cross-reference to annual statement claims data (amount) to ensure completeness of exam data submitted;
- Cross-reference with the company's in force data file to ensure completeness of exam data submitted; and
- Cross-reference to state (s) licensing information to ensure proper adjuster licensure.

Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A		NAIC company code
PolPre	6	3	A		Policy prefix ( <b>Blank if NONE</b> )
PolNo	9	20	A		Policy number
PolSuf	29	3	A		Policy suffix ( <b>Blank if NONE</b> )
ClmNo	32	15	A		Claim number
ClmPre	47	3	A		Claim number prefix ( <b>Blank if NONE</b> )
ClmSuf	50	3	A		Claim number suffix ( <b>Blank if NONE</b> )
Cov	53	5	A		Coverage under which claim was submitted (Coverage A, B, C, etc.)
CovClCod	58	3	A		Description of item for which claim was submitted (e.g. barns, silos, tractors, livestock) <b>Please provide a list to explain any codes used</b>
CATCode	61	6	A		Catastrophe (CAT) loss code, if applicable ( <b>Blank if NONE</b> )
COL	67	20	A		Cause of loss (water, hail, medical, theft, fire, etc.)
DedDesc	87	20	A		Description of deductible applied (e.g. standard, wind/hail/earthquake)
Ded Type	107	15	A		Describe if the deductible is reflected as dollars or as a percentage
DedAmt	122	11	N	2	Deductible amount (Dollar amount or percentage amount)
Endorse	133	20	A		List endorsements applicable to this claim transaction (if any) <b>Please provide a list to explain any codes used</b>
InsFirst	153	15	A		First name of insured
InsMid	168	15	A		Middle name of insured
InsLast	183	20	A		Last name of insured
InsAddr	203	100	A		Insured street address (residence premises)
InsCity	303	20	A		Insured city (residence premises)

Field Name	Start	Length	Type	Decimals	Description
InsSt	323	2	A		Insured resident state (residence premises)
InsZip	325	5	A		Insured ZIP code (residence premises)
CmtFirst	330	15	A		First name of claimant
CmtMid	345	15	A		Middle name of claimant
CmtLast	360	20	A		Last name of claimant (Entity filing proof of loss, e.g. business, etc.)
CmtAddr	380	100	A		Claimant street address
CmtCity	480	20	A		Claimant city
CmtSt	500	2	A		Claimant state
CmtZip	502	5	A		Claimant ZIP code
ClmStat	507	1	A		Claim status P = Paid, D = Denied, N = Pending, H = Partial Payment, C = Closed Without Payment, R = Rescinded
Litig	508	1	A		Y/N - Is claim currently in litigation?
AdjCode	509	9	A		Internal adjuster identification code <b>Please provide a list to explain any codes used</b>
NPN	518	6	A		National (adjuster) number
LossDt	524	10	D		Date loss occurred [MM/DD/YYYY]
RcvdDt	534	10	D		First notice of loss [MM/DD/YYYY]
ClmAckDt	544	10	D		Date company or its producer acknowledged the claim [MM/DD/YYYY]
DtClmFrm	554	10	D		Date claim forms sent to claimant [MM/DD/YYYY]
AppDt	564	10	D		Date of company appraisal [MM/DD/YYYY]
NtcInvDt	574	10	D		Date of written notice to insured/claimant regarding incomplete investigation [MM/DD/YYYY]
DepTkn	584	1	A		Was depreciation taken? (Y/N)
DepAmt	585	11	N	2	Amount of depreciation taken
DepPdAmt	596	11	N	2	Amount of recoverable depreciation paid
DepPdDt	607	10	D		Date recoverable depreciation paid [MM/DD/YYYY]
PdClmAmt	617	11	N	2	Total amount of claim paid
ClmPay	628	50	A		Claim payee
ClmPdDt	678	10	D		Claim paid date [MM/DD/YYYY]
IntPdAmt	688	11	N	2	Amount of interest paid, if applicable
IntPdDt	699	10	D		Date interest paid [MM/DD/YYYY]
ClmDnyDt	709	10	D		Date claim was denied [MM/DD/YYYY]
ClmDenRsn	719	100	A		Reason for claim denial <b>Please provide a list to explain any codes used</b>
Subro	819	1	A		Indicate whether claim was subrogated (Y/N)
SubRecdDt	820	10	D		Date company received subrogation refund [MM/DD/YYYY]
SubAmt	830	11	N	2	Subrogation received amount
AmtDedRm	841	11	N	2	Amount of deductible reimbursed to insured
SubRefDt	852	10	D		Date deductible refunded to insured [MM/DD/YYYY]

Field Name	Start	Length	Type	Decimals	Description
EndRec	862	1	A		End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.

G:\MKTREG\DATA\D Working Groups\D WG 2019 MCES (PCW)\Docs\_WG Calls 2019\SDRs\Current Drafts\FO Claims 10-29-19.docx

DRAFT

## Chapter 26A—Conducting the Limited Long-Term Care Examination

### IMPORTANT NOTE:

The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in Chapter 1—Introduction.

This chapter applies to ~~all limited~~ long-term care insurance policies. This chapter does not apply to including qualified limited long-term care insurance contracts, group and individual annuities and life insurance policies or riders that provide directly or supplement limited long-term care insurance. This chapter also does not apply to life insurance contracts that accelerate benefits in the form of a lump sum payment, in anticipation of death or some other specified occurrence.

This chapter provides a format for conducting limited long-term care insurance examinations. Procedures for conducting other types of specialized examinations may be found in separate chapters.

The examination of limited long-term care insurance operations may involve any review of one or a combination of the following business areas:

- A. Operations/Management
- B. Complaint Handling
- C. Marketing and Sales
- D. Producer Licensing
- E. Policyholder Service
- F. Appeal of Benefit Trigger Adverse Determination
- G. Underwriting and Rating
- H. Claims

When conducting an exam that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the entity is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). Many states have executed an agreement to share complaint information with one or more of these federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

### HIPAA—Federal Minimum Requirements

~~Examiners should be aware that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Section 7702B of the Internal Revenue Code impose minimum requirements for health insurance coverage in certain areas and prohibits the application of any state law to the extent that it prevents the application of a HIPAA requirement. However, states that have laws in these areas that extend beyond HIPAA's minimum requirements may enforce those laws.~~

~~Group and individual long term care insurance issues affected by HIPAA include minimum standards for tax-qualified long term care policies.~~

### ~~Long-Term Care Insurance~~

~~Two sections of HIPAA (7702B and 4980C) establish requirements for qualified long term care insurance contracts and companies issuing those contracts. For the purposes of HIPAA requirements, the following definitions apply: “Qualified long term care services” are necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services; and “maintenance or personal care services” are services required by a chronically ill individual that are provided pursuant to a plan of care prescribed by a licensed health care practitioner. Under HIPAA, qualified long term care insurance contracts and issuers of those contracts are required to satisfy certain requirements of the *Long-Term Care Insurance Model Act* (#640) and *Long-Term Care Insurance Model Regulation* (#641).~~

~~Many states have requirements that impose more consumer protection requirements on carriers than HIPAA, in which case the state’s requirements should be enforced. (For example, a state may include a group of 1 in its definition of “group” or “small group.”)~~

### **IIPRC-Approved Products**

When conducting an exam that includes limited long-term care insurance products, rates, advertisements and associated forms approved by the Interstate Insurance Product Regulation Commission (IIPRC) on behalf of a compacting state, it is important to keep in mind the uniform standards, and not state-specific statutes, rules and regulations, are applicable to the content and approval of the product. The IIPRC website is [www.insurancecompact.org](http://www.insurancecompact.org) and the uniform standards are located on its rulemaking record. Compacting states have access through the NAIC System for Electronic Rate and Form Filing (SERFF) to product filings submitted to the IIPRC for approval and use in their respective state or jurisdiction and can also use the export tool in SERFF to extract relevant information. Each IIPRC-approved product filing has a completed reviewer checklist(s) to document the applicable uniform standards compliance review. The IIPRC office should be included when a compacting state(s) is concerned that an IIPRC-approved product constitutes a violation of the provisions, standards or requirements of the IIPRC (including the uniform standards). Under the uniform standards, a limited long-term care insurance product approved by the IIPRC can be used in a compacting state’s partnership program provided the company has obtained the necessary approval from the compacting state or made the necessary certification to the compacting state, as applicable. Please note that the company must still comply with a compacting state’s laws for minimum daily benefit amounts, minimum benefit periods and maximum elimination periods when selling a limited long-term care insurance product approved by the IIPRC.

### **A. Operations/Management**

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.



**STANDARDS  
OPERATIONS/MANAGEMENT**

**Standard 1**

**The entity files all reports and certifications with the insurance department as required by applicable statutes, rules and regulations.**

**Apply to:** All limited long-term care companies

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations

\_\_\_\_\_ Insurance department records of reports and certifications made by the entity

Others Reviewed

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

*Limited Long-Term Care Insurance Model Act* (#640642)

*Limited Long-Term Care Insurance Model Regulation* (#641643)

**Review Procedures and Criteria**

~~Each insurer should file with the insurance commissioner, prior to offering group long-term care insurance to a resident of the state, evidence that the group policy or certificate has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in the state of issue. (Note: Section 21 of the *Long-Term Care Model Regulation* (#641)) requires an evidentiary filing only from discretionary groups. Review individual state statutes, rules and regulations to determine the extent of the state's jurisdiction over coverage sold to state residents under an out-of-state group policy.)~~

Each insurer shall file with the insurance commissioner, prior to offering group limited long-term care insurance to a resident of the state, evidence that the group policy or certificate has been approved by a state having statutory or regulatory limited long-term care insurance requirements substantially similar to those adopted in the state of issue (Model #643 Section 20 & Model 642 Section 5). (Note: Section 20 of the *Limited Long-Term Care Model Regulation* (#643) requires an evidentiary filing only from discretionary groups.

Each insurer should file with the insurance commissioner a copy of any limited long-term care insurance advertising intended for use in the state—whether through written, radio or television medium—for review or approval to the extent required by state law. All advertisements should be retained for at least three years from the date of first use.

Determine if replacement/lapse reporting is submitted by the entity as required. Items to be reported are:

- Top 10 percent of producers with the highest percentage of replacements and lapses; and
- Number of lapsed policies as a percentage of annual sales and policies in force at the end of the previous calendar year.

Determine that the entity complies with filing and certification requirements set forth by statutes, rules and regulations for associations endorsing or selling limited long-term care insurance. Generally, these requirements are imposed on an association group meeting the definition of a professional/trade/occupational association found in Section 4E(2) of the Limited Long-Term Care Insurance Model Act (#640642).

Ensure that the insurer has filed all requested advertising with the insurance department regarding association sold or endorsed limited long-term care insurance, as may be requested by the insurance department. Any such advertising must disclose:

- The specific nature and amount of compensation that the association receives from the endorsement or sale of the policy or certificate to its members; and
- A brief description of the process under which the policies and the issuing insurer were selected.

Determine that the entity submits suitability and rescission information as required by applicable statutes, rules and regulations.

Determine the regulated entity has proper procedures in place to ensure its producers are properly trained and that the training meets the minimum standards established by the applicable laws and regulations.

Insurers subject to the Limited Long-Term Care Insurance Model Act (#640642) shall maintain records with respect to the training of its producers concerning the distribution of its partnership policies that will allow the state insurance department to provide assurance to the state Medicaid agency that producers have received the training contained in Subsection B(2)(a) as required by Subsection A of the Long-Term Care Insurance Model Act (#640) and that producers have demonstrated an understanding of the partnership policies and their relationship to public and private coverage of limited long-term care, including Medicaid, in a state. These records shall be maintained in accordance with state record retention requirements and shall be made available to the commissioner upon request. Pursuant to Model#642, Section 9 – Producer Training Requirements are optional.

Most states have a limited long-term care partnership policy forms certification process in order for limited long-term care partnership forms to be sold in their state.

## **B. Complaint Handling**

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

## **C. Marketing and Sales**

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

DRAFT

**STANDARDS  
MARKETING AND SALES**

**Standard 1**

The entity has suitability standards for its products, ~~when~~ where required by applicable statutes, rules and regulations.

**Apply to:** All limited long-term care products

**Priority:** Recommended

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations

\_\_\_\_\_ Producer records

\_\_\_\_\_ Training materials

\_\_\_\_\_ Procedure manuals

\_\_\_\_\_ Underwriting/Policy files

Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

Limited Long-Term Care Insurance Model Act (#~~640~~642)

Limited Long-Term Care Insurance Model Regulation (#~~641~~643)

**Review Procedures and Criteria**

Determine whether the entity makes multiple sales to individuals of the same product. Use random selection of policyholders and have the entity run a policyholder history to identify the number of policies sold to those individuals.

Determine if entity guidelines place limitations on multiple sales; i.e., limits on coverage, determination of suitability, detection of predatory sales practices, etc.

~~Ensure that the entity has developed and uses suitability standards for the purchase or replacement of limited long term care insurance, including, but not limited to:~~

- ~~• Presentation to the applicant, at or prior to application, of the “Long Term Care Insurance Personal Worksheet” and any other suitability related information requested by the insurer;~~
- ~~• Presentation, at the same time as the personal worksheet, of the disclosure form titled “Things You Should Know Before You Buy Long Term Care Insurance”;~~
- ~~• Confirm that a completed personal worksheet was returned to the issuer prior to the consideration of the applicant for coverage, except that the personal worksheet need not be returned for sales of employer group long term care insurance to employees and their spouses; and This paragraph removed by Mary Lou Moran~~

- ~~If the issuer has determined that the applicant did not meet its financial suitability standards, confirmation that the insurer informed the applicant that the policy may not be suitable and obtained the applicant's written verification to proceed with the transaction prior to issuance of coverage (using a letter similar to Appendix D of the *Long Term Care Insurance Model Regulation #641*). If the applicant has declined to provide financial information, confirm that the insurer verified the applicant's intent to purchase the coverage by either written verification (using a letter similar to Appendix D of Model #641) or alternative means. If an alternative method of verification was used for those who declined to provide financial information, confirm that the insurer has a record of the alternative method used.~~ *This paragraph removed by Mary Lou Moran*

~~Develop and use~~ Determine if the entity has developed and uses *Changes submitted by Mary Lou Moran* suitability standards and procedures to determine whether the purchase or replacement of limited long-term care insurance is appropriate for the needs of the applicant. Suitability standards and procedures should include:

- ~~Consideration of the advantages and disadvantages of insurant to meet the needs of the applicant; and~~
- ~~Discussion with applicants of how the benefits and costs of limited long-term care insurance compare with long-term care insurance.~~
- ~~Agent training in its suitability standards and procedures~~
- ~~Maintain a copy of suitability standards and procedures and make them available for inspection upon request by the commissioner.~~

~~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. 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 alternate method of verification shall be made a part of the applicant's file.~~

~~Note: Pursuant to Section 24A of the *Long Term Care Insurance Model Regulation (#641)*, suitability standards do not apply to life insurance policies or riders that accelerate benefits for long term care as defined in the *Long Term Care Model Act (#640)*, Section 4A.~~ *This paragraph removed by Mary Lou Moran*

~~Note: Pursuant to Section 25H of the Limited Long-Term Care Insurance Model Regulation (#643), suitability standards do not apply to life insurance policies or riders that accelerate benefits for limited long-term care as defined in the Limited Long-Term Care Model Act, Section (# 642), Section 4(D).~~

~~Determine whether the personal worksheet and disclosure form are in the form, content and text prescribed by applicable statutes, rules and regulations.~~

~~Determine whether the required personal worksheet and disclosure forms are retained as required by applicable statutes, rules and regulations.~~

Determine if the insurer is reporting suitability information to the insurance commissioner as required by applicable statutes, rules and regulations.

Determine whether marketing materials encourage multiple issues of policies; for example, use of existing policyholder list for additional sales of similar products to those held, birth date solicitations, scare tactics, etc.

Determine if negative enrollment practices are permitted and used by the entity.

Ensure the entity maintains a written statement specifying the standards of suitability used by the insurer and provides the standards to its producers, and that both follow the standards. The standards should specify that no recommendation should be made and/or no policy issued in the absence of reasonable grounds to believe that the purchase of the policy is not unsuitable for the applicant (based on information known to the insurer or producer making the recommendation).

**STANDARDS  
MARKETING AND SALES**

**Standard 2**

**Policy forms provide required disclosure material regarding standards for benefit triggers.**

**Apply to:** All limited long-term care products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

\_\_\_\_\_ Claim procedure/Underwriting manuals

\_\_\_\_\_ Claim files

\_\_\_\_\_ Policy forms

Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

Limited Long-Term Care Insurance Model Act (#640642)

Limited Long-Term Care Insurance Model Regulation (#641643)

**Review Procedures and Criteria**

Ensure the policy conditions the payment of benefits on a determination of the insured's ability to perform activities of daily living (ADLs) and cognitive impairment.

Ensure that the policy contains the definition of ADLs, cognitive impairment and other key terms as required by statutes, rules and regulations.

Determine that the eligibility for payment of benefits is not more restrictive than requiring either a deficiency in the ability to perform not more than 3 of the ADLs or the presence of cognitive impairment. Ensure that payment of benefits is not more restrictive than those allowed by statutes, rules and regulations.

Ensure that the policy contains a clear description of the process for appealing and resolving benefit determinations.

**STANDARDS  
MARKETING AND SALES**

**Standard 3**

**Marketing for limited long-term care products complies with applicable statutes, rules and regulations.**

**Apply to:** All limited long-term care products

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
- \_\_\_\_\_ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, telemarketing scripts and pictorial materials
- \_\_\_\_\_ Required reports filed with the insurance department
- \_\_\_\_\_ Marketing materials filed with the insurance department
- \_\_\_\_\_ Underwriting files or other files containing proof of issuance of outline of coverage
- \_\_\_\_\_ Review state statutes, rules and regulations to determine if state limited long-term care requirements apply to annuity products with a limited long-term care element. If so, then the applicable *Annuity Disclosure Model Regulation* (#245) would apply

**Others Reviewed**

- \_\_\_\_\_
- \_\_\_\_\_

**NAIC Model References**

- Limited Long-Term Care Insurance Model Act (#640642)
- Limited Long-Term Care Insurance Model Regulation (#641643)
- Life Insurance Disclosure Model Regulation* (#580)
- Life Insurance Illustrations Model Regulation* (#582)
- Unfair Trade Practices Act* (#880)

**Review Procedures and Criteria**

Verify that the entity uses applications for limited long-term care insurance policies or certificates containing clear and unambiguous questions designed to ascertain the health condition of the applicant. (In most cases, application forms should have been reviewed by the insurance department's rates and forms division.)

Verify that the entity complies with right to return/"free look" requirements.

Verify that the outline of coverage is delivered to the applicant at time of initial solicitation through means that prominently directs the attention of the recipient to the document and its purpose.

Verify that at the time of policy delivery the insurer has delivered a policy summary for an individual life insurance policy that provides limited long-term care benefits within the policy or by rider. In the case of direct response solicitations, verify that the insurer has delivered the policy summary upon the applicant's request, but regardless of request has made delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, ensure that the summary also includes:

- An explanation of how the limited long-term care benefit interacts with other components of the policy, ~~including deductions from death benefits;~~
- ~~An illustration of the amount of benefits, the length of benefits, and the guaranteed lifetime benefits, if any, for each covered person;~~
- Any exclusions, reductions and limitations on benefits of limited long-term care; and
- A statement that any limited long-term care inflation protection option required by the applicable state's statutes, rules and regulations regarding inflation protection option requirements comparable to Section 13 of the *Limited Long-Term Care Insurance Model Regulation* (~~#641643~~) is not available under this policy.

In addition to the above, if applicable to the policy type, ensure that the summary includes the following:

- A disclosure of the effects of exercising other rights under the policy; and
- A disclosure of guarantees related to limited long-term care costs of insurance charges; ~~and~~
- ~~Current and projected maximum lifetime benefits.~~

The required provisions of the policy summary may be incorporated into a basic illustration required to be delivered in accordance with the applicable state's basic illustration requirements comparable to Sections 7 and 8 of the *Life Insurance Illustrations Model Regulation* (#582) or into the life insurance policy summary, which is required to be delivered in accordance with the applicable state's life insurance policy summary requirements comparable to Section 5 of the *Life Insurance Disclosure Model Regulation* (#580).

Verify that the entity complies with records maintenance and reporting requirements:

- Entity must maintain records for each producer of that producer's amount of replacement sales as a percentage of the producer's total annual sales and the amount of lapses of limited long-term care insurance policies sold by the producer as a percentage of the producer's total annual sales;
- Every insurer shall report annually by June 30 the 10 percent of its producers with the greatest percentages of lapses and replacements;
- Every insurer shall report annually by June 30 the number of lapsed policies as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the end of the preceding calendar year; and
- Every insurer shall report annually by June 30 the number of replacement policies sold as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the preceding calendar year; ~~and~~
- ~~Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied.~~



**STANDARDS  
MARKETING AND SALES**

**Standard 4**

**All advertising and sales materials are in compliance with applicable statutes, rules and regulations.**

**Apply to:** All limited long-term care products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for advertisements approved by the IIPRC)

\_\_\_\_\_ All company advertising and sales materials, including radio and audiovisual items, such as TV commercials, telemarketing scripts and pictorial materials

\_\_\_\_\_ Policy forms, including any required buyer's guides, outline of coverage, limited long-term care insurance personal worksheets and disclosure forms as they coincide with advertising and sales materials

\_\_\_\_\_ Producer's own advertising and sales materials

Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

Limited Long-Term Care Insurance Model Act (#640642)

Limited Long-Term Care Insurance Model Regulation (#641643)

Unfair Trade Practices Act (#880)

**Review Procedures and Criteria**

Evaluate the company's system for controlling advertisements. Every insurer should have and maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All advertisements, regardless of by whom written, created, designed or presented, are the responsibility of the insurer.

Ensure the company maintains, at its home or principal office, a complete file containing a specimen copy of every printed, published or prepared advertisement of its individual policies and specimen copies of typical printed, published or prepared advertisements of its blanket, franchise and group policies. There should be a notation indicating the manner and extent of distribution and the form number of every policy advertised. All advertisements should be maintained in the file for a period of either at least three years from the date the advertisement was first used or later if required by state statutes, rules and regulations.

Review advertising materials in conjunction with the appropriate policy form. Materials should not:

- Misrepresent policy benefits, advantages or conditions by failing to disclose limitations, exclusions or reductions, or use terms or expressions that are misleading or ambiguous;
- Make unfair or incomplete comparisons with other policies;
- Make false, deceptive or misleading statements or representations with respect to any person, company or organization in the conduct of insurance business;
- Offer unlawful rebates;
- Use terminology that would lead prospective buyers to believe that they are purchasing an investment or savings plan. Problematic terminology may include the following terms: investment, investment plan, founder's plan, charter plan, deposit, expansion plan, profit, profits, profit sharing, interest plan, savings or savings plan;
- Omit material information or use words, phrases, statements, references or illustrations, if such omission or such use has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable or state or federal tax consequences;
- Use terms such as "non-medical" or "no medical examination required," if the issue is not guaranteed, unless the terms are accompanied by a further disclosure of equal prominence and juxtaposition that issuance of the policy may depend on the answers to the health questions set forth in the application;
- State that a purchaser of a policy will share in or receive a stated percentage or portion of the earnings on the general account assets of the company;
- State or imply that the policy or combination of policies is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless that is a fact. Enrollment periods may not be described in terms such as "special" or "limited" when the insurer uses successive enrollment periods as its usual method of marketing its policies;
- State or imply that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy;
- Offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the reduced initial premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, all references to the reduced initial premium should be followed by an asterisk or other appropriate symbol that refers the reader to that specific portion of the advertisement that contains the full rate schedule for the policy being advertised;
- Imply licensing beyond limits, if an advertisement is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed;
- Exaggerate, suggest or imply that competing insurers or insurance producers may not be licensed, if the advertisement states that an insurer or insurance producer is licensed in the state where the advertisement appears;
- Create the impression that the insurer, its financial condition or status, the payment of its claims or the merits, desirability or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by any governmental entity. However, where a governmental entity has recommended or endorsed a policy form or plan, that fact may be stated, if the entity authorizes its recommendation or endorsement to be used in the advertisement;
- State or imply that prospective insureds are or become members of a special class, group or quasi-group and enjoy special rates, dividends or underwriting privileges, unless that is a fact; and
- Misrepresent any policy as being shares of stock.

Materials should:

- Clearly disclose the name and address of the insurer;
- If using a trade name, disclose the name of the insurer, insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device or reference, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy;
- Prominently describe the type of policy being advertised;
- Indicate that the product being marketed is insurance;
- Comply with applicable statutes, rules and regulations;
- Cite the source of statistics used;
- Identify the policy form that is being advertised, where appropriate;
- Clearly define the scope and extent of a recommendation by any commercial rating system;
- Only include testimonials, appraisals or analysis if they are genuine, represent the current opinion of the author, are applicable to the policy advertised and accurately reproduced to avoid misleading or deceiving prospective insureds. Any financial interest by the person making the testimonial in the insurer or related entity must be prominently disclosed; and
- Only state or imply endorsement by a group of individuals, society, association, etc., if it is a fact. Any proprietary relationship or payment for the testimonial must be disclosed.

Determine if the company approves producer sales materials and advertising. Ensure that copies of sales material other than company-approved materials, if permitted, are maintained in a central file. Determine if advertisements or lead-generating calls falsely project the image that they were sent by a government agency.

Determine if the advertising and solicitation materials mislead consumers relative to the producer's capacity as an insurance producer. Improper terms may include "financial planner," "investment advisor," "financial consultant" or "financial counseling," if they imply the producer is primarily engaged in an advisory business in which compensation is unrelated to sales, if such is not the case.

Review the use of the words "free," "no cost," "without cost," "no additional cost," "at no extra cost" or words of similar import. Those words should not be used with respect to any benefit or service being made available with a policy, unless it is a fact. If there is no charge to the insured, then the identity of the payor must be prominently disclosed. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the premium or use other appropriate language.

Ensure the advertisement does not contain a statement or representation that premiums paid for a limited long-term care insurance policy can be withdrawn under the terms of the policy. Reference may be made to amounts paid into an advance premium fund, which are intended to pay premiums at a future time, to the effect that they may be withdrawn under the conditions of the prepayment agreement. Reference may also be made to withdrawal rights under any unconditional premium refund offer.

Determine that company procedures and materials relative to limited long-term care products comply with right to return/"free look" requirements.

Review the company and producer's Internet sites with the following questions in mind:

- Does the website disclose who is selling/advertising/servicing for the website?
- Does the website disclose what is being sold or advertised?
- If required by statutes, rules or regulations, does the website reveal the physical location of the company/entity?
- Does the website reveal the jurisdictions where the advertised products are (or are not) approved, or use some other mechanism (including, but not limited to, identifying persons by geographic location) to accomplish an appropriate result?
- For the review of Internet advertisements:

- Run an inquiry with the company's name;
- Review the company's home page;
- Identify all lines of business referenced on the company's home page;
- Research the ability to request more information about a particular product and verify that the information provided is accurate; and
- Review the company's procedures related to producers' advertising on the Internet and ensure that the company requires prior approval of the producers' web pages, if the company name is used.

DRAFT

**STANDARDS  
MARKETING AND SALES**

**Standard 5**

**Company rules pertaining to producer requirements in connection with replacements are in compliance with applicable statutes, rules and regulations.**

**Apply to:** All limited long-term care products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations

\_\_\_\_\_ Replacement register

\_\_\_\_\_ Policy/Underwriting file

\_\_\_\_\_ Loan and surrender files, if applicable

Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

*Life Insurance and Annuities Replacement Model Regulation* (#613), if applicable

Limited *Long-Term Care Insurance Model Regulation* (~~#641~~643)

**Review Procedures and Criteria**

Review policy/underwriting files to determine if producers have identified replacement transactions on applications.

Review replacement register and policy/underwriting files to determine if required disclosure forms have been submitted on replacement transactions.

Review policy/underwriting files to confirm applicant's receipt of replacement notice.

Review replacement disclosure forms for completeness and signatures as required.

**STANDARDS  
MARKETING AND SALES**

**Standard 6**

**Company rules pertaining to company requirements in connection with replacements are in compliance with applicable statutes, rules and regulations.**

**Apply to:** All limited long-term care products

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Replacement register
- \_\_\_\_\_ Policy/Underwriting file
- \_\_\_\_\_ Agency correspondence file/Agency bulletins
- \_\_\_\_\_ Agency procedural manual
- \_\_\_\_\_ Claim files
- \_\_\_\_\_ Agency sales/Lapse records
- \_\_\_\_\_ Company systems manual

**Others Reviewed**

- \_\_\_\_\_
- \_\_\_\_\_

**NAIC Model References**

*Life Insurance and Annuities Replacement Model Regulation* (#613), if applicable  
limited *Long-Term Care Insurance Model Regulation* (~~#641~~643)

**Review Procedures and Criteria**

Determine if the company has advised its producers of its replacement policy.

Determine if the company has separate commission schedules for replacement business, pursuant to applicable state statutes, rules and regulations. Note: Some states limit the compensation payable on replacement business to no more than that payable on renewal policies.

Determine if the company has provided timely notice to the existing insurers of the replacement.

Examine the company system of identifying undisclosed replacements for effectiveness.

Determine if the company has the capacity to produce the data required by replacement regulation to assess producer replacement activity.

Determine if the company has issued letters in a timely manner to policyholders advising of the effects of preexisting conditions on covered benefits.

Review policy/underwriting files to determine if the company is retaining required records for required time frames.

Examine company procedures for verifying producer compliance with requirements on replacement transactions.

Review claim files to determine if the company provides required credit for preexisting conditions or probationary periods on replacements.

DRAFT

## **D. Producer Licensing**

Use the ~~standards for this business area~~ Producer Licensing Standard 2 that ~~are listed~~ is provided in Chapter 20—General Examination Standards.

## **E. Policyholder Service**

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

DRAFT



**STANDARDS  
POLICYHOLDER SERVICE**

**Standard 1**

**Policy renewals are applied consistently and in accordance with policy provisions.**

**Apply to:** All limited long-term care products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

\_\_\_\_\_ Underwriting/Policy file

\_\_\_\_\_ Underwriting/Administrative procedure manuals

Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

*Limited Long-Term Care Insurance Model Regulation (#643)*

**Review Procedures and Criteria**

Review renewal business to determine if the entity's procedures for handling renewals are in accordance with applicable statutes, rules and regulations.

Ensure that individual policies or certificates do not contain renewal provisions other than "guaranteed renewable" or "noncancellable," and that these terms are adequately defined in the policy or certificate.

Review the underwriting/policy file to determine if premium notices were sent in a timely and accurate manner.

Review mailroom records for billings sent by the entity to ensure they were sent in a timely manner.

**STANDARDS  
POLICYHOLDER SERVICE**

**Standard 2**  
**Nonforfeiture upon lapse and reinstatement provisions is applied consistently and in accordance with policy provisions.**

**Apply to:** All limited long-term care products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

\_\_\_\_\_ Underwriting/Administrative files

Others Reviewed

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

Limited Long-Term Care Insurance Model Act (#640642)

Limited Long-Term Care Insurance Model Regulation (#641643)

**Review Procedures and Criteria**

Determine if the required notification of lapse or termination is sent to the proper addressee(s), within the required time frames and that the required information is provided, per applicable statutes, rules and regulations.

Ensure that the entity receives designation of a person(s), other than the insured, to receive notice of lapse or termination of the policy or certificate for nonpayment of premiums or a written waiver by the insured not to designate an additional person(s) to receive notice.

Ensure that the insurer notifies existing insureds of their right to change their written designation at least once every two years, or as specified by state statutes, rules and regulations.

Verify that nonforfeiture and reinstatement provisions were applied consistently and in a non-discriminatory manner. Nonforfeiture provisions upon lapse and reinstatements should be applied per policy provisions and in accordance with applicable statutes, rules and regulations.

Ensure that the policy includes a provision that provides for reinstatement of coverage in the event of lapse, if the entity has provided evidence that the policyholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option should be made available to the insured for a period of 5 months after the date of termination.

**STANDARDS  
POLICYHOLDER SERVICE**

**Standard 3**  
**Nonforfeiture options are communicated to the policyholder and correctly applied in accordance with the policy contract.**

**Apply to:** All limited long-term care products, ~~except life insurance policies or riders containing accelerated benefits as defined in Section 4A of the Long-Term Care Insurance Model Act (#640)~~

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

\_\_\_\_\_ Underwriting/Administrative file

\_\_\_\_\_ Entity procedures manual

Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

Limited Long-Term Care Insurance Model Act (#640642)

Limited Long-Term Care Insurance Model Regulation (#641643)

**Review Procedures and Criteria**

Determine if the entity offers applicants the opportunity to purchase a limited long-term care policy that includes a nonforfeiture benefit, as required by applicable statutes, rules and regulations.

If the applicant declines the nonforfeiture benefit, ensure that the entity provides a contingent benefit upon lapse of the policy for a specified period following a substantial increase in premium rates, as required and defined by applicable statutes, rules and regulations.

Ensure that a policy offered with nonforfeiture benefits contains the same coverage elements, eligibility, benefit triggers and benefit length as a policy without the nonforfeiture benefit.

Determine if the entity provides notice as required by applicable statutes, rules and regulations prior to the due date of the premium reflecting a substantial premium increase.

Ensure that the entity offers the proper nonforfeiture benefit, and nonforfeiture credit ~~and attained age rating~~, as required by applicable statutes, rules and regulations.

Determine if the policy contains the proper time frames for nonforfeiture benefit and the contingent benefit upon lapse, as required by applicable statutes, rules and regulations.

Determine if the correct nonforfeiture option is provided in case of policy lapse.

Review correspondence with policyholders to determine if options were explained adequately.

If there are questions related to nonforfeiture values, refer to applicable statutes, rules and regulations regarding the calculation of nonforfeiture values.

Review the entity's procedures and policies regarding the handling of each type of nonforfeiture transaction (including whether the request may be made verbally).

Ensure that the entity notifies policyowners of material changes to any nonforfeiture benefits in accordance with applicable statutes, rules and regulations.

DRAFT

**STANDARDS  
POLICYHOLDER SERVICE**

**Standard 4**

**Policyholder service for limited long-term care products complies with applicable statutes, rules and regulations.**

**Apply to:** All limited long-term care products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

\_\_\_\_\_ Underwriting/Policy file

\_\_\_\_\_ Underwriting/Administrative procedures manuals

\_\_\_\_\_ Procedure manuals

Others Reviewed

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

Limited Long-Term Care Insurance Model Act (#640642)

Limited Long-Term Care Insurance Model Regulation (#641643)

Unfair Trade Practices Act (#880)

**Review Procedures and Criteria**

~~Verify that the entity issues monthly reports to policyholders, when the long term care benefit is funded through a life insurance vehicle by the acceleration of the death benefit and is in benefit payment status.~~

Verify that the entity offers nonforfeiture benefits.

**F. Appeal of Benefit Trigger Adverse Determination**

Use the standard set forth below.

DRAFT

**STANDARDS**  
**APPEAL OF BENEFIT TRIGGER ADVERSE DETERMINATION**

**Standard 1**

**Insurers shall be in compliance with applicable state statutes, rules and regulations regarding appeal of adverse benefit trigger determination.**

**Apply to:** All limited long-term care insurers

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Company's written procedures explaining administration of appeals process and template denial letters

\_\_\_\_\_ Internal company procedures which describe the appeals process

\_\_\_\_\_ Applicable statutes, rules and regulations

\_\_\_\_\_ Request copies of correspondence on actual claimants who have appealed benefit trigger decisions (e.g., request for appeal, acknowledgement of appeal, appeal outcome communicated) after state statutes, rules and regulations became effective

Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

Limited Long-Term Care Insurance Model Regulation (#641643)

**Review Procedures and Criteria**

Ask insurer how it describes its appeal procedures to the insured.

Ask for copies of correspondence on actual claimants who have appealed benefit trigger decisions (e.g., request for appeal, acknowledgement of appeal, appeal outcome communicated) after state statutes, rules and regulations became effective.

In the event the insurer has determined that the benefit trigger of a limited long-term care insurance policy has not been met, verify that the insurer has provided a clear, written notice to the insured and the insured's authorized representative, if applicable, of all of the following:

- The reason that the insurer determined that the insured's benefit trigger had not been met;
- The insured's right to internal appeal and the right to submit new or additional information relating to the benefit trigger denial with the appeal request within 120 calendar days of receipt of the notice; and
- The insured's right, after exhaustion of the insurer's internal appeal process, to have the benefit trigger determination reviewed under the independent review process to contact their state insurance department and their State Health Insurance Program (SHIP) office.

Ensure that the individual or individuals making the internal appeal decision are not the same individual or individuals who made the initial benefit determination.

Verify that the insurer, within 30 calendar days of the insurer's receipt of all necessary information upon which a final determination can be made, has completed and sent written notice of the internal appeal decision to the insured and the insured's authorized representative, if applicable.

If the insurer's original determination is upheld upon internal appeal, ensure that the notice of the internal appeal decision describes any additional internal appeal rights offered by the insurer.

If the insurer's original determination is upheld after the internal appeal process has been exhausted, and new or additional information has not been provided to the insurer, ~~the insured has the right to contact their state insurance department and their State Health Insurance Program (SHIP) office, pursuant to applicable state statutes, rules and regulations. verify that the insurer has provided a written description of the insured's right to request an independent review of the benefit determination to the insured and the insured's authorized representative, if applicable.~~ *Changes submitted by Mary Lou Moran*

~~If the insurer's original determination is upheld after the internal appeal process has been exhausted, and new or additional information has not been provided to the insurer, the insured has the right to contact their state insurance department and their State Health Insurance Program (SHIP) office, pursuant to applicable state statutes, rules and regulations.~~ *This paragraph removed by Mary Lou Moran*

~~As part of the written description of the insured's right to request an independent review, verify that the insurer has included in the written description of the insured's right to request an independent review of benefit determination the following, or substantially equivalent, language:~~ *This paragraph removed by Mary Lou Moran*

~~"We have determined that the benefit eligibility criteria ("benefit trigger") of your [policy] [certificate] has not been met. You may have the right to an independent review of our decision conducted by long term care professionals who are not associated with us. Please send a written request for independent review to us at [address]. You must inform us, in writing, of your election to have this decision reviewed within 120 days of receipt of this letter. Listed below are the names and contact information of the independent review organizations approved or certified by your state insurance commissioner's office to conduct long term care insurance benefit eligibility reviews. If you wish to request an independent review, please choose one of the listed organizations and include its name with your request for independent review. If you elect independent review, but do not choose an independent review organization with your request, we will choose one of the independent review organizations for you and refer the request for independent review to it."~~ *This paragraph removed by Mary Lou Moran*

~~Examiners should be aware that not all jurisdictions maintain a list of independent review organizations qualified to review long term care benefit trigger decisions, and the language of the above paragraph may have been modified in accordance with state statutes, rules and regulations.~~

~~In the event that the insurer has not considered a benefit trigger decision eligible for independent review, verify that the insurer has informed the insured and the insured's authorized representative, if applicable, and the commissioner in writing and has included in the notice the reasons for its determination of independent review ineligibility.~~

~~Verify that the cost of independent review is borne solely by the insurer.~~

~~Verify that the insurer refers requests to the independent review organization that the insured or the insured's authorized representative has chosen within five business days of receiving a written request for independent review. If the insured or the insured's authorized representative has not chosen an approved independent review organization to perform the review, verify that the insurer has chosen an independent review organization approved or certified by the state. Verify that the insurer varies its selection of authorized independent review organizations on a rotating basis.~~



~~Verify that the insurer refers requests for independent review of a benefit trigger determination to an independent review organization, which may include, but not be limited to the following provisions, subject to applicable state statutes, rules and regulations:~~

- ~~• An independent review organization shall be on a list of certified or approved independent review organizations that satisfy the requirements of a qualified long term care insurance independent review organization; and~~
- ~~• Independent review shall be limited to the information or documentation provided to and considered by the insurer in making its determination, including any information or documentation considered as part of the internal appeal process.~~

~~If the insured or the insured's authorized representative has new or additional information not previously provided to the insurer, whether submitted to the insurer or the independent review organization, ensure that such information is considered first in the internal review process:~~

- ~~• Verify that the insurer completes its review of the information and provides written notice of the results of the review to the insured and the insured's authorized representative, if applicable, and the independent review organization within five business days of the insurer's receipt of such new or additional information; and~~
- ~~• If the insurer maintains its denial after such review, the independent review organization shall continue its review. If the insurer overturns its decision following its review, the independent review request shall be considered withdrawn the consumer may reach out to the State Health Insurance Assistance Program (SHIP). This paragraph removed by Mary Lou Moran~~

~~Verify that the insurer acknowledges in writing to the insured and the insured's authorized representative, if applicable, and the commissioner that a request for independent review was received, accepted and forwarded to an independent review organization for review. Ensure that the notice includes the name and address of the independent review organization. This paragraph removed by Mary Lou Moran~~

~~Verify that if any new or additional information not previously provided to the insurer is submitted by the insured or the insured's authorized representative, the insurer either (1) considers and affirms or (2) overturns its benefit trigger determination. In the event that the insurer affirms its benefit trigger determination, verify that the insurer promptly provides such new or additional information to the independent review organization for its review, along with the insurer's analysis of such information. This sentence removed by Mary Lou Moran~~

~~If the insurer overturns its benefit trigger determination, verify that the insurer has provided notice to the independent review organization and the insured and the insured's authorized representative, if applicable, and the commissioner of its decision. Verify that the independent review process ceased immediately upon receipt of such notice. Changes submitted by Mary Lou Moran~~

~~Verify that the insurer abides by the decision of the independent review organization with respect to whether the insured met the benefit trigger. This sentence removed by Mary Lou Moran~~

~~Ensure that the insurer has not in any way restricted the insured's right to submit a new request for benefit trigger determination after the independent review decision, should the independent review organization uphold the insurer's decision. This sentence removed by Mary Lou Moran~~

## G. Underwriting and Rating

### 1. Purpose

The underwriting portion of the examination is designed to provide a view of how the entity treats the public and whether that treatment is in compliance with applicable statutes, rules and regulations. It is typically determined by testing a random sampling of files and applying various tests to the sampled files. It is concerned with compliance issues. The areas to be considered in this kind of review include:

- Rating practices;
- Underwriting practices;
- Use of correct and properly filed and approved forms and endorsements;
- Termination practices;
- Unfair discrimination;
- Use of proper disclosures, outlines of coverage and delivery receipts;
- Reinsurance; and
- Marketing and sales materials.

### 2. Techniques

During an examination, it is necessary for examiners to review a number of information sources, including:

- Rating manuals and rate cards;
- Underwriting manuals, guidelines and classification manuals;
- Medical underwriting manuals;
- Individual and group issued and renewed policy files;
- Policy summaries;
- Replacement and conservation materials;
- Documentation of required disclosures and delivery receipts;
- Individual and group canceled policy files and certificates;
- Documentation of premium refund upon election of “free look” period;
- Recessions occurring prior to a claim;
- Policy forms, endorsements and applications, along with appropriate filings;
- Producer licensing information;
- Producer compensation agreements, where applicable;
- Premium statements and billing statements;
- Group trust arrangements, where applicable;
- Declined applications and notices;
- Individual and group lapsed policy files and notices;
- Individual and group nonforfeiture files and notices;
- Reinsurer policies/treaties; and
- Reinsurer guidelines and manuals.

For the purposes of this chapter, “underwriting file” means the file or files containing the new business application, renewal application, certificates or evidences of coverage, including binders, rate calculation sheets, billings, medical information, credit information, inspection or interview reports, all underwriting information obtained or developed, policy summary page, endorsements, cancellation or reinstatement notices, correspondence and any other documentation supporting selection, classification, rating or termination of the policy.

In selecting samples for testing, individual policies should generally not be combined with group policies. Because these two areas are generally not homogeneous, any conclusions or inferences made from the results of sampling may not be valid if combined. The examiner should be familiar with the process for gathering and processing underwriting information and the quality controls for the issuance of policies, endorsements and premium statements. The list of files from which a sample is to be drawn may be generated through a computer run or, in some cases, through a policy register covering the period of time selected in the notice of the examination.

Next, determine the entity's policy population (policy count) by line of business. Review a random selection of business for application of a particular test or apply specific tests to a census population using automated tools. (In the event specific files are chosen for a target review, the examiner must be certain that the examination results are clearly identified as representative of the target selection.) The examiner should maintain a list of the various tests to be applied to each file in the sample. This will aid in consistency by ensuring that each test is considered for each file in the sample.

If exceptions are noted, the examiner must determine if the exception is caused by such practices as the use of faulty automated rating systems, or the development and use of improperly or vaguely worded manuals or guidelines. When exceptions are noted, it is advisable to determine the scope and extent of the problem. The examiner's responses should maximize objectivity; the examiner should avoid replacing examiner judgment for entity judgment.

a. Rating Practices

It is necessary to determine if the entity is in compliance with rating systems that have been filed with and, in some cases, approved by the insurance department. Where rates are not required to be filed with an applicable regulatory agency, it is prudent to determine if rates are being applied consistently and in accordance with the entity's own rating methods. In general, rates should not be unfairly discriminatory. Wide-scale application of incorrect rates by an entity might raise financial solvency questions or be indicative of inadequate management oversight. Deviation from established rating plans might also indicate that an entity is engaged in unfair competitive practices. Inconsistent application of rates or classifications can result in unfair discrimination.

If rating exceptions are noted, the examiner must determine if the exception is caused by such practices as the use of faulty automated rating systems or the use of improperly worded, vague or obsolete rating manuals. When exceptions are noted, it is advisable to determine the scope and extent of the problem.

Occasionally, the examiner may need to review loss statistics to determine if premiums are fair and reasonable in relation to the associated claims experience. When possible, the examination team should make use of audit software to verify the correct application of specific rating components and the consistent use of rates. This allows for a more thorough review and can save time during the examination process. All new automated audit applications that are developed should be submitted to the NAIC File Repository, in order to assist in building a comprehensive set of audit programs.

The rating practices for renewal policies and newly issued policies should be reviewed. The examination team should also review premium notices and billing statements. The examiner should ensure the proper application of rate increases or rate decreases.

The examiner should also ensure that the underwriting files contain sufficient information to support the rates that have been developed.

b. Underwriting Practices

The examiner should review relevant underwriting information; e.g., the entity's underwriting manuals, underwriting guidelines, underwriting bulletins, declination procedures, agency agreements and correspondence with producers. Interoffice memoranda and entity minutes that may furnish evidence of anti-competitive behavior may also be requested. In addition to reviewing the content of the above information for indications of unfairly discriminatory practices, the examination team also should use the above information to determine the entity's compliance with its own manuals and guidelines. The examiner should confirm that the entity's underwriters and producers consistently apply the entity guidelines for all business selected or rejected. The examination team should verify that the entity has correctly classified insured individuals.

File documentation should be sufficient to support the underwriting decisions made. Underwriting decisions that are adequately documented generally afford the entity's management team with the opportunity to know what business it has selected through its underwriters and producers. The examiner should verify that properly licensed and appointed (where applicable) producers have been used in the production of the business. Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each applicable field office.

Any practice suggesting anti-competitive behavior may involve legal considerations that should be referred to the insurance department's counsel. Ultimately, the information obtained may be useful in drafting legislation or regulations.

c. Use of Correct and Properly Filed Forms and Endorsements

The examination team should verify that all policy forms and endorsements used have been filed with the appropriate regulatory authority, if applicable. In addition, the examination team should verify the consistent and correct use of policy forms and endorsements. The examiner should be mindful of possible outdated forms or endorsements. If coverage and riders requested by the applicant are not issued, proper notification should be provided to the applicant. In some cases, supplemental applications are appropriate.

d. Termination Practices

The examination team should review the entity's policy cancellation and reinstatement practices to determine compliance with applicable statutes, rules and regulations, as well as to determine compliance with the entity's own rules, guidelines and policy provisions.

Cancellation and lapsed policy processing should include a formal notice to the insured, including secondary addressees, where elected by the insured. Adherence to policy provisions for renewal language and for applicable grace periods should be reviewed.

The examination team should verify that premium refunds upon election of "free look" provisions are handled correctly, uniformly and in a timely manner.

The examination team should review reinstatement offers and determine what the entity's practice is for offering reinstatement. In addition, the examination team should be mindful of billing practices that may encourage policy lapses.

e. Unfair Discrimination

The examination team should be mindful of entity underwriting practices that may be unfairly discriminatory. The classification of insureds into rating or underwriting groups must be based on sound business or actuarial principles. Failure to follow established rating and underwriting guidelines may result in unintentional, yet unfair discrimination. Unfair trade practice acts and related regulatory rules adopted by the applicable jurisdiction also may prohibit specific underwriting practices.

f. Use of Proper Disclosures, Buyer's Guides and Outlines of Coverage

The examination team should review the entity's use of required disclosure forms, buyer's guides, policy summaries, replacement notices, "free look" periods and outlines of coverage. In addition to the use of such required items, the examiner may wish to verify that the above items contain the correct content and are in the correct format.

g. Reinsurance

Most state statutes include a feature that for many lines of business the entity is not permitted to place more than 10 percent of its surplus to policyholders at risk on any one placement of insurance. While this is primarily a solvency issue, it is one that market conduct examiners are in an ideal position to test in view of the sampling of underwriting files.

Adherence to the requirement is easy to test, but requires familiarity with the structure and content of the reinsurance treaties covering the business written by the entity. This item is particularly important for companies that hold minimal policyholder surplus accounts (i.e., surplus of less than \$10 million). It also may reflect on the care that the entity's management places on its selection of business, and represent a danger to the financial health of the entity. Errors in this area should be forwarded to the appropriate state financial examiners. Any tests of this type must be coordinated with the state's financial examiners.

h. Marketing and Sales Materials

It is recommended that a review of all forms and materials be conducted by reviewing the marketing and sales standards simultaneously during the underwriting and rating review.

### 3. Tests and Standards

The underwriting and rating review includes, but is not limited to, the following standards addressing various aspects of the entity's underwriting activities. The sequence of the standards listed here does not indicate priority of the various standards.

**STANDARDS  
UNDERWRITING AND RATING**

**Standard 1**

All mandated definitions and requirements for group limited long-term care insurance are followed in accordance with applicable statutes, rules and regulations.

**Apply to:** All group limited long-term care products

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Underwriting files
- \_\_\_\_\_ Rating/Quote information provided electronically
- \_\_\_\_\_ Marketing materials
- \_\_\_\_\_ Correspondence to producers

**Others Reviewed**

- \_\_\_\_\_
- \_\_\_\_\_

**NAIC Model References**

Limited Long-Term Care Insurance Model Act (#640642)

Limited Long-Term Care Insurance Model Regulation (#641643)

**Review Procedures and Criteria**

If a group policy is issued to an employer or labor organization or association, determine if the group meets the required criteria to qualify the association or organization as a bona fide organization established for the benefits of its members.

Determine if all group limited long-term care policies offered in one state and issued in another state comply with applicable extraterritorial jurisdiction statutes, rules and regulations.

Ensure that any group limited long-term care policy standard provisions that are applicable in the examining jurisdiction are incorporated into the group policy. These provisions include, but are not limited to, grace periods, periods of incontestability, required copies of applications, deemers of representations and not warranties, medical or other evidence of insurability, provision for a certificate of insurance and conversion to an individual policy in the event of termination or total disability.

~~Ensure that when a group long term disability policy is replaced by another policy, the succeeding carrier offers coverage to all persons covered under the previous group policy on its date of termination and that the coverage and premium amounts meet the requirements of applicable statutes, rules and regulations.~~

**STANDARDS  
UNDERWRITING AND RATING**

**Standard 2**

**Pertinent information on applications that form a part of the policy is complete and accurate, and applications conform to applicable statutes, rules and regulations.**

**Apply to:** All limited long-term care products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

\_\_\_\_\_ All applications

Others Reviewed

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

**Review Procedures and Criteria**

Determine if the requested coverage is issued.

Determine if the entity has a verification process in place to determine the accuracy of application information.

Verify that applicable nonforfeiture options and inflation protection options are indicated on the application.

Verify that changes to the application and supplements to the application are initialed by the applicant.

Verify that supplemental applications are used, where appropriate.

Determine if the application complies with applicable statutes, rules and regulations regarding form and content.

**STANDARDS  
UNDERWRITING AND RATING**

**Standard 3**

**The entity complies with specific requirements for AIDS-related concerns in accordance with applicable statutes, rules and regulations.**

**Apply to:** All limited long-term care products

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Applications and related disclosure and consent forms
- \_\_\_\_\_ Health questionnaires for applicants
- \_\_\_\_\_ Medical underwriting guidelines
- \_\_\_\_\_ Entity guidelines regarding the handling of AIDS-related test results, if such tests are allowed

**Others Reviewed**

- \_\_\_\_\_
- \_\_\_\_\_

**NAIC Model References**

*Limited Long-Term Care Insurance Model Regulation (#643)*

**Review Procedures and Criteria**

Ensure the entity does not use medical records indicating AIDS-related concerns to discriminate against applicants without medical evidence of disease. Companies shall establish reasonable procedures related to the administration of an AIDS-related test.

Medical underwriting guidelines may consider factual matters that reveal the existence of a medical condition. For example, no adverse underwriting decision shall be based on medical records that only indicate the applicant demonstrated AIDS-related concerns by seeking counseling from a health care professional.

Disclosure forms signed by the applicant must clearly disclose the requirement, if any, for applicants to take an AIDS-related test, and should be a part of the underwriting file. Applications must contain a consent form for such testing.

Review any application forms and health questionnaires used by the entity or its producers for questions that would require the applicant to provide information regarding sexual orientation.

Questions may ask if the applicant has been diagnosed with AIDS or ARC, if they are designed to establish the existence of the condition, but are not to be used as a proxy to establish sexual orientation of the applicant.



Ensure the entity or insurance support organization does not use the sexual orientation of an applicant in the underwriting process or in the determination of insurability.

Underwriting guidelines must not consider an applicant's sexual orientation a factor in the determination of insurability.

Review a sample of underwriting files for denied applications in order to verify that denials were non-discriminatory.

Review inspection reports to determine if they are being used in a discriminatory manner, or ordered on the basis of the entity guidelines (e.g., based on the amount of insurance).

Neither the marital status, the living arrangements, the occupation, gender, medical history, beneficiary designation, nor the ZIP code or other territorial classification may be used to establish the applicant's sexual orientation.

DRAFT

**STANDARDS  
UNDERWRITING AND RATING**

**Standard 4**

**Policies, riders, amendments, endorsements, applications and certificates of coverage contain required provisions, definitions and disclosures.**

**Apply to:** All limited long-term care products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

\_\_\_\_\_ Underwriting/Administration file

\_\_\_\_\_ Policies, riders, amendments, endorsements, applications and certificates of coverage

**Others Reviewed**

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

*Limited Long-Term Care Insurance Model Act (#640642)*

*Limited Long-Term Care Insurance Model Regulation (#641643)*

**Review Procedures and Criteria**

Determine if the policy contains the required terms and definition of such terms per applicable statutes, rules and regulations, including, but not limited to:

- Guaranteed renewable and noncancellable;
- Activities of daily living, acute condition, adult day care, bathing, cognitive impairment, continence, dressing, eating, hands-on assistance, home health care services, Medicare, mental or nervous disorder, personal care, skilled nursing care, toileting and transferring; ~~and~~ In addition, coverage specific to limited long-term care benefits may include non-skilled nursing care by providers of service, 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; and
- Reasonable and customary/usual and customary.

Determine if riders and endorsements added after the original date of issue, at reinstatement or renewal that reduce or eliminate benefits or coverage (except as requested by the insured) require signed acceptance by the insured.

Ensure that the entity has not established a new waiting period in the event existing coverage is converted or replaced by a new or other form within the same entity, except with respect to an increase in benefits voluntarily selected by the individual or group policyholder.

Ensure that the entity does not apply preexisting condition provisions more restrictive than "...a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services

within 6 months preceding the effective date of coverage of an insured person,” unless the insurance commissioner has extended limitation periods.

A limited long-term care insurance policy or certificate, other than a policy or certificate issued to a defined group, may not exclude coverage for a loss or confinement that is the result of a preexisting condition, unless such loss or confinement begins within 6 months following the effective date of coverage of an insured person.

A limited long-term care insurance policy or certificate may not exclude or use riders or waivers to exclude, limit or reduce benefits for specifically named or described preexisting conditions or physical conditions beyond the defined waiting period.

Determine if the policy meets the requirements under applicable statutes, rules and regulations with regard to prior hospitalization/institutionalization. The policy may not:

- Condition eligibility of any benefits on a prior hospitalization requirement, or, in the case of benefits provided in an institutional care setting, on the receipt of a higher level of institutional care;
- Condition eligibility for benefits (other than waiver of premium, post-confinement, post-acute care or recuperative benefits) on a prior institutionalization requirement;
- Condition eligibility of non-institutional benefits based on the prior receipt of institutional care on a prior institutional stay of more than 30 days; and
- Condition the receipt of benefits following institutionalization upon admission to a facility for the same or related conditions within a period of less than 30 days after discharge.

A policy or rider containing post-confinement, post-acute care or recuperative benefit shall contain in a separate paragraph titled “Limitations or Conditions on Eligibility for Benefits” such limitations or conditions, including any required number of days of confinement.

Determine if the policy contains any limitations regarding preexisting conditions, and, if so, ensure that they are outlined in a separate paragraph titled “Preexisting Condition Limitations.”

Ensure that the policy measures the need for limited long-term care on the activities of daily living (ADLs) and cognitive impairment, and that they are described—along with any additional benefit triggers, benefits and entity-required certification of functional dependency—in a separate paragraph titled “Eligibility for the Payment of Benefits.”

If a limited long-term care policy provides benefits for home health care or community care services, ensure that it meets the required minimum standards required by applicable statutes, rules and regulations.

**STANDARDS  
UNDERWRITING AND RATING**

**Standard 5**  
**Underwriting and rating for limited long-term care products complies with applicable statutes, rules and regulations.**

**Apply to:** All group limited long-term care products

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
- \_\_\_\_\_ Policy contract
- \_\_\_\_\_ Notice of cancellation/nonrenewal
- \_\_\_\_\_ Insurance department approval of forms
- \_\_\_\_\_ Underwriter's file or notes on a system log
- \_\_\_\_\_ Insured's request (if applicable)
- \_\_\_\_\_ Entity cancellation/nonrenewal guidelines
- \_\_\_\_\_ Certificate of mailing

**Others Reviewed**

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

Limited Long-Term Care Insurance Model Act (#640642)

Limited Long-Term Care Insurance Model Regulation (#641643)

**Review Procedures and Criteria**

Determine if the notice of cancellation/nonrenewal was valid according to policy provisions and applicable statutes, rules and regulations.

Review entity procedures for cancellation/nonrenewal to determine if the entity is following its own guidelines.

Review cancellation and billing notices, grace period descriptions, reinstatement offers, lapse notices, etc., to ensure the forms, if necessary, were approved by the insurance department.

In addition to other applicable review procedures, verify the following:

- The entity has not cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificateholder;
- The entity has not established a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same entity, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder;
- The entity does not provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care; and
- The entity does not apply preexisting condition provisions more restrictive than "...a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within 6 months preceding the effective date of coverage of an insured person," unless limitation periods have been extended by the insurance commissioner.

Verify that standards for incontestability periods are no more restrictive than as follows:

- Within 6 months, misrepresentations must be material;
- Within 2 years and more than 6 months, misrepresentation must be material and pertain to the condition for which benefits are sought; and
- After 2 years, benefits are contestable only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

Verify that the entity's underwriting practices reflect minimum requirements related to guaranteed renewability, noncancellability and continuation or conversion.

Replacement of a group limited long-term care policy with another group limited long-term care policy shall offer coverage to all persons covered under the previous group policy on its date of termination, with no preexisting condition exclusions that would have been covered on the prior policy and shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of limited long-term care services.

Verify that the entity provides notice to the designated person, in addition to the applicant, for termination of a policy or certificate for nonpayment of premium.

Verify that the entity allows for reinstatement of coverage in the event of lapse if 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.

Verify that prior to issuance of a limited long-term care policy or certificate to an applicant age 80 or older, the insurer obtains one of the following:

- A report of a physical examination;
- An assessment of functional capacity;
- An attending physician's statement; or
- Copies of medical records.

Verify that the entity delivers a copy of the completed application or enrollment form (whichever is applicable) 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.

Verify that the entity maintains a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated. The entity shall annually furnish this information to the insurance commissioner in the format prescribed by applicable statutes, rules and regulations.

Verify that the premium charged does not increase due to increase of age beyond 65 or the duration the insured has been covered under the policy.

**STANDARDS  
UNDERWRITING AND RATING**

**Standard 6**

**The company's underwriting practices are not unfairly discriminatory. The company adheres to applicable statutes, rules and regulations and company guidelines in the selection of risks.**

**Apply to:** All limited long-term care products

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ New business application
- \_\_\_\_\_ All underwriting information obtained
- \_\_\_\_\_ Company underwriting guidelines and bulletins
- \_\_\_\_\_ Declination procedures
- \_\_\_\_\_ Agency agreements and correspondence with producers
- \_\_\_\_\_ Riders or extensions of coverage
- \_\_\_\_\_ Interoffice memoranda and company minutes
- \_\_\_\_\_ Policy specifications page
- \_\_\_\_\_ Underwriter's file or notes on a system log

**Others Reviewed**

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

- Insurance Fraud Prevention Model Act (#680)*
- Limited Long-Term Care Insurance Model Act (#641642)*
- Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basis of Physical or Mental Impairment (#887)*
- Model Regulation on Unfair Discrimination on the Basis of Blindness or Partial Blindness (#888)*
- Unfair Discrimination Against Subjects of Abuse in Life Insurance Model Act (#896)*
- Unfair Trade Practices Act (#880)*
- Credit Reports and Insurance Underwriting White Paper*

## Review Procedures and Criteria

Ensure the file documentation adequately supports the decisions made:

- The application should be complete and signed;
- Determine when, and under what conditions the company requires motor vehicle reports, inspection reports, credit reports, Medical Information Bureau (MIB) or other medical physician reports or other underwriting information to confirm exposure or premium basis;
- Determine if the file contains the necessary information to support the classification, rating and selection decision made; and
- Verify that when a policy is issued on a basis other than applied for, that notice of an adverse underwriting decision is provided in accordance with applicable statutes, rules and regulations.

Review relevant underwriting information to ensure that no unfair discrimination is occurring, according to the state's definition of unfair discrimination.

Determine if the company is following its underwriting guidelines, and that the guidelines conform to applicable statutes, rules and regulations, including, but not limited to:

- The insurer shall obtain one of the following prior to issuance of a policy or certificate to an applicant aged 80 or older:
  - A report of physical examination;
  - An assessment of functional capacity;
  - An attending physician's statement; or
  - Copies of medical records.
- All applications for limited long-term care, except policies issued on a guaranteed-issue basis, shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant; and
- If an application for limited long-term care coverage contains a question regarding whether the applicant has had medication prescribed by a physician, the company shall also ask the applicant to list the medication.

Determine if the company underwriting guidelines have been filed, where applicable.

Review interoffice memoranda for evidence of anti-competitive behavior, collusive practices or improper replacement tactics.

Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each office being examined.

Inconsistent handling of rating or underwriting practices, even if not intentional, can result in unfair discrimination. Companies may not permit discrimination between individuals of the same class and equal health status.

Ensure that underwriting requirements are not applied in an unfairly discriminatory manner.

Review guaranteed-issue criteria to ensure correct handling.

Review policy provisions for skilled nursing care to ensure that no restrictions are placed on the proper level of care; i.e., the company does not provide only skilled nursing care or does not provide more coverage for skilled care in a facility than coverage for lower levels of care.

Verify that the questions on applications are sufficiently clear and applicable to the coverage being requested.

Verify that Medical Information Bureau (MIB) information is not used as the sole basis for an underwriting decision.

Companies may not refuse to insure, continue to insure or limit coverage based on:

- Sex;
- Marital status;
- Race;
- Religion;
- National origin;
- Physical or mental impairment (except where based on sound actuarial principles or actual or reasonably anticipated experience);
- Blindness or partial blindness only\* (however, all other conditions, including the underlying cause of the blindness or partial blindness, are subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as a sighted person); and
- Abuse status.

\*Note: Review individual state statutes, rules and regulations that may provide that an insurer may not refuse to insure, refuse to continue to insure or limit the amount, extent or kind of coverage available to an individual solely because of blindness or partial blindness.

Many jurisdictions have enacted legislation regarding subjects of abuse. Examiners should be familiar with their statutes, rules and regulations in this area.

Examine new business applications for the required fraud statement.



## **H. Claims**

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

DRAFT

**STANDARDS  
CLAIMS**

**Standard 1**

**Claim files are handled in accordance with policy provisions and applicable statutes, rules and regulations.**

**Apply to:** All limited long-term care products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

\_\_\_\_\_ Company claim procedure manuals

\_\_\_\_\_ Claim training manuals

\_\_\_\_\_ Internal company claim audit reports

\_\_\_\_\_ Insured's requests (if applicable)

\_\_\_\_\_ Claim bulletins and procedure manuals

\_\_\_\_\_ Company claim forms manual

\_\_\_\_\_ Claim files

Others Reviewed

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

*Insurance Fraud Prevention Model Act (#680)*

*Limited Long-Term Care Insurance Model Act (#640642)*

*Unfair Claims Settlement Practices Act (#880)*

*Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)*

*Limited Long-Term Care Insurance Model Regulation (#643)*

**Review Procedures and Criteria**

Review company procedures, training manuals and claim bulletins to determine if company standards exist and whether standards comply with state statutes. Determine if company procedures provide for the detection and reporting of fraudulent or potentially fraudulent insurance acts to the insurance commissioner.

Determine if claim handling meets applicable statutes, rules and regulations, including:

- Correct payees and addresses; and
- Correct benefit amounts.

Ascertain whether the company has misrepresented relevant facts or policy provisions relating to coverages at issue.

Determine if claim files are handled according to policy provisions.

If a claim under a limited long-term care insurance contract is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificateholder, or a representative thereof:

- Provide a written explanation of the reasons for the denial; and
- Make available all information directly related to the denial.

Determine if the insurer is in compliance with proper payment of “clean claims,” as defined in applicable state statutes, rules and regulations. Verify that the insurer pays clean claims within 30 business days after receipt of a clean claim. For claims that do not fall within the category of a clean claim, verify that the insurer has sent a written notice acknowledging the date of receipt of the claim and containing one of the following provisions within 30 business days:

- The insurer has declined to pay all or part of the claim and the specific reason(s) for denial; or
- That additional information is necessary to determine if all or any part of the claim is payable and the specific additional information that is necessary.

Verify that the insurer has paid clean claims within 30 business days after receipt of all requested additional information, or has sent a written notice that the insurer has declined to pay all or part of the claim within 30 days. The notice should specify the specific reason(s) for denial.

If, upon review of insurer clean claim payment practices, an examiner determines that an insurer has failed to comply with clean claim requirements, verify that the insurer has paid interest at the rate of one percent per month on the amount of the claim that should have been paid but that remains unpaid 45 business days after the receipt of the claim or, in the event the insurer has requested additional information, upon receipt of all requested additional information.

Verify that the insurer has included interest payable in any late reimbursement without requiring the individual who filed the original claim to make any additional claim for such interest.

It is an unfair practice to settle, or attempt to settle, a claim on the basis of an application that was materially altered without the consent of the insured.

Confirm that a monthly report is issued to the policyholder whenever limited long-term care benefits are issued through acceleration of death benefit provisions of a life insurance product.

Confirm that mandatory nonforfeiture benefits are offered.

Determine that eligibility for the payment of benefits is based on a deficiency in the ability to perform not more than 3 of the activities of daily living (ADLs) or the presence of cognitive impairment.

Ensure that determination of deficiency is not more restrictive than:

- Requiring the hands-on assistance of another person to perform the prescribed ADLs; and
- For a cognitive impairment, supervision or verbal cueing by another person is needed to protect the insured or others.

Ensure that licensed or certified professionals, such as physicians, nurses or social workers, perform assessments of ADLs and cognitive impairment.

G:\MKTREG\DATA\D Working Groups\D WG 2019 MCES (PCW)\Docs\_WG Calls 2019\Limited LTC\Chapter26A\_Limited\_LTC\_Chapter 12-11-19.doc

**To: Petra Wallace**

**From: Reva Vandevoorde**

**Date: December 3, 2019**

**Re: Chapter 26A Limited Long-Term Care Chapter**

**COMMENTS:**

I have reviewed the proposed draft of Chapter 26A Limited Long-Term Care Chapter and would offer the following comments:

Add the word "limited" in front of all long-term care words. Do a word search for long-term care and add limited.

On page 6, Marketing and Sales, Standard 1, under the Review Procedures and Criteria, the third paragraph should end after limited long-term care insurance.

On page 7, remove the bullet point and start as a new paragraph.

Also on page 7, do we need to state "Note: Pursuant to Section 24A of the Long-Term Care Insurance Model Regulations", if this chapter is addressing Limited Long-Term Care? I would recommend deleting this.

On page 25, Appeal of Benefit Trigger Adverse Determination, Standard 1, I found the Review Procedures and Criteria to be extremely confusing. Beginning with the last bullet point of the third paragraph. It appears to have been revised to "The insured's right, after exhaustion of the insurer's internal appeal process, to have the benefit trigger determination to contact their state insurance department and their State Health Insurance Program (SHIP) office." Does not make sense. With the deletion of "reviewed under the independent review process", does this mean that the insured does not have the right to an independent review process?

The third paragraph on page 26 looks like it was rewritten and not deleted. (See fourth paragraph underlined and in blue ink) The next paragraph states that the insured does have a right to request an independent review. Why was that previously deleted if the insured does have the right to an independent review? I am confused at this point. Should this be left in or removed?

On page 27, the second paragraph continues with stating that the examiners should verify that the insurer acknowledges that the commissioner received, accepted and forwarded to an independent review organization requests for independent review requests. This discussion continues in the following paragraphs. This section needs to be looked at and possibly be rewritten or at least be better explained for the examiners.

G:\MKTREG\DATA\D Working Groups\D WG 2019 MCES (PCW)\Docs\_WG Calls 2019\Limited LTC\Comments Received\NE 12-03-19  
Comments.docx