Title 31
MARYLAND INSURANCE ADMINISTRATION

Subtitle 14 LONG-TERM CARE

Chapter 01 Long-Term Care Insurance

Authority: Health-General Article, §19-705; Insurance Article, §§2-109, 14-124, Title 18, Subtitle 1, and Title 27; Annotated Code of Maryland

.01 Applicability and Scope.

Except as otherwise specifically provided, this chapter applies to all long-term care insurance policies delivered or issued for delivery in this State on or after the effective date by insurers, nonprofit health service plans, and health maintenance organizations. These regulations are not intended to supersede other applicable insurance laws or regulations which do not conflict with this chapter.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

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

(2) "Acute condition" means that the individual is medically unstable and requires frequent monitoring by physicians, registered nurses, or other medical professionals in order to maintain the individual's health status.

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

(4) "Alzheimer's disease" means a progressive brain disease diagnosed as Alzheimer's disease by the licensed attending physician of the insured or certificate holder and confirmed by a second opinion of a licensed physician.

(5) "Applicant" means in the case of:

(a) An individual long-term care insurance policy or contract, the person who seeks to contract for benefits; and

(b) A group long-term care insurance policy, the proposed certificate holder.

(6) "Association" means any association described in Insurance Article, §15-302(c)(2), Annotated Code of Maryland.

(7) "Bathing" means washing oneself:

(a) By sponge bath; or

(b) In either a tub or shower, including the task of getting into or out of the tub or shower.

(8) "Certificate" means any certificate issued under a group long-term care insurance policy if the certificate is delivered or issued for delivery in the State and covers individuals who reside in the State.

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

(10) "Continence" means the ability to:

(a) Maintain control of bowel and bladder function; or

(b) When unable to maintain control of bowel or bladder function, perform associated personal hygiene, including caring for catheter or colostomy bag.

(11) "Domiciliary care" means care, including general supervision and assistance in daily living, such as, but not limited to, aid in walking, getting in and out of bed, bathing, dressing, or eating, which is provided on a prearranged basis in a licensed residential facility for three or more unrelated individuals who need the care because of advanced age, infirmity, or physical or mental limitations.

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

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

(14) "Employer group long-term care insurance" means a long-term care insurance policy that is:

(a) Issued or delivered in Maryland to:

(i) One or more employers or labor organizations; or

(ii) A trust or the trustees of a fund established by one or more employers or labor organizations, or by a combination of employers or labor organizations; and

(b) Designed for:

(i) Employees or former employees, or a combination of employees and former employees, of the employer or employers; or

(ii) Members or former members, or a combination of members and former members, of the labor organization or labor organizations.

(15) "Field issued" means a policy or certificate issued by an insurance producer or a third-party administrator:

(a) Pursuant to the underwriting authority granted to the insurance producer or third-party administrator by an insurer; and

(b) Using the insurer's underwriting guidelines.

(16) "Guaranteed renewable" means that the:

(a) Policyholder or certificate holder has the right to continue long-term care insurance in force during the lifetime of the covered person by the timely payment of premiums; and

(b) Insurer may not decline to renew the policy or unilaterally make any change in any provision of the policy while the policy is in force, except that the insurer may revise the premium rates on a class basis.

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

(18) Home Health Care Services.

(a) "Home health care services" means medical and nonmedical services provided to ill, disabled, or infirm persons in their residences.

(b) "Home health care services" includes:

(i) Assistance with activities of daily living;

(ii) Homemakers' services; and

(iii) Respite care services.

(19) "Insurance producer" has the meaning stated in Insurance Article, §1-101, Annotated Code of Maryland.

(20) "Insurer" means an insurance company, nonprofit health service plan, health maintenance organization, or preferred provider organization.

(21) "Limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public.

(22) Long-Term Care Insurance.

(a) "Long-term care insurance" means any group or individual insurance policy, contract, certificate, or rider issued, delivered, or offered by an insurer that:

(i) Is advertised, marketed, offered, or designed to provide coverage for not less than 24 consecutive months for covered persons on an expense incurred, indemnity, prepaid, or insured basis; and

(ii) Provides one or more necessary or appropriate diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services furnished in a situation other than an acute care unit of a hospital.

(b) Long-term care insurance includes any product that is advertised, marketed, or offered as long-term care insurance.

(c) "Long-term care insurance" does not include any insurance policy, contract, certificate, or rider which is offered primarily to provide:

(i) Basic Medicare supplement coverage;

(ii) Hospital confinement indemnity coverage;

(iii) Basic hospital expense or medical-surgical expense coverage;

(iv) Disability income protection coverage;

(v) Accident only coverage;

(vi) Specified disease or specified accident coverage; or

(vii) Skilled nursing care.

(d) "Long-term care insurance" does not include a life insurance policy:

(i) That accelerates the death benefit specifically for one or more of the qualifying events of terminal illness, a medical condition requiring extraordinary medical intervention, or permanent institutional confinement;

(ii) That provides a lump sum payment for any of the events in §B(22)(d)(i) of this regulation; or

(iii) In which neither benefits nor eligibility for benefits is conditioned on receipt of long-term care.

(e) "Long-term care insurance" does not include any certificate issued under an out-of-State employer group contract.

(23) "Medicaid" means the Maryland Medical Assistance Program or any similar program provided by the state in which the insured person resides.

(24) "Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

(25) "Mental or nervous disorder" means a condition diagnosed as neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

(26) "Noncancellable policy" means a policy which the policyholder has the right to continue in force by the timely payment of premiums, and in which the insurer is precluded from unilaterally making any change in any provision of the policy or in the premium rates while the policy is in force.

(27) "Nursing care" means service for a patient that is ordered by a physician and provided or supervised by a registered or licensed practical nurse.

(28) "Nursing home" means a licensed organized institution that maintains conditions or facilities and equipment to provide domiciliary, personal, or nursing care for a number of unrelated individuals who are dependent on the administrator, operator, or proprietor for nursing care or the subsistence of daily living in a safe, sanitary, and healthy environment, and which admits or retains the individuals for overnight care.

(29) "Out-of-State employer group contract" means a group contract that is:

(a) Entered into with an employer in a state other than Maryland; and

(b) Issued directly to an employer under the laws of that employer's state.

(30) "Partnership policy" means a long-term care insurance policy that is:

(a) Certified by the Commissioner to meet the requirements under §1917(b) of the Social Security Act; and

(b) Issued on or after the date of the State plan amendment.

(31) "Partnership Program" means the program established by Health-General Article, Title 15, Subtitle 4, Annotated Code of Maryland.

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

(33) Policy.

(a) "Policy" means any policy, contract, individual certificate, subscriber agreement, rider, or endorsement delivered or issued for delivery in this State by:

(i) An insurer;

(ii) A nonprofit health service plan;

(iii) A health maintenance organization; or

(iv) A preferred provider organization.

(b) "Policy" does not include a life insurance policy which contains an optional provision for acceleration of payment of all or a portion of the face amount under stated conditions relating to the medical condition, the disability, or the need for long-term care of the insured.

(34) "Preexisting condition" means a condition for which medical advice or treatment was recommended by or received from a provider of health care services within 6 months before the effective date of coverage of the insured or certificate holder.

(35) "Qualified long-term care insurance" has the meaning stated in §C of this regulation.

(36) "Service benefit long-term care insurance policy" means a long-term care insurance policy that provides for benefits based on the amount of expenses incurred, rather than on an indemnity basis.

(37) "State of policy issue" means the state in which the individual policy or group certificate was originally issued.

(38) "State plan amendment" means an amendment filed by the Department of Health and Mental Hygiene with the Centers for Medicare and Medicaid Services under Title 42, U.S.C., which provides for the disregard of any assets or resources by the Department of Health and Mental Hygiene in an amount equal to the insurance payments that are made to or on behalf of the individual who is covered under a partnership policy.

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

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

C. Qualified Long-Term Care Insurance.

(1) "Qualified long-term care insurance" means:

(a) An individual or group insurance contract that meets the requirements of §7702B(b) of the Internal Revenue Code of 1986, as amended, as follows:

(i) The only insurance protection provided under the contract is coverage of qualified long-term care services;

(ii) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act, as amended, or would be reimbursable under Title XVIII of the Social Security Act but for the application of a deductible or coinsurance amount;

(iii) The contract is guaranteed renewable, within the meaning of §7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended;

(iv) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in §C(1)(a)(v) of this regulation;

(v) All refunds of premiums, and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract; and

(vi) The contract meets the consumer protection provisions set forth in §7702B(g) of the Internal Revenue Code of 1986, as amended; and

(b) The portion of a life insurance contract that:

(i) Provides long-term care insurance coverage by rider or as part of the contract; and

(ii) Satisfies the requirements of §§7702B(b) and (e) of the Internal Revenue Code of 1986, as amended.

(2) A contract may not fail to satisfy the requirements of §C(1)(a)(i) or (ii) of this regulation by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(3) The requirements of §C(1)(a)(ii) of this regulation do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payor.

.03 Policy Terms.

A. A long-term care policy shall define "skilled nursing care", "intermediate care", "domiciliary care", "custodial care", "personal care", "home care", "specialized care", "assisted living care", and other services in relation to the level of skill required, the nature of the care, and the setting in which care shall be delivered.

B. Definitions in Contracts Regarding Providers of Services.

(1) A long-term care insurance policy shall define all providers of services, including, but not limited to, "skilled nursing facility", "extended care facility", "convalescent nursing home", "personal care facility", "specialized care providers", "assisted living facility", and "home care agency" in relation to the services and facilities required to be available and the licensure, certification, registration, or degree status of those providing or supervising the services.

(2) When the definition of a type of provider requires that the provider be appropriately licensed, certified, or registered, the definition shall also state what requirements a provider must meet instead of licensure, certification, or registration when the state in which the service is to be furnished:

(a) Does not require a provider of these services to be licensed, certified or registered; or

(b) Licenses, certifies, or registers the provider of services under another name.

C. A long-term care insurance policy may not use any of the terms defined in Regulation .02 of this chapter in a manner which is less favorable to the policyholder, the certificate holder, or the covered person.

.04 Policy Practices and Provisions.

A. Renewability and Premium Charges.

(1) Renewability Provision.

(a) Individual long-term care insurance policies shall contain an appropriately captioned renewability provision on the first page of the policy form.

(b) The renewability provision shall clearly state that the coverage is guaranteed renewable or noncancellable.

(c) Section A(1)(a) of this regulation is not applicable to policies that do not contain a renewability provision and under which the right to nonrenew is reserved solely to the policyholder.

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

(3) An individual long-term care policy may not be issued on any basis other than on a noncancellable or a guaranteed renewable basis.

(4) The premiums for a noncancellable policy shall be level for the duration of the policy and may not vary by policy duration or by the attained age of the insured.

(5) An insurer may not charge a renewal premium rate for a long-term care policy which exceeds by more than 15 percent any premium charged for the policy during the preceding 12 months.

(6) With the approval of the Commissioner, the insurer may charge a renewal premium exceeding a 15 percent increase upon a showing that a larger increase is necessary because of utilization of policy benefits greatly in excess of the expected rate.

(7) Premium Rate Increases.

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

(i) The increasing age of the insured; or

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

(b) The purchase of additional coverage may not be considered a premium rate increase, but for purposes of the calculation required under Regulation .13 of this chapter, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

(c) A reduction in benefits may not be considered a premium change, but for the purposes of the calculation required under Regulation .13 of this chapter, the initial annual premium shall be based on the reduced benefits.

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

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

B. Limitations and Exclusions.

(1) Long-term care insurance policies may not:

(a) Be cancelled, nonrenewed, or otherwise terminated on the grounds of the age or of the deterioration of the mental or physical health of the insured individual or certificate holder;

(b) Except with respect to an increase in benefits voluntarily selected by an insured individual or a group policyholder, contain a provision establishing a new waiting period if existing coverage is converted to or replaced by a new or other form of long-term care coverage in the same or another insurer;

(c) Limit coverage to skilled nursing care only, or provide an increased level of coverage in a facility for skilled care greater than the coverage for lower levels of care.

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

(a) Preexisting conditions or diseases to the extent permitted in §C of this regulation;

(b) Mental and nervous disorders, except that there may be no limitation or exclusion for Alzheimer's disease or senile dementia disorders;

(c) Alcoholism and drug addiction;

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

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

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

(iii) Service in the armed forces,

(iv) Attempted suicide or intentionally self-inflicted injury, whether sane or insane, or

(v) Aviation when the covered person is not a fare-paying passenger;

(e) Services provided by a member of the covered person's immediate family;

(f) Services provided or available under a workers' compensation, employer's liability, or occupational disease law;

(g) Treatment provided in a government facility, unless otherwise required by law;

(h) Services for which benefits are available under Medicare or other governmental programs, except Medicaid; or

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

(3) Section B(2) of this regulation does not prohibit limitations by territory.

(4) Section B(2) of this regulation does not prohibit exclusions and limitations by type of provider, but a long-term care insurer may not deny a claim because services are provided in a state other than the state of policy issue under the following conditions:

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

(b) When the state, other than the state of policy issue, licenses, certifies or registers the provider under another name.

C. Preexisting Condition.

(1) A long-term care insurance policy or certificate may not exclude coverage for a loss or confinement which results from a preexisting condition unless the loss or confinement begins within 6 months following the effective date of coverage of the covered person.

(2) The definition of "preexisting condition" does not prohibit an insurer from using an application form designed to elicit the health history of an applicant and, on the basis of the answers on the application, from underwriting the risk in accordance with the insurer's established underwriting standards.

(3) A preexisting condition, regardless of whether it is disclosed on an application form, may not be excluded beyond the 6-month waiting period, or the period provided in the policy, if shorter.

(4) A long-term care insurance policy or certificate may not exclude, or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting conditions beyond the 6-month waiting period.

D. A long-term care insurance policy may not be delivered or issued for delivery in the State if the policy conditions eligibility for benefits on:

(1) A requirement for earlier hospitalization; or

(2) The earlier receipt of a higher level of institutional care.

E. A long-term care insurance policy may provide for coordination of benefits with other long-term care coverage in force on the same covered person.

F. Termination.

(1) A long-term care insurance policy may be terminated by the insurer only:

(a) For nonpayment of premiums;

(b) Within the contestable period for material misrepresentation in the application; or

(c) For fraud in the application.

(2) An insurer may not terminate a long-term care insurance policy for nonpayment of premiums unless the insurer provides 30 days written notice to the:

(a) Covered person, and in the case of an individual policy, to the covered person and the policyowner if different; and

(b) Individual designated by the covered person or the policyholder to receive notice of termination.

G. Extension of Benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care insurance was in force may be:

(1) Limited by the duration of the benefit period, if any, or by the payment of the maximum benefits under the policy; and

(2) Subject to any policy waiting period and all other applicable provisions of the policy.

H. Continuation or Conversion.

(1) Group long-term care insurance policies issued or delivered in this State shall provide covered individuals with the rights of continuation or conversion of coverage.

(2) Continuation of coverage may be provided by the right of the certificate holder to maintain coverage under the existing group policy subject only to the continued timely payment of premiums.

(3) A group policy that restricts benefits and services to certain providers or facilities under a managed care or preferred provider arrangement, or that contains incentives to use certain providers or facilities, may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. In determining whether the benefits of a converted policy are substantially equivalent to the original coverage, the Commissioner shall consider the difference between managed care and nonmanaged care plans.

(4) Conversion Policy.

(a) Written application for the conversion policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than 31 days after termination of coverage under the group policy.

(b) The conversion policy shall be issued effective on the day following the termination of coverage under the group policy and shall be renewable annually.

(5) Premium for Conversion Policies.

(a) Unless the group policy from which conversion is made replaced previous group coverage, the premium for an individual policy issued as a conversion from a group policy shall be calculated on the basis of the insured's age at inception of the coverage under the group policy from which conversion is made.

(b) If 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.

(6) Continuation of coverage or issuance of a converted policy shall be mandatory, except if:

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

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

(i) Benefits for the replacement group coverage are identical to, or determined by the Commissioner to be substantially equivalent to or in excess of, those provided by the terminating coverage; and

(ii) Premium for the replacement group coverage is calculated in a manner consistent with the requirements of §H(5) of this regulation.

(7) 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. If this provision is included in the converted policy, the policy shall also provide for a decrease in premiums or a partial refund reflecting the reduction in benefits payable.

(8) A converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the extension of benefits of the group policy from which conversion is made, do not exceed the benefits that would have been payable had the individual's coverage under the group policy remained in full force and effect.

(9) An insured individual whose eligibility for individual or group long-term care coverage is based upon the individual's relationship to another person is entitled to continuation of coverage under the individual or group policy upon termination of the qualifying relationship by death or dissolution of marriage or otherwise.

I. Discontinuance and Replacement. If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder within 12 months of the termination of the previous policy, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination and to all persons who could qualify for reinstatement under the previous policy. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy may not:

(1) Result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

(2) Vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.

J. Right to Return Policy.

(1) Except for an employer-employee group policy, a long-term care policy shall provide that the policyholder or certificate holder may return the policy or certificate to the insurer or agent within 30 days after receipt of the policy or certificate, and obtain a full refund of premium paid. A statement to this effect shall be printed in a prominent manner on the first page of the policy or certificate.

(2) The statement required under §J(1) of this regulation shall read as follows:

"NOTICE TO BUYER: YOU MAY SURRENDER THIS (POLICY) (CERTIFICATE) OF LONG-TERM CARE INSURANCE WITHOUT PENALTY OR OBLIGATION WITHIN 30 DAYS FROM THE DATE OF DELIVERY OF THE (POLICY) (CERTIFICATE). IF YOU DECIDE TO SURRENDER THIS (POLICY) (CERTIFICATE), YOU MUST PROVIDE NOTICE OF THE SURRENDER TO THE INSURER OR ITS AGENT. ANY ATTEMPT BY THE INSURER TO OBTAIN A WAIVER OF YOUR RIGHT TO SURRENDER IS UNLAWFUL. YOUR NOTICE OF SURRENDER WILL CAUSE THIS (POLICY) (CERTIFICATE) TO BE VOID AND WITHOUT BENEFIT FROM ITS BEGINNING. SURRENDER ENTITLES YOU TO A REFUND OF ALL MONIES WITHIN 30 BUSINESS DAYS AFTER RECEIPT BY THE INSURER OR ITS AGENT OF NOTICE OF SURRENDER."

(3) This section does not apply to any "cafeteria plan" issued under §125 of the Internal Revenue Service Code.

K. Electronic Enrollment for Group Policies.

(1) In the case of employer group long-term care insurance, any requirement that a signature of an insured be obtained by an insurance producer or insurer shall be deemed satisfied if the:

(a) Consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer;

(b) Telephonic or electronic enrollment provides necessary and reasonable safeguards to ensure the accuracy, retention, and prompt retrieval of records; and

(c) Telephonic or electronic enrollment provides necessary and reasonable safeguards to ensure that the confidentiality of individually identifiable information is maintained.

(2) If the consent is obtained by telephonic or electronic enrollment as described in §K(1)(a) of this regulation, a verification of enrollment information shall be provided to the enrollee.

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

.05 Disclosure.

A. Riders and Endorsements.

(1) Except for riders or endorsements by which the insurer fulfills a request made in writing by the policyholder under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after the date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage of the policy shall require signed acceptance by the policyholder.

(2) After the date of policy issue, any rider or endorsement which increases benefits or coverage and which will require an increase in premium shall be agreed to in writing and signed by the insured, unless the increased benefits are required by law.

(3) When a separate additional premium is charged for benefits provided in connection with riders or endorsements, the additional premium charge shall be set forth in the policy or in the rider or endorsement.

B. 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 these terms. The outline of coverage accompanying the policy shall include an explanation of these terms if used.

C. Preexisting Condition Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear in a separate paragraph of the policy or certificate under the heading "Preexisting Condition Limitations".

D. Disclosure of Tax Consequences.

(1) This section is not applicable to qualified long-term care insurance contracts.

(2) If a life insurance policy or rider to a life insurance policy provides an accelerated death benefit for long-term care, a disclosure statement shall be provided by the insurer at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted.

(3) The disclosure statement required in §D(2) of this regulation shall state that:

(i) Receipt of the accelerated benefits may be taxable; and

(ii) Assistance should be sought from a personal tax advisor.

(4) The disclosure statement required in §D(2) of this regulation shall be prominently displayed on the first page of the policy or rider and any other related documents.

E. Benefit Triggers

(1) An insurer shall:

(a) Use activities of daily living and cognitive impairment to measure an insured's need for long-term care; and

(b) Describe in the policy or certificate in a separate provision the benefit triggers described in §E(1)(a) of this regulation.

(2) Additional Benefit Triggers.

(a) If the policy or certificate contains any additional benefit triggers other than described in §E(1) of this regulation, these triggers shall be described in the same provision described in §E(1)(b) of this regulation.

(b) If the additional benefit triggers differ for different benefits, explanation of the trigger shall accompany each benefit description.

(3) If the contract or certificate requires that an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this requirement shall appear in the provision described in §E(1)(b) of this regulation.

F. Each qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage that the policy is intended to be a qualified long-term care insurance contract under §7702B(b) of the Internal Revenue Code of 1986, as amended.

G. Each nonqualified long-term care insurance contract shall include a disclosure statement in the policy and the outline of coverage that the policy is not intended to be a qualified long-term care insurance contract.

.06 Requirements for Applications.

A. If the application for a long-term care insurance policy is to be made part of the policy or certificate, the insurer shall print:

(1) Conspicuously and in close conjunction with the applicant's signature block on the application form for the policy or certificate:

> "CAUTION: If your answers on this application are incorrect or untrue, the insurance company may have the right to deny benefits or rescind your policy.";

(2) On the first page of the policy or certificate the following or substantially similar language:

> "CAUTION: The issuance of this long-term care insurance (policy) (certificate) is based upon your answers to the questions on your application. A copy of your application is (attached)(enclosed)(was retained by you when you applied). If your answers are incorrect or untrue, the insurance company may have the right to deny benefits or deny your coverage. The best time to clear up any questions is now, before a claim arises. If, for any reason, any of your answers are not correct, contact the insurance company at this address: (insert address and toll-free telephone number, if available)."

B. Application forms for individual policies and for certificate holders under group policies other than employer-employee groups shall include the questions in §C of this regulation, designed to elicit information as to whether at the time of the application the applicant has another long-term care insurance policy or certificate in force, or whether a long-term care policy or certificate is intended to replace any other long-term care policy or certificate or other insurance then in force. A supplementary application to be signed by the applicant may be used for this purpose.

C. Application questions include the following:

(1) "Do you have other long-term care insurance in force or other health insurance, including membership in a health maintenance organization?";

(2) "Did you have another long-term care insurance policy or certificate in force during the last 12 months?":

(a) "If so, with which company?";

(b) "If that policy lapsed, when did it lapse?";

(c) "Are you covered by Medicaid?"; and

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

D. An agent soliciting applications for long-term care insurance shall list any other long-term care coverage or other health insurance policies which the applicant has or has had. The agent shall list policies which:

(1) Are still in force;

(2) Have lapsed or otherwise terminated during the past 5 years.

E. Solicitations Other Than Direct Response. Upon determining that a sale will involve replacement, the agent or the insurer, other than an insurer using direct response solicitation, shall furnish the applicant a notice regarding replacement of long-term care coverage or other health insurance before delivering an individual long-term care insurance policy. A copy of the notice shall be given to the applicant, and another copy signed by the applicant shall be retained by the insurer. The required notice shall be substantially in the form and language shown in Regulation .22 of this chapter.

F. Direct Response Solicitation. Insurers using direct response solicitation shall deliver a notice regarding replacement of long-term care coverage or other health insurance to the applicant upon issuance of a long-term care policy. The required notice shall be substantially in the form and language shown in Regulation .23 of this chapter.

G. When replacement is intended, the replacing insurer shall give written notice to the existing insurer of the proposed replacement. This notice shall identify the insured and the policy number or the address of the insured. The notice shall be given within 5 working days from the date the application for the newly applied coverage is received at the home office of the insurer, or the date the policy is issued, whichever is earlier.

H. Before issuing a long-term care insurance policy or certificate to an applicant 80 years old or older, unless the policy or certificate is to be issued on a guaranteed issue basis, the insurer shall obtain at least one of the following:

(1) A report of a recent physical examination;

(2) An assessment by a qualified person of the applicant's functional capacity;

(3) An attending physician's statement; or

(4) A copy of recent medical records.

I. A copy of the completed application or enrollment form shall be delivered to the insured at the time of delivery of the policy or certificate.

J. Life Insurance Policies.

(1) Life insurance policies that accelerate death benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy.

(2) If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of COMAR 31.09.05.

(3) If a life insurance policy that accelerates the death benefits for long-term care is replaced by another life insurance policy that accelerates the death benefits for long-term care, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

.07 Person To Be Notified.

A. Except as provided in §E of this regulation, an insurer may not issue an individual long-term care insurance policy or certificate to an insured until the insurer has received from the applicant either a written:

(1) Designation of at least one person in addition to the insured who is to receive notice of termination of the policy or certificate for nonpayment of premium; or

(2) Waiver dated and signed by the applicant electing not to designate additional persons to receive notice of nonpayment of premium.

B. The written designation shall be on a form provided by the insurer and shall:

(1) Provide space clearly designated for listing at least one person; and

(2) Include a space for listing the full name and home address of the designated person.

C. If the applicant elects to waive the right to designate additional persons to receive notice of nonpayment of premium, the insurer shall use a waiver form that states: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

D. An insurer shall notify the insured of the right to change the written designation described in §§A—C of this regulation, at least once every 2 years.

E. Payroll or Pension Deduction Plans.

(1) If the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the insurer is not required to satisfy the requirements contained in §§A — C of this regulation until 60 days after the policyholder or certificate holder is no longer on a payroll or pension deduction plan.

(2) The application or enrollment form for a long-term care insurance policy or certificate through a payroll or pension deduction plan shall clearly indicate the payment plan selected by the applicant.

F. Lapse or Termination for Nonpayment of Premium.

(1) Notice of Lapse.

(a) An individual long-term care policy or certificate may not lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, provides notice to the insured and to those persons designated under §§A and B of this regulation.

(b) The notice required by §F(1) of this regulation shall be provided by the insurer to the addresses provided by the insured for purposes of receiving notice of lapse or termination.

(2) The notice required in §F(1) of this regulation:

(a) Shall be given by first class United States mail, postage prepaid; and

(b) May not be given until 30 days after a premium is due and unpaid.

(3) The notice required in §F(1) of this regulation shall be deemed to be given as of 5 days after the date of mailing.

G. Reinstatement.

(1) A long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse, if the insurer is provided proof that, before the grace period contained in the policy expired, the policyholder or certificate holder:

(a) Was cognitively impaired; or

(b) Had a loss of functional capacity.

(2) The reinstatement option described in §G(1) of this regulation shall be available to the insured if it is requested within 5 months after termination and shall allow for the collection of past due premium, if appropriate.

(3) The standard of proof of cognitive impairment or loss of functional capacity referenced in §G(1) of this regulation may not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

.08 Applicant's Options.

A. Except as provided in §§B and C of this regulation, the application for a long-term care insurance policy or certificate, or a form attached to the policy or certificate, shall contain a statement to be signed separately by the applicant to the effect that the:

(1) Applicant has been informed of the applicant's right to:

(a) Designate a person to receive any notice of termination;

(b) Purchase:

(i) Inflation protection,

(ii) Home health care if not included in the policy, and

(iii) Nonforfeiture benefits; and

(c) Choose the form of nonforfeiture benefit if the policy provides a choice; and

(2) Benefits and any costs of each of the options in this regulation have been fully explained to the applicant.

B. The statement of the applicant's right to purchase inflation protection specified in §A(1)(b)(i) of this regulation is not required when the policy is issued to an employer-employee group described in Regulation .12D of this chapter.

C. The statement of the applicant's right to purchase nonforfeiture benefits specified in §A(1)(b)(iii) of this regulation is not required when the policy is issued to a group described in Regulation .13B(1)(b) or (c) of this chapter.

.09 Prohibition Against Post-Claims Underwriting.

A. Except in a case of guaranteed issue, application forms for long-term care insurance policies or certificates shall contain clear and unambiguous questions designed to ascertain the condition of health of the applicant.

B. Medical Condition—Medication.

(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 shall also ask the applicant to name the medication which has been prescribed.

(2) A long-term care insurance policy or certificate may not be rescinded for failure by the applicant to list in the application for the policy or certificate a medical condition, if the medications listed in the application were known or should have been known by the insurer at the time of application to be directly related to a medical condition for which coverage would otherwise be denied.

C. An insurer issuing long-term care insurance shall maintain a record of all policy or certificate rescissions, both Statewide and countywide, except those which the policyholder voluntarily effectuated. The insurer shall annually furnish this information to the Insurance Commissioner in the format in Regulation .29 of this chapter.

.10 Preexisting Condition and Waiting Period Provisions in Replacement Policies.

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

.11 Minimum Standards for Home Health Care Benefits in Long-Term Insurance Policies.

A. Optional Home Health Care Benefit.

(1) An insurer issuing a long-term care insurance policy shall offer the applicant for the policy the option to purchase a policy that provides for home health care benefits in addition to the benefits provided for nursing home care.

(2) The benefits required to be offered for home health care under this section are as follows:

(a) If the benefit for nursing home care is on a scheduled or indemnity-type basis, the daily limit for home health care benefits shall be at least 50 percent of the daily benefit for nursing home care;

(b) The period of eligibility for home health care benefits shall be at least equal to the period of eligibility for benefits for nursing home care; and

(c) If the policy provides for an overall lifetime limit, the benefits for home health care shall be at least equal to 50 percent of the overall lifetime limit.

(3) The minimum benefits required in §A(2) of this regulation do not apply to policies or certificates issued to residents of continuing care retirement communities.

B. If the offer required by §A of this regulation is rejected in writing by the applicant, then the insurer may offer a home health care rider providing benefits for a longer or shorter duration or for differing benefit levels.

C. A long-term care insurance policy or certificate may not limit benefits for home health care by:

(1) Requiring that the insured would need skilled nursing care or care in a hospital and skilled nursing facility if home health care services were not provided;

(2) Requiring that the insured first receive nursing care or therapeutic services, or both, in a community setting before home health care services are covered;

(3) Requiring that eligibility for services be limited to services provided by registered nurses or licensed practical nurses;

(4) Requiring that a nurse or licensed therapist provide services covered by the policy if the services can be provided by a home health aide or other home health care worker, unless required by applicable licensing regulations;

(5) Requiring that the insured have an acute condition before home health care services are covered;

(6) Limiting benefits to services provided by Medicare-certified agencies or providers;

(7) Excluding coverage for personal care services provided by a home health aide; or

(8) Requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service.

D. Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate to determine maximum coverage under the terms of the policy or certificate.

E. An insurer soliciting the sale of a long-term care insurance policy shall offer the applicant the option of including the policy home health care benefits in accordance with the provision in §§A—D of this regulation.

F. A qualified long-term care insurance policy that provides benefits for home health care or community care services may not exclude coverage for adult day care services.

.12 Requirement To Offer Inflation Protection.

A. An insurer issuing a long-term care insurance policy shall offer the applicant for the policy the option to purchase a policy that provides for benefit levels to increase at a rate not less than 5 percent compounded annually.

B. Instead of the requirement of §A of this regulation, the insurer may offer a policy that guarantees the policyholder the right to increase periodically benefit levels without providing evidence of insurability of health status as long as the option for the preceding period has not been declined, with the amount of the additional benefit being not less than the difference between the existing policy benefit and the amount of the benefit which would have been payable if the policy provided the option described in §A of this regulation.

C. Instead of the requirement of §A of this regulation, the insurer may offer a policy that provides a specified percentage, not less than 50 percent, of actual and reasonable charges and does not include a maximum specified indemnity amount or limit.

D. In a policy issued to an employer-employee group, the offer required in §A, B, or C of this regulation shall be made to the group policyholder. In a policy issued to any other group, the offer shall be made to each proposed certificate holder.

E. The offer in §A of this regulation may not be required of life insurance policies or riders on life insurance policies containing accelerated death benefits for long-term care.

F. In connection with the offer to provide inflation protection, the insurer shall provide the applicant with:

(1) A graphic comparison and a table illustrating for at least the first 20 policy years the benefits or the reasonably anticipated benefits which would be available if the inflation protection is purchased, in comparison with a policy which does not provide inflation protection; and

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

G. The initial premium for including the inflation protection provision in the policy shall be calculated on the basis of a level premium for the duration of the policy.

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

I. Disclosure of Premium in Offer of Inflation Protection.

(1) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant.

(2) The offer described in §I(1) of this regulation shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

J. Rejection of Inflation Protection.

(1) Inflation protection as provided in §A of this regulation shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this section.

(2) The rejection described in §J(1) of this regulation may be either in the application or on a separate form.

(3) The rejection required by this section shall be considered a part of the application and shall state:

"I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans (insert names or descriptions of plans), and I reject inflation protection."

.13 Nonforfeiture Benefit Requirement.

A. This regulation does not apply to life insurance policies or riders containing accelerated death benefits for long-term care.

B. Required Option.

(1) An insurer may not deliver or issue a long-term care insurance policy in Maryland unless the option of purchasing a policy including a nonforfeiture benefit has been offered to the:

(a) Applicant, when the policy is an individual long-term care insurance policy;

(b) Group policyholder, when the policy is an employer group long-term care insurance policy;

(c) Group policyholder, when the policy is a group long-term care insurance policy issued to a professional, trade, or occupational association for its members, former members, or retired members, or a combination of members, former members or retired members, if the association:

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

(ii) Has been maintained in good faith for purposes other than obtaining insurance; or

(d) Proposed certificate holder, when the group long-term care insurance policy is a policy other than one of the policies described in §B(1)(b)—(c) of this regulation.

(2) The offer of a nonforfeiture benefit required by §B(1) of this regulation may be in the form of a rider that is attached to the policy.

C. To comply with the requirement to offer a nonforfeiture benefit under §B of this regulation:

(1) A policy offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers, and benefit length that are the same as coverage to be issued without nonforfeiture benefits;

(2) The nonforfeiture benefit included in the offer shall be the benefit described in §F of this regulation; and

(3) The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the applicant.

D. Options if Nonforfeiture Offer is Rejected.

(1) If the offer required to be made under §B(1) of this regulation is rejected, the insurer shall provide the contingent benefit upon lapse described in §E of this regulation.

(2) Even if the offer under §B(1) of this regulation is accepted, for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in §E(6) of this regulation shall still apply.

(3) The requirement of §D(2) of this regulation shall apply to:

(a) Except as provided in §D(3)(b) of this regulation, any long-term care insurance policy or certificate issued in Maryland on or after March 1, 2008; and

(b) Any certificate issued under an employer group long-term care insurance policy, if the certificate is issued on or after September 10, 2008.

E. Contingent Benefit Upon Lapse Provision.

(1) Except as provided in §E(6)(e) and (11) of this regulation, the requirements of this section become effective on April 1, 2003, and apply as follows:

(a) Except as provided in §E(1)(b) of this regulation, the provisions of this section apply to any long-term care insurance issued in this State on or after April 1, 2003; and

(b) The requirements of this section do not apply to certificates issued on or after April 1, 2003, under an employer group long-term care insurance policy which was in force before April 1, 2003.

(2) If the offer required to be made under §B(1) of this regulation is rejected, the insurer shall provide the contingent benefit upon lapse provided in this section.

(3) The contingent benefit on lapse shall be triggered each time:

(a) An insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in §E(5) of this regulation based on the insured's issue age; and

(b) The policy or certificate lapses within 120 days of the due date of the premium increase described in §E(3)(a) of this regulation.

(4) Unless otherwise required, policyholders shall be notified at least 30 days before the due date of the premium reflecting the rate increase described in §E(3)(a) of this regulation.

(5) The following table lists the triggers for a substantial premium increase:

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
29 and younger	200%
30—34	190%
35—39	170%
40—44	150%
45—49	130%
50—54	110%

Triggers for a Substantial Premium Increase

55—59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%

Triggers for a Substantial Premium Increase

89	11%
90 and older	10%

(6) Policies With a Fixed or Limited Premium Paying Period.

(a) A contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period every time:

(i) An insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in §E(6)(c) of this regulation, based on the insured's age;

(ii) The policy or certificate lapses within 120 days of the due date of the premium that was increased as described in §E(6)(a)(i) of this regulation; and

(iii) The ratio in §E(9)(b) of this regulation is 40 percent or more.

(b) Unless otherwise required, policyholders shall be notified at least 30 days before the due date of the premium reflecting the rate increase.

(c) The following table lists the triggers for a substantial premium increase for a long-term care insurance policy with a fixed or limited premium paying period:

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65—80	30%
Over 80	10%

(d) The contingent benefit upon lapse described in §E(6) of this regulation shall be in addition to the contingent benefit provided by §E(3) of this regulation and where both contingent benefits are triggered, the benefit provided shall be at the option of the insured.

(e) The requirements found in §E(6) of this regulation shall apply to:

(i) Except as provided in §E(6)(e)(ii) of this regulation, any long-term care insurance policy or certificate issued in Maryland on or after March 1, 2008; and

(ii) Any certificate issued under an employer group long-term care insurance policy, if the certificate is issued on or after September 10, 2008.

(7) On or before the effective date of a substantial premium increase as described in §E(3) and (5) of this regulation, the insurer shall:

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

(b) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of §F of this regulation; and

(c) Notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period in §E(3)(b) of this regulation shall be deemed to be the election of the offer to convert in §E(7)(b) of this regulation, unless the automatic option in §E(9)(c) of this regulation applies.

(8) The conversion to a paid-up contract option in §E(7)(b) of this regulation may be elected at any time during the 120-day period in §E(3)(b) of this regulation.

(9) On or before the effective date of a substantial premium increase as described in §E(6)(a) and (c) of this regulation, the insurer shall:

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

(b) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is 90 percent of the amount payable in effect immediately before lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period; and

(c) Notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period described in §E(6)(a)(ii) of this regulation shall be deemed to be the election of the offer to convert described in §E(9)(b) of this regulation, if the ratio is 40 percent or more.

(10) The option to convert coverage as described in §E(9)(b) of this regulation may be elected at any time during the 120-day period described in §E(6)(a)(ii) of this regulation.

(11) The requirements found in §E(9)—(10) of this regulation shall apply to:

(a) Except as provided in §E(11)(b) of this regulation, any long-term care insurance policy or certificate issued in Maryland on or after March 1, 2008; and

(b) Any certificate issued under an employer group long-term care insurance policy, if the certificate is issued on or after September 10, 2008.

F. Description of Nonforfeiture Benefits.

(1) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with §E(3) of this regulation, but not §E(6) of this regulation, are described in §F of this regulation.

(2) For purposes of this section, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse.

(3) The shortened benefit period nonforfeiture benefit required by §F(2) of this regulation shall:

(a) Have the same benefit amounts and frequency in effect at the time of lapse but not increased after the time of lapse; and

(b) Be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as described in §F(4) of this regulation.

(4) Calculation of the Nonforfeiture Credit.

(a) Except as provided in §F(4)(c) of this regulation, the standard nonforfeiture credit shall be equal to 100 percent of the sum of all premiums paid, including the premiums paid before any changes in benefits.

(b) The insurer may offer other shortened benefit period options in addition to the option described in §F(4)(a) of this regulation, provided the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration.

(c) The minimum nonforfeiture credit may not be less than 30 times the daily nursing home benefit at the time of lapse.

(d) The calculation of the nonforfeiture credit shall be subject to the limitation described in §G of this regulation.

(5) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date.

(6) The contingent benefit upon lapse shall be effective during the first 3 years the policy is in force, as well as after the first 3 years the policy is in force.

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

G. An insurer may limit benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status so that the benefits will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.

H. There shall be no difference in the minimum nonforfeiture benefits as required under this regulation for group and individual policies.

I. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit upon lapse shall be subject to the loss ratio requirements of COMAR 31.14.02.05 or .06, whichever is applicable, treating the policy as a whole.

J. To determine whether contingent nonforfeiture upon lapse provisions are triggered under §E(3) or (6) of this regulation, a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

K. A nonforfeiture benefit for qualified long-term care insurance contracts shall be offered that meets the following requirements:

(1) The nonforfeiture provision shall be appropriately captioned;

(2) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums; and

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

(a) Reduced paid-up insurance;

(b) Extended term insurance;

(c) Shortened benefit period; or

(d) Other similar offerings approved by the Commissioner.

(4) The nonforfeiture benefit option provided by the insurer under this section shall comply with the requirements of §F of this regulation.

.14 Group Coverage.

Group long-term care insurance coverage may not be offered to a resident of this State under a group policy issued in another jurisdiction unless the coverage complies with the statutes and regulations pertaining to group long-term care insurance issued in this State.

.15 Advertising.

A. An insurer soliciting long-term care insurance in the State shall provide the Commissioner with a copy of any long-term care insurance advertisement intended for use in the State. For purposes of this regulation, "advertising" includes any material:

(1) Published, disseminated, circulated, or placed before the public in a newspaper, magazine, or other publication;

(2) In the form of a notice, circular, pamphlet, letter, or poster;

(3) Seen or heard over any radio or television station;

(4) Sent by direct mail; or

(5) Issued in any other manner intended to be seen or heard by the general public.

B. The insurer shall submit a copy of the advertising in advance to be received in the office of the Commissioner at least 30 days before its intended use.

C. The Commissioner may exempt an insurer's advertising form or material from the requirements of this regulation when, in the Commissioner's opinion, these requirements cannot be reasonably applied.

D. An insurer shall maintain in its home office a file of all long-term care advertisements for at least 3 years from the date the advertisements were first issued.

E. An insurer may not use the term "level premium" in a guaranteed renewable policy.

F. An insurer may not describe a policy which provides benefits for less than 24 months as a long-term care insurance policy.

.16 Standards for Marketing.

A. An insurer marketing long-term care insurance coverage in Maryland, either directly or through its producers, shall:

(1) Establish marketing procedures and insurance producer requirements to ensure that:

(a) Any comparison of policies by its producers is fair and accurate; and

(b) Excessive insurance is not sold or issued;

(2) Display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and of the policy, the following: "Notice to Buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.";

(3) Provide copies of the disclosure forms required by COMAR 31.14.02.03, .08, and .09 to the applicant;

(4) Inquire, and otherwise make every reasonable effort to identify, whether a prospective applicant or enrollee for long-term care insurance already has long-term care insurance and the types and amounts of the existing insurance;

(5) Establish written procedures for verifying compliance with this regulation, with a record of the procedures implemented by the insurer being maintained in the home office of the insurer for at least 3 years following the procedures' introduction; and

(6) Provide an explanation of contingent benefit upon lapse provided for in Regulation .13E(3)—(5) of this chapter and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium periods provided for in Regulation .13E(6) of this chapter.

B. In soliciting long-term care coverage the insurer, at the time of solicitation, shall:

(1) Provide written notice to the prospective policyholders and certificate holders that senior insurance counselling programs are available in the State; and

(2) Give prospective applicants the name, address, and telephone number of an available counselling program.

C. Prohibited Practices.

(1) In addition to the practices prohibited in Insurance Article, Title 27 and §14-136, Annotated Code of Maryland, the acts and practices described in §C(2)—(4) of this regulation are prohibited.

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

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

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

D. Associations.

(1) The primary responsibility of an association, as defined in Regulation .02B(6) of this chapter, when endorsing long-term care insurance, shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions.

(2) An association shall provide objective information regarding long-term care insurance policies or certificates endorsed by the association to ensure that members of the association receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed.

(3) An insurer intending to issue association long-term care coverage shall file with the Commissioner the following material:

(a) The policy and certificate;

(b) An outline of coverage that corresponds to the policy and certificate described in §D(3)(a) of this regulation; and

(c) All advertisements used to solicit members of the association.

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

(a) The specific nature and amount of the compensation arrangements that the association receives from endorsement or sale of the policy or certificate to its members; and

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

(5) The compensation arrangements discussed in §D(4)(a) of this regulation include all fees, commissions, administrative fees, and other forms of financial support.

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

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

(8) An association endorsing long-term care insurance to its members shall:

(a) Engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to:

(i) Conduct an examination of the policies, including their benefits, features, and rates at the time of the association's decision to endorse particular long-term care insurance; and

(ii) Update the examination described in §D(8)(a)(i) of this regulation in the event of material change in a policy's benefits, features, or rates;

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

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

(9) The requirements set forth in §D(8) of this regulation do not apply to qualified long-term care insurance contracts.

(10) An insurer may not issue a group long-term care insurance policy or certificate to an association unless the insurer files with the Commissioner the information required in this section.

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

(12) Failure to comply with the filing and certification requirements of this section is an unfair trade practice in violation of Insurance Article, Title 27, Subtitle 2, Annotated Code of Maryland.

.17 Appropriateness of Recommended Purchase.

A. In recommending the purchase or replacement of any long-term care insurance policy or certificate, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

B. In recommending the purchase or replacement of any long-term care insurance policy or certificate, the insurer or its agent shall make a reasonable effort to identify whether a prospective applicant for long-term care insurance:

(1) Already has long-term care insurance, and the types and amounts of insurance;

(2) Had long-term care insurance in force during the last 12 months;

(3) Is covered or is eligible for coverage under the Medical Assistance Program (Medicaid); or

(4) Intends to replace an existing hospital, medical, surgical, or other health insurance coverage with long-term care insurance.

.18 Outline of Coverage.

A. An insurer or the agent soliciting long-term care coverage shall deliver to a prospective applicant, at the time of the initial solicitation, an outline of coverage in a manner which prominently directs the attention of the recipient to the document and its purpose.

B. Time of Delivery. In the case of:

(1) Solicitation by an agent, the agent shall deliver the outline of coverage before presenting an applicant or enrollment form to the prospective applicant;

(2) Direct response solicitations, the insurer shall deliver the outline of coverage in conjunction with any application or enrollment form.

C. The outline of coverage shall include:

(1) A description of the principal benefits and coverage provided under the policy or certificate;

(2) A statement of the principle exclusions, reductions, and limitations under the policy or certificate;

(3) A statement of the renewal provisions, including any reservation of the insurer's right to change the schedule of premiums;

(4) A statement of probable or expected premium increases, or additional premiums to pay for automatic or optional benefit increases, with these being presented in tabular form together with a graphic demonstration of the magnitude of potential premiums the applicant will need to pay from the effective date of the coverage up to age 75;

(5) A statement that the outline of coverage is a summary of the coverage applied for and that the individual policy or the group master policy should be consulted to determine the governing contractual provisions;

(6) A statement of the terms under which the policy or certificate may be returned for a refund of the premium;

(7) A brief description of the relationship of cost of care and benefits; and

(8) A statement that discloses to the policyholder or certificate holder whether the policy is intended to be a federally tax-qualified long-term care insurance contract under §7702B(b) of the Internal Revenue Code of 1986, as amended.

D. The format of the outline of coverage shall comply with the following:

(1) The outline of coverage shall be a free-standing document printed in at least 12-point or larger type;

(2) The outline of coverage may not contain any material of an advertising nature;

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

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

E. The insurer shall use the standard format and the required text of the outline of coverage shown in Regulation .21 of this chapter.

.19 Requirement To Deliver Buyer's Guide.

A. An insurer or agent shall deliver a long-term care insurance buyer's guide to prospective applicants of long-term care coverage in a format developed by the National Association of Insurance Commissioners or in a format approved by the Commissioner.

B. The insurer shall include in the buyer's guide information regarding the purchase of a long-term care insurance policy, including a reference of the right of the purchaser to return the policy for a refund during the first 30 days after the policy is delivered.

C. In the case of solicitation by an agent, the agent shall deliver the buyer's guide before presenting an application or enrollment form to the prospective applicant.

D. In the case of direct response solicitations, the insurer shall provide the buyer's guide to the applicant in conjunction with any application or enrollment form.

E. Life insurance policies or riders containing accelerated death benefits for long-term care are not required to furnish the long-term care insurance buyer's guide required by §A of this regulation, but shall furnish the policy summary required under Insurance Article, §18-108, Annotated Code of Maryland.

.20 Waivers.

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

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

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

C. Either the:

(1) Modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care,

(2) 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 that community, or

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

.21 Form of Outline of Coverage.

The format and the required text of the outline of coverage referred to in Regulation .18E of this chapter shall read as follows:

[COMPANY NAME]
[ADDRESS—CITY AND 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 may have 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. FEDERAL TAX CONSEQUENCES. This [policy][certificate] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

OR

Federal Tax Implications of this [policy] [certificate] This [policy] [certificate] is not intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. Benefits received under the [policy] [certificate] may be taxable as income.

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) [For long-term care health insurance policies or certificates, describe one of the following permissible policy renewability provision.]

(i) [Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS [POLICY] [CERTIFICATE] IS GUARANTEED RENEWABLE. (This means you have the right, subject to the terms of your [policy] [certificate] to continue this policy as long as you pay your premiums on time.) [Company name] cannot change any terms of your policy on its own except that in the future [the company] it may increase the premium you pay.

(ii) [Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS (POLICY) (CERTIFICATE) IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time.[Company name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, the company may increase your premium at that time for those additional benefits.

(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 no such provisions;

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

6. 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.]

7. 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 [insert 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.

8. 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, 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 a service benefit long-term care insurance rather than an indemnity policy.]

9. BENEFITS PROVIDED BY THIS POLICY.

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

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

(c) [Noninstitutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits.

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.]

[Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers 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.]

10. LIMITATIONS AND EXCLUSIONS.[Describe:

(a) Preexisting conditions;

(b) Noneligible facilities/providers;

(c) Noneligible levels of care (for example, 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 the benefits described in 9. above.] THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs 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) [Describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

12. 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.]

13. 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.]

14. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

.22 Replacement Notice.

The notice to an applicant regarding replacement of individual long-term care policies or other health insurance referred to in Regulation .06E of this chapter shall read as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF INDIVIDUAL LONG-TERM CARE OR HEALTH INSURANCE
(Insurance company's name and address)
SAVE THIS NOTICE!
IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing long-term care or health 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 protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all long-term care or health insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]: (Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

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. The law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent of time elapsed under the original policy or certificate.
3. If you are replacing existing long-term care insurance coverage, 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 everything that is involved in replacing your present coverage.
4. If, after you have thought about it, 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 in 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.

_____

(Signature of Agent, Broker or Other Representative)

_____

(Typed Name and Address of Agent or Broker)

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

(Date)

_____

(Applicant's Signature)

.23 Replacement Notice for Direct Response Business.

The notice to an applicant with respect to direct response solicitation of individual long-term care policies or other health insurance referred to in Regulation .06F of this chapter shall read as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF LONG-TERM CARE OR HEALTH INSURANCE
(Insurance company's name and address)
SAVE THIS NOTICE!
IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing long-term care or health insurance and replace it with the long-term care insurance policy issued by [company name] Insurance Company and delivered with this notice. 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.

You should review this new coverage carefully, comparing it with all long-term care and health insurance coverage you now have, and terminate your present policy only if, after you have thought about it, you find that purchase of this long-term care coverage is a wise decision.

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. The law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your new insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent of time elapsed under the original policy or certificate.
3. If you are replacing existing long-term care insurance coverage, 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 everything that is involved in replacing your present coverage.
4. If, after due consideration and more thought to the matter, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application delivered with this notice 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 relevant matters and particularly any past medical history have been left out of the application.

_____

(Company Name)

.24 Reporting Requirements.

A. Every insurer shall maintain records for each insurance producer of the:

(1) Insurance producer's amount of replacement sales as a percent of the insurance producer's total annual sales; and

(2) Amount of lapses of long-term care insurance policies sold by the insurance producer as a percent of the insurance producer's total annual sales.

B. Each insurer shall report annually by June 30 the 10 percent of its insurance producers with the greatest percentages of lapses and replacements as measured by §A of this regulation.

C. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing.

D. The reports required under §§C, E, and F of this regulation are for the purpose of reviewing more closely insurance producer activities regarding the sale of long-term care insurance.

E. Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

F. Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.

G. Qualified Long-Term Care Contracts.

(1) 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.

(2) The report required in §G(1) of this regulation shall be in the format specified in Regulation .32 of this chapter.

.25 Suitability.

A. This regulation does not apply to life insurance policies that accelerate the death benefits for long-term care.

B. Each insurer shall:

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

(2) Train its insurance producers in the use of its suitability standards; and

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

C. Procedures.

(1) To determine whether the applicant meets the standards developed by the insurer, the insurance producer and insurer shall develop procedures that take the following into consideration:

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

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

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

(2) Collection of Information from Applicant.

(a) The insurer, and if an insurance producer is involved, the insurance producer shall make reasonable efforts to obtain the information described in §C(1) of this regulation.

(b) The efforts to obtain the information described in §C(1) of this regulation shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet".

(c) The personal worksheet used by the insurer shall contain, at a minimum, the information in the format contained in COMAR 31.14.02.08, in not less than 12-point type.

(d) The insurer may request the applicant to provide additional information to comply with its suitability standards.

(e) A copy of the insurer's personal worksheet shall be filed with the Commissioner.

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

(4) An insurer or insurance producer may not sell or disseminate outside the company or agency any information obtained through the personal worksheet set forth in COMAR 31.14.02.08.

D. The insurer shall use the suitability standards it has developed under this regulation in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

E. Insurance producers shall use the suitability standards developed by the insurer in marketing long-term care insurance.

F. Disclosure Form.

(1) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided.

(2) The form described in §F(1) of this regulation shall be in the format contained in Regulation .30 of this chapter, in not less than 12-point type.

G. Procedure to Follow if Applicant Does Not Meet Suitability Standards.

(1) If the insurer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the insurer may reject the application.

(2) As an alternative to rejecting the application as described in §G(1) of this regulation, the insurer shall send the applicant a letter similar to that found in Regulation .31 of this chapter.

(3) If the applicant has declined to provide financial information, the insurer may use some other method than the method described in this regulation to verify the applicant's intent.

(4) The insurer shall make either the applicant's returned letter or a record of the alternative method of verification a part of the applicant's file.

H. The insurer shall report annually by March 31 to the Commissioner the:

(1) Total number of applications received from residents of this State;

(2) Number of those who declined to provide information on the personal worksheet;

(3) Number of applicants who did not meet the suitability standards; and

(4) Number of those who chose to confirm after receiving a suitability letter.

.26 Standards for Benefit Triggers.

A. Conditions for Payment of Benefits.

(1) A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment.

(2) An insurer may not establish the eligibility criteria for the payment of benefits on a more restrictive basis than:

(a) A deficiency in the ability to perform not more than three of the activities of daily living; or

(b) The presence of cognitive impairment.

B. Activities of Daily Living.

(1) Activities of daily living shall include at least the following as defined in Regulation .02 of this chapter and in the policy:

(a) Bathing;

(b) Continence;

(c) Dressing;

(d) Eating;

(e) Toileting; and

(f) Transferring.

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

C. Additional Provisions for Benefit Determination.

(1) An insurer may use provisions in addition to those described in §§A and B of this regulation for the determination of when benefits are payable under a policy or certificate.

(2) The provisions permitted by §C(1) of this regulation may not restrict, and are not in place of, the requirements contained in §§A and B of this regulation.

D. For purposes of this regulation, the determination of a deficiency may not be more restrictive than:

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

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

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

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

G. The requirements set forth in this regulation are effective April 1, 2003, and apply as follows:

(1) Except as provided in §G(2) of this regulation, the provisions of this regulation apply to a long-term care policy issued in Maryland on or after April 1, 2003; and

(2) The provisions of this regulation do not apply to certificates issued on or after April 1, 2003, if the certificates are issued under an employer group long-term care insurance policy that was in force before April 1, 2003.

.27 Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts.

A. In this regulation, the following terms have the meanings indicated.

B. Terms Defined.

(1) Chronically Ill Individual.

(a) "Chronically ill individual" means any individual who has been certified by a licensed health care practitioner as:

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

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

(b) "Chronically ill individual" does not include an individual otherwise meeting the requirements in §B(1)(a) of this regulation unless within the preceding 12-month period a licensed health care practitioner has certified that the individual meets the requirements of §B(1)(a) of this regulation.

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

(3) Maintenance or Personal Care Services.

(a) "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual.

(b) "Maintenance or personal care services" includes care that provides protection from threats to health and safety due to severe cognitive impairment.

(4) Qualified Long-Term Care Services.

(a) "Qualified long-term care services" means services that meet the requirements of §7702(c)(1) of the Internal Revenue Code of 1986, as amended.

(b) "Qualified long-term care services" includes the following necessary services that are required by a chronically ill individual, and are provided under a plan of care prescribed by a licensed health care practitioner:

(i) Diagnostic services;

(ii) Preventive services;

(iii) Therapeutic services,

(iv) Curative services;

(v) Treatment services;

(vi) Mitigation services;

(vii) Rehabilitative services; and

(viii) Maintenance or personal care services.

C. A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided under a plan of care prescribed by a licensed health care practitioner.

D. A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.

E. Certifications regarding activities of daily living and cognitive impairment required under §D of this regulation shall be performed by the following licensed or certified professionals:

(1) Physicians;

(2) Registered professional nurses;

(3) Licensed social workers; or

(4) Other individuals who meet requirements prescribed by the United States Secretary of the Treasury.

F. Permissible Frequency of Certifications.

(1) Certifications required under §D of this regulation may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except as described in §F(2) of this regulation.

(2) If a licensed health care practitioner has certified that the insured is unable to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and if the insured is in claim status, an insurer may not rescind a certification or require that additional certifications be performed until the 90-day period under §F(1) of this regulation expires.

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

.28 Penalties.

In addition to any other penalties provided by the laws of this State, any insurer and any insurance producer found to have violated any requirement of this State relating to the regulation of long-term care insurance or the marketing of long-term care insurance shall be subject to a penalty of up to three times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

.29 Rescission.

Reporting Form for Long-Term Care Policies. The following form is to be used for reporting rescissions made by each insurer as required by Regulation .09C of this chapter:

RESCISSION REPORTING FORM FOR LONG-TERM CARE POLICIES FOR THE STATE OF FOR THE REPORTING YEAR 20[ ]

Company Name: _____

Address: _____

Phone Number: _____

Due: March 1 annually

Instructions:

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form#	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission: _____

_____

_____
Signature

_____
Name and Title (please type)

_____
Date

.30 Things You Should Know Before You Buy Long-Term Care Insurance.

The following form is to be used for providing the disclosure required by Regulation .25F of this chapter:

Things You Should Know Before You Buy Long-Term Care Insurance

Long-Term Care Insurance	• A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
	• [You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]
Drafting Note: For single premium policies, delete bracketed bullet above; for noncancellable policies, delete the second sentence only.	
	• The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
Medicare	• Medicare does **not** pay for most long-term care.
Medicaid	• Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
	• Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
	• When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
	• Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.
Shopper's Guide	• Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have

	decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.
Counseling	• Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.
Facilities	• Some long term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

.31 Long-Term Care Insurance Suitability Letter.

The following form is to be used for providing the disclosure required by Regulation .25G of this chapter:

Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, State law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

Drafting Note: Choose the paragraph that applies.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

[] Yes, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

[] No. I have decided not to buy a policy at this time.

_____ _____
APPLICANT'S SIGNATURE DATE

Please return to [issuer] at [address] by [date].

.32 Claims Denial Reporting Form.

The following form is to be used for reporting claim denials made by each insurer as required by Regulation .24G of this chapter:

For the State of

Company Name: _____ Due: June 30 annually
Company Address: _____
Company NAIC Number: _____
Contact Person: _____ Phone Number: _____
Line of Business: _____ Individual _____ Group

Instructions

The purpose of this form is to report all long-term care claim denials under in force long-term care insurance policies. "Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

		State Data	Nationwide Data[1]
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Long-Term Care Claim Denied due to:		
8	• Long-Term Care Services Not Covered under the Policy[2]		
9	• Provider/Facility Not Qualified under the Policy[3]		
10	• Benefit Eligibility Criteria Not Met[4]		
11	• Other		

1 The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.

2 Example—home health care claim filed under a nursing home only policy.

3 Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.

4 Examples—a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

.33 Incontestability Period.

A. Except as provided in §G of this regulation, §§B—F of this regulation apply to each qualified long-term care insurance policy.

B. Policies In Force Less Than 6 Months.

(1) This section applies to a long-term care insurance policy that has been in force for less than 6 months.

(2) Unless the insurer demonstrates that the applicant misrepresented information on the application for the long-term insurance policy that is material to the acceptance for coverage, an insurer may not:

(a) Rescind the policy described in §B(1) of this regulation; or

(b) Deny an otherwise valid long-term care insurance claim under the policy described in §B(1) of this regulation.

C. Policies in Force at Least 6 Months, but Less than 2 Years.

(1) This section applies to a long-term care insurance policy that has been in force for at least 6 months, but less than 2 years.

(2) Unless the insurer demonstrates that the applicant misrepresented information on the application for the long-term insurance policy that is material to the acceptance for coverage and that pertains to the condition for which benefits are sought, an insurer may not:

(a) Rescind a long-term care insurance policy described in §C(1) of this regulation; or

(b) Deny an otherwise valid long-term care insurance claim under a policy described in §C(1) of this regulation.

D. Policies In Force 2 Years or More.

(1) After a long-term care insurance policy has been in force for 2 years it is not contestable upon the grounds of misrepresentation alone.

(2) An insurer may not contest a policy described in §D(1) of this regulation, unless the insurer can demonstrate that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

E. A long-term care insurance policy may be field issued, if the compensation to the field issuer is not based on the number of policies or certificates issued.

F. If an insurer has paid benefits under the long-term care insurance policy, the insurer may not recover the benefit payments if the policy is rescinded.

G. Life Insurance Policy That Accelerates Benefits for Long-Term Care.

(1) In the event of the death of the insured, this regulation may not be applied to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care.

(2) In the situation described in §G(1) of this regulation, the remaining death benefits under the life insurance policy that accelerates the benefits for long-term care shall be governed by Insurance Article, §16-203, Annotated Code of Maryland.

(3) Except as described in §G(1)—(2) of this regulation, this regulation shall apply to life insurance policies that accelerate benefits for long-term care.

.34 Producer Training Requirements.

A. An insurance producer is not authorized to sell, solicit, or negotiate with respect to long-term care insurance except as authorized by Insurance Article, Title 10, Subtitle 1, Annotated Code of Maryland.

B. An individual may not sell, solicit, or negotiate long-term care insurance unless the individual is licensed as an insurance producer for health insurance or life insurance and complies with the following training requirements:

(1) Completes a one-time training course before:

(a) The date the individual sells, solicits, or negotiates long-term care insurance in Maryland, if the individual is not licensed and selling, soliciting, or negotiating long-term care insurance on the effective date of this regulation; or

(b) September 10, 2008, if the individual is already licensed and selling, soliciting, or negotiating long-term care insurance on the effective date of this regulation; and

(2) Completes ongoing training every 24 months after completing the one-time training course described in §B(1) of this regulation.

C. The training required by §B of this regulation shall meet the requirements set forth in §E of this regulation.

D. The training requirements of §E of this regulation may be approved as continuing education courses under Insurance Article, §10-116, Annotated Code of Maryland.

E. Specific Training Requirements for Solicitation of Long-Term Care Insurance.

(1) Required Length of Training.

(a) The one-time training required by §B(1) of this regulation may not be less than 8 hours.

(b) The ongoing training required by §B(2) of this regulation may not be less than 4 hours.

(2) The training required under §E(1) of this regulation shall consist of topics related to long-term care insurance, long-term care services, and qualified long-term care insurance Partnership programs, including, but not limited to:

(a) State and federal regulations and requirements and the relationship between qualified State long-term care insurance Partnership programs and other public and private coverage of long-term care services, including Medicaid;

(b) Available long-term care services and providers;

(c) Changes or improvements in long-term care services or providers;

(d) Alternatives to the purchase of private long-term care insurance;

(e) The effect of inflation on benefits and the importance of inflation protection; and

(f) Consumer suitability standards and guidelines.

(3) The training required by this regulation may not include training that:

(a) Is insurer or company product specific; or

(b) Includes any sales or marketing information, materials, or training, other than those required by State or federal law.

F. Insurers subject to this chapter shall:

(1) Obtain verification that an insurance producer receives training required by §B of this regulation before an insurance producer is permitted to sell, solicit, or negotiate the insurer's long-term care insurance products;

(2) Maintain records subject to the State's record retention requirements; and

(3) Make the verification described in §F(1) of this regulation available to the Commissioner upon request.

G. Maintenance of Records.

(1) Insurers subject to this chapter shall maintain records with respect to the training of its insurance producers concerning the distribution of its Partnership policies that will allow the Maryland Insurance Administration to provide assurance to the State Medicaid agency that insurance producers have:

(a) Received the training contained in §E(2)(a) of this regulation as required by §B of this regulation; and

(b) Demonstrated an understanding of the Partnership policies and their relationship to public and private coverage of long term care, including Medicaid, in Maryland.

(2) The records required by §G(1) of this regulation shall be:

(a) Maintained in accordance with the State's record retention requirements; and

(b) Made available to the Commissioner upon request.

H. The satisfaction of the training requirements described in this regulation in any state shall be deemed to satisfy the training requirements in Maryland.

.35 Availability of New Services or Providers.

A. Notice Requirement.

(1) Except as provided in §B of this regulation, an insurer shall notify policyholders and certificate holders of the availability of a new long-term care insurance policy series that provides coverage for new long-term care services or providers, material in nature, and not previously available through the insurer to the general public.

(2) The notice required by §A(1) of this regulation shall be provided within 12 months of the date the new policy series is made available for sale in Maryland.

B. The notification described in §A of this regulation is not required to be provided:

(1) For any policy issued prior to the effective date of this regulation; or

(2) To any policyholder or certificate holder who:

(a) Is currently eligible for benefits within an elimination period or on a claim;

(b) Previously had been in claim status; or

(c) Would not be eligible to apply for coverage due to issue age limitations under the new policy.

C. The insurer may require that policyholders or certificate holders meet all eligibility requirements, including underwriting and payment of the required premium, to add the new services or providers described in §A of this regulation.

D. The insurer shall make the new coverage available in one of the following ways:

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

(2) By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate;

(3) By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged; or

(4) By an alternative program developed by the insurer that meets the intent of this regulation, if the program is filed with and approved by the Commissioner.

E. The premium credits described in §D(2) of this regulation shall be based on premiums paid or reserves held for the prior policy or certificate.

F. The cost for the new policy or certificate described in §D(3) of this regulation may recognize the difference in reserves between the new policy or certificate and the original policy or certificate.

G. Notification When New Policies Used in Limited Distribution Channels.

(1) An insurer is not required to notify policyholders or certificate holders of a new proprietary policy series created and filed for use in a limited distribution channel.

(2) Policyholders or certificate holders that purchased the new proprietary policy described in §G(1) of this regulation shall be notified when a new long-term care policy series that provides coverage for new long-term care services or providers, material in nature, is made available to that limited distribution channel.

H. Exchanges.

(1) Policies issued pursuant to this regulation shall be considered exchanges and not replacements.

(2) Exchanges made under this regulation are not subject to:

(a) The requirements of Regulations .06 and .25 of this chapter; and

(b) The reporting requirements of §§A—F of Regulation .24 of this chapter.

I. Notices for Group Policies.

(1) Except as provided in §I(2) of this regulation, if the policy is offered through an employer, labor organization, professional, trade or occupational association, the required notification in §A of this regulation shall be made to the offering entity.

(2) If the policy is issued to a group not listed in Insurance Article, §15-302(b)(2), (c)(2), or (d)(2), Annotated Code of Maryland, the notification required by §A of this regulation shall be provided to each certificate holder.

J. Right to Purchase New Benefits.

(1) This regulation does not prohibit an insurer from offering any policy, rider, certificate, or coverage change to any policyholder or certificate holder.

(2) Upon request, any policyholder or certificate holder may apply for currently available coverage that includes the new services or providers.

(3) The insurer may require that policyholders or certificate holders meet all eligibility requirements, including underwriting and payment of the required premium to add the new services or providers.

K. This regulation does not apply to life insurance policies or riders containing accelerated death benefit long-term care benefits.

L. This regulation shall become effective on September 10, 2007.

.36 Right to Reduce Coverage and Lower Premiums.

A. Required Provision in Long-Term Care Insurance Policies and Certificates.

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

(a) Reducing the maximum benefit; or

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

(2) An insurer may also offer reduction options other than those described in §A(1) of this regulation, if the reduction options are consistent with the policy or certificate design or the insurer's administrative processes.

B. The provision required by §A of this regulation shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

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

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

E. If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificate holder of his or her right to reduce coverage and premiums in the notice required by Regulation .07F of this chapter.

F. This regulation does not apply to life insurance policies or riders containing accelerated death benefit long-term care benefits.

G. The requirements of this regulation shall apply to any long-term care policy issued in Maryland on or after September 10, 2008.

Administrative History

Effective date: September 1, 1994 (21:13 Md. R. 1156)

_____

Chapter recodified from COMAR 09.30.88 to COMAR 31.14.01, July 1998
Chapter revised effective April 1, 2002 (29:6 Md. R. 570)

_____

Chapter revised effective September 10, 2007 (34:18 Md. R. 1581)
Regulation .01 amended effective September 1, 2014 (41:17 Md. R. 972)

This Page Intentionally Left Blank

Title 31
MARYLAND INSURANCE ADMINISTRATION

Subtitle 14 LONG-TERM CARE

Chapter 02 Long-Term Care Insurance — Premium Rates and Reserves

Authority: Health-General Article, §19-705; Insurance Article, §§2-109, 14-124, Title 18, Subtitle 1, and Title 27; Annotated Code of Maryland

.01 Applicability and Scope.

This chapter applies to all long-term care insurance delivered or issued for delivery in this State by insurers, nonprofit health service plans, and health maintenance organizations. This chapter is not intended to supersede other applicable insurance laws or regulations which do not conflict with this chapter.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Employer group long-term care insurance" means a long-term care insurance policy that is:

(a) Issued or delivered in Maryland to:

(i) One or more employers or labor organizations; or

(ii) A trust or the trustees of a fund established by one or more employers or labor organizations, or by a combination of employers or labor organizations; and

(b) Designed for:

(i) Employees or former employees, or a combination of employees and former employees, of the employer or employers; or

(ii) Members or former members, or a combination of members and former members, of the labor organization or labor organizations.

(2) "Exceptional increase" means only those increases filed by an insurer as exceptional for which the Commissioner determines that the need for a premium rate increase is justified due to:

(a) Changes in laws or regulations applicable to long-term care coverage in the State; or

(b) Increased and unexpected utilization that affects the majority of insurers of similar products.

(3) "Incidental" means that the value of the long-term care benefits provided, as of the date of issue, is less than 10 percent of the total value of the benefits provided over the life of the policy.

(4) Long-Term Care Insurance.

(a) "Long-term care insurance" means any group or individual insurance policy, contract, certificate, or rider issued, delivered, or offered by an insurer that:

(i) Is advertised, marketed, offered, or designed to provide coverage for not less than 24 consecutive months for covered persons on an expense incurred, indemnity, prepaid, or insured basis; and

(ii) Provides one or more necessary or appropriate diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a situation other than an acute care unit of a hospital.

(b) Long-term care insurance includes any product that is advertised, marketed, or offered as long-term care insurance.

(c) "Long-term care insurance" does not include any insurance policy, contract, certificate, or rider which is offered primarily to provide:

(i) Basic Medicare supplement coverage;

(ii) Hospital confinement indemnity coverage;

(iii) Basic hospital expense or medical-surgical expense coverage;

(iv) Disability income protection coverage;

(v) Accident-only coverage;

(vi) Specified disease or specified accident coverage; or

(vii) Skilled nursing care.

(d) "Long-term care insurance" does not include benefits provided under any life insurance policy, contract, or rider:

(i) That accelerates the death benefit specifically for one or more of the qualifying events of terminal illness, a medical condition requiring extraordinary medical intervention, permanent institutional confinement, or institutional confinement for a lengthy confinement;

(ii) That provides the option of a lump-sum payment for one or more of the benefits in §B(4)(d)(i) of this regulation; or

(iii) In which neither benefits nor eligibility for benefits is conditioned on receipt of long-term care.

(e) "Long-term care insurance" does not include any certificate issued under an out-of-State employer group contract.

(5) "Loss ratio" means the ratio of losses incurred to premiums earned on policies issued, delivered, or renewed in the State.

(6) "Out-of-State employer group contract" means a group contract that is:

(a) Entered into with an employer in a state other than Maryland; and

(b) Issued directly to an employer under the laws of that employer's state.

(7) "Policy" means any group or individual policy, contract, subscriber agreement, rider, certificate, or endorsement delivered or issued for delivery in the State by an insurer, a nonprofit health service plan, health maintenance organization, or a preferred provider organization.

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

(9) Similar Policy Forms.

(a) "Similar policy forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered.

(b) With respect to certificates issued under employer group long-term care insurance policies, "similar policy forms" includes other certificates issued under employer group long-term care insurance policies with the same long-term care benefit classifications.

(c) With respect to certificates issued under employer group long-term care insurance policies, "similar policy forms" does not include certificates or policies issued as long-term care insurance, except those certificates described in §B(9)(b) of this regulation.

(d) For purposes of determining similar policy forms, long-term care policies and certificates shall be considered in the following three separate long-term care benefit classifications:

(i) Institutional long-term care benefits only;

(ii) Noninstitutional long-term care benefits only; or

(iii) Comprehensive long-term care benefits.

.03 Required Disclosure of Rating Practices to Consumers.

A. Applicability.

(1) Except as provided in §A(2) of this regulation, the provisions of this regulation apply to any long-term care policy or certificate issued in this State on or after October 1, 2002.

(2) For certificates issued on or after April 1, 2002, under an employer group long-term care insurance policy that was in force on April 1, 2002, the provisions of this regulation apply on the policy anniversary following April 1, 2003.

B. Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in §D of this regulation to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time.

C. If the method of application does not allow for delivery at the time of application or enrollment, an insurer shall provide all of the information listed in §D of this regulation to the applicant no later than the time of delivery of the policy or certificate.

D. The insurer shall provide the following information to the applicant in accordance with §§B and C of this regulation:

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

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

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

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

(a) A description of when premium rate or rate schedule adjustments will be effective (for example, next anniversary date or next billing date); and

(b) The right to a revised premium rate or rate schedule as provided in §D(2) of this regulation if the premium rate or rate schedule is changed; and

(5) Information regarding each premium rate increase on the policy form or similar policy forms over the past 10 years for Maryland or any other state that, at a minimum, identifies:

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

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

(c) The amount or percent of each increase, expressed as a percentage of the premium rate before the increase, or as minimum and maximum percentages if the rate increase is variable by rating characteristics.

E. The insurer may, in a fair manner, provide explanatory information related to the rate increases in addition to the information required in §D(5) of this regulation.

F. An insurer may exclude premium rate increases from the disclosure required by §D(5) of this regulation, if the premium rate increases only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred before the acquisition.

G. Disclosure Required for Initial Rate Increases on Acquired Insurance.

(1) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of April 1, 2002, or the end of a 24-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure required by §D(5) of this regulation.

(2) The nonaffiliated selling company shall include the disclosure of the rate increase referenced in §G(1) of this regulation in accordance with §D(5) of this regulation.

H. Disclosure Required for Subsequent Rate Increases on Acquired Insurance.

(1) This section applies if the acquiring insurer referenced in §G of this regulation files for a rate increase after the rate increase described in §G of this regulation on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in §G of this regulation.

(2) The acquiring insurer described in §H(1) of this regulation shall make all disclosures required by §D(5) of this regulation.

(3) The disclosures required under §H(2) of this regulation apply to all rate increases after the initial rate increase described in §G of this regulation, including subsequent rate increases within the 24-month period referenced in §G of this regulation.

(4) The disclosure required by this section shall include the disclosure of the earlier rate increase referenced in §G of this regulation.

I. Acknowledgement.

(1) Unless the method of application does not allow for signature at the time of application, an applicant shall sign an acknowledgement at the time of application that the insurer made the disclosure required under §D(1) and (5) of this regulation.

(2) If, due to the method of application, the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

J. An insurer shall use the forms set forth in Regulations .08 and .09 of this chapter to comply with the requirements of §D of this regulation.

K. Notice of Premium Rate Schedule Increase.

(1) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, if applicable, at least 45 days before the implementation of a premium rate schedule increase by the insurer.

(2) A notice shall include the information required by §D of this regulation when a rate increase is implemented.

.04 Initial Filing Requirements.

A. This regulation applies to any long-term care policy issued in Maryland on or after October 1, 2002.

B. An insurer shall provide the following information to the Commissioner at least 60 days before making a long-term care insurance form available for sale:

(1) A copy of the disclosure documents required by Regulation .03 of this chapter; and

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

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

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

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

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

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

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

(iii) A statement that the net valuation premium for renewal years does not increase; and

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

(e) One of the following:

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

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

C. In providing the statement required by §B(2)(d)(iv) of this regulation, the insurer may base this statement on the following:

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

(2) If the gross premiums for certain age groups appear to be inconsistent with the requirement in §B(2)(d)(iv) of this regulation, the Commissioner may request a demonstration under §D of this regulation based on a standard age distribution.

D. Additional Information.

(1) The Commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums.

(2) The actuarial demonstration shall include:

(a) Premium and claim experience on similar policy forms, adjusted for any premium or benefit differences;

(b) Relevant and credible data from other studies; or

(c) Information described in §D(2)(a) and (b) of this regulation.

(3) If the Commissioner asks for additional information under this section, the period in §B of this regulation does not include the period during which the insurer is preparing the requested information.

.05 Loss Ratio.

A. This regulation applies to all long-term care insurance policies or certificates except those covered under Regulations .04 and .06 of this chapter.

B. Minimum Loss Ratios.

(1) Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums if the expected loss ratio is at least 60 percent, calculated in a manner which provides for adequate reserving of the long-term care insurance risk.

(2) In evaluating the expected loss ratio described in §B(1) of this regulation, 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 the coverage;

(k) Policy reserves;

(l) Mix of business by risk classification; and

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

C. Life Insurance Policies that Accelerate Benefits for Long-Term Care.

(1) Section B of this regulation does not apply to life insurance policies that accelerate benefits for long-term care.

(2) A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if all of the following requirements are met:

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

(b) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of Insurance Article, Title 16, Subtitle 3, Annotated Code of Maryland;

(c) The policy meets the disclosure requirements of Insurance Article, §§18-108 and 18-117, Annotated Code of Maryland;

(d) Any policy illustration used for the policy meets the applicable requirements of COMAR 31.09.09; and

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

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

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

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

(iv) A description and a table of each actuarial assumption used;

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

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

(vii) A statement as to whether underwriting is performed at the time of application; and

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

(3) For the expense assumptions under §C(2)(e)(iv) of this regulation, an insurer shall include the percent of premium dollars per policy and the dollars per unit of benefits, if any.

(4) The statement required by §C(2)(e)(vii) of this regulation shall indicate whether underwriting is used. If underwriting is used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. If coverage is under a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs.

.06 Premium Rate Schedule Increases.

A. Applicability.

(1) Except as provided in §A(2) of this regulation, the provisions of this regulation apply to any long-term care policy or certificate issued in this state on or after October 1, 2002.

(2) For certificates issued on or after the effective date of this amended regulation under an employer group long-term care insurance policy that was in force on April 1, 2002, the provisions of this regulation apply on the policy anniversary following April 1, 2003.

B. Premium Rate Increase Filing Requirements.

(1) An insurer shall request approval of a pending premium rate schedule increase, including an exceptional increase, to the Commissioner at least 45 days before the notice to the policyholders.

(2) The notice to the Commissioner required by §B(1) of this regulation shall include:

(a) Information required by Regulation .03 of this chapter;

(b) Certification by a qualified actuary that:

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

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

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

(i) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase;

(ii) The method and assumptions used in determining the lifetime projections described in §B(2)(c)(i) of this regulation, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

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

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

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

(vi) If it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, composite rates reflecting projections of new certificates;

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

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

(3) The lifetime projection and assumptions required to be filed under §B(2)(c)(i) and (ii) of this regulation shall comply with the following requirements:

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

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

(c) The projections shall demonstrate compliance with §C of this regulation; and

(d) For exceptional increases:

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

(ii) If the Commissioner determines as provided in Regulation .07C of this chapter that offsets may exist, the insurer shall use appropriate net projected experience.

C. All premium rate schedule increases shall be determined in accordance with the following requirements:

(1) Exceptional increases shall provide that 70 percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(2) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, is not less than the sum of the following:

(a) The accumulated value of the initial earned premium times 58 percent;

(b) 85 percent of the accumulated value of prior premium rate schedule increases on an earned basis;

(c) The present value of future projected initial earned premiums times 58 percent; and

(d) 85 percent of the present value of future projected premiums not in §C(2)(c) of this regulation on an earned basis;

(3) If a policy form has both exceptional and other increases, the values in §C(2)(b) and (d) shall also include 70 percent for exceptional rate increase amounts;

(4) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in Regulation .13 of this chapter; and

(5) The actuary shall disclose as a part of the actuarial memorandum the use of any appropriate averages.

D. Updated Projections.

(1) For each rate increase that is implemented, the insurer shall file for approval by the Commissioner updated projections, as described in §B(2)(c)(i) and (ii) of this regulation, annually for the next 3 years and include a comparison of actual results to projected values.

(2) The Commissioner may extend the period to greater than 3 years if actual results are not consistent with projected values from prior projections.

(3) For group insurance policies that meet the conditions in §K of this regulation, the projections required by this section shall be provided to the policyholder instead of filing with the Commissioner.

E. Lifetime Projections.

(1) If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as described in §B(2)(c)(i) and (ii) of this regulation, shall be filed for approval by the Commissioner every 5 years following the end of the required period in §D of this regulation.

(2) For group insurance policies that meet the conditions in §K of this regulation, the projections required by this section shall be provided to the policyholder instead of filing with the Commissioner.

F. Commissioner's Authority if Actual Experience Does Not Match Projected Experience.

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

(a) Premium rate schedule adjustments; or

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

(2) In determining whether the actual experience adequately matches the projected experience, consideration shall be given to §B(2)(c)(vi) of this regulation, if applicable.

G. Filing Required if Rate Increase Causes Eligibility for Contingent Benefit.

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

(a) A plan, subject to Commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; and

(b) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to §C of this regulation had the greater of the original anticipated lifetime loss ratio or 58 percent been used in the calculations described in §C(2)(a) and (c) of this regulation.

(2) If the insurer fails to file the plan required by §G(1)(a) of this regulation or fails to receive approval from the Commissioner of the plan filed under §G(1)(a) of this regulation, the Commissioner may impose the condition in §H of this regulation.

H. Lapse Rates.

(1) The Commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated, if a rate increase filing meets the following criteria:

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

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

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

(2) If the Commissioner determines during the review described in §H(1) of this regulation that significant adverse lapsation has occurred, is anticipated in the filing, or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the Commissioner may determine that a rate spiral exists.

(3) If the Commissioner determines that a rate spiral exists as described in §H(2) of this regulation, the Commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(4) The offer required by §H(3) of this regulation shall:

(a) Be subject to the approval of the Commissioner;

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

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

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

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

(b) The maximum rate increase determined based only on the experience of insureds originally issued the form plus 10 percent.

I. If the Commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the Commissioner may, in addition to the provisions of §H of this regulation, prohibit the insurer from either of the following:

(1) Filing and marketing comparable coverage for a period of up to 5 years; or

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

J. Exemption for Incidental Coverage.

(1) Sections A—I of this regulation do not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in Regulation .02B(3) of this chapter, if the policy complies with all of the following requirements:

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

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

(i) The standard nonforfeiture requirements for life insurance found in Insurance Article, Title 16, Subtitle 3, Annotated Code of Maryland;

(ii) The standard nonforfeiture requirements for individual deferred annuities found in Insurance Article, Title 16, Subtitle 5, Annotated Code of Maryland; or

(iii) The requirements for variable annuities found in COMAR 31.09.04;

(c) The policy meets the disclosure requirements of Insurance Article, §§18-108 and 18-117, Annotated Code of Maryland;

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

(i) Policy illustrations for life insurance as required by COMAR 31.09.09;

(ii) Disclosure requirements for annuities as required by COMAR 31.15.04; and

(iii) Disclosure requirements for variable annuities as required by COMAR 31.09.04;

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

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

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

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

(iv) A description and a table of each actuarial assumption used;

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

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

(vii) A statement as to whether underwriting is performed at the time of application; and

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

(2) For the expense assumptions used in §J(1)(e)(iv) of this regulation, an insurer shall include percent of premium dollars per policy and dollars per unit, if any.

(3) Contents of Statement on Underwriting.

(a) The statement required by §J(1)(e)(vii) of this regulation shall indicate whether underwriting is used.

(b) If underwriting is used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting.

(c) If coverage is under a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs.

K. Sections F and H of this regulation do not apply to employer group long-term care insurance if:

(1) The policies insure 250 or more individuals and the policyholder has 5,000 or more eligible employees of a single employer; or

(2) The policyholder, and not the certificate holders, pays a material portion of the premium, which may not be less than 20 percent of the total premium for the group in the calendar year before the year a rate increase is filed.

.07 Exceptional Premium Rate Increases.

A. Except as provided in Regulation .06 of this chapter, exceptional increases are subject to the same requirements as other premium rate schedule increases.

B. The Commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.

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

.08 Long-Term Care Personal Worksheet.

The disclosure required by Regulation .03J of this chapter shall read as follows:

Long-Term Care Insurance

Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _____

The premium for the coverage you are considering will be [$_____ per month, or $_____ per year,] [a one-time single premium of $_____.]

Type of Policy (noncancellable/guaranteed renewable):

The Company's Right to Increase Premiums:

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.]

Drafting Note: A company may use the first bracketed sentence above only if it has never increased rates under any prior policy forms in this state or any other state. The issuer shall list each premium increase it has instituted on this or similar policy forms in this state or any other state during the last 10 years. The list shall provide the policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.

Questions Related to Your Income

How will you pay each year's premium?

[ ] From my Income

[ ] From my Savings/Investments

[ ] My Family will Pay

[[ ] Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?]

Drafting Note: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.

What is your annual income? (check one)

[ ] Under $10,000

[ ] $[10-20,000]

[ ] $[20-30,000]

[ ] $[30-50,000]

[ ] Over $50,000

Drafting Note: The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)

[ ] No change

[ ] Increase

[ ] Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) [ ] Yes [ ] No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

[] From my Income

[ ] From my Savings/Investments

[ ] My Family will Pay

The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In 10 years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

Drafting Note: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.

What elimination period are you considering? Number of days ____ Approximate cost $_____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

[ ] From my Income

[ ] From my Savings/Investments

[ ] My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

[ ] Under $20,000

[ ] $20,000-$30,000

[ ] $30,000-$50,000

[ ] Over $50,000

How do you expect your assets to change over the next 10 years? (check one)

[ ] Stay about the same

[ ] Increase

[ ] Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

[ ] The answers to the questions above describe my financial situation.

Or

[ ] I choose not to complete this information.

(Check one.)

[ ] I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history, and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history, and potential for premium increases in the future.] I understand the above disclosures. I understand that the rates for this policy may increase in the future. (This box must be checked).

Signed: _____

(Applicant) (Date)

([ ] I explained to the applicant the importance of completing this information.

Signed: _____

(Agent) (Date)

Agent's Printed Name: _____)

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____]

(Applicant) (Date)

Drafting Note: Choose the appropriate sentences depending on whether this is a direct mail or agent sale.

The company may contact you to verify your answers.

Drafting Note: When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.

.09 Potential Rate Increase Disclosure Form.

The disclosure required by Regulation .03J of this chapter shall read as follows:

Long-Term Care Insurance

Potential Rate Increase Disclosure Form

1. **[Premium Rate] [Premium Rate Schedules]:** [Premium rate] [Premium rate schedules] that [is] [are] applicable to you and that will be in effect until a request is made and [filed] [approved] for an increase [is] [are] [on the application] [$])

Drafting Note: Use "approved" in states requiring prior approval of rates.

2. **The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.**

3. **Rate Schedule Adjustments:**

The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): .

4. **Potential Rate Revisions:**

This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can **NOT** be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

*** Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

• Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and

• You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

• You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.

• In the 11th year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).

• Your "paid-up" policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your policy.)

Contingent Nonforfeiture

Cumulative Premium Increase over Initial Premium
That Qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue.
It does **NOT** represent a one-time increase.)

Issue Age	***Percent Increase Over Initial Premium***
29 and under	200%
30—34	190%
35—39	170%
40—44	150%
45—49	130%
50—54	110%
55—59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%

70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

{The following contingent nonforfeiture disclosure need only be included for those limited pay policies to which COMAR 31.14.01.13E(6) and (9) are applicable.} In addition to the contingent nonforfeiture benefits described above, the following reduced "paid-up" contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced "paid up" benefit AND the contingent benefit described above are triggered by the same rate increase, you can choose either of the two benefits. You are eligible for the reduced "paid up" contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below;

Triggers for a Substantial Premium Increase

Issue Age	*Percent Increase Over Initial Premium*
Under 65	50%
65—80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect; AND

3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

a. The total lifetime amount of benefits your reduced paid up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy.

.10 Reserve Standards.

A. Life Insurance Policies That Accelerate Benefits for Long-Term Care.

(1) This section applies to long-term care benefits that are provided through the acceleration of benefits under group or individual life insurance policies or riders to group or individual life insurance policies.

(2) Policy reserves for the benefits for the policies and riders subject to this section shall be determined in accordance with Insurance Article, Title 5, Subtitle 3, Annotated Code of Maryland.

(3) Claim reserves for the policies and riders subject to this section shall be established in the case when the policy or rider is in claim status.

(4) Except as permitted in §A(5) of this regulation, reserves for policies and riders subject to this section shall be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates.

(5) An insurer may determine the reserves based on single decrement approximations, if:

(a) The calculation produces essentially similar reserves as the calculation described in §A(4) of this regulation;

(b) The calculation produces a reserve that is clearly more conservative than the calculation described in §A(4) of this regulation; or

(c) The reserve is immaterial.

(6) The calculations described in §A(4) and (5):

(a) May take into account the reduction in life insurance benefits due to the payment of long-term care benefits; and

(b) May not result in a reserve that is less than the reserve for the life insurance benefit under the policy, without a long-term care benefit.

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

(a) Definition of insured events;

(b) Covered long-term care facilities;

(c) Existence of home convalescence care coverage;

(d) Definition of facilities;

(e) Existence or absence of barriers to eligibility;

(f) Premium waiver provision;

(g) Renewability;

(h) Ability to raise premiums;

(i) Marketing method;

(j) Underwriting procedures;

(k) Claims adjustment procedures;

(l) Waiting period;

(m) Maximum benefit;

(n) Availability of eligible facilities;

(o) Margins in claim costs;

(p) Optional nature of benefit;

(q) Delay in eligibility for benefit;

(r) Inflation protection provisions; and

(s) Guaranteed insurability option.

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

B. When long-term care benefits are provided other than as described in §A of this regulation, reserves shall be determined in accordance with Regulations .11—.14 of this chapter.

.11 Claim Reserves.

A. General Claim Reserve Requirements.

(1) An insurer shall establish a claim reserve for all incurred but unpaid claims on all long-term care insurance.

(2) An insurer shall establish an appropriate claim expense reserve with respect to the estimated expense of settlement of all incurred but unpaid claims under long-term care insurance.

(3) An insurer shall test the long-term care claim reserve and claim expense reserve for prior valuation years for adequacy and reasonableness along the lines of claim runoff schedules in accordance with the statutory financial statement including consideration of any residual unpaid liability.

(4) In establishing claim reserve for long-term care insurance, an insurer shall include reserves for premiums expected to be waived, valuing as a minimum the valuation net premium being waived.

B. Minimum Standards for Claim Reserves.

(1) The maximum interest rate for claim reserves for long-term care insurance is the maximum rate permitted by Insurance Article, Title 5, Subtitle 3, Annotated Code of Maryland, in the valuation of whole life insurance issued on the same date as the claim incurral date.

(2) An insurer's long-term care insurance claim reserve shall be based on the insurer's experience, if the experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

C. Claim Reserve Methods Generally.

(1) An insurer may use a generally accepted or reasonable actuarial reserving method or a combination of methods to estimate all claim liabilities for long-term care insurance.

(2) The methods used for estimating liabilities generally may be aggregate methods, or various reserve items may be separately valued.

(3) Approximations based on groupings and averages may also be employed.

(4) Adequacy of the claim reserves, however, shall be determined in the aggregate.

.12 Premium Reserves.

A. General Premium Reserve Requirements.

(1) An insurer shall establish an unearned premium reserve for all long-term care insurance with respect to the period of coverage for which premiums, other than premiums paid in advance, have been paid beyond the date of valuation.

(2) If long-term care insurance premiums due and unpaid are carried as an asset, the insurer shall treat the premiums that are due and unpaid as premiums in force, subject to unearned premium reserve determination.

(3) The insurer shall carry the value of unpaid commissions, premium taxes, and the cost of collection associated with due and unpaid premiums as an offsetting liability.

(4) An insurer may appropriately discount to the valuation date the long-term care gross premiums paid in advance for a period of coverage beginning after the next premium due date that follows the date of valuation.

(5) An insurer shall hold the amount described in §A(4) of this regulation as one of the following:

(a) A separate liability; or

(b) An addition to the unearned premium reserve which would otherwise be required as a minimum.

(6) An insurer shall consider long-term care insurance contracts on premium waiver as in-force contracts when calculating the premium reserve. The insurer shall value the premium reserve for the contracts on premium waiver, as a minimum amount, at the unearned modal valuation net premium being waived.

B. Minimum Standards for Unearned Premium Reserves.

(1) Subject to §B(2) of this regulation, the minimum unearned premium reserve with respect to a long-term care insurance contract is the pro rata gross modal unearned premium that applies to the premium period beyond the valuation date.

(2) The sum of the unearned premium and contract reserves for all long-term care insurance contracts may not be less than the gross modal unearned premium reserve on all long-term care insurance contracts, as of the date of valuation.

(3) The reserve may not be less than the expected claims for the period beyond the valuation date represented by the unearned premium reserve, to the extent not provided for elsewhere.

C. Premium Reserve Methods Generally.

(1) The insurer may employ suitable approximations and estimates, including, but not limited to groupings, averages, and aggregate estimation, in computing long-term care insurance premium reserves.

(2) Approximations or estimates should be tested periodically to determine their continuing adequacy and reliability.

.13 Contract Reserves.

A. General Contract Reserve Requirements.

(1) The insurer shall establish a contract reserve in addition to claim reserves and premium reserves for long-term care insurance.

(2) An insurer shall:

(a) Use methods and procedures for long-term care contract reserves that are consistent with those for claim reserves for a long-term care contract; or

(b) If the insurer uses different methods and procedures for long-term care contract reserves than are used for long-term care claim reserves, make appropriate adjustment when necessary to assure provision for the aggregate liability.

(3) The insurer shall use the same definition of date of incurral when determining contract reserves for long-term care insurance as when determining claim reserves for long-term care insurance.

(4) When determining contract reserves for long-term care insurance, the insurer shall include recognition of the waiver of premium benefit in addition to other contract benefits provided for, valuing as a minimum the valuation net premium to be waived.

B. Minimum Standards for Contract Reserves.

(1) Basis of Contract Reserves.

(a) Valuation net premiums used under each long-term care insurance contract shall have a structure consistent with the gross premium structure at issuance of the contract as this relates to advancing age of insured, contract duration, and the period for which gross premiums have been calculated.

(b) An insurer shall value long-term care insurance contracts using tables which are:

(i) Established for reserve purposes by a qualified actuary; and

(ii) Acceptable to the Commissioner.

(c) The morbidity tables used by the insurer shall contain a pattern of incurred claims cost that reflects the underlying morbidity and may not be constructed for the primary purpose of minimizing reserves.

(d) The maximum interest rate used in developing long-term care insurance contract reserves is the same maximum rate permitted by Insurance Article, Title 5, Subtitle 3, Annotated Code of Maryland, in the valuation of whole life insurance:

(i) Issued on the same date as the long-term care insurance contract; and

(ii) With guarantee duration of more than 20 years.

(e) Termination rates used in the computation of contract reserves for long-term care insurance shall be on the basis specified in §B(1)(f), (h), and(i) of this regulation.

(f) The termination rates used in the computation of contract reserves for terminations due to mortality shall be on the basis of:

(i) For policies or group certificates issued before January 1, 2015, the 1983 Group Annuity Mortality Table, as found in COMAR 31.05.05, without projection;

(ii) For policies or group certificates issued on or after January 1, 2015, the 1994 Group Annuity Reserving Table, as found in COMAR 31.05.05, without the projection found in COMAR 31.05.06; or

(iii) Mortality tables that are adopted by the National Association of Insurance Commissioners (NAIC) if the mortality tables are appropriate for the type of benefits and approved by the Commissioner.

(g) The insurer shall request approval to use a table described in §B(1)(f)(iii) of this regulation and shall include in the request for approval the reason that the table specified in §B(1)(f)(i) or (ii) of this regulation is inappropriate.

(h) For policies or group certificates issued before January 1, 2015, the termination rates used in the computation of contract reserves for terminations due to other than mortality may not exceed:

(i) For policy years one through four, the lesser of 80 percent of the voluntary lapse rate used in the calculation of gross premiums and 8 percent; and

(ii) For policy years five and later, the lesser of 100 percent of the voluntary lapse rate used in the calculation of gross premiums and 4 percent.

(i) For policies or group certificates issued on or after January 1, 2015, the termination rates used in the computation of contract reserves for terminations due to other than mortality may not exceed:

(i) For policy year one, the lesser of 80 percent of the voluntary lapse rate used in the calculation of gross premiums and 6 percent;

(ii) For policy years two through four, the lesser of 80 percent of the voluntary lapse rate used in the calculation of gross premiums and 4 percent; and

(iii) For policy years five and later, the lesser of 100 percent of the voluntary lapse rate used in the calculation of gross premiums and 2 percent, except that for employer group long-term care insurance as defined in Regulation .02B(1) of this chapter, 3 percent shall be used in place of 2 percent.

(2) Reserve Method.

(a) For long-term care insurance, the minimum reserve is the reserve calculated on the 1-year full preliminary term method.

(b) For return of premium or other deferred cash benefits in long-term care insurance contracts, the minimum reserve is the reserve calculated as follows:

(i) On the 1-year preliminary term method if the benefits are provided at any time before the 20th anniversary; or

(ii) On the 2-year preliminary term method if the benefits are only provided on or after the 20th anniversary.

(c) The preliminary term method may be applied only in relation to the date of issue of a contract. Reserve adjustments introduced later, as a result of rate increases, revisions in assumptions, or for other reasons, shall be applied immediately as of the effective date of adoption of the adjusted basis.

(d) An example of a revision in assumption described in §B(2)(c) of this regulation is projected inflation rates.

(3) Negative Reserves. Negative reserves on any benefit may be offset against positive reserves for other benefits in the same contract, but the total contract reserve with respect to all benefits combined may not be less than zero.

(4) Nonforfeiture Benefits. The contract reserve for long-term care insurance established by an insurer on a policy basis may not be less than the net single premium for the nonforfeiture benefits at the appropriate policy duration, where the net single premium is computed according to the specifications found in §B(1) and (2) of this regulation.

C. Alternative Valuation Methods and Assumptions Generally. If the contract reserve on all contracts to which an alternative method or basis is applied is not less in the aggregate than the amount determined according to the applicable standards specified in §B of this regulation, an insurer may use, subject to approval by the Commissioner, any reasonable assumptions as to interest rates, termination and mortality rates, and rates of morbidity or other contingency.

D. Tests for Adequacy and Reasonableness of Contract Reserves. If future gross premiums for an insurer's long-term care insurance reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims, the insurer shall establish contract reserves for the shortfall in the aggregate.

.14 Reinsurance Effect on Reserves.

Increases to, or credits against reserves carried, arising because of reinsurance assumed or reinsurance ceded, shall be determined in a manner consistent with the minimum reserve standards set forth in Regulations .11, .12, and .13 of this chapter and with all applicable provisions of the reinsurance contracts which affect the insurer's liabilities.

Administrative History

Effective date: November 8, 1993 (20:22 Md. R. 1707)

_____

Chapter recodified from COMAR 09.30.89 to COMAR 31.14.02, July 1998

_____

Chapter revised effective April 1, 2002 (29:6 Md. R. 572)
Regulation .01 amended effective September 1, 2014 (41:17 Md. R. 972)
Regulation .09 amended effective September 10, 2007 (34:18 Md. R. 1581)
Regulation .11B amended effective September 1, 2014 (41:17 Md. R. 972)
Regulation .13B amended effective September 1, 2014 (41:17 Md. R. 972)
Regulation .14 amended effective September 1, 2014 (41:17 Md. R. 972)

Title 31
MARYLAND INSURANCE ADMINISTRATION

Subtitle 14 LONG-TERM CARE

Chapter 03 Long-Term Care Partnership

Authority: Health-General Article, §15-407; Insurance Article, §§18-102, 18-106, and 18-107; Annotated Code of Maryland

.01 Scope.

A. This chapter applies to carriers that issue or deliver partnership policies to Maryland residents.

B. The certification process described in this chapter is not a replacement for, and may not impact the form approval process set forth in, COMAR 31.04.17.

C. Nothing in this chapter exempts carriers from complying with the requirements found in COMAR 31.14.01 and .02.

D. Nothing in this chapter exempts insurance producers from complying with the training requirements found in COMAR 31.14.01.34.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Applicant" means:

(a) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and

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

(2) "Carrier" means an insurer or a nonprofit health service plan.

(3) "Certificate" means any certificate issued under a group long-term care insurance policy, if the certificate is delivered or issued for delivery in Maryland.

(4) "Commissioner" has the meaning stated in Insurance Article, §1-101, Annotated Code of Maryland.

(5) "Department" has the meaning stated in Health-General Article, §1-101, Annotated Code of Maryland.

(6) "Insured" means an individual who is covered under a partnership policy.

(7) "Insurer" has the meaning stated in Insurance Article, §1-101, Annotated Code of Maryland.

(8) Long-Term Care Insurance.

(a) "Long-term care insurance" means any group or individual insurance policy, contract, certificate, or rider issued, delivered, or offered by a carrier that:

(i) Is advertised, marketed, offered, or designed to provide coverage for not less than 24 consecutive months for covered persons on an expense incurred, indemnity, prepaid, or insured basis; and

(ii) Provides one or more necessary or appropriate diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services furnished in a situation other than an acute care unit of a hospital.

(b) "Long-term care insurance" includes any product that is advertised, marketed, or offered as long-term care insurance.

(c) "Long-term care insurance" does not include any insurance policy, contract, certificate, or rider which is offered primarily to provide:

(i) Basic Medicare supplement coverage;

(ii) Hospital confinement indemnity coverage;

(iii) Basic hospital expense or medical-surgical expense coverage;

(iv) Disability income protection coverage;

(v) Accident only coverage;

(vi) Specified disease or specified accident coverage; or

(vii) Skilled nursing care.

(d) "Long-term care insurance" does not include a life insurance policy:

(i) That accelerates the death benefit specifically for one or more of the qualifying events of terminal illness, a medical condition requiring extraordinary medical intervention, or permanent institutional confinement;

(ii) That provides a lump sum payment for any of the events in §B(8)(d)(i) of this regulation; or

(iii) In which neither benefits nor eligibility for benefits is conditioned on receipt of long-term care.

(9) "Medicaid" means the Maryland Medical Assistance Program.

(10) "Nonprofit health service plan" means an entity that holds a certificate of authority from the Commissioner to act as a nonprofit health service plan in Maryland.

(11) "Partnership policy" or "partnership coverage" means a long-term care insurance policy that is:

(a) Certified by the Commissioner to meet the requirements under §1917(b) of the Social Security Act; and

(b) Issued on or after the effective date of the State plan amendment.

(12) Policy.

(a) "Policy" means any policy, contract, individual certificate, subscriber agreement, rider, or endorsement delivered or issued for delivery in this State by a carrier.

(b) "Policy" does not include a life insurance policy that contains an optional provision for acceleration of payment of all or a portion of the face amount under stated conditions relating to the medical condition, the disability, or the need for long-term care of the insured.

(13) "Qualified long-term care insurance" has the meaning stated in COMAR 31.14.01.02C.

(14) "State plan amendment" means an amendment filed by the Department with the Centers for Medicare and Medicaid Services under Title 42, U.S.C., which provides for the disregard of any assets or resources by the Department in an amount equal to the insurance benefit payments that are made to, or on behalf of, the individual who is covered under a partnership policy.

.03 Commissioner Certification.

A. A carrier may not solicit a partnership policy in Maryland until the Commissioner has notified the carrier in writing that the Commissioner has certified the policy to be a partnership policy.

B. The Commissioner shall notify the Department in writing within 30 days after the date the Commissioner certifies a new partnership policy.

.04 Filing Requirements for Certification.

A carrier seeking certification of a long-term care insurance policy to a partnership policy status shall file the following with the Commissioner:

A. Proof of prior approval of the long-term care insurance policy in accordance with COMAR 31.04.17, provided in the following manner:

(1) If the long-term care insurance policy that the carrier intends to use or market as a partnership policy in Maryland was approved by the Commissioner within 3 years before the date the carrier files for its certification as a partnership policy, the carrier shall provide the form number and date of approval of the previously approved long-term care insurance policy; or

(2) If the long-term care insurance policy that the carrier intends to use or market as a partnership policy was approved by the Commissioner more than 3 years before the date the carrier files for its certification as a partnership policy, the carrier shall provide a copy of the previously approved long-term care insurance policy, including the date of its approval;

B. A copy of the previously approved long-term care insurance policy schedule page or certificate schedule page with the disclosure notice required by Regulation .05B of this chapter;

C. The form number and date of approval of the application that the carrier intends to use with the partnership policy in Maryland, which meets the requirements of Regulation .06 of this chapter;

D. A copy of the disclosure notice that the carrier intends to use to satisfy the requirements of Regulation .05C of this chapter; and

E. A copy of the policy summary that the carrier intends to use to satisfy the requirements of Regulation .08 of this chapter.

.05 Long-Term Care Insurance Policy Requirements for Partnership Policies.

A. The partnership policy shall comply with the requirements for long-term care insurance under Insurance Article, Title 18, Subtitle 1, Annotated Code of Maryland.

B. Schedule Page Disclosure.

(1) Each long-term care insurance policy that is designed or marketed as a partnership policy shall prominently disclose in at least 12-point type, on the individual long-term care insurance policy schedule page or group certificate schedule page, the notice set forth in §B(2) of this regulation.

(2) The notice required by §B(1) of this regulation shall read as follows: "This {long-term care insurance policy, certificate, or contract} is intended to meet the standards for the Qualified State Long-Term Care Insurance Partnership program in Maryland. Nothing in this {long-term care insurance policy, certificate, or contract} is a guarantee of Medicaid eligibility nor is it a guarantee of any ability to disregard assets for purposes of Medicaid eligibility."

(3) If the only change to a previously approved schedule page is the addition of the disclosure notice required by §B(1) and (2) of this regulation, the previously approved schedule page revised to comply with §B(1) and (2) of this regulation is not required to be refiled for approval by the Commissioner.

C. Disclosure Requirement Regarding Partnership Coverage.

(1) A carrier issuing or marketing long-term care insurance policies that qualify as partnership policies in Maryland, shall provide a disclosure notice, on the carrier's letterhead, indicating that at the time of its issuance, the long-term care insurance policy is intended to qualify as a long-term care insurance partnership policy.

(2) The disclosure notice required by §C(1) of this regulation shall:

(a) Explain the benefits associated with a partnership policy; and

(b) Disclose that the partnership policy status may be lost if:

(i) The insured moves to a different state;

(ii) The coverage is modified after issue; or

(iii) Changes in federal or state laws occur.

(3) The carrier may use the Partnership Policy Status Disclosure Notice set forth in Regulation .09 of this chapter to satisfy the disclosure notice requirement found in §C(1) of this regulation.

(4) If the carrier uses the Partnership Policy Status Disclosure Notice set forth in Regulation .09 of this chapter, without modification, the carrier is not required to file the form for approval with the Commissioner.

(5) If the carrier chooses to modify the Partnership Policy Status Disclosure Notice set forth in Regulation .09 of this chapter, the carrier may not use the modified Partnership Policy Status Disclosure Notice in Maryland until the Commissioner approves the modified Partnership Policy Status Disclosure Notice.

(6) The disclosure notice required by §C(1) of this regulation shall be provided to the insured not later than:

(a) The time of partnership policy delivery, for individual partnership policies; and

(b) The time of certificate delivery, for certificates issued under group partnership policies.

D. The partnership policy shall comply with all the requirements for a qualified long-term care insurance policy found in COMAR 31.14.01.

E. The premiums and reserves for a partnership policy shall be developed in compliance with the requirements found in COMAR 31.14.02.

F. Inflation Protection.

(1) Each partnership policy issued to an individual who is younger than 76 years old shall contain the following minimum inflation protection benefit:

(a) If the applicant, at the time the partnership policy is issued, is younger than 61 years old, the partnership policy shall provide, at a minimum, one of the following:

(i) A 1 percent compound annual inflation protection benefit; or

(ii) A compound annual inflation protection benefit at an interest rate equal to the annual increase in the Consumer Price Index — All Urban Consumers, U.S. City Average, All Items; and

(b) If the applicant, at the time the partnership policy is issued, is at least 61 years old, but younger than 76 years old, the partnership policy is required to provide inflation protection, but the applicant is permitted to reject the level of inflation protection required by COMAR 31.14.01.12A.

(2) Subject to Regulation .06B(4) of this chapter, if the applicant, at the time the partnership policy is issued, is 76 years old or older, the partnership policy is not required to provide inflation protection.

(3) The inflation protection benefit required by §F(1) of this regulation may not be the alternative inflation protection option permitted under COMAR 31.14.01.12B.

(4) The provisions of §F(1)(b) and (2) of this regulation do not eliminate the requirement found in COMAR 31.14.01.12A that each applicant be offered a minimum inflation protection benefit.

(5) Inflation Protection Based on Changes in the Consumer Price Index.

(a) If the Consumer Price Index described in §F(1)(a)(ii) of this regulation is discontinued, or if the calculation of the Consumer Price Index described in §F(1)(a)(ii) of this regulation is changed substantially, the carrier may substitute a comparable index, subject to prior approval by the Commissioner.

(b) If the inflation protection benefit selected is based on increases in the Consumer Price Index as described in §F(1)(a)(ii) of this regulation, the carrier shall:

(i) Increase the benefit payable under the partnership policy each policy anniversary; and

(ii) Calculate the increased benefit based on the percentage change in the Consumer Price Index described in §F(1)(a)(ii) of this regulation on the date 3 months before the anniversary date of the individual's partnership policy as compared to the same month's Consumer Price Index 1 year earlier.

(c) If the change in the Consumer Price Index described in §F(1)(a)(ii) of this regulation is a negative number for the time period in question, the carrier may not apply the change in the index to reduce the benefit payable under the partnership policy.

.06 Applications.

A. Identification of Partnership Policy Application.

(1) Except as provided in §A(2) and (3) of this regulation, the first page of each application for a partnership policy shall clearly indicate that the application is for a partnership policy.

(2) If the application is designed to be used with both partnership policies and nonpartnership long-term care insurance policies, the application shall contain a separate section that identifies the inflation protection options required for a partnership policy.

(3) If the partnership policy is provided by means of a rider or endorsement to a life insurance policy, the application shall contain a separate section that clearly identifies that the long-term care insurance coverage provided by the listed rider or endorsement qualifies as partnership coverage.

B. Inflation Protection Option.

(1) Unless the application requires all applicants, regardless of age, to purchase an inflation protection benefit of at least 5 percent compounded annually, the application shall have separate inflation protection options for applicants to elect, depending on the age of the applicant.

(2) The application shall indicate that for applicants who are younger than 61 years of age, the applicant is required to purchase an inflation protection benefit:

(a) Of at least 3 percent compounded annually; or

(b) That is a compound annual inflation protection benefit at an interest rate equal to the annual increase in the Consumer Price Index—All Urban Consumers, U.S. City Average, All Items.

(3) The application shall indicate that for applicants who are at least 61 years old, but who are younger than 76 years old, the applicant is required to purchase an inflation protection option.

(4) The application for each applicant shall include the option to purchase the inflation protection benefit of 5 percent compounded annually as required by COMAR 31.14.01.12A.

.07 Repealed.

.08 Required Provision of Information Regarding A Partnership Policy.

A. Except as provided in §C of this regulation, at the request of the insured or a representative of the Department on behalf of an insured, a carrier shall provide a completed Long-Term Care Partnership Program Policy Summary in the form set forth in §D of this regulation.

B. The completed Long-Term Care Partnership Program Policy Summary required by §A of this regulation shall be:

(1) Provided within 14 days after the date the carrier receives the request from the insured or the representative of the Department on behalf of the insured; and

(2) Given to:

(a) The insured, if the request for the Long-Term Care Partnership Program Policy Summary was received from the insured; or

(b) The insured and the representative of the Department, if the request for the Long-Term Care Partnership Program Policy Summary was received from a representative of the Department on behalf of the insured.

C. A carrier may develop its own partnership policy summary to provide the information found in the Long-Term Care Partnership Program Policy Summary form in §D of this regulation, if the carrier's policy summary includes all of the information and content found in the Long-Term Care Partnership Program Policy Summary form in §D of this regulation.

D. The format and required text of the Long-Term Care Partnership Program Policy Summary referred to in §A of this regulation shall read as follows:

LONG TERM CARE PARTNERSHIP PROGRAM POLICY SUMMARY

1. Name of insured _____
2. Insured's Social Security # _____
3. Insured's Date of Birth _____
4. Policy/certificate number _____
5. Effective date of coverage _____
6. The policy/certificate was issued in the state of: _____
7. Issue age of the insured at the time the coverage was issued _____
8. The policy/certificate was issued ? With ? Without inflation coverage
9. The inflation coverage is:

[ ] Simple Inflation with an annual percentage rate of _____

[ ] Compound Inflation with an annual percentage rate of _____

[ ] Compound annual inflation protection benefit at an interest rate equal to the annual increase in the Consumer Price Index—All Urban Consumers, U.S. City Average, and All Items.

[ ] None

10. The inflation coverage is currently in effect [ ] Yes [ ] No
11. If the answer to item 10 is no, the date inflation coverage ceased:_____
12. The policy meets the standards of a tax qualified long-term care insurance policy [ ] Yes [ ] No
13. The cumulative dollar amount of long-term care insurance benefits paid: $_____

(Note: The indicated amount does not include any payments for cash surrender, return of premium death benefits, or waiver of premium, and if joint coverage, the amount is for the indicated insured only.)

14. The total dollar amount of long-term care insurance benefits remaining available under the policy $ _____ as of the date this form was completed _____.

15. The name, phone number, and email address of the person completing this form

Name _____

Phone Number _____

Email Address _____

I hereby certify that the above information is true and accurate and that the coverage

[ ] meets [ ] does not meet partnership policy status in Maryland at the time of this certification.

Signature _____ Date _____

E. A carrier shall provide to the Department within 45 days after issuance of a partnership policy, the following information:

(1) Name of the insured;

(2) Insured's Social Security number;

(3) Insured's date of birth; and

(4) Policy or certificate number.

F. A carrier shall provide reports to the Centers for Medicare and Medicaid Services in accordance with federal regulations developed, including any information that is deemed appropriate according to federal requirements.

.09 Partnership Policy Status Disclosure Notice.

The format and required text of the Partnership Policy Status Disclosure Notice referred to in Regulation .05C(3) of this chapter shall read as follows:

[Carrier letterhead]

Important Notice Regarding Your Policy's Long-Term Care Insurance Partnership Policy Status

(Please keep this Notice with Your Policy or Certificate)

Qualified State Long-Term Care Insurance Partnership. The Qualified State Long-Term Care Insurance Partnership is an innovative partnership between Maryland and private insurers of long-term care insurance policies. The Qualified State Long-Term Care Insurance Partnership is established in accordance with the Deficit Reduction Act of 2005 (P.L. 109—171).

Notice of Partnership Policy Status. Your long-term care insurance {policy} {certificate} is intended to qualify as a Partnership {policy} {certificate} under the {insert state} Long-Term Care Partnership Program as of your {policy's} {certificate's} effective date.

Medicaid Asset Protection Provided. Long-term care insurance is an important tool that helps individuals prepare for future long-term care needs. Partnership Policies provide an additional level of protection. In particular, such policies permit individuals to protect additional assets from spend-down requirements under a Medicaid program if assistance under this program is ever needed and you otherwise qualify for Medicaid.

Specifically, the asset eligibility and recovery provisions of the Medicaid program of Maryland are applied by disregarding an additional amount of assets which is equal to the amount of long-term care insurance benefits you have received from your Partnership Policy. For example, if you receive $200,000 of insurance benefits from your Partnership Policy, you generally would be able to retain $200,000 of assets above and beyond the amount of assets normally permitted for Medicaid eligibility.

Other Medicaid eligibility requirements apart from permissible assets must be met, including special rules that may apply if the equity in your home exceeds $500,000. This equity value limit may change over time based on Federal standards. In addition, you must meet the Medicaid program's income requirements and may be required to contribute some of your income to the costs of your care once you become eligible for Medicaid.

Additional Consumer Protections. In addition to providing Medicaid asset protection, your Partnership Policy has other important features. Under the rules governing the Qualified State Long-Term Care Insurance Partnership, your Partnership Policy must be a qualified long-term care insurance contract under Federal tax law, and as such the insurance benefits you receive from the policy generally will be subject to beneficial income tax treatment. (Please note that a policy can be a qualified long-term care insurance contract under Federal tax law, with the same beneficial income tax treatment, even if it is not a Partnership Policy.) In addition, if you were under age 76 when you purchased your Partnership Policy, it must provide inflation protection to help protect against potential future increases in the cost of long-term care. (For older purchasers, an offer of inflation protection is required.)

What Could Disqualify Your Policy as a Partnership Policy. If you make any changes to your Partnership Policy or certificate, such changes could affect whether your policy or certificate continues to qualify as a Partnership Policy. Before you make any changes, you should consult with the issuer of your Partnership Policy to determine the effect of a proposed change. In addition, if you move to a state that does not maintain a Qualified Partnership or does not recognize your policy as a Partnership Policy, you would not receive Medicaid asset protection in that state. Also, changes in Federal or State law could affect the Medicaid asset protection available with respect to your Partnership Policy.

.10 Reporting Requirements.

A. Beginning October 1, 2009, and on or before October 1 of each year after October 1, 2009, each carrier that is certified to issue partnership policies in Maryland shall file a report with the Commissioner that includes the information required by §B of this regulation.

B. The report required by §A of this regulation shall include the following information:

(1) The number of insureds the carrier covers under partnership policies issued or delivered in Maryland, as of the July 1 immediately preceding the date of the report;

(2) The number of partnership policies the carrier has issued or delivered in Maryland for the 12 month period ending on the July 1 immediately preceding the date of the report;

(3) A list, by form number and date of approval, of the partnership policies that the carrier made available in Maryland as of the July 1 immediately preceding the date of the report; and

(4) The number of licensed insurance producers who were appointed by the carrier in Maryland and who met the training requirements found in COMAR 31.14.01.34 for any portion of the 12 month period ending on the July 1 immediately preceding the date of the report.

Administrative History

Effective date: December 15, 2008 (35:25 Md. R. 2152)
Regulation .04 amended effective March 22, 2010 (37:6 Md. R. 481)
Regulation .05B, C amended effective March 22, 2010 (37:6 Md. R. 481)
Regulation .05F amended effective June 6, 2016 (43:11 Md. R. 635)
Regulation .07 repealed effective March 22, 2010 (37:6 Md. R. 481)
Regulation .09 amended effective March 22, 2010 (37:6 Md. R. 481)
Regulation .10 amended effective December 26, 2011 (38:26 Md. R. 1697)