Part3 Chapter 8: (90-102) Long-Term Care Insurance Regulation.

Rule 8.01: Purpose

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

Source: *Miss Code Ann* §83-5-1 (Rev. 2011)

Rule 8.02: Authority

This regulation is issued pursuant to the authority vested in the Commissioner under Miss. CodeAnn. Section 83-5-1 and Sections 83-5-29 through 83-5-51 (1972), as Amended, and other applicable provisions of the Mississippi Insurance Laws and is being adopted in accordance with the provisions of Miss Code Ann. Chapter 43, Title 25, and Mississippi Insurance Department Regulation Number 88-101, said regulation being the Rules of Practice and Procedure before the Mississippi Insurance Department.

Source: *Miss Code Ann* §§83-5-1; 83-5-29 (Rev. 2011)

Rule 8.03: Applicability and Scope

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

Source: *Miss Code Ann* §83-5-1 (Rev. 2011)

Rule 8.04: Definitions

For the purpose of this regulation, the following terms shall have the following meanings:

A. "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, or maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Long-term

care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset –protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

B. "Applicant" means:

1. In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits, and

2. In the case of a group long-term care insurance policy, the proposed certificate holder.

C. "Certificate" means, for the purposes of this Regulation, any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

D. "Commissioner" means the Insurance Commissioner of this state.

E. "Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this state and issued to:

1. One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations; or

2. Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:

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

    b. has been maintained in good faith for purposes other thanobtaining insurance; or

3. An association or a trust or the trustee(s) of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence

with the Commissioner that the association or associations have at the outset a minimum of 100 persons and have been organized and maintained in good faith for purposes other than that of obtaininginsurance, have been in active existence for at least one year; and have a constitution and bylaws which provide that:

a. The association or associations hold regular meetings not less than annually to further purposes of the members;

b. Except for credit unions, the association or associations collect dues or solicit contributions from members; and

c. The members have voting privileges and representation on the governing board and committees.

d. Thirty (30) days after such filing the association or associations will be deemed to satisfy such organizational requirements, unless the Commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

4. A group other than as described in Subsections E(1), E(2) and E(3), subject to a finding by the Commissioner that:

a. The issuance of the group policy is not contrary to the best interest of the public;

b. The issuance of the group policy would result in economies of acquisition or administration; and

c. The benefits are reasonable in relation to the premiums charged.

F. "Policy" means, for the purposes of this Regulation, any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this state by an insurer; fraternal benefit society; nonprofit health, hospital, or medical service corporation; prepaid health plan; health maintenance organization or any similar organization.

Source: *Miss Code Ann* §83-5-1 (Rev. 2011)

Rule 8.05: Policy Definitions

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

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

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

C. “Medicare” shall be defined as “The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as “Then Constituted or Later Amended”, or “Title I, Part 1 of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof”, or words of similar import.

D. .“Mental or nervous disorder” shall no be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

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

F. All providers of services, including but not limited to “skilled nursing facility”, “extended care facility”, “intermediate care facility”, “convalescent nursing home”, “personal care facility”, and “home care agency” shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

Source: *Miss Code Ann* §83-5-1 (Rev. 2011)

Rule 8.06: Disclosure and Performance Standards for Long-Term Care Insurance

A. No long-term care insurance policy may:

1. Be cancelled, non-renewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insuredindividual or certificateholder; or

2. Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

3. Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lowerlevels of care.

B. Pre-existing condition:

1. No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4E(1) of this

Regulation shall use a definition of "preexisting condition" which is more restrictive than the following: Preexisting condition means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six (6) months preceding the

effective date of coverage of an insured person.

2. No long-term care insurance policy or certificate other than a policy orcertificate thereunder issued to a group as defined in Section 4E(1) mayexclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six (6) months following the effective date of coverage of an insured person.

3. The Commissioner may extend the limitation periods set forth in Sections 6B (1) and (2) above as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

4. The definition of "preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in Section 6B(2) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in Section 6B(2).

C. Prior hospitalization/institutionalization:

1. No long-term care insurance policy may be delivered or issued for delivery in the State if such policy:

    a. Conditions eligibility for benefits on a prior hospitalizationrequirement;

    b. Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

    c. Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care or recuperativebenefits on a prior institutionalization requirement.

2. a. A long-term care insurance policy containing post-confinement, post acute care or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits" such limitations or conditions, including any required number of days of confinement.

    A long-term care insurance policy or rider which conditions eligibility of non-institutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty (30) days.

D. Right to return-free look:

Long-term care insurance applicants shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined under Section 4(E)1 of the Regulation, the applicant is not satisfied for any reason.

E. 1. An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

    a. In the case of agent solicitations, the outline of coverage must

be presented in conjunction with any application or enrollment form.

b. In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

2. The outline of coverage shall include:

a. A description of the principal benefits and coverage provided in the policy;

b. A statement of the principal exclusions, reductions, and limitationscontained in the policy;

c. A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including anyreservation in the policy of a right to change premium. Continuation or conversation provisions of group coverage shall be specifically described.

d. A statement that the outline of coverage is a summary only, nota contract of insurance, and that the policy or group master policycontain governing contractual provisions;

e. A description of the terms under which the policy or certificate may be returned and premium refunded; and

f. A brief description of the relationship of cost of care and benefits.

F. A certificate issued pursuant to a group long-term insurance policy which policy is delivered or issued for delivery in this state shall include:

1. A description of the principal benefits and coverage provided in the policy.

2. A statement of the principal exclusions, reductions and limitations contained in the policy; and

3. A statement that the group master policy determines governing contractual provisions.

G. At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery, In addition to complying with all applicable requirements, the summary shall also include:

1. An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

2. An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits, if any, for each covered person:

3. Any exclusions, reductions and limitations on benefits of long-term care: and

4. If applicable to the policy type, the summary shall also include:

    a. A disclosure of the effects of exercising other rights under the policy;

    b. A disclosure of guarantees related to long-term care cost of insurance charges; and

    c. Current and projected maximum lifetime benefits.

H. Any time a long-term care benefit, funded through a life insurance vehicle bythe acceleration of the death benefit, is in benefit payment status, a monthlyreport shall be provided to the policyholder. Such report shall include:

1. Any long-term care benefits paid out during the month;

2. An explanation of any changes in the policy, e.g. death benefits or cashvalues, due to long-term care benefits being paid out; and

3. The amount of long-term care benefits existing or remaining.

I. .Any policy or rider advertised, marketed or offered as long-term care or nursing home insurance shall comply with the provisions of this Regulation.

Source: *Miss Code Ann* §83-5-1 (Rev. 2011)

Rule 8.07: Policy Practices and Provisions

A. Renewability. The terms “guaranteed renewable” and “noncancellable” shall not be used in any individual long-term care insurance policy without further explanatorylanguage in accordance with the disclosure requirements of Section 8 of this Regulation.

1. No such policy issued to an individual shall contain renewal provisions lessfavorable to the insured than “guaranteed renewable”. However, the Commissioner may authorize nonrenewal on a statewide basis, on terms and conditions deemed necessary by the Commissioner, to best protect the interests of the insureds, if the insurer demonstrates:

    a. That renewal will jeopardize the insurer’s solvency; or

    b. That:

        i. The actual paid claims and expenses have substantially exceeded thepremium and investment income associated with the policies; and

        ii. The policies will continue to experience substantial and unexpectedlosses over their lifetime; and

        iii. The projected loss experience of the policies cannot be significantlyimproved or mitigated through reasonable rate adjustments or otherreasonable methods; and

        iv. The insurer has made repeated and good faith attempts to stabilize lossexperience of the policies, including the timely filing for rate adjustments.

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

3. The term “noncancellable” may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of

premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

B. Limitations and Exclusions. No policy may be delivered or issued for delivery inthis state as long-term care insurance if such policy limits or excludes coverage bytype of illness, treatment, medical condition or accident, except as follows:

1. Preexisting conditions or diseases;

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

3. Alcoholism and drug addiction;

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

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

   b. Participation in a felony, riot or insurrection;

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

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

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

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

6. This Subsection B is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

C. Extension of Benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continueswithout interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited tothe duration of the benefit period, if any, or to payment of

the maximum benefitsand may be subject to any policy waiting period, and all other applicable provisions of the policy.

D. Continuation or Conversion.

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

2. For the purposes of this section, “a basis for continuation of coverage” means a policy provision which maintains coverage under the existinggroup policy when such coverage would otherwise terminate and whichis subject only to the continued timely payment of premium when due.Group policies which restrict provision of benefits and services to, orcontain incentives to use certain providers and/or facilities may provide continuation benefits which are substantially equivalent of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, providersystem arrangements, service availability, benefit levels and administrative complexity.

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

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

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

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

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

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

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

        i. Providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

        ii. The premium for which is calculated in a manner consistent with the requirements of Paragraph (6) of this section.

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

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

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

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

Source: *Miss Code Ann* §83-5-1 (Rev. 2011)

Rule 8.08: Required Disclosure Provisions

A. Renewability. Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for whichthe policy is issued and for which it may be renewed. This provision shall notapply to policies which do not contain a renewability provision, and under whichthe right to non-renew is reserved solely to the policyholder.

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

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

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

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

Source: *Miss Code Ann* §83-5-1 (Rev. 2011)

Rule 8.09: Prohibition against Post-Claims Underwriting

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

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

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

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

1. The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for

a long-term care insurance policy or certificate.

Caution: If your answers on this application are incorrect or untrue,

(company) has the right to deny benefits or rescind your policy.

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

Caution: The issuance of this long-term care insurance (policy)

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

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

    a. A report of a physical examination;

    b. An assessment of functional capacity;

    c. An attending physician's statement; or

    d. Copies of medical records.

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

E. Every insurer or other entity selling or issuing long-term care insurancebenefits shall maintain a record of all policy or certificate rescissions, bothstate and countrywide, except those which the insured voluntarilyeffectuated and shall annually furnish this information to the InsuranceCommissioner in the format prescribed by the National Association of Insurance Commissioners.

Source: *Miss Code Ann* §83-5-1 (Rev. 2011)

Rule 8.10: Minimum Standards for Home Health Care Benefits in Long-Term Care Insurance Policies

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

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

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

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

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

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

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

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

Source: *Miss Code Ann* §83-5-1 (Rev. 2011)

Rule 8.11: Requirement to Offer Inflation Protection

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

1. Increases benefit levels annually, (in a manner so that the increases are compounded annually);

2. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined; or

3. Covers a specified percentage of actual or reasonable charges.

B. Where the policy is issued to a group, the required offer in Subsection A above shall be made to the group policyholder; except, if the policy is issued to a group defined in Section

4E(4) of this Regulation, other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder.

C. The offer in Subsection A above shall no be required of:

1. Life insurance policies or riders containing accelerated long-term care benefits, nor

2. Expense incurred long-term care insurance policies.

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

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

2. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases.

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

Source: *Miss Code Ann* §83-5-1 (Rev. 2011)

Rule 8.12: Requirements for Replacement

A. Question Concerning Replacement. Individual and direct response solicited long-term care insurance application forms shall include a question designed to elicit information as to whether the proposed insurance policy is intended to replace any other accident and sickness or long-term care insurance policy presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

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

NOTICE TO APPLICANT REGARDING REPLACEMENT

OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

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

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

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

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

   The above "Notice to Applicant" was delivered to me on:

   _____
   (date)

   _____
   (Applicant's Signature)

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

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

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-

term care insurance policy delivered herewith issued by (company name) Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

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

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. (To be included only if the application is attached to the policy.)

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

_____

(Company Name)

Source: *Miss Code Ann* §§83-5-1; 83-5-29 (Rev. 2011)

Rule 8.13: Discretionary Powers of Commissioner

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

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

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

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

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

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

Source: *Miss Code Ann* § 83-5-1 (Rev. 2011)

Rule 8.14: Reserve Standards

A. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for such benefits shall be determined in accordance with Miss Code Ann. Section 83-7-23 (1972), as Amended. Claim reserves must also be established in the case when such policy or rider is in claim status.

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

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

   1. Definition of insured events;

   2. Covered long-term care facilities;

   3. Existence of home convalescence-care coverage;

   4. Definition of facilities;

   5. Existence or absence of barriers to eligibility;

   6. Premium waiver provision;

   7. Renewability;

8. Ability to raise premiums;

9. Marketing methods;

10. Underwriting procedures;

11. Claims adjustment procedures;

12. Waiting period;

13. Maximum benefit;

14. Availability of eligible facilities;

15. Margin in claim cost;

16. Optional nature of benefit;

17. Delay in eligibility for benefit;

18. Inflation protection provisions; and

19. Guaranteed insurability option.

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

C. When long-term care benefits are provided other than as in Subsection A above, reserves shall be determined in accordance with standards adopted by the National Association ofInsurance Commissioners.

Source: *Miss Code Ann* §83-7-23 (Rev. 2011)

Rule 8.15: Loss Ratio

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

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

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

C. Experienced and projected trends;

D. Concentration of experience within early policy duration;

E. Expected claim fluctuation;

F. Experience refunds, adjustments or dividends;

G. Renewability features;

H. All appropriate expense factors;

I. Interest;

J. Experimental nature of coverage;

K. Policy reserves;

L. Mix of business by risk classification; and

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

Source: *Miss Code Ann* §§83-5-1; 83-5-29 (Rev. 2011)

Rule 8.16: Filing Requirement

Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state, it shall file with the Commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

Source: *Miss Code Ann* §§83-5-1; 83-9-5(7) (Rev. 2011)

Rule 8.17: Standard Format Outline of Coverage

This section of the Regulation implements, interprets and makes specific, the provisions of Section 6E of this Regulation, in prescribing a standard format and the content of an outline of coverage.

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

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

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

D. Use of the text and sequence of text of the standard format outline of coverageis mandatory, unless otherwise specifically indicated.

E. Format for outline of coverage:

(Company Name)

(Address-City & State)

(Telephone Number)

Long-Term Care Insurance

Outline of Coverage

(Policy Number or Group Master Policy and Certificate Number)

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

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

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

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

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

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

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

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

(a) (For agents) Neither (inset company name) nor its agents represent Medicare, the federal government or any state government.

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

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

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

6. BENEFTIS PROVIDED BY THIS POLICY.

(a) (Covered services, related deductibles(s), waiting periods, elimination periods and benefit maximums.)

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

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

(Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.)

7. LIMITATIONS AND EXCLUSIONS.

(Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities/provider;

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

(d) Exclusions/exceptions;

(e) Limitations.)

(This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of benefits described in (6) above.)

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

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

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

(b) Any automatic benefit adjustment provisions;

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

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

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

9. TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.

[(a) Describe the policy renewability provisions:

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

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

(d) State whether or not the company has a right to change premium, and if such a right exists, describe clearly and concisely each circumstance under which premium may change.]

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

(State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.)

11. PREMIUM.

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

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

12. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

Source: *Miss Code Ann* §§83-5-1; 83-9-5 (Rev. 2011)

Rule 8.18: Requirement to Deliver Shopper's Guide

A. A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the Commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

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

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

B. Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary

required under Section 6 of this Regulation.

Source: *Miss Code Ann* §83-5-1 (Rev. 2011)

Rule 8.19: Effective Date

This regulation shall become effective thirty (30) days after its adoption and filing with the Mississippi Secretary of State's Office, as required by law.

Source: *Miss code Ann* §25-43-3.113 (Rev. 2010)