CHAPTER 45-06-05
LONG-TERM CARE INSURANCE MODEL REGULATION

45-06-05-01. Applicability and scope.

Except as otherwise specifically provided, this section applies to all long-term care insurance policies delivered or issued for delivery in this state between July 1, 1988, and February 29, 2004, by insurers, fraternal benefit societies, nonprofit health, hospital and medical service corporations, prepaid health maintenance organizations, and all similar organizations. Policies delivered or issued for delivery in this state on or after March 1, 2004, are governed by chapter 45-06-05.1.

History: Effective July 1, 1988; amended effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05-02. Definitions.

For the purpose of this regulation, the terms "long-term care insurance", "group long-term care insurance", "commissioner", "applicant", "policy", and "certificate" have the meanings set forth in North Dakota Century Code section 26.1-45-01.

History: Effective July 1, 1988.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05-03. Policy definitions.

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

1. "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain the individual's health status.

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

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

4. "Medicare" must be defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended", or "Title I, Part I of Public Law 89-97, as enacted by the Eighty-ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof", or words of similar import.

5. "Mental or nervous disorder" may not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

6. "Personal care" means the provisions of hands-on services to assist an individual with activities of daily living (such as bathing, eating, dressing, transferring, continence, and toileting).

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

8. All providers of services, including "skilled nursing facility", "extended care facility", "intermediate care facility", "convalescent nursing home", "personal care facility", and "home care agency" must be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

History: Effective July 1, 1988; amended effective July 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05-04. Policy practices and provisions.

1. **Renewability**. The terms "guaranteed renewable" and "noncancelable" may not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of section 45-06-04-05.

   a. No such policy issued to an individual may contain renewal provisions less favorable to the insured than "guaranteed renewable" or "noncancelable".

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

   c. The term "noncancelable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which

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

2. **Limitations and exclusions.** No policy may be delivered or issued for delivery in this state as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:

   a. Preexisting conditions or diseases;

   b. Mental or nervous disorders; however, this does not permit exclusion or limitation of benefits on the basis of alzheimer's disease;

   c. Alcoholism and drug addiction;

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

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

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

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

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

      (5) Aviation (this exclusion applies only to nonfare paying passenger).

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

   f. This subsection is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

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

4. **Continuation or conversion.**

   a. Group long-term care insurance issued in this state on or after October 1, 1989, shall provide covered individuals with a basis for continuation or conversion of coverage.

   b. For the purposes of this section, "a basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to use, certain providers or facilities may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed and

nonmanaged plans, including provider system arrangements, service availability, benefit levels, and administrative complexity.

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

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

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

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

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

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

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

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

(b) The premium for which is calculated in a manner consistent with the requirements of subdivision f.

h. Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under

the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than one hundred percent of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

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

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

5. **Discontinuance and replacement.** If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

   a. May not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

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

6. The premiums charged to an insured for long-term care insurance may not increase due to either:

   a. The increasing age of the insured at ages beyond sixty-five; or

   b. The duration the insured has been covered under the policy.

History: Effective July 1, 1988; amended effective October 1, 1989; July 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05-04.1. Unintentional lapse.

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

1. a. Notice before lapse or termination. An individual long-term care policy or certificate may not be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation does not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation must include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver must state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or

termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate any person to receive such notice."

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

b. When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in subdivision a need not be met until sixty days after the policyholder or certificate holder is no longer on such a payment plan. The application or enrollment form for such policies or certificates must clearly indicate the payment plan selected by the applicant.

c. Lapse or termination for nonpayment of premium. An individual long-term care policy or certificate may not lapse or be terminated for nonpayment of premium unless the insurer, at least thirty days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to subdivision a of subsection 1, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice must be given by first-class mail, postage prepaid, and notice may not be given until thirty days after a premium is due and unpaid. Notice is deemed to have been given as of five days after the date of mailing.

2. Reinstatement. In addition to the requirement in subsection 1, a long-term care insurance policy or certificate must include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof of cognitive impairment or the loss of functional capacity. This option must be available to the insured if requested within five months after termination and must allow for the collection of past due premium, when appropriate. The standard of proof of cognitive impairment or loss of functional capacity may not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity, if any, contained in the policy and certificate.

History: Effective July 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05-05. Required disclosure provisions.

1. **Renewability.** Individual long-term care insurance policies must contain a renewability provision. Such provision must be appropriately captioned, must appear on the first page of the policy, and must clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

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

3. **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 must include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

4. **Limitations.** If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations must appear as a separate paragraph of the policy or certificate and be labeled as "preexisting condition limitations".

5. **Other limitations or conditions on eligibility for benefits.** Effective July 1, 1990, a long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in subsection 2 of North Dakota Century Code section 26.1-45-07 must set forth a description of such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and must label such paragraph "limitations or conditions on eligibility for benefits".

6. **Disclosure of tax consequences.** With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax adviser. The disclosure statement must be prominently displayed on the first page of the policy or rider and any other related documents.

History: Effective July 1, 1988; amended effective October 1, 1989; July 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05-05.1. Prohibition against post-claims underwriting.

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

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

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

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

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

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

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

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

claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

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

(1) A report of a physical examination;

(2) An assessment of functional capacity;

(3) An attending physician's statement; or

(4) Copies of medical records.

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

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

History: Effective November 1, 1990.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05-05.2. Minimum standards for home health and community care benefits in long-term care insurance policies.

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

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

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

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

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

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

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

g. By excluding coverage for personal care services provided by a home health aide;

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

i. By excluding coverage for adult day care services.

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

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

History: Effective November 1, 1990; amended effective July 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05-05.3. Requirement to offer inflation protection.

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

   a. Increases benefit levels annually, in a manner so that the increases are compounded annually at a rate not less than five percent;

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

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

2. Where the policy is issued to a group, the required offer in subsection 1 must be made to the group policyholder; except, if the policy is issued to a group defined in subdivision d of subsection 3 of section 26.1-45-01 other than to a continuing care retirement community, the offering must be made to each proposed certificate holder.

3. The offer in subsection 1 is not required of life insurance policies or riders containing accelerated long-term care benefits.

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

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

   b. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

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

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

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

7. a. Inflation protection as provided in subdivision a of subsection 1 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 subsection.

   b. The rejection 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 _____, and I reject inflation protection."

History: Effective November 1, 1990; amended effective July 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05-06. Requirements for application forms and replacement coverage.

1. Application forms must include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except when the coverage is sold without an agent, containing such questions may be used. With regard to a replacement policy issued to groups defined by subsection 3 of North Dakota Century Code section 26.1-45-01, the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced; provided, however, that the certificate holder has been notified of the replacement.

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

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

      (1) If so, with which company?

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

   c. Are you covered by Medicaid?

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

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

   a. List policies sold which are still in force.

b. List policies sold in the past five years which are no longer in force.

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

"NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE 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 accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and 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 accident and sickness or long-term care 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. State 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 such time was spent (depleted) under the original policy.

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 all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical

information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

_____

(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)"

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

"NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE 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 accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care 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.

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. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your 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 such time was spent (depleted) under the original policy.

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 all the relevant factors involved in replacing your present coverage.

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

_____

(Company Name)"

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

History: Effective July 1, 1988; amended effective November 1, 1990; July 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05-06.1. Reporting requirements.

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

2. Each insurer shall report annually by June thirtieth the ten percent of its agents with the greatest percentages of lapses and replacements as measured by subsection 1.

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

4. Every insurer shall report annually by June thirtieth the number of lapsed policies as a 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.

5. Every insurer shall report annually by June thirtieth 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.

6. For purposes of this section, "policy" means only long-term care insurance and "report" means on a statewide basis.

History: Effective July 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05-07. Discretionary powers of commissioner.

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

1. The modification or suspension would be in the best interest of the insureds; and
2. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and
    a. The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care;
    b. The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or
    c. The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

History: Effective July 1, 1988.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05-08. Loss ratio.

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

1. Statistical credibility of incurred claims experience and earned premiums;
2. The period for which rates are computed to provide coverage;
3. Experienced and projected trends;
4. Concentration of experience within early policy duration;
5. Expected claim fluctuation;
6. Experience refunds, adjustments, or dividends;
7. Renewability features;
8. All appropriate expense factors;
9. Interest;
10. Experimental nature of the coverage;
11. Policy reserves;
12. Mix of business by risk classification; and
13. Product features such as long elimination periods, high deductibles, and high maximum limits.

History: Effective July 1, 1988; amended effective July 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05-08.1. Reserve standards.

1. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for such benefits must be determined in accordance with North Dakota Century Code chapter 26.1-35. Claim reserves must also be established in the case when such policy or rider is in claim status.

   Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, the reserves for the long-term care benefit and the life insurance benefit may not be less than the reserves for the life insurance benefit assuming no long-term care benefit.

   In the development and calculation of reserves for policies and riders subject to this subsection, due regard must be given to the applicable policy provisions, marketing methods, administrative procedures, and all other considerations that have an impact on projected claim costs, including the following:

   a. Definition of insured events;

   b. Covered long-term care facilities;

   c. Existence of home convalescence care coverage;

   d. Definition of facilities;

   e. Existence or absence of barriers to eligibility;

   f. Premium waiver provision;

   g. Renewability;

   h. Ability to raise premiums;

   i. Marketing method;

   j. Underwriting procedures;

   k. Claims adjustment procedures;

   l. Waiting period;

   m. Maximum benefit;

   n. Availability of eligible facilities;

   o. Margins in claim costs;

   p. Optional nature of benefit;

   q. Delay in eligibility for benefit;

r. Inflation protection provisions; and

s. Guaranteed insurability option.

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

2. When long-term care benefits are provided other than as in subsection 1, reserves must be determined in accordance with generally accepted industry standards.

History: Effective July 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05-09. Filing requirement.

Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state pursuant to North Dakota Century Code section 26.1-45-03, it shall file with the commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

History: Effective July 1, 1988.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05-09.1. Filing requirements for advertising.

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

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

History: Effective July 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05-09.2. Standards for marketing.

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

   a. Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

   b. Establish marketing procedures to assure excessive insurance is not sold or issued.

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

d. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance.

e. Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this subsection.

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

g. For long-term care health insurance policies and certificates, use the terms "noncancelable" or "level premium" only when the policy or certificate conforms to subdivision c of subsection 1 of section 45-06-05-04.

2. In addition to the practices prohibited in North Dakota Century Code section 26.1-04-03, the following acts and practices are prohibited:

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

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

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

3. a. With respect to the obligations set forth in this subsection, the primary responsibility of an association, as defined in subdivision b of subsection 3 of North Dakota Century Code section 26.1-45-01, when endorsing long-term care insurance is to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed.

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

(1) The policy and certificate;

(2) A corresponding outline of coverage; and

(3) All advertisements requested by the insurance department.

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

(1) The specific nature and amount of the compensation arrangements, including all fees, commissions, administrative fees, and other forms of financial support, that the

association receives from endorsement or sale of the policy or certificate to its members; and

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

d. If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose such fact to its members.

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

f. The association shall also:

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

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

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

g. A group long-term care insurance policy or certificate may not be issued to an association unless the insurer files with the insurance department the information required in this subsection.

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

i. Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice under North Dakota Century Code section 26.1-04-03.

History: Effective July 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05-09.3. Appropriateness of recommended purchase.

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.

History: Effective July 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05-10. Standard format outline of coverage.

This section implements, interprets, and makes specific the provisions of subsection 2 of North Dakota Century Code section 26.1-45-09 in prescribing a standard format and the content of an outline of coverage.

1. The outline of coverage must be a freestanding document, using no smaller than ten point type.

2. The outline of coverage must contain no 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 such capitalization or underscoring.

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

5. Format for outline of coverage:

[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 has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

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

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

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

   a. [Provide a brief description of the right to return - "free look" provision of the policy.]

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

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

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

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

6. 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.]

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

7. LIMITATIONS AND EXCLUSIONS.

   [Describe:

   a. Preexisting conditions.

   b. Noneligible facilities and provider.

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

   d. Exclusions and 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 (6) above.]

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

8. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the 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. And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

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

a. [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable must 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 of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancelable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELABLE. 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, [Company Name] 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 not such provisions;]

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

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

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

11. PREMIUM.

a. [State the total annual premium for the policy.

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

12. ADDITIONAL FEATURES.

a. [Indicate if medical underwriting is used;

b. Describe other important features.]

History: Effective October 1, 1989; amended effective November 1, 1990; July 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05-11. Requirement to deliver shopper's guide.

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

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

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

2. Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under subsection 4 of North Dakota Century Code section 26.1-45-09.

History: Effective July 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

APPENDIX A

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

Company Name: _____

Address: _____

_____

Telephone 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 recissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form Number	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