CHAPTER 3. LIFE, ACCIDENT AND HEALTH INSURANCE AND ANNUITIES

SUBCHAPTER Y. STANDARDS FOR LONG-TERM CARE INSURANCE, NON-PARTNERSHIP AND PARTNERSHIP LONG-TERM CARE INSURANCE COVERAGE UNDER INDIVIDUAL AND GROUP POLICIES, ANNUITY CONTRACTS, AND LIFE INSURANCE POLICIES THAT PROVIDE LONG-TERM CARE BENEFITS WITHIN THE POLICY

DIVISION 1. GENERAL PROVISIONS
28 TAC §§3.3801 - 3.3804

DIVISION 2. NON-PARTNERSHIP AND PARTNERSHIP LONG-TERM CARE INSURANCE
28 TAC §§3.3821, 3.3826, 3.3829, 3.3830, 3.3833, 3.3834, 3.3837 - 3.3839, 3.3842, 3.3844, 3.3846, 3.3848, and 3.3849

DIVISION 3. NON-PARTNERSHIP LONG-TERM CARE INSURANCE ONLY
28 TAC §3.3860

DIVISION 4. PARTNERSHIP LONG-TERM CARE INSURANCE ONLY
28 TAC §§3.3870 - 3.3874

1. INTRODUCTION. The Texas Department of Insurance proposes amendments to §§3.3801 - 3.3804, 3.3821, 3.3826, 3.3829, 3.3830, 3.3833, 3.3834, 3.3837 - 3.3839, 3.3842, 3.3844, and 3.3846, and new §§3.3848, 3.3849, 3.3860, and 3.3870 - 3.3874, concerning standards for long-term care non-partnership insurance coverage, long-term care partnership insurance coverage under individual and group policies, annuity contracts, and life insurance policies that provide long-term care benefits within the policy or by rider. The proposed amendments and new sections are necessary to implement the insurance related provisions of Senate Bill 22, as enacted by the 80th

Legislature, Regular Session, effective March 1, 2008. SB 22 establishes a state partnership for long-term care program in Texas that is intended to promote consumers' purchase of long-term care insurance from insurers by providing consumers access to Medicaid under special eligibility rules in the event that an individual consumer should ever need Medicaid long-term care coverage that is in addition to that provided by the purchased coverage. In enacting SB 22, the Legislature found that long-term care is currently one of the leading cost drivers in the Medicaid program. (TEXAS SENATE STATE AFFAIRS COMMITTEE, BILL ANALYSIS (Enrolled), SB 22, 80th Legislature, Regular Session (October 18, 2007)). Further legislative findings indicate several other relevant factors. Although Medicaid pays for 67 percent of all nursing facility days in Texas, less than five percent of Texans have private long-term care insurance. As the population in Texas ages, the fiscal impact of publicly financing long-term care may lessen if more Texans purchase private long-term care insurance. However, prior to the enactment of SB 22, the law did not provide any incentive for Texans to purchase private long-term care insurance due to strict asset limits for Medicaid eligibility and required estate recovery of assets. In response, the Legislature enacted SB 22 to create a long-term care partnership program in Texas to provide the necessary incentive for Texans who can afford to purchase long-term care partnership insurance to do so. Texans who purchase long-term care partnership policies under the partnership program will be eligible for asset disregard equal to the long-term care insurance benefits that have been received to the date of Medicaid application from a partnership policy should they ever apply for Medicaid long-term care benefits. However, in order for a long-term care

partnership insurance policy to be offered in Texas, a state plan amendment must meet the requirements of, and be approved under, the Deficit Reduction Act of 2005 (DRA) (Pub. L. No. 109-171). This proposal implements those provisions of SB 22 that establish the state partnership program that is to be administered, implemented, and monitored by the Texas Health and Human Services Commission (HHSC) with assistance from the Texas Department of Insurance. SB 22 adds new Subchapter C to Chapter 1651 of the Insurance Code relating to the Partnership for Long-Term Care Program. The amendments and new sections of Subchapter Y are proposed to implement new Subchapter C of Chapter 1651.

In addition to amending Chapter 1651 of the Insurance Code, SB 22 also amends Chapter 32 of the Human Resources Code to add new Subchapter C, relating to the Partnership for Long-Term Care Program. Section 32.102 of the Human Resources Code requires that the Partnership for Long-Term Care Program must be consistent with provisions governing the expansion of a state long-term partnership program established under the federal Deficit Reduction Act of 2005 (DRA), Pub. L. No. 109-171. Under the DRA, a Qualified State Long-Term Care Insurance Partnership Program (Qualified Partnership) means an approved state plan amendment filed by the State Medicaid Director with the U.S. Department of Health and Human Services that provides an exemption from estate recovery in an amount equal to the benefits paid under partnership policies, where those benefits were disregarded in determining an individual's Medicaid eligibility. Under the Qualified Partnership, individuals who purchase partnership policies can apply for Medicaid under special HHSC rules for

determining financial eligibility and estate recovery. These special rules generally allow the individual to protect assets equal to the insurance benefits received from a partnership policy so that such assets will not be taken into account in determining financial eligibility for Medicaid and will not subsequently be subject to Medicaid liens and recoveries. This feature of the Qualified Partnership is known as "asset disregard" and the asset disregard applies to all insurance benefits received from a partnership policy. The asset disregard applies to all insurance benefits paid on a reimbursement, cash benefit basis, indemnity insurance basis, or on a "per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate" (within the meaning of §7702B(b)(2)(A) of the Internal Revenue Code). Similarly, the asset disregard applies to all insurance benefits received from a partnership policy regardless of whether such insurance benefits are for costs for long-term care that would be covered by Medicaid. The asset disregard as of any date equals the insurance benefits that have been received to that date from a partnership policy, even if additional benefits may be received in the future from a partnership policy. The asset disregard does not include the return of premium payments made upon the termination of a partnership policy (due to cancellation or death) since such payments do not represent insurance benefits.

Minimum Standards for a Long-Term Care Partnership Benefit Plan. With respect to the insurance related aspects of the Partnership for Long-Term Care Program, new §1651.104 of the Insurance Code requires the Commissioner, in consultation with the HHSC, to adopt minimum standards for a long-term care benefit

plan that may qualify as an approved plan under the partnership for long-term care program. New §1651.104 also requires that the standards be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. A partnership policy is a long-term care insurance policy that satisfies all of the insurance related requirements of the DRA. The requirements of the DRA that a partnership policy must satisfy relate to federal tax law qualification, issue date, state of residence, compliance with DRA consumer requirements, inflation protection, and agent training requirements. These requirements are more fully explained in the following paragraphs.

Qualified under Federal Tax Law. Pursuant to §1917(b)(1)(C)(iii)(II) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(II)), a partnership policy must be a qualified long-term care insurance contract, as defined in §7702b(b) of the Internal Revenue Code of 1986 (26 U.S.C. 7702B(b)) issued not earlier than the effective date of the state plan amendment.

Issue Date. Pursuant to §1917(b)(1)(C)(iii)(I) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(I)), a partnership policy must not be issued earlier than the effective date of the Qualified Partnership. The issue date is the effective date of coverage under the partnership policy. Thus, for example, in the case of a certificate issued under a group insurance contract, the effective date of coverage with respect to such certificate is the issue date of the certificate. Pursuant to §1917(b)(1)(C)(iii)(VII) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C.

§1396p(b)(1)(C)(iii)(VII)) a policy received in an exchange of an existing non-partnership policy or certificate for a partnership policy or certificate after the effective date of the Qualified Partnership is treated as newly issued and thus is eligible for partnership policy status.

State of Residence. Pursuant to §1917(b)(1)(C)(iii)(I) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(I)), a partnership policy must cover an insured who was a resident of the State when coverage first became effective under the policy. In the case of an exchange of an existing non-partnership policy or certificate for a partnership policy or certificate, this state of residence requirement is applied based on the coverage date of the first long-term care insurance policy that was exchanged (State Medicaid Director's Letter (SMDL #06-019) July 27, 2006, issued by CMS, Supplement 8c to Attachment 2.6-A page 2 paragraph 2).

Consumer Protection Requirements. A partnership policy must meet all of the Federal consumer protection requirements specified in the DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the National Association of Insurance Commissioners' (NAIC) Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)).

Inflation Protection. Pursuant to §1917(b)(1)(C)(iii)(IV) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)), a partnership policy must include at least one of the following levels of inflation protection: (i) if the policy is sold to an individual who has not attained age 61 as of the date of purchase, the policy must provide compound annual inflation protection; (ii) if the policy is sold to an individual who has attained age 61 but has not attained age 76 as of the date of purchase, the policy must provide some level of inflation protection; and (iii) if the policy is sold to an individual who has attained age 76 as of the date of purchase, the policy may (but is not required to) provide some level of inflation protection.

Agent Training Requirements. Additionally, pursuant to §1917(b)(1)(C)(iii)(V) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(V)), each individual who sells a long-term care partnership policy must complete training and demonstrate evidence of understanding partnership policies and how they relate to other public and private coverage of long-term care. Insurers that offer partnership policies shall certify to the Commissioner that each individual who sells partnership policies for the insurer has complied with the agent training requirements. The Department's proposed rules regulating long-term care partnership certification and continuing education course and licensee requirements were published in the March 21, 2008 edition of the *Texas Register* (33 *TexReg* 2512).

The following is a section-by-section overview of the proposal.

§3.3802. Purpose. The proposed amendments to §3.3802 divide the existing section into six paragraphs and add new paragraph (7) to state the new purpose relating to the long-term care partnership program. Proposed paragraph (7) provides that the new purpose is to adopt, in consultation with the Texas Health and Human Services Commission, minimum standards for a long-term care partnership benefit plan as required in SB 22, codified as §1651.104 of the Insurance Code.

§3.3803. Applicability and Severability. The proposed amendments to §3.3803 amend the title of the section to remove the word "Scope" and add the word "Severability." This is necessary because §3.3850 (pertaining to Severability) is being repealed and the severability provisions are being relocated without change to §3.3803(b). The proposed new subsection (a)(1) specifies that §§3.3801 - 3.3804 (relating to General Provisions) apply to all long-term care insurance coverage that is regulated under Subchapter Y of Chapter 3. The introductory paragraph to existing §3.3803 is proposed to be redesignated as subsection (a)(2). The proposed amendments to the newly designated subsection (a)(2) specify that §§3.3805 – 3.3849 (relating to Non-partnership and Partnership Long-Term Care Insurance) apply to non-partnership and partnership long-term care benefit plans as defined in the Insurance Code §1651.003 and §3.3804 of this subchapter (relating to Definitions) and long-term care riders attached to life insurance policies or certificates or annuity contracts or certificates delivered or issued for delivery in this state, except as specified in §3.3803(a)(5). Additionally, proposed new subsection (a)(3) specifies that §3.3860 (relating to Policy Summary Requirements for Non-Partnership Life Insurance Policies

and Annuity Contracts That Provide Long-Term Care Benefits) applies only to non-partnership life insurance policies that provide long-term care benefits by rider, except as specified in §3.3803(a)(5). Proposed new §3.3803(a)(4) specifies that §§3.3870 - 3.3874 of this subchapter (relating to Partnership Long-Term Care Insurance Only) apply only to long-term care partnership benefit plans as that term is defined in the Insurance Code §1651.101 and §1651.104 except as specified in §3.3803(a)(5). The existing provisions in §3.3803(1) and (2), relating to policies and certificates that are not subject to the requirements of the subchapter, are proposed to be re-designated as §3.3803(a)(5)(A) and (B). Additionally, the existing provision in §3.3803(2), which is proposed to be re-designated as §3.3803(a)(5)(B), is proposed to be amended to clarify that certificates as well as policies that are not designed, advertised, marketed, or offered as long-term care or nursing home insurance are not subject to regulation under the subchapter. These proposed amendments to §3.3803 are necessary to clarify the different types of policies and certificates that are being regulated under Subchapter Y and to specify which specific provisions in Subchapter Y apply to the various types of policies and certificates being regulated for purposes of clarity, implementation, and compliance. The proposed amendments to §3.3803 also add new subsection (b) to relocate without change the existing §3.3850 severability provisions that are being repealed, and the proposed repeal is also published in this edition of the *Texas Register*.

§3.3804. Definitions. The proposed amendments to §3.3804 add new paragraph (19) to include a definition of “long-term care benefit plan,” a term that is

used frequently throughout the subchapter. This definition is consistent with the definition in §1651.003 of the Insurance Code. Additionally, amendments are proposed to existing §3.3804(19), which is also proposed to be re-designated as paragraph (20), to amend the term “long-term care insurance contract” to conform the term to the NAIC definition of “long-term care insurance." The proposed amendments to existing §3.3804(19) change the term from “long-term care insurance contract” to “long-term care insurance” as that term is defined by the NAIC because most of the existing and proposed regulations in Subchapter Y are based on the NAIC Model Regulations and Model Act. Because the term “long-term care insurance” is used throughout Subchapter Y, it is imperative that the definition of long-term care insurance in Subchapter Y conform with the NAIC definition. Subchapter Y is consistent with the NAIC definition which specifies that “the term includes group and individual annuities and life insurance policies or riders that provide directly or supplement long-term care insurance.” To conform the proposed §3.3804(20) definition of “long-term care insurance” to the NAIC definition, the following requirements are proposed to be added: (i) the term includes a policy, certificate, or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity; and (ii) long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; and health maintenance organizations to the extent they are authorized to issue life or health insurance. Additionally, an amendment is proposed to specify that the term long-term care insurance does not include life insurance policies that accelerate death benefits for

one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for benefits is conditioned upon the receipt of long-term care. The proposed amendments to §3.3804 add new paragraph (21) to include a definition of "long-term care insurance partnership contract." This definition defines the term to mean a long-term care insurance contract established under the Human Resources Code Chapter 32 Subchapter C and that meets the requirements of the Federal Deficit Reduction Act of 2005 (DRA), Pub. L. No. 109-171 and the Insurance Code Chapter 1651 Subchapter C. This proposed new definition is necessary to clarify what constitutes a long-term care partnership insurance contract under the proposed amendments to Subchapter Y in this proposal and because these amendments are proposed to implement the requirement in SB 22 that the Commissioner, in consultation with the Health and Human Services Commission, adopt minimum standards for a long-term care benefit plan that will qualify as an approved plan under the partnership for long-term care program. In addition, paragraphs (20) - (30) are proposed to be redesignated as paragraphs (22) - (32).

§3.3826. Limitations and Exclusions. The proposed amendments to §3.3826 add new paragraph (6) to subsection (a) to permit exclusions and limitations for expenses for services or items paid under another long-term care or health insurance policy. The proposed amendments to §3.3826 further add new subsection (b) to specify that with respect to this section the "state of policy issue" is the state in which the

individual policy or certificate was originally issued; existing subsection (b), which is proposed to be redesignated as subsection (c), permits exclusions and limitations for payment for services provided outside the United States. However, as required by the DRA, the issuer of long-term care insurance policies and certificates being claimed against in a state other than where the policy or certificate was issued must cover those services that would be covered in the state of policy issue irrespective of any licensing, registration, or certification requirements for providers in the other state. The proposed amendments to §3.3826 that add new paragraph (6) and new subsection (b) are necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. This section requires that a partnership policy be consistent with provisions established under the DRA. The DRA requires a partnership policy to conform with specific consumer protection provisions of the National Association of Insurance Commissioners (NAIC) Long-Term Care Model Regulations and Model Act. Section 6B of the NAIC model regulations permits exclusions and limitations for expenses for services or items paid under another long-term care or health insurance policy and permits exclusions and limitations for payment for services provided outside the United States. These two NAIC provisions are reflected in proposed §3.3826(a)(6), §3.3826(b), and §3.3826(c), respectively.

§3.3829. Required Disclosures. The proposed amendments to §3.3829(b)(2) specify the two disclosure forms that must be provided to an applicant at the time of application or enrollment, or if the method of application does not allow for delivery at that time, the information must be provided at the time of delivery of the policy or

certificate. The two disclosure forms are Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form. Proposed amendments to §3.3829(b)(8) specify the requirements and procedures that apply to the two disclosure forms, including text size and content, recommended format, and filing and approval procedures as applicable. A representation of proposed Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet is specified in new subparagraph (b)(8)(H). A representation of proposed Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form is specified in new subparagraph (b)(8)(I). Proposed new Form Number LHL560(LTC) Long-Term Care Personal Worksheet requires the insurer to obtain detailed information from the individual who is considering the purchase of a long-term care policy. Such information includes the applicant's current insurance and premium payments, the applicant's income and net worth, and also a disclosure of the insurer's rate history, and right to increase premiums. This form will assist the insurer and the applicant to make an informed decision on whether it is prudent for the applicant to purchase the long-term care policy. Proposed new Form Number LHL561(LTC) Long-Term Care Potential Rate Increase Disclosure Form requires the insurer to provide detailed information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policy options in the event of a rate increase. The proposed amendments to §3.3829 are necessary to implement the provision of SB 22, codified as Insurance Code §1651.104 which requires that a partnership policy be consistent with provisions

established under the DRA. The DRA requires a partnership policy to conform with specific consumer protection provisions of the National Association of Insurance Commissioners' (NAIC) Long-Term Care Model Regulations and Model Act. These NAIC consumer protection requirements for partnership policies include the provisions of §9 of the NAIC Long-Term Care Model Regulations, which pertain to Required Disclosures of Rating Practices to Consumers, and included in §9 is the requirement to use the new forms specified in §3.3829(b)(8)(H) and (I). These consumer protection provisions, which are required under the DRA, are necessary to require the use of these new forms in the marketing of long-term care policies. Additionally, based on input from the Office of Public Insurance Counsel (OPIC), consumer protection requirements in the form of additional questions have been added to proposed Form Number LHL560(LTC) Long-Term Care Personal Worksheet. These questions are listed in the part of the form titled "Questions Related to Your Needs" and include questions to applicants regarding: (i) knowledge of what inabilities trigger long-term care benefits; (ii) awareness and meaning of the term "cognitive impairment;" (iii) understanding of policy limitations; and (iv) what type of long-term care service the applicant anticipates utilizing. These additional questions are included on the proposed Personal Worksheet form in order to more prominently disclose some of the most important limitations that are currently contained in long-term care policies.

§3.3830. Requirements for Application Forms and Replacement Coverage.

The proposed amendment to §3.3830 adds new subsection (h). This new subsection requires that if a long-term care policy is being replaced by a life insurance policy with a

long-term care rider that accelerates life insurance benefits to cover the cost of long-term care, the sale of the replacement policy must comply with all of the requirements of §3.3830. Additionally, if the policy being replaced is a life insurance policy, the insurer must comply with the replacement requirements of the Insurance Code Chapter 1114 (relating to Replacement of Certain Life Insurance Policies and Annuities), and Chapter 3 Subchapter NN (relating to Consumer Notices for Life Insurance Policy and Annuity Contract Replacements), and any additional rules adopted by the Department pursuant to the Insurance Code Chapter 1114. Further, if a life insurance policy with a long-term care rider that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer must comply with §3.3830, Chapter 3, Subchapter NN, and the Insurance Code Chapter 1114. This proposed amendment is necessary to implement the provisions of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions in §14 of the NAIC Long-Term Care Model Regulations

relating to Requirements for Application Forms and Replacement Coverage. These §14 provisions are included in proposed new §3.3830(h).

§3.3837. Reporting Requirements. The proposed amendments to §3.3837 amend subsection (a) by adding new provisions to specify the requirements for insurers to report information to the Commissioner on a statewide basis regarding long-term care insurance policy or certificate replacements and lapses. Existing §3.3837(a) is proposed to be re-designated as subsection (a)(1)(A. The proposed amendments to §3.3837 divide existing subsection (a) into subsection (a)(1) relating to agent records; this is existing subsection (a); subsection (a)(2) relating to reporting of 10 percent of agents; this is existing subsection (a)(1) with proposed amendments; subsection (a)(3) relating to reporting the number of lapsed long-term care policies; this is existing subsection (a)(3) with proposed amendments; and subsection (a)(4) reporting number of replacement long-term care policies; this is existing subsection (a)(4) with proposed amendments. Existing §3.3837(a)(2) is proposed to be moved to new subsection (a)(1)(B) without changes; it provides that the purpose of the replacement and lapse reports is to review more closely agent activities regarding the sale of long-term care insurance and that reported replacement and lapse rates do not alone constitute a violation of insurance laws. Amendments to subsection (a)(2), pertaining to reporting of 10 percent of agents, are proposed to specify that each insurer shall report the information in accordance with the parts of Form Number LHL562(LTC) Long-Term Care Insurance Replacement and Lapse Reporting Form concerning the 10 percent of the insurer’s agents with the greatest percentages of policy or certificate lapses or

replacements during the preceding calendar year and that insurers must submit the required information in an electronic format prescribed by the Department. Proposed Form Number LHL562(LTC) specifies the data elements that insurers will be required to report for such lapses and replacements. Specifically, each insurer must maintain records for each agent that is in the 10 percent of that insurer's agents with the greatest percentage of replacements and for each agent that is in the 10 percent of that insurer's agents with the greatest percentage of lapses. The proposed form requires information on each agent's name, number of policies sold by the agent, number of policies replaced and lapsed by the agent, and number of replacements and lapses as percent of number of policies sold by the agent. The proposed amendments to §3.3837 further amend subsection (a)(3) and (4) to require insurers to use the part of proposed Form Number LHL562(LTC) relating to Company Totals to comply with the reporting requirements in subsection (a)(3) and (4). The data that insurers are required to report under proposed subsection (a)(3) and (4) are insurance company totals for the number of lapsed and replacement long-term care policies sold as a percentage of its total number of long-term care policies in force as of the end of the preceding year. Under the proposed amendments to subsection (a)(3) and (4), the required information must be submitted electronically in a format prescribed by the Department. The proposed amendments to §3.3837(a)(1), (2), (3), and (4) are necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. This section requires that a partnership policy be consistent with the provisions established under the DRA. The DRA requires a partnership policy to conform with specific reporting requirement

provisions of the National Association of Insurance Commissioners' (NAIC) Long-Term Care Model Regulations and Model Act. These NAIC reporting requirements for partnership policies include the provisions of §15 of the NAIC Long-Term Care Model Regulations, which pertain to Reporting Requirements. Section 15 requires insurers to use the new form specified in §3.3837(a)(2) to report the data specified in proposed amendments to subsection (a)(1), (2), (3), and (4). Existing §3.3837(a)(5) is proposed to be deleted because the requirement for reporting of the annual rate filings required under former Insurance Code Article 3.70-12 §4(b) (revised as Insurance Code §1651.053(c) as part of the non-substantive Insurance Code revision) is proposed to be moved to proposed new §3.3837(g) for purposes of organizational clarity.

The proposed amendments to §3.3837(b), pertaining to insurer reporting requirements relating to rescissions, are necessary to require the use of proposed Form Number LHL563(LTC) Rescission Reporting Form for Long-Term Care Policies specified in §3.3837(b) in lieu of existing form LTC RESCIND that is currently adopted by reference in §3.3848. The existing form is proposed to be included in §3.3837(b) with a new form number but without changes to the form requirements. The adoption by reference of the LTC RESCIND form in existing §3.3848 is proposed to be repealed, and the proposed repeal is also published in this edition of the *Texas Register*. The proposed amendments to §3.3837(b) clarify that each insurer must report to the Commissioner, by no later than June 30 annually for the preceding calendar year, all rescissions of long-term care insurance policies or certificates except those rescissions voluntarily effectuated by an insured. The proposed new Form Number LHL563(LTC),

consistent with existing form LTC RESCIND, requires each insurer to report for each rescission the policy form number, the policy and certificate number, the name of the insured, the date of the policy issuance, the date or dates that a claim or claims were submitted, the date of rescission, and a detailed reason for each rescission. Under the proposed amendments to §3.3837(b), the required information in proposed new Form Number LHL563(LTC) must be submitted electronically in a format prescribed by the Department. The proposed amendments to §3.3837(b), including the proposed new Form Number LHL563(LTC), are necessary to place all of the insurer reporting requirements in the subchapter in §3.3837. This will result in more efficient organization and greater clarity that will facilitate implementation, compliance, and enforcement of the rules.

The proposed amendments to §3.3837(c), pertaining to reporting requirements for claims denied by class of business, add new paragraph (1) to include the definitions of the terms “claim” and “denied” when those terms are used in the subsection. Amendments to subsection (c) are also proposed to require insurers to use proposed new Form Number LHL564(LTC) Long-Term Care Claim Denials Reporting Form, which is specified in §3.3837(c)(2), to comply with the reporting requirements in subsection (c)(2). Under the proposed amendments, each insurer is required to report 11 data elements for both state data and nationwide data for all long-term care insurance claim denials under in-force long-term care insurance policies, including total number of long-term care claims reported, total number of long-term care claims denied/not paid, number of claims not paid due to preexisting condition exclusion, and

number of claims not paid due to waiting period not being met. The proposed amendments to §3.3837(c)(2) require the data in Form Number LHL564(LTC) to be submitted electronically in a format prescribed on the Department's website. The proposed amendments to §3.3837(c)(2) are necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions in §15 of the NAIC Long-Term Care Model Regulations, relating to Reporting Requirements. Section 15 contains the requirement that insurers must report state and nationwide data relating to claim denials in accordance with the proposed new form specified in §3.3837(c)(2).

The proposed amendments to §3.3837(d), pertaining to reporting requirements for the long-term care partnership program, delete the existing subsection (d) and propose new reporting requirements for all insurers that market partnership policies in Texas. Proposed new §3.3837(d) requires that each insurer report to the Department by June 30 of each year the information required in §32.107 of the Human Resources

Code. Each insurer must specify the number of approved partnership plans sold in the state during the preceding calendar year and the average age of individuals purchasing approved partnership plans during the preceding calendar year. The information required in subsection (d) must be reported in accordance with Form Number LHL565(LTC) Long-Term Care Policies Sold Reporting Form as specified in §3.3837(e). The required information includes reporting for two long-term care partnership policy types: comprehensive (institutional and community care) and nursing home (institutional only). Each insurer must submit the required information electronically in a format prescribed on the Department's website. SB 22 enacted new §32.107 of the Human Resources Code that requires the Texas Health and Human Services Commission (HHSC) to report this information in a biennial report to the Legislature by not later than September 30 of each even-numbered year. The purpose of the report is to provide information to the Legislature on the progress of the partnership program for the preceding biennium. Section 32.107 also provides that the HHSC may request information from the Texas Department of Insurance as necessary to prepare the biennial report. The Department will report this data to the HHSC for use in fulfilling HHSC's requirements under §32.107 of the Human Resources Code. Existing §3.3837(d) specifies that the reporting requirements in §3.3837 relate only to long-term care insurance delivered or issued for delivery in this state; this provision is redundant of proposed new provisions in §3.3837 and is proposed to be deleted.

The proposed amendments to §3.3837, pertaining to reporting requirements for both partnership and non-partnership plans, add new subsection (e) to require that all

insurers that market long-term care insurance in Texas report to the Department by June 30 of each year the number of non-partnership plans sold in the state during the preceding calendar year and the average age of individuals purchasing the non-partnership plans during the preceding calendar year. The information required in proposed new subsection (e) must be reported in accordance with Form Number LHL565(LTC) as specified in §3.3837(e). The required information includes reporting for four long-term care non-partnership policy types: comprehensive (institutional and community care); nursing home (institutional only); home health care (community-based services); and riders (attached to life policies or annuity contracts.) Each insurer must submit the required information electronically in a format prescribed on the Department's website. Proposed new §3.3837(e) is necessary to implement the provision of SB 22, codified as Human Resources Code §32.107. Section 32.107 requires that not later than September 30 of each even-numbered year the Texas Health and Human Services Commission (HHSC) shall submit a report to the Legislature on the progress of the partnership program for the preceding biennium. Section 32.107 also provides that the HHSC may request information from the Texas Department of Insurance as necessary to prepare the biennial report. Therefore, the Department has determined that the most effective approach to measuring the progress of the partnership program in Texas is to compare partnership data as required pursuant to proposed §3.3837(d) and non-partnership data as required pursuant to proposed §3.3837(e). In order to provide a meaningful, comprehensive report on the progress of the partnership program to the Legislature, it is necessary that insurers

report the non-partnership data specified in proposed new §3.3837(e) as well as the partnership data specified in the proposed amendments to §3.3837(d). The Department is authorized to require non-partnership data from insurers under the Insurance Code §1651.004, which authorizes the Department to adopt reasonable rules that are necessary and proper to carry out Chapter 1651. Subchapter C of Chapter 1651 specifies the Department's regulatory functions with regard to the long-term care partnership program. While the Human Resources Code §32.107(a) requires the HHSC to submit the biennial report on the progress of the partnership program, any information that may be requested of the Department as provided in §32.107(b) of the Human Resources Code would have to be requested from insurers pursuant to the Commissioner's rulemaking authority in the Insurance Code §1651.004.

Proposed new §3.3837(f) provides new suitability reporting requirements for all insurers that market long term care insurance policies in Texas. Insurers are required to provide suitability data on non-partnership and partnership policies sold in Texas in accordance with the requirements indicated in proposed new Form Number LHL566(LTC) Long-Term Care Suitability Reporting Form as specified in §3.3837(f). The data is required to be reported to the Commissioner by no later than June 30 annually for the preceding calendar year. Under the proposed new requirements, insurers are required to report suitability data for long-term care partnership comprehensive (institutional and community care) and nursing home (institutional only) policies that includes total number of applications received, total number of applicants who declined to provide the personal worksheet information, total number of applicants

who did not meet the suitability standards, and total number of applicants who chose to confirm after receiving a suitability letter. Proposed new §3.3837(f) requires insurers to report the same suitability data for long-term care non-partnership comprehensive, nursing home, and home health care policies, and riders attached to life policies and annuity contracts. The proposed reporting requirements require insurers to submit the data electronically in a format prescribed on the Department's website. Proposed new §3.3837(f) requirements for reporting suitability data for partnership policies sold in Texas are necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions of §24 of the NAIC Long-Term Care Model Regulations, which pertain to Suitability. Section 24 contains the requirement that insurers must report the long-term care partnership data specified in proposed new §3.3837(f). Proposed new §3.3837(f) requirements for reporting suitability data are necessary for the Department to have an understanding of what is going on in terms of the marketing practices of those insurers that market partnership

policies as well as those insurers that market non-partnership policies. The data will provide an essential tool in the Department's monitoring of whether long-term care policies are being sold appropriately, i.e., to those who actually need the coverage. The Department is authorized to require the non-partnership data from insurers under the Insurance Code §1651.004, which authorizes the Department to adopt reasonable rules that are necessary and proper to carry out Chapter 1651. Chapter 1651 specifies the Department's regulatory functions with regard to long-term care benefit plans, including suitability as provided in §3.3842, which was adopted pursuant to §1651.004 of the Insurance Code for the purpose of implementing Chapter 1651.

Proposed new §3.3837(g) contains the requirement in existing §3.3837(a)(5) that requires insurers to file an annual rate filing required under former Insurance Code Article 3.70-12 §4(b) (revised as Insurance Code §1651.053(c) as part of the non-substantive Insurance Code revision) to demonstrate compliance with the applicable loss ratios of this state and any other filing requirement adopted by the Commissioner relating to loss ratios. The requirement applies to both partnership and non-partnership long-term care policies. Existing §3.3837(a)(5) is proposed to be redesignated as new §3.3837(g) and amended to clarify that the demonstration of compliance with applicable loss ratio standards that is in the current rule is in addition to any demonstration required under §§3.3831(c)(2)(B) - 3.3831(c)(2)(D) and that compliance with the statutory requirement includes providing the following information by calendar duration and separately by form number: (i) calendar duration; (ii) first year issued; (iii) actual earned premium by duration; (iv) actual incurred claims; (v) actual calendar duration

loss ratio; (vi) anticipated calendar duration loss ratio; and (vii) number of insured lives. This also applies to partnership and non-partnership long-term care policies. The proposed requirements in re-designated §3.3837(g) are necessary to clarify the information a company must provide in order to demonstrate compliance with the Insurance Code 1651.053(c)(1).

§3.3838. Filing Requirements for Advertising. The proposed amendments to §3.3838(1) refine the requirements for the advertising of partnership and non-partnership long-term care insurance to exclude the necessity of filing institutional advertisements (as that term is defined in §21.102 of this title) if the advertisement only references long-term care insurance as a line of coverage. Institutional advertisements that provide details regarding the insurer's long-term care insurance products that go beyond merely identifying long-term care insurance as a line of coverage that is available from the insurer would continue to be subject to prior approval by the Commissioner, subject to the requirements in existing §3.3838. The proposed amendments to §3.3838(1) are necessary to exclude from the filing and review requirements long-term care insurance advertisements that do not provide any details on the long-term care insurance product. Because these advertisements are not currently a source of false, misleading, or deceptive marketing practices, the Department has determined that the Commissioner's review is not necessary. The result will be more efficient and cost-effective advertising filing requirements for long-term care insurers. Also, the reduction in the number of institutional advertisements that are filed with the Department for review will enable the Department to more effectively

utilize Departmental resources without compromising consumer protection. The Department will be able to redirect its resources to advertising practices that are a more frequent source of false, misleading, or deceptive marketing practices. There are no changes proposed to existing §3.3838(2) and (3). The amendments to §3.3838(1), which apply to both partnership and non-partnership policies, are not required by SB 22 or any other state or federal legislation but rather are proposed pursuant to the Commissioner's rulemaking authority in the Insurance Code §1651.004. Chapter 1651 specifies the Department's regulatory functions with regard to long-term care benefit plans, including non-partnership and partnership plans.

§3.3839. Standards for Marketing. Section 3.3839 specifies the marketing procedures that must be established and implemented by each insurer, health care service plan, or other entity marketing, either directly or through its agents, partnership or non-partnership long-term care insurance in this state. Proposed new §3.3839(a)(8), (9) and (10) mandate three new requirements: (i) each insurer or other entity marketing long-term care insurance in this state must, at the time of solicitation, provide written notice to the prospective policyholder that a senior insurance counseling program is available; (ii) each insurer or other entity must provide to the applicant at the time of application an explanation of the contingent nonforfeiture benefit upon lapse specified in §3.3844(g)(1), and if applicable, an explanation of the additional contingent nonforfeiture benefit upon lapse provided to policies with fixed or limited premium payment periods provided in §3.3844(g)(2); and (iii) each insurer or other entity must provide to the applicant, at the time of application, copies of the Long-Term Care

Personal Worksheet as specified in §3.3829(b)(8)(H) and the Long-Term Care Potential Rate Increase Disclosure Form as specified in §3.3829(b)(8)(I). These new requirements are necessary to ensure that more consumers are better informed about the availability of the senior insurance counseling program and therefore, more consumers will participate in the counseling program. The Health Information Counseling and Advocacy Program of Texas is the senior counseling program and is operated by the Department. The program provides consumer information on long-term care insurance, including planning, insurance basics, need for such coverage, costs, and methods of financing. This information will mean that more consumers will be able to make more informed decisions regarding the purchase of long-term care insurance. Also, more consumers will be better informed about the contingent nonforfeiture benefit on lapse provisions, including the additional contingent nonforfeiture benefit upon lapse provided to policies with fixed or limited premium payment periods. A contingent nonforfeiture benefit upon lapse allows the insured to either choose a reduced benefit amount to prevent premium increases or to convert their policy to a paid-up status. The required information will explain the different contingent nonforfeiture benefit on lapse options that are available to a consumer if the consumer decides to allow their long-term care policy to lapse within 120 days of a substantial rate increase. With such information, more consumers will be aware of the possible range of benefits that they will have in the event that they are unwilling or unable to pay the long-term care premium in the face of a substantial rate increase by the insurer. This type of

information will also assist consumers in making more informed decisions regarding the purchase of long-term care insurance.

As previously stated, the required use of these new forms, which is also required under proposed §3.3829, will provide additional information obtained from the applicant to assist the insurer and the applicant to make an informed decision on whether it is prudent for the applicant to purchase the long-term care policy given the financial circumstances of the applicant. This will ensure that those consumers who do not need or cannot afford such a policy will be less likely to purchase one. Additionally, from the perspective of marketing standards, each agent marketing long-term care insurance will have information pertaining to each applicant or potential applicant that will enable the agent to identify those individuals who are financially suitable to purchase such insurance.

The proposed amendments to §3.3839 provide that the required notices in existing §3.3839(b)(1) and (2), relating to the existence or non-existence of inflation protection provisions in each policyholder's policy, are also marketing procedure requirements, along with the other marketing procedure requirements specified in §3.3839(a), that are subject to Department audit to verify compliance. These current notices, which are redesignated as §3.3839(a)(11)(A) and (B), respectively, must be provided to each policyholder who purchases a policy that contains inflation protection provisions and to each policyholder who purchases a policy that does not contain inflation protection provisions.

Existing §3.3839(b), which is proposed to be redesignated as §3.3839(a)(11), specifies the requirements for providing the required notices to policyholders. No changes are proposed to the existing required notices or to the existing requirements for providing the notice to policyholders. The proposed redesignation of existing §3.3839(b)(1) and (2) as §3.3839(a)(11)(A) and (B) is necessary to clarify that the required notices in existing §3.3839(b)(1) and (2) are also marketing procedure requirements, along with the other marketing procedure requirements specified in §3.3839(a), that are subject to Department audit to verify compliance. The proposed amendments to §3.3839, as applicable to partnership policies, are necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions of §23 of the NAIC Long-Term Care Model Regulations, relating to Standards for Marketing. Section 23 contains the requirements specified in the proposed amendments to §3.3839. Section 23 A(5) requires each long-term care insurer to establish an auditable procedure for verifying compliance with all marketing

procedures, including the required notices that are specified in redesignated §3.3839(a)(11)(A) and (B). In existing §3.3839 as currently structured, it is not clear that the inflation protection notice requirements in §3.3839(b)(1) and (2) are subject to audit. The Department has determined that it is also necessary to apply the consumer protection requirements in the proposed amendments to §3.3839 to policyholders and applicants for all long-term care insurance policies, not just partnership policies. The Department has determined that prospective policyholders and applicants for non-partnership policies are entitled to the same consumer protections as those for partnership policies. The Department's position is that in order to fulfill its regulatory functions pursuant to Chapter 1651 of the Insurance Code with regard to long-term care insurance, the same consumer protections must be afforded to both partnership and non-partnership long-term care applicants and policyholders. The Department is authorized to adopt the proposed amendments to the §3.3839 requirements for non-partnership policies under the Insurance Code §1651.004, which authorizes the Department to adopt reasonable rules that are necessary and proper to carry out Chapter 1651. Chapter 1651 specifies the Department's regulatory functions with regard to long-term care benefit plans, including non-partnership and partnership plans.

Proposed new §3.3839(a)(8), (9) and (10) and the proposed amendments to existing §3.3839(b) that provide that the required inflation notices are also marketing procedure requirements that are subject to Department audit to verify compliance, as applicable to partnership policies, implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be

consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C.§1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C.§1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions of §23 of the NAIC Long-Term Care Model Regulations, relating to Standards for Marketing. Included in §23 are the requirements specified in proposed new §3.3839(a)(8), (9) and (10) and the proposed amendments to existing §3.3839(b) that provide that the required inflation notices are also marketing procedure requirements that are subject to Department audit to verify compliance.

Existing §3.3839(c) and (d) are proposed to be redesignated as §3.3839(b) and (c) because of the proposed redesignation of existing §3.3839(b) as proposed §3.3839(a)(11).

§3.3842. Appropriateness of Recommended Purchase. Existing §3.3842 provides that in recommending the purchase or replacement of any long-term care insurance policy or certificate, the company and the agent shall make reasonable efforts to determine the appropriateness of the recommended purchase or replacement. This requirement, which is proposed to be redesignated as §3.3842(a), constitutes the entirety of existing §3.3842. The proposed amendments to §3.3842 add several new

requirements relating to the suitability standards of the insurer, health service plan, or other entity (issuer) marketing long-term care insurance. These requirements apply to both partnership and non-partnership long-term care insurance coverage. Proposed new §3.3842(b)(1) – (3) requires that each issuer develop and use suitability standards to determine whether the purchase or replacement of a long-term care policy is appropriate to the needs of the applicant, train its agents in the use of the issuer's suitability standards, and maintain a copy of its suitability standards that is available to the Commissioner for inspection upon request.

Proposed new §3.3842(c) requires that the agent and issuer develop suitability procedures to determine whether the applicant meets the issuer's standards. These procedures must consider the following factors: the applicant's ability to pay for the proposed coverage and other pertinent financial information; the applicant's goals and needs with respect to long-term care; and the values, benefits, and costs of the applicant's existing insurance as compared to the values, benefits, and costs of the recommended purchase or replacement.

Proposed new §3.3842(d) requires the issuer or, if an agent is involved, the agent to make reasonable efforts to obtain the information required in proposed new §3.3842(c) and that the efforts shall include presentation to the applicant of the Long-Term Care Personal Worksheet that is in proposed new Form Number LHL560(LTC) specified in §3.3829(b)(8)(H). Under proposed new §3.3842(d), the issuer may request the applicant to provide additional information on the Personal Worksheet to comply with the issuer's suitability standards. However, if the issuer requests such additional

information, the issuer must comply with the following requirements that are specified in proposed new §3.3842(d)(1) – (3): (i) a copy of the issuer's Personal Worksheet that includes the additional information must be filed with the Department for approval at least 60 days prior to use; (ii) the filing is subject to the requirements and procedures in Chapter 3, Subchapter A of this title; and (iii) the filing should be submitted to the Filings Intake Division of the Department.

Proposed new §3.3842(e) requires the completed Long-Term Care Personal Worksheet to be returned to the issuer prior to the issuer's consideration of the applicant for coverage; however, this is not required for sales of employer group long-term care insurance. Proposed new §3.3842(f) prohibits the sale or dissemination of information obtained through completion of the Long-Term Care Personal Worksheet. Proposed new §3.3842(g) requires the issuer to use suitability standards that it has developed pursuant to §3.3842 in determining the appropriateness of issuing long-term care insurance to an applicant. Proposed new §3.3842(h) requires agents to use the suitability standards developed by the issuer in marketing the issuer's long-term care insurance.

Proposed new §3.3842(i) requires issuers to provide to the applicant at the same time the Personal Worksheet is provided the proposed new disclosure Form Number LHL567(LTC) Things You Should Know Before You Buy Long-Term Care Insurance. This form provides important information to the consumer concerning the general functions of a long-term care insurance policy, Medicare and Medicaid as those programs relate to long-term care insurance, the availability of a Shopper's Guide for

Long-Term Care, the availability of a senior health insurance counseling program, and general information concerning long-term care facilities. This disclosure form will help the applicant decide whether or not it is prudent to purchase a long-term care policy. Additionally, proposed new §3.3842(i)(1) – (6) specify the requirements and procedures that apply to proposed new Form Number LHL567(LTC), including text size and content, recommended format, and filing and approval procedures as applicable. A representation of proposed new Form Number LHL567(LTC) Things You Should Know Before You Buy Long-Term Care Insurance is in §3.3842(i)(7).

Proposed new §3.3842(j) addresses actions to be taken if the issuer determines that the applicant does not meet its financial suitability standards or if the applicant has declined to provide the requested information. If either of these events occur, the proposed subsection provides that the insurer may either reject the application or, if the issuer does not opt to reject the application, the issuer is required to send the applicant a letter in accordance with proposed new Form Number LHL568(LTC) Long-Term Care Insurance Suitability Letter. However, only in the event that the applicant has declined to provide the requested financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned Suitability Letter containing the applicant's response or a record of the alternative method of verification must be made a part of the applicant's file. If the issuer elects to send the applicant a Suitability Letter to comply with the requirements of proposed new §3.3842(j), the Suitability Letter must comply with the proposed requirements and procedures specified in §3.3842(j)(1) – (4), including text size and content. The content of the letter is specified in proposed

new Form Number LHL568(LTC) Long-Term Care Insurance Suitability Letter. The letter will inform an applicant that the issuer has reviewed the financial information provided by the applicant on the personal worksheet and has determined that the applicant is not financially suitable to purchase long-term care insurance and that review of the application has been suspended or that the applicant has not provided any or has provided insufficient financial information for the issuer to make a determination as to the applicant's suitability to purchase a long-term care policy and that review of the application has been suspended.

Proposed new §3.3842(b) – (j) are necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions of §24 of the NAIC Long-Term Care Model Regulations, which pertain to Suitability. These §24 requirements are specified in proposed new §3.3842(b) - (j). Section 24 requires the use of the proposed disclosure form LHL567(LTC) Things You Should Know Before You Buy Long-Term Care Insurance that is specified in

§3.3842(i)(7) and the proposed Suitability Letter specified in proposed new Form Number LHL568(LTC) Long-Term Care Insurance Suitability Letter as represented in §3.3842(j). The Department has determined that it is also necessary to apply the consumer protection requirements in proposed new §3.3842(b) – (h) to issuers and their agents who market non-partnership long-term care policies, not just partnership policies. The Department has determined that applicants for non-partnership policies are entitled to the same consumer protections as those for partnership policies. The Department's position is that in order to fulfill its regulatory functions pursuant to Chapter 1651 of the Insurance Code with regard to long-term care insurance, the same consumer protections must be afforded to both partnership and non-partnership long-term care applicants. The Department is authorized to adopt the proposed new §3.3842(b) – (h) requirements for non-partnership policies under the Insurance Code §1651.004, which authorizes the Department to adopt reasonable rules that are necessary and proper to carry out Chapter 1651. Chapter 1651 specifies the Department's regulatory functions with regard to long-term care benefit plans, including non-partnership and partnership plans.

§3.3844. Nonforfeiture and Contingent Nonforfeiture Benefits. Existing §3.3844, pertaining to nonforfeiture and contingent benefits in long-term care policies and certificates, addresses: (i) requirements for the offering of nonforfeiture benefits and the provision of contingent benefits upon lapse in subsection (a); (ii) requirements for nonforfeiture benefit provisions in subsection (b); (iii) requirements for nonforfeiture benefit options in subsection (c); (iv) nonforfeiture and contingent benefit

standards/requirements in subsection (d); (v) requirements for insurers offering a shortened benefit period in subsection (e); (vi) required disclosure of nonforfeiture benefits in subsection (f); and (vii) requirements for contingent nonforfeiture benefits in subsection (g). No changes are proposed to existing §3.3844 (a), (b), (d), or (f). An amendment is proposed to §3.3844(c)(3) to correct the erroneous word “shorten” to read “shortened.” No changes are proposed to §3.3844(g)(1); however, a new §3.3844(g)(2) is proposed.

Proposed new §3.3844(g)(2) provides that in addition to the provision in §3.3844(g)(1) for the triggering of contingent nonforfeiture benefits on lapse, such contingent nonforfeiture benefits shall be triggered for policies or certificates with limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium specified in the proposed table in §3.3844(g)(2) based on the insured's issue age, the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio specified in proposed §3.3844(g)(4)(B) is 40 percent or more. Proposed §3.3844(g)(2) also provides that unless otherwise required, policyholders must be notified at least 45 days prior to the due date of the premium reflecting the rate increase. A contingent nonforfeiture benefit is a type of nonforfeiture benefit that becomes available to the policyholder when the contingency of a substantial rate increase occurs. The triggers for a substantial rate increase are contained in the tables in §3.3844(g)(1) and

§3.3844(g)(2) and are expressed as a function of the issue age of the insured and the percent increase over initial premium that the insured paid.

The proposed revised contingent nonforfeiture benefit on lapse provision for policies with limited premium payment periods are necessary to require insurers to include these protections in their policies, and it is in the best interest of consumers who purchase policies on such payment plans to be able to receive greater protections if their policies lapse. The reasons for this are the following. The contingent nonforfeiture benefit on lapse is triggered every time an insurer increases the premium rate to a level that corresponds to the issue age of the insured at the time of the rate increase and the corresponding percent increase over the initial premium that the insured paid. Once the policyholder receives notice of a substantial rate increase the policyholder has 120 days to either pay the substantial rate increase or allow the policy to lapse and choose from the insurer's offer to: (i) reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that the required premium payments are not increased; or (ii) convert the coverage to a paid-up policy with a shortened benefit period. Therefore, the contingent nonforfeiture benefit on lapse provisions provide a safety net to policyholders who are forced to allow their long-term care policies to lapse because they are unable to pay a substantial rate increase.

Proposed new §3.3844(g)(4)(A) and (B) require the insurer to make certain offers to the insured for a policy or certificate with a fixed or limited premium payment period when there is a substantial rate increase and the policy has lapsed within 120 days of the due date of the premium that was substantially increased. The insurer must offer to

the policyholder the option to either: (i) reduce the policy or certificate benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased; or (ii) 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 prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period.

Proposed new §3.3844(g)(4)(C) requires the insurer to notify the policyholder that a lapse or default at any time during the 120-day period shall be deemed to be the insured's election of the offer to convert as set forth in §3.3844(g)(4)(B).

The proposed amendments to §3.3844(e) limit the application of subsection (e) to contingent nonforfeiture benefits upon lapse in the event of a default in payment of premiums in accordance with §3.3844(g)(1). The proposed amendments also provide that subsection §3.3844(e) does not apply to contingent nonforfeiture benefits upon lapse in accordance with §3.3844(g)(2), which provides that a contingent nonforfeiture benefit on lapse is also triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium as set forth in the table Triggers for a Substantial Premium Increase in §3.3844(g)(2) based on certain specified factors. The proposed addition of this revised contingent nonforfeiture benefit on lapse provision will provide consumers with greater protections if their policies lapse. This provision ensures that, in

the event that an insured is unable to pay the substantial rate increase and is therefore forced to let their policy lapse, the insured will receive at least some benefits for the premiums he or she has paid in over the years.

The proposed amendments to §3.3844 that amend subsection (e) and add new paragraphs (2) and (4) to subsection (g) implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C.§1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the nonforfeiture benefit requirements in the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C.§1396p(b)(5)(A)). These NAIC nonforfeiture benefit requirements for partnership policies are in §28D(4), D(6), E, and E(1) of the NAIC Long-Term Care Model Regulations, relating to Nonforfeiture Benefit Requirements. Section 28D(4), D(6) , E, and E(1) are specified in the proposed amendments to §3.3844(e), (e)(3), (g)(2), and (4).

The Department has determined that it is also necessary to apply the proposed new contingent nonforfeiture benefit requirements for limited premium payment policies in the proposed amendments to §3.3844(e) and (g) to non-partnership policies and insureds for all long-term care insurance policies, not just partnership policies and insureds.

The application of the proposed new nonforfeiture and contingent nonforfeiture benefit requirements to non-partnership policies and insureds is necessary to provide the same benefits to these insureds as is provided to partnership policy insureds. This is necessary to ensure that those insureds covered by non-partnership policies will also receive some benefits if they are unable to pay the higher premiums and are required to allow their policies to lapse. The Department has determined that insureds covered under non-partnership policies should receive the same consumer protections and benefits as insureds covered under partnership policies. There is no regulatory or public interest reason to exempt non-partnership policy insureds from these consumer protection requirements and benefits. To the contrary, there are significant regulatory and public interest reasons for providing all long-term care insureds the same consumer protections and benefits. Providing the same consumer protections and benefits to all long-term care insureds will mean that all long-term care insurance policyholders in Texas will be uniformly treated in the event that an insured is unable to pay the substantial rate increase and is therefore forced to let their policy lapse. Like the partnership policy insured, the non-partnership policy insured will receive at least some benefits for the premiums he or she has paid in over the years. The Department's position is that in order to fulfill its regulatory functions pursuant to Chapter 1651 of the Insurance Code with regard to long-term care insurance that the same consumer protections must be afforded to both partnership and non-partnership long-term care applicants and policyholders. The Department is authorized to adopt the proposed amendments to §3.3844(e) and (g) requirements for non-partnership policies under the

Insurance Code §1651.004, which authorizes the Department to adopt reasonable rules that are necessary and proper to carry out Chapter 1651. Chapter 1651 specifies the Department's regulatory functions with regard to long-term care benefit plans, including non-partnership and partnership plans.

§3.3848. Requirements for Limited Premium Payment Options in Long-Term Care Policies, Certificates, and Riders. The regulatory requirements in proposed §3.3848, which apply to both partnership and non-partnership long-term care policies, govern noncancellation, guaranteed renewability, and return of premium practices for long-term care plans with limited premium payment options. Proposed new §3.3848(a) specifies the definition and applicability and proposed new §3.3848(b) specifies the requirements for limited premium payment options in long-term care plans. Long-term care policies, certificates, and riders with limited premium payment options limit premium payments to a single payment or to a stated number of years not to exceed 10 years and must comply with Subchapter A and Subchapter Y of Chapter 3 in Title 28 of the Texas Administrative Code and with the additional requirements specified in §3.3848(b).

The proposed requirements in §3.3848(b)(1) and (2) include: (i) notice on the face page of the policy or certificate that the plan has a limited premium payment option; and (ii) the provisions in long-term care policies, certificates, and riders with limited premium payment options must be at least as favorable as the requirements and provisions specified in §3.3848. Proposed §3.3848(b)(3) – (5) specify the requirements for three types of limited premium payment policies, certificates, and riders, including

single-premium payment option, one-to-four-year premium payment options, and five-to-ten year premium payment options.

Single-premium payment option policies must be noncancellable and the renewability provision in the policy must conform with the provision specified in §3.3848(b)(3) that states the premiums are paid by a single premium, that the policy cannot be cancelled by the insurer, and that no changes can be made to the policy unless requested by the insured. One-to-four year premium payment option policies must be noncancellable, and the renewability provision in the policy must conform with the provision specified in §3.3848(b)(4) that states the premiums are paid over a period of [n] (n may equal 1, 2, 3, or 4) years, that the policy cannot be cancelled by the insurer, and that no changes can be made to the policy unless requested by the insured.

For those policies, certificates, and riders with a five-to-ten year premium payment option, a provision must be included in the policy, certificate, or rider that provides for a return of premium upon cancellation, as provided in the Return of Premium Schedule in §3.3848(b)(5)(C)(ii) and must be accompanied by the disclosure notice specified in §3.3848(b)(5)(C)(i). The return of Premium Schedule chart in §3.3848(b)(5)(C)(ii) specifies the percentage of premium that the insurer is required to return to the insured expressed as a function of the premium payment option (5, 6, 7, 8, 9, and 10 year premium payment options) and of the number of completed years prior to the policy, certificate or rider being canceled and must comply with the requirements specified in §3.3848(b)(5)(C)(ii)(I) and (II), including text font size and format. Proposed

§3.3848(b)(5)(D) and (E) provide a formula for using the Return of Premium chart to determine the total return of premium amount.

The provisions in proposed §3.3848 are not required by SB 22 or the DRA. The proposed requirements, which apply to both partnership and non-partnership policies, are proposed to protect Texas insureds who have limited premium payment plans from unfair cancellation, nonrenewal, and return of premium practices.

Proposed new §3.3848 is proposed pursuant to the Insurance Code §1651.004, which authorizes the Department to adopt reasonable rules that are necessary and proper to carry out Chapter 1651. Chapter 1651 specifies the Department's regulatory functions with regard to long-term care benefit plans, including partnership and non-partnership plans.

§3.3849. Requirements for Insurers that Issue Long-Term Care Policies to Associations and Marketing Standards for Associations that Market the Policies. Existing §3.3849 relating to 1997 effective dates and grace period, is being repealed, and the proposed repeal is also published in this edition of the *Texas Register*. Proposed new §3.3849 specifies certification requirements for insurers that issue partnership and non-partnership policies to associations and marketing standards for associations, as defined in the Insurance Code §1251.052, that market partnership and non-partnership policies. Insurers that issue such policies to associations are required under proposed §3.3849(a)(1) to file with the Department the partnership and/or non-partnership policy and certificate, a corresponding outline of coverage, and an annual certification of the association's compliance with marketing standards for partnership

and/or non-partnership policies and certificates in accordance with the Insurer Certification of Association Marketing Compliance specified in §3.3849(e)(1)(F). A representation of proposed Form Number LHL573(LTC) Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates is specified in new Figure: 28 TAC §3.3849(e)(1)(F).

Proposed new §3.3849(a)(2) provides that no group long-term care partnership and/or non-partnership policy or certificate may be issued to an association unless the insurer files with the Department the information required in §3.3849(a)(1).

Proposed new §3.3849(e)(1)(A) – (D) specify the requirements and procedures that apply to the Insurer Certification of Association Marketing Compliance Form, including text content, text font size, recommended format, and filing for approval as applicable. Proposed new §3.3849(e)(2) requires that the initial certification be submitted to the Department between January 1, 2009 and January 31, 2009, for the calendar year 2008, and thereafter be submitted annually between January 1 and January 31 for the preceding calendar year.

Proposed new §3.3849(e)(3) provides that the certification form is an informational filing pursuant to §3.5(b)(1) of this title (relating to Filing Authorities and Categories) and is subject to the requirements and procedures in Chapter 3, Subchapter A of this title. Proposed new §3.3849(e)(4) specifies where the annual completed certification form should be filed. This requirement is necessary to provide information to assist the Department in monitoring each association's compliance with

the §3.3849 requirements, including an association's compliance with marketing standards for partnership and non-partnership policies and certificates in accordance with the Insurer Certification of Association Marketing Compliance. The monitoring will enable the Department to identify possible violations, including unfair marketing practices, in a timely manner so that the Department can take corrective action to protect association members. Additionally, the proposed certification form in §3.3849(e)(1)(F) will ensure timely and efficient filing of the required certification information with the Department.

Proposed new §3.3849(b) requires advertisements for long-term care partnership and non-partnership insurance to be filed with the Department in accordance with §3.3838(1) (relating to Filing Requirements for Advertising). This requirement is necessary to enable the Department to timely identify and prevent unfair or deceptive advertising to association members who are considering applying for long-term care insurance coverage. This will help to ensure that association members are protected from unscrupulous and dishonest sales and enrollment practices.

Proposed §3.3849(c)(1) requires an association to disclose in any long-term care partnership and/or non-partnership insurance solicitation to its members: (i) the specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and (ii) a brief description of the process under which the policies and the insurer issuing the policies were selected. Under proposed §3.3849(c)(2), an

association is required to disclose to its members the fact of any interlocking directorates or trustee arrangements between the association and the insurer. The Department is proposing these new requirements in order to make consumers aware of factors, such as the financial arrangements between the insurer and the association and the extent of the insurer selection process, that will enable them to more effectively evaluate the pros and cons of the long-term care insurance solicitation. Also, more consumers will have information to enable them to more readily identify possible bias or deception in the marketing or solicitation of long-term care products by the association. These types of information will enable association members to be more than just pro forma participants in the purchase of their long-term care insurance if they so choose.

Proposed new §3.3849(d) requires an association's board of directors to review and approve the insurance policies and compensation arrangements the association has with the insurer. This requirement will enable the association's board of directors to examine and evaluate the long-term care benefits being purchased by the association's members and the financial arrangements between the insurer and the association to ensure that they are in the best interest of the members of the association.

Proposed new §3.3849(a) - (d) implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must

meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions in §23 of the NAIC Long-Term Care Model Regulations, relating to Standards for Marketing. The provisions in proposed §3.3849(a) - (d) are consistent with the provisions in §23 in the Model Regulations. While §23 of the Model Regulations does not specifically require a certification form, §23C(8) of the Model Regulations includes the requirement that insurers make the annual certification that is proposed in §3.3849(a)(1)(C).

The Department has determined that it is also necessary to apply the consumer protection requirements in proposed new §3.3849 to insurers, their agents, and associations that market non-partnership long-term care policies, not just partnership policies. The Department has determined that members of associations being solicited for non-partnership policies should receive the same consumer protections as members of associations being solicited for partnership policies. There is no regulatory or public interest reason to exempt association member applicants for non-partnership policies from these consumer protection requirements. In fact, there are significant regulatory and public interest reasons for providing all association member applicants for long-term care coverage the same consumer protections. Providing the same consumer protections to all long-term care association member applicants will mean that that all consumers who are members of associations in Texas will be uniformly protected from

unscrupulous or dishonest marketing practices that can cause economic harm to the consumers.

§3.3860. Policy Summary Requirements for Non-partnership Life Insurance Policies That Provide Long-Term Care Benefits. Proposed new §3.3860 sets forth the delivery and content requirements for the policy summary for non-partnership life insurance policies that provide long-term care benefits by rider. The proposed requirements do not apply to any long-term care partnership policy. Proposed §3.3860(a) specifies that at the time of delivery of a life insurance policy that provides long-term care benefits by rider the insurer shall also deliver a policy summary. Proposed §3.3860(a) also provides requirements for policy summary delivery for direct response solicitations. Proposed §3.3860(a)(1) – (5) specify the policy summary content requirements: (1) an explanation of how the benefits interact with other components of the policy; (2) an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefit; (3) any exclusions, reductions, and limitations on benefits; (4) a statement that the long-term care inflation protection option required by §3.3820 (relating to Requirement to Offer Inflation Protection) and the long-term care inflation protection provisions required for partnership policies by §3.3872 (relating to Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates) are not available under this policy; and (5) if applicable to the policy type, a disclosure of the effects of exercising other rights under the policy; a disclosure of guarantees related to the cost of insurance charges, and a disclosure of current and projected lifetime benefits. Proposed §3.3860(b) provides that the provisions of the

policy summary may be incorporated into a basic life insurance illustration that is required to be delivered in accordance with Chapter 21 Subchapter N of Title 28, relating to Life Insurance Illustrations. Proposed §3.3860(c) specifies that any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit by rider, is in benefit payment status, a monthly report must be provided to the policyholder. Additionally, proposed §3.3860(c) specifies the information the monthly report is required to contain. The provisions in proposed §3.3860 are necessary to provide important information to the consumer to assist in determining whether to purchase a long-term care policy that is funded by a life insurance policy. Proposed §3.3860 is necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a long-term care policy that is funded by a life insurance policy be consistent with the provisions in §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). The policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements include the provisions in §6J and §6K of the NAIC Long-Term Care Model Act. Proposed §3.3860 is consistent with the §6J and §6K requirements.

§3.3870. Exchange Requirements for Long-Term Care Partnership Policies.

Proposed new §3.3870 specifies the requirements for the exchange of an existing long-term care policy for a new long-term care partnership policy. Proposed new §3.3870(a)

addresses requirements for notification to policyholders eligible for exchange and the requirements for the offer of exchange. The proposed requirements in subsection (a) include the following: (i) any insurer that advertises, markets, sells, or issues partnership policies is required to offer on a one-time basis to all policyholders or certificate holders that were issued long-term care coverage on or after February 8, 2006, the option to exchange their existing policy or certificate for a partnership policy or certificate; and (ii) the insurer is required to offer the option to exchange in writing by December 31, 2009. The Department is proposing the December 31, 2009 date as the cut-off date for insurers to offer the option to insureds to exchange any already purchased non-partnership policies for partnership policies in order to allow insurers sufficient time to take the necessary steps to have the product on the market and available to insureds who have already purchased non-partnership policies.

Proposed new §3.3870(b) specifies the methods by which insurers may make the new coverage available, including: by adding a rider or endorsement to the existing policy or by exchanging the existing policy or certificate for a new partnership policy or certificate. Proposed new §3.3870(b)(2)(A) specifies the conditions for exchange for new coverage that has an actuarial value of benefits equal to or lesser than the actuarial value of the benefits of the existing coverage. Proposed new §3.3870(b)(2)(B) specifies the conditions for exchange for new coverage that has an actuarial value of benefits exceeding the benefits of the existing coverage.

Proposed new §3.3870(c) addresses the general requirements for the exchange of an existing long-term care policy or certificate for a partnership policy or certificate.

These proposed requirements which are specified in §3.3870(c)(1) – (5) are: (1) All offers of policy exchanges must be made on a nondiscriminatory basis. (2) An exchange offer shall be deferred to all policyholders who are currently eligible for benefits, within an elimination period on a claim, or who would not be eligible to apply for coverage due to issue age limitations under the new policy, until such time when such condition expires. (3) All rates for exchanges must be in accordance with §3.3831 (relating to Standards and Rates); exchange policies may be underwritten and the premium may be increased in accordance with §3.3831. (4) The new coverage offered must be on a currently approved form. (5) In the event of an exchange the insured shall not lose any rights, benefits, or built-up value under the original policy.

Proposed new §3.3870(d) provides that policies issued pursuant to this section shall be considered exchanges and not replacements.

Proposed new §3.3870(e) requires that an insurer is required to report exchanges made pursuant to §3.3870 on a one-time basis for the 2009 reporting period (to be reported by June 30, 2010) on Form Number LHL562(LTC) specified in §3.3837(a)(4).

SB 22 establishes a partnership for long-term care program in Texas, and the Department is proposing to adopt minimum standards for an approved long-term care partnership benefit plan. These new partnership policies will be available upon the adoption of the new minimum standards for partnership policies. Under the DRA, policies sold prior to the establishment of the partnership program may be exchanged for partnership policies, and the terms and requirements of such policy exchanges are

left to the discretion of each individual state. After careful review of the relevant issues and stakeholder input, the Department is proposing the requirements in new §3.3870 to regulate long-term care policy exchanges in Texas. The Department has determined that it is beneficial to insureds to provide them an opportunity to exchange their existing policy for a partnership policy. This exchange of existing policies for partnership policies will give Texas residents the opportunity to purchase long-term care policies that have the advantages of asset disregard and estate recovery benefits, which their existing non-partnership policies do not have.

§3.3871. Standards and Reporting Requirements for Approved Long-Term Care Partnership Policies. Proposed new §3.3871 applies only to long-term care partnership policies and specifies the standards and reporting requirements for approved long-term care partnership policies. In addition to the required filing and approval pursuant to §3.3873 of this subchapter (relating to Filing Requirements for Long-Term Care Partnership Policies), any policy or certificate marketed or represented to qualify as a long-term care partnership policy or certificate must comply with the requirements specified in §3.3871(a)(1)(A) - (D): (i) the insured individual must be a resident of Texas when coverage first became effective under the policy, and if the policy or certificate is later exchanged for a different long-term care policy or certificate the individual was a resident of Texas when the coverage under the first policy became effective; (ii) a partnership policy must be a tax qualified policy under the provisions of §3.3847 (relating to Qualified Long-Term Care Insurance Contracts: Prohibited Representations); (iii) the policy is issued with and retains inflation protection coverage

which meets the inflation standards based on the insured's attained age; and (iv) the effective date of the partnership policy must be the date that the partnership policy is issued or the date the application for the partnership policy was signed. Proposed §3.3871(a)(1)(A) - (D) are necessary to establish a Partnership Program in Texas in accordance with the DRA and SB 22 enacted by the 80th Legislature. The state Partnership Program is intended to promote consumers' purchase of long-term care insurance from insurers by providing consumers access to Medicaid under special eligibility rules in the event that an individual consumer should ever need Medicaid long-term care coverage that is in addition to that provided by the purchased coverage. Adopted by the Texas Health and Human Services Commission, these special rules generally allow the individual to protect assets equal to the insurance benefits received from a partnership policy so that such assets will not be taken into account in determining financial eligibility for Medicaid and will not subsequently be subject to Medicaid liens and recoveries.

Proposed new §3.3871(a)(1)(A), (B) and (C) implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the DRA. Pursuant to §1917(b)(1)(C)(iii)(I), (II) and (IV) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(I), (II), and (IV)), the partnership policy must meet the general requirements of those sections in the DRA. Proposed §3.3871(a)(1)(A), (B) and (C) are consistent with §1917(b)(1)(C)(iii)(I), (II) and (IV) of the Social Security Act

(SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(I), (II), and (IV)).

The proposed effective date in §3.3871(a)(1)(D) that provides that the effective date of the partnership policy is the date that the partnership policy is issued is consistent with the effective date in 42 U.S.C. §1396p, Historical and Statutory Notes, "Expansion of State Long-Term Care Partnership Program," Pub. L. 109-171, Title VI, § 6021, Feb. 8, 2006, 120 Stat. 68; (a) Expansion Authority, (3) "Effective Date." The proposed effective date in §3.3871(a)(1)(D) that provides that the alternative effective date is the date that the application for the partnership policy was signed is based on input from stakeholders.

A policy or certificate represented or marketed as a long-term care partnership policy or certificate must be accompanied by a disclosure notice (a representation of which is specified in §3.3871(a)(2)(B)(vii)) that explains the benefits associated with the policy or certificate in accordance with the requirements in §3.3871(a)(2)(A) and (B). While proposed new §3.3871(a)(2)(A) and (B) pertaining to the required disclosure notice are not required by SB 22 or the DRA, the Department is proposing these provisions pursuant to the Commissioner's rulemaking authority in the Insurance Code §1651.004 to provide necessary information to the insured to protect the insured from inadvertently losing partnership status and to inform the insured of various essential facts relating to the partnership policy. The required disclosure notice, titled "Important Information Regarding the Texas Long-Term Care Insurance Partnership Program," provides essential information to the insured relating to certain disclosures, including:

(i) the policy purchased qualifies for the Texas partnership program; (ii) the partnership policy may protect the insured's assets through "asset disregard" under the Texas Medicaid program; (iii) the meaning of "asset disregard" and the fact that the purchase of a partnership policy does not guarantee the ability to disregard assets and does not automatically qualify the insured for Medicaid; (iv) the long-term care policy purchased confers partnership status as of the effective of the policy; (v) what could disqualify one's policy status as a partnership policy; and (vi) how the insured can obtain additional information on the partnership policy program. The notice, which is approximately one and one-half pages long, must be in at least 12-point type and must follow the order of the information presented in §3.3871(a)(2)(B)(vii). The text in the notice is mandated; the format for the form is a recommended format. An insurer may format the mandated text in a different format from that specified in §3.3871(a)(2)(B)(vii) if the insurer files the form for review and approval by the Commissioner in accordance with the procedures in §3.3871(a)(2)(B)(iii) and (vi). This Partnership Status Disclosure Notice is not required by SB 22 or the DRA. The disclosure notice is necessary to ensure that individuals who purchase partnership policies have information in a separate document that accompanies the partnership policy that explains the benefits of the partnership program. Additionally, this notice will also be helpful in notifying family members or others who are administering the estate of the insured of the partnership status of the policy and of the estate recovery exemptions available for benefits paid under a partnership policy. The requirements and procedures related to the disclosure notice are necessary for the following reasons: (i) the 12-point type requirement will

assist the consumer to more easily read and comprehend the information in the notice; and (ii) while the text and order of presentation of the information in the forms is mandated by the DRA, insurers will have flexibility with regard to the formatting of the forms subject to Department approval.

Proposed new §3.3871(a)(2)(B)(ix) requires that when an insurer is made aware that a policyholder has initiated an action that will result in the loss of partnership status, the insurer must advise the policyholder in writing of how to retain the partnership status if possible. Proposed new §3.3871(a)(2)(B)(x) requires that when a partnership plan loses partnership status, the insurer must explain in writing to the policyholders the reason for the loss of status. While proposed new §3.3871(a)(2)(B)(ix) and (x) are not required by SB 22 or the DRA, the Department is proposing these provisions pursuant to the Commissioner's rulemaking authority in the Insurance Code §1651.004 to provide important information to the insured to enable the insured to retain the partnership status of the policy if possible and to explain to the insured why there has been a loss of partnership status. These provisions will help protect the insured from inadvertently losing partnership status and will provide vital information to the insured concerning any loss of partnership status by the insurer. Because of the important benefits of a partnership long-term care policy, including the advantages of asset disregard and estate recovery benefits, it is in the insured's interest to be informed about any possible loss of the partnership status of the long-term care policy. With this information, the insured may have the opportunity to take steps to either prevent the loss of partnership

status or to replace the policy that has lost partnership status with another partnership policy.

Proposed new §3.3871(b) specifies new reporting requirements for insurers that issue partnership policies. In accordance with §1917(b)(1)(C)(iii)(VI) and (v) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(VI) and (v)), all issuers of partnership policies or certificates must provide regular reports to the Secretary of the Department of Health and Human Services (Secretary) in accordance with regulations to be developed by the Secretary. As provided under proposed §3.3871(b)(1) – (3), such information shall include but not be limited to the following: (i) notification of when insurance benefits provided under a partnership policy have been paid and the amount of such benefits, (ii) notification regarding when such policies terminate, and (iii) any other information the Secretary determines is appropriate. Proposed new §3.3871(b) implements the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the DRA. Section 1917(b)(1)(C)(iii)(VI) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(VI)) includes the requirements that are proposed in §3.3871(b). Proposed new §3.3871(b) is necessary to provide Department rules that are consistent with the DRA reporting requirements for insurers that issue long-term care partnership policies. The information that insurers report to the Secretary of Health and Human Services will enable the Secretary to monitor the

partnership program in Texas in accordance with the insurer reporting requirements established under the DRA. The Department is authorized to adopt the proposed new §3.3871 pursuant to the Insurance Code §1651.004, which authorizes the Department to adopt reasonable rules that are necessary and proper to carry out Chapter 1651. Chapter 1651 specifies the Department's regulatory functions with regard to long-term care benefit plans, including partnership plans.

§3.3872. Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates. Proposed new §3.3872 sets forth the inflation protection requirements for long-term care partnership policies and certificates. Proposed new §3.3872(1) specifies that for a person who is less than 61 years of age as of the date of purchase, the policy or certificate must provide compound annual inflation protection from the date of purchase until the person attains age 61. Proposed new §3.3872(1)(A) requires the insurer to offer to each applicant at the time of purchase the option to purchase compound annual inflation protection that automatically increases each year on a compounded basis at a rate of not less than 5.0 percent annually throughout the interval of coverage; the inflation protection is required to automatically increase benefits each year on a compounded basis. Proposed new §3.3872(1)(B) specifies that if the applicant declines the offer of not less than 5.0 percent compound annual inflation protection, then the insurer must offer and the applicant must purchase and retain compound annual inflation protection until the insured attains age 61 or goes on claim status, whichever comes first. The inflation protection is required to automatically increase benefits each year on a compounded basis at a rate that the insured elects

which may be in a range of from one percent to four percent or tied to the Consumer Price Index for All Urban Consumers (CPI-U). Proposed new §3.3872(1)(C) specifies that a person who is less than 61 years of age who has purchased a long-term care partnership policy or certificate with the required compound inflation protection may upon attaining 61 years of age choose to amend the compound inflation protection provision in the policy or certificate in accordance with the requirements specified in §3.3872(2). Proposed new §3.3872(2) specifies that for a person who is between 61 and 76 years old, the policy must provide some acceptable level of inflation protection until the person attains 76 years of age. Proposed new subparagraph (2)(A) specifies that regardless of the insured's health status the insurer must offer inflation protection and the insured must accept and retain inflation protection until the insured attains age 76 or goes on claim status. Proposed new §3.3872(2)(A) – (D) specify that acceptable inflation protection includes: (i) regardless of the insured's health status, the insurer must offer and the insured must purchase and retain inflation protection until the insured attains age 76 or goes on claim status, whichever comes first; (ii) acceptable coverage includes automatic annual inflation protection, either simple or compound, paid with either level or stepped premium; (iii) the Inflation protection may be in a range of from one percent to five percent or tied to the Consumer Price Index for All Urban Consumers (CPI-U); and (iv) a person who is less than 76 years of age who has purchased a long-term care partnership policy or certificate with the required inflation protection may upon attaining 76 years of age choose to amend the inflation protection provision in the policy or certificate in accordance with the requirements specified in

§3.3872(3). Proposed new §3.3872(3) specifies that for a person who is 76 years old, inflation protection may be provided but is not required. Proposed new §3.3872(4) specifies that an option to purchase inflation protection in the future does not constitute compliance with the requirements in §3.3872(1) and (2). Proposed new §3.3872 is necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Section 1917(b)(1)(C)(iii)(IV) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)) includes the requirements that are proposed in §3.3872.

§3.3873. Filing Requirements for Long-Term Care Partnership Policies. Proposed new §3.3873(a) specifies the prior approval requirements that apply to any partnership policy, certificate, or endorsement that is to be delivered or issued for delivery in this state. Proposed new §3.3873(a)(1) requires that each partnership policy, certificate, or endorsement must be filed with the Department and approved in accordance the procedures in Chapter 3, Subchapter A of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings) and §3.3873(b) and (c) as applicable. Proposed new §3.3873(a)(2) requires that each partnership policy, certificate, or endorsement filing must include Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form specified in §3.3873(a)(2)(F). Proposed new §3.3873(a)(2)(A) – (F) set forth the requirements and procedures that apply to Form Number LHL570(LTC), including text content and

font size, order of information presented, format requirements, and filing and approval requirements if applicable. The proposed certification form specifies the elements of information that are required to be provided by each insurer for each partnership policy, certificate, or endorsement that is filed by the insurer for approval by the Commissioner for use under the Qualified Partnership Program. Pursuant to §1917(b)(5)(B)(iii) of the Social Security Act as amended by the Deficit Reduction Act (DRA) (42 U.S.C. 1396p(b)(5)(B)(iii)), the Commissioner of Insurance, when implementing a qualified state long-term care insurance partnership program, is authorized to certify that long-term care insurance policies (including certificates issued under a group insurance contract) covered under the Qualified Partnership meet certain consumer protection requirements, and policies so certified are deemed to satisfy such requirements. These consumer protection requirements are set forth in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. 1396p(b)(5)(A)) and principally include certain specific provisions of the 2000 NAIC Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act. The certification form to be filed by the insurer requests information relating to: (i) in Section I, general information relating to the insurer's name and address, a contact person for information relating to the filing, the policy form number(s) or other identifying information; for a policy form not previously approved, copies of the policy forms including any riders or endorsements must be included; and for a policy form previously approved, only identifying policy information must be included; (ii) in Section II, the insurer's response regarding whether the specified requirements of the Model

Regulations and Model Act are met with respect to all policies and certificates that are intended to be included under the Qualified Partnership Program; and (iii) in Section III, the insurer's certification to the Commissioner that all of the attached or identified policy forms, riders and endorsements meet all of the requirements of the Model Regulations and Model Act that are specified in the Federal Deficit Reduction Act of 2005 and that all of the answers, accompanying information, and other information contained in the certification form are true, correct and complete.

Proposed new §3.3873(b) sets forth the requirements and procedures for the filing of a policy, certificate, or endorsement that has not been previously approved by the Commissioner. Prior to offering the policy for sale in Texas as a partnership policy, the policy, certificate, or endorsement must comply with the proposed requirements in §3.3873(b)(1) – (4), including (i) the policy, certificate, or endorsement must be filed with the Department and approved by the Commissioner, and Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form must be submitted for each policy, certificate, or endorsement form submitted for partnership approval; (ii) the policy, certificate, or endorsement form must be in at least 10 point type; (iii) the policy form filing must be filed at least 60 days prior to use and is subject to the requirements and procedures in Chapter 3, Subchapter A of this title (relating to Submission Requirements For Filings and Departmental Actions Related to Such Filings); and (iv) and any policy form filing should be filed with the Filings Intake Division of the Texas Department of Insurance.

Proposed new §3.3873(c) specifies the requirements and procedures for insurers requesting to use a previously approved non-partnership long-term policy as a long-term care partnership policy. Prior to offering the policy for sale in Texas as a partnership policy, the policy, certificate, or endorsement must comply with the proposed requirements in §3.3873(c)(1) – (6), including: (i) the insurer must file Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form and a copy of any endorsement that is needed to comply with the partnership policy requirements; (ii) the policy form numbers or other identifying information must be included on Form Number LHL570(LTC); (iii) the filing must be approved by the Commissioner prior to the use of the form as a partnership policy; (iv) a previously approved policy or certificate does not have to be included in the filing; (v) the filing made must be made at least 60 days prior to use and is subject to the procedures in Chapter 3, Subchapter A of this title (relating to Submission Requirements For Filings and Departmental Actions Related to Such Filings); and (vi) the filing should be submitted to the Filings Intake Division of the Texas Department of Insurance.

Proposed new §3.3873 is necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Section 1917(b)(5)(B)(iii) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(B)(iii)) authorizes the insurance commissioner of a state implementing a qualified state long-term care insurance partnership ("Qualified

Partnership") to certify to the state Medicaid agency that long-term care insurance policies (including certificates issued under a group insurance contract) covered under the Qualified Partnership meet certain consumer protection requirements, and policies so certified are deemed to satisfy such requirements. Proposed §3.3873, including the information to be provided in the proposed Long-Term Care Partnership Program Insurer Certification Form, are necessary to provide the Commissioner of Insurance with the information necessary to provide a certification for the policies.

§3.3874. Insurer Requirements for Agents That Market Partnership Policies and Certificates. Proposed new §3.3874 specifies insurer requirements for reporting information to the Department on agents that market long-term care partnership plans. Proposed new §3.3874(a)(1) - (3) specify training verification and certification requirements for insurers with agents who market partnership plans. These proposed requirements are: (i) obtaining of verification that an agent has received the training specified in §19.1022 of this title (relating to Long-Term Care Partnership Certification Course); (ii) insurer certification to the Commissioner that each agent who sells partnership policies or certificates on behalf of the insurer complies with the training requirements of this subsection; and (iii) insurer's maintenance of verification records for at least four years; records are subject to review by the Department or its designee at any time. The initial certification (for the period from the effective date of the rules to January 31, 2009) must be submitted on Form Number LHL571(LTC) Initial Long-Term Care Partnership Agent Training Certification Form specified in §3.3874(b)(6)(A). Any subsequent certification must be submitted on Form Number LHL572(LTC) Annual

Long-Term Care Partnership Agent Training Certification Form specified in §3.3874(b)(6)(B).

Proposed new §3.3874(b) specifies the requirements and procedures that apply to proposed Form Number LHL571(LTC) and Form Number LHL572(LTC), including text content, text font size, recommended format, and filing and approval requirements and procedures as applicable.

Proposed new §3.3874(c)(1) – (3) specify the filing requirements for the agent training certification by each insurer. An insurer offering partnership policies or certificates must submit: (i) Form Number LHL571(LTC) Initial Long-Term Care Partnership Agent Training Certification Form for the initial certification, and (ii) Form Number LHL572(LTC) Annual Long-Term Care Partnership Agent Training Certification Form for each subsequent annual certification. The initial certification form, Form Number LHL571(LTC), is to be used for certification by the insurer for the initial certification period (from the effective date of the rules to January 31, 2009). This form will be used by the insurer to certify that each individual who is currently selling partnership policies has completed training and demonstrated evidence of understanding long-term care partnership policies. There will be a grace period from the effective date of the rules to January 31, 2009, during which agents who have a license to sell accident and health insurance but may not have completed the specialized partnership training will be eligible to sell partnership policies. Insurers will file the annual certification Form Number LHL572(LTC) annually with the Department beginning in January 2010 to certify that each individual who currently sells partnership

policies for the insurer has completed the required training before the agent sells or solicits the insurer's partnership products. Proposed new §3.3874 implements the provision of SB 22, codified as Insurance Code §§1651.104 and 1651.105. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Section 1651.105 requires that each long-term care benefit plan issuer that offers a plan under the partnership for long-term care program shall certify to the Commissioner, in the form required by the Commissioner that each individual who sells on behalf of the issuer has complied with the training requirements of §1651.105(a). Section 1917(b)(1)(C)(iii)(V) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(V)) and §1651.105 of the Insurance Code include the requirements that are proposed in §3.3874.

Update of Obsolete Statutory Citations. The Department is proposing amendments to §§3.3801, 3.3802, 3.3803, 3.3804, 3.3821, 3.3829, 3.3833, 3.3834, 3.3839, and 3.3846 to update obsolete statutory citations to the Insurance Code as a result of the non-substantive revision of the Insurance Code. Insurance Code Article 1.03A, which is referenced in §3.3801, was enacted as §36.001, in the non-substantive Insurance Code revision, Acts 1999, 76th Legislature, Chapter 101, §1, effective September 1, 1999 and amended by Acts 2003, 78th Legislature, Chapter 206, §15.01, effective June 11, 2003. Insurance Code Article 3.70-12, which is referenced in §§3.3801, 3.3802, 3.3803, and 3.3829 was enacted as Chapter 1651, in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §4,

effective April 1, 2005. Insurance Code Article 3.70-12 §2(4), which is referenced in §3.3803, was enacted as §1651.003, in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §4, effective April 1, 2005. Insurance Code Article 3.51-6 §1(a)(6), which is referenced in §3.3821, was enacted as §1251.056, in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §3, effective April 1, 2005. Insurance Code Article 3.50 §1(6), which is referenced in §3.3821, was enacted as §1131.064 in the non-substantive Insurance Code revision, Acts 2001, 77th Legislature, Chapter 1419, §2, effective June 1, 2003. Insurance Code Article 3.51-6 §1(a), which is referenced in §3.3833, was enacted as §1251.001, in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §3, effective April 1, 2005. Insurance Code Article 3.70-2(A)(4), which is referenced in §3.3834, was enacted as §1201.054 in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §3, effective April 1, 2005. Insurance Code Article 21.21, which is referenced in §3.3839 was enacted as Chapter 541, in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §2, effective April 1, 2005. Insurance Code Article 3.70-12 §2, which is referenced in §3.3839, was enacted as §1651.003, in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §4, effective April 1, 2005. Article 3.51-6 §1(d)(2)(ii), which is referenced in §3.3846, was enacted as §1251.103, in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §3, effective April 1, 2005. Article 3.70-3(A)(2), which is

referenced in §3.3846, was enacted as §1201.208, in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §3, effective April 1, 2005.

2. FISCAL NOTE. Ana Smith-Daley, Deputy Commissioner for the Life and Health Division, has determined that for each year of the first five years the proposed amendments and new sections will be in effect, there will be no fiscal impact to state and local governments as a result of the enforcement or administration of the proposal. There will be no measurable effect on local employment or the local economy as a result of the proposal.

3. PUBLIC BENEFIT/COST NOTE. Ms. Smith-Daley has further determined that for each year of the first five years the proposed amendments and new sections are in effect, there are several public benefits anticipated as a result of the proposal, and there will be potential costs for persons required to comply with the proposal.

Overall, the anticipated public benefits of this proposal include: (i) the implementation of a state partnership for long-term care program in Texas that is intended to promote consumers' purchase of long-term care insurance from insurers; (ii) the adoption of minimum standards for a long-term care benefit plan that qualifies as an approved plan under the state partnership for long-term care program that will enable consumers to purchase long-term care partnership insurance and thereby be eligible for asset disregard equal to the long-term care insurance benefits that have been received

to the date of Medicaid application from a partnership policy should they ever apply for Medicaid long-term care benefits; (iii) adoption of consumer protection requirements for long-term care non-partnership insurance, annuity contracts, and life insurance policies that provide long-term care benefits by rider that will provide insureds under these types of products with the same consumer protection requirements as those for consumers who purchase partnership long-term care insurance; and (iv) a re-organization of the Subchapter Y rules on long-term care insurance into four divisions to clarify the different types of policies and certificates that are being regulated under Subchapter Y and the specific provisions applicable to the various types of policies and certificates being regulated; this will assist the Department in the implementation of the rules and regulated entities with compliance with the rules.

Those insurers and agents marketing on behalf of those insurers that currently write and that will continue to write non-partnership long-term care policies will incur costs to comply with the proposed amendments and new sections. While no individual or entity is required by law to write long-term care policies, either partnership or non-partnership, those insurers and agents marketing on behalf of those insurers that opt to write such policies will also incur costs to comply with the proposal. However, with regard to long-term care partnership policies, most of these costs are the result of the legislative enactment of SB 22 and the federal Deficit Reduction Act of 2005 (DRA) and are not the result of the adoption, enforcement, or administration of the proposed amendments and new sections. With regard to the writing of non-partnership policies, the costs that will be incurred to comply with the proposed amendments and new

sections are the result of this proposal, pursuant to the Commissioner's rulemaking authority in the Insurance Code §1651.004.

The anticipated public benefits and the potential costs required to comply with this proposal are discussed in the following section-by-section analysis.

Proposed Amendments to §3.3826. The proposed amendments to §3.3826, pertaining to Limitations and Exclusions, add new paragraph (6) to subsection (a) to permit exclusions and limitations for expenses for services or items paid under another long-term care or health insurance policy. The anticipated public benefit will be to ensure that policyholders will only be indemnified for the amount of an actual loss and thereby prevent the policyholder from receiving a double recovery on a claim filed. By preventing double recoveries on claims, the premium rates for long-term insurance benefit plans will not experience rate increases that would occur if double recoveries were factored into the premium rate. The proposed amendments to §3.3826 also add new subsection (b) to specify that with respect to this section the "state of policy issue" is the state in which the individual policy or certificate was originally issued and to permit exclusions and limitations for payment for services provided outside the United States. However, as required by the DRA, the issuer of long-term care insurance policies and certificates being claimed against in a state other than where the policy or certificate was issued must cover those services that would be covered in the state of policy issue irrespective of any licensing, registration, or certification requirements for providers in the other state. The anticipated public benefit will be that policyholders will receive the

benefits and services for which they have paid, regardless of their state of residency or where they are at the time that the services are needed.

Proposed Amendments to §3.3829. The proposed amendments to §3.3829, pertaining to Required Disclosures, specify the two disclosure forms (the Long-Term Care Insurance Personal Worksheet and the Long-Term Care Insurance Potential Rate Increase Disclosure Form) that must be provided to an applicant at the time of application or enrollment, or if the method of application does not allow for delivery at that time, the information must be provided at the time of delivery of the policy or certificate. Under existing §3.3832(b)(3)(A), the person to whom the policy is issued is permitted to return the policy within 30 days (or more, if so provided for in the policy) of its delivery to that person, and if the policy is returned, the person shall receive the return of the premium in full.

The anticipated public benefits from requiring the dissemination of the two forms to the applicant at the time of application or enrollment are: (i) The Long-Term Care Insurance Potential Rate Increase Disclosure Form provides detailed information to the applicant concerning the potential for a rate increase prior to the applicant purchasing a long-term care policy; this will assist the applicant in determining whether to purchase the policy in light of the applicant's financial circumstances. (ii) The Long-Term Care Insurance Personal Worksheet provides information for the insurer to assess the applicant's suitability to purchase a long-term care policy prior to the applicant's purchasing a long-term care policy. The Long-Term Care Personal Worksheet requires the insurer to obtain detailed information from any individual who is considering the

purchase of a long-term care policy. Such information includes the applicant's current insurance and premium payments, the applicant's income and net worth. The Long-Term Care Potential Rate Increase Disclosure Form requires the insurer to provide detailed information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, the insurer's rate history, and also a disclosure of the insurer's right to increase premiums and policy options in the event of a rate increase. The anticipated public benefit resulting from the use of these new forms is that the additional information obtained from the applicant on the Personal Worksheet and the information provided to the applicant regarding potential rate increases on the Potential Rate Disclosure Form will assist the insurer and the applicant to make an informed decision on whether it is prudent for the applicant to purchase the long-term care policy given the financial circumstances of the applicant. This will ensure that those consumers who do not need or cannot afford such a policy will be less likely to purchase one. Also, additional questions have been added to the proposed Long-Term Care Personal Worksheet in the section titled "Questions Related to Your Needs" and include questions to applicants regarding: (i) knowledge of what inabilities trigger long-term care benefits; (ii) awareness and meaning of the term "cognitive impairment"; (iii) understanding of policy limitations; and (iv) what type of long-term care service the applicant anticipates utilizing. The anticipated public benefit is that these direct questions to consumers are an effective method of more prominently disclosing and emphasizing some of the most important limitations that are currently in long-term care policies that need to be considered by consumers prior to purchasing a long-term care

policy. This will result in more consumers being better informed about such limitations before making the important decision of whether to purchase a long-term care policy. The proposed amendments to §3.3829(b)(8) specify the requirements and procedures that apply to the two disclosure forms, including text size and content, recommended format, and filing and approval procedures as applicable. The anticipated public benefit of these requirements and procedures are: (i) the 12-point type requirement will assist the consumer to more easily read and comprehend the information in the forms; and (ii) while the text and order of presentation of the information in the forms is mandated by the DRA, insurers will have flexibility with regard to the formatting of the forms subject to Department approval.

The proposed amendments to §3.3829 implement the provision of SB 22, codified as Insurance Code §1651.104 which requires that a partnership policy be consistent with provisions established under the DRA. The DRA requires a partnership policy to conform with specific consumer protection provisions of the NAIC Long-Term Care Model Regulations and Model Act. These NAIC consumer protection requirements for partnership policies include the provisions of §9 of the NAIC Long-Term Care Model Regulations, which pertain to Required Disclosures of Rating Practices to Consumers, and included in §9 is the requirement to use the new forms specified in §3.3829(b)(8)(H) and (I). These consumer protection provisions, which are required under the DRA, are necessary to require the use of these new forms in the marketing of long-term care policies.

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3829 will incur no additional cost as a result of the amendments, except for the proposed additional questions in the part of the form entitled “Questions Related to Your Needs,” because the amendments are the result of the legislative enactment of SB 22, and any cost to comply result directly from the enactment of SB 22 and the DRA and are not from the adoption, enforcement, or administration of the proposed amendments. However, those insurers that opt to write partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3829 that add the additional questions in the part of the form entitled “Questions Related to Your Needs,” will incur minimal additional costs as a result of the requirement of these additional questions on the Personal Worksheet. These additional questions will add approximately a half page to the Long-Term Care Personal Worksheet, which may result in additional costs for paper, printing, and postage. Based on the Department’s experience, an additional printed page costs approximately $0.05 per page. Insurers that print the additional questions in the part of the Personal Worksheet entitled “Questions Related to Your Needs,” on a separate page from the questions in the remainder of the worksheet could incur as much as an additional printing cost of $0.05 per disclosure form. However, the Department does not anticipate that any necessary return envelope or return postage costs will increase for the additional questions because this part of the form is no more than a half-page that is in addition to the part of the form that is required by SB 22, the DRA, and §9 of the NAIC Long-Term Care Model Regulations, as previously explained.

The actual total costs will vary based on factors that pertain to each individual insurer, including the size of the insurer; the type of office equipment, including printers and computers; and the number of forms that are needed.

The proposed amendment to §3.3826(a) that adds new paragraph (6) and proposed new §3.3826(b) implements the provision of SB 22, codified as Insurance Code §1651.104 which requires that a partnership policy be consistent with provisions established under the DRA. The DRA requires a partnership policy to conform with specific consumer protection provisions of the National Association of Insurance Commissioners (NAIC) Long-Term Care Model Regulations and Model Act. These NAIC consumer protection requirements for partnership policies include the provisions of §6B of the NAIC model regulations, which pertain to Policy Practices and Provisions, and included in §6B are the requirements specified in §3.3826(a)(6) and (b).

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3826 will incur no additional cost as a result of the amendments. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed amendments.

Those insurers that currently write or that opt to write non-partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3826 will incur costs relating to the amendment of policy forms that may include the following: personnel, computer reprogramming, and printing and distribution. These actual costs will vary based on several factors that pertain to each individual insurer,

including the size of the insurer; type of office equipment, including printers and computers; employee salaries; and number of forms that are needed. An insurer can calculate its estimated costs based on the company's own operation and needs.

Those insurers that currently write or that opt to write non-partnership long-term care policies and are therefore required to comply with the proposed new §3.3829(b)(8), relating to use of the new Personal Worksheet form, will incur costs relating to the following: personnel, computer reprogramming, agent training, and printing and distribution. The estimated probable costs related to the new Personal Worksheet form are detailed in the preceding paragraph. These actual costs will vary based on several factors that pertain to each individual insurer, including the size of the insurer; type of office equipment, including printers and computers; employee salaries; and number of forms that are needed. An insurer can calculate its estimated costs based on the company's own operation and needs. In order to comply with proposed §3.3829(b)(8), which requires the use of the Potential Rate Increase form, there will only be the printing and distribution costs for the new form because a version of this form is already in use by those insurers that write non-partnership policies. Again, the actual cost for compliance with proposed §3.3829(b)(8) will vary based on the individual insurer and can be calculated by the insurer based on the company's own operation and needs.

Proposed Amendment to §3.3830. Proposed new §3.3830(h), pertaining to Requirements for Application Forms and Replacement Coverage, specifies the requirements that apply: (i) if a long-term care policy is being replaced by a life insurance policy with a long-term care rider that accelerates life insurance benefits to

cover the cost of long-term care; (ii) if the policy being replaced is a life insurance policy; and (iii) if a life insurance policy with a long-term care rider that accelerates benefits for long-term care is replaced by another such policy. The anticipated public benefits will be the provision of minimum standards of conduct to be observed by agents and insurers in long-term care policy replacements and the provision of information to the purchaser of the replacement policy that is necessary to make an informed decision about the replacement.

The proposed amendments to §3.3830 implement the provision of SB 22, codified as Insurance Code §1651.104 which requires that a partnership policy be consistent with provisions established under the DRA. The DRA requires a partnership policy to conform with specific consumer protection provisions of the NAIC Long-Term Care Model Regulations and Model Act. These NAIC consumer protection requirements for partnership policies include the provisions of §14 of the NAIC Long-Term Care Model Regulations, which pertain to Requirements for Application Forms and Replacement Coverage, and included in §14 are the requirements specified in §3.3830(h).

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3830 will incur no additional cost as a result of the amendments. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed amendments.

Those insurers that currently write or that opt to write non-partnership long-term care policies and are therefore required to comply with the proposed new §3.3830(h), relating to Requirements for Application Forms and Replacement Coverage will incur costs relating to the following: personnel, computer reprogramming, agent training, printing, and distribution. These actual costs will vary based on several factors that pertain to each individual insurer, including the size of the insurer; type of office equipment, including printers and computers; employee salaries; and number of forms that are needed. An insurer can calculate its estimated costs based on the company's own operation and needs.

Proposed Amendments to §3.3837. Section 3.3837, pertaining to Reporting Requirements, addresses certain insurer reporting requirements for long-term care policies. The proposed amendments to §3.3837(a) specify the requirements for insurers to report information to the Commissioner on a statewide basis regarding long-term care insurance policy or certificate replacements and lapses. These requirements include: (i) existing requirements in §3.3837(a)(1) for maintenance of agent records relating to sales attributable to long-term care products; (ii) requirements in §3.3837(a)(2) for record maintenance and annual reporting of data concerning the 10 percent of each insurer's agents with the greatest percentages of policy or certificate lapses and the 10 percent of each insurer's agents with the greatest percentages of replacements during the preceding calendar year; and (iii) new requirements in §3.3837(a)(3) and (4) for insurers to report company totals for the number of lapsed and replacement long-term care policies sold as a percentage of its total number of long-

term care policies in force as of the end of the preceding year. Insurers are required to report the information pertaining to the reporting of the top 10 percent of the insurer's agents with the greatest percentages of policy or certificate lapses or replacements during the preceding calendar year in accordance with the Long-Term Care Insurance Replacement and Lapse Reporting Form and in an electronic format prescribed by the Department. Specifically, each insurer must maintain records for each agent that is in the 10 percent of that insurer's agents with the greatest percentage of replacements and for each agent that is in the 10 percent of that insurer's agents with the greatest percentage of lapses. The Insurance Replacement and Lapse Reporting Form requires information on each agent's name, number of policies sold by the agent, number of policies replaced and lapsed by the agent, and number of replacements and lapses as percent of number of policies sold by the agent. Insurers are required to report company totals for the number of lapsed and replacement long-term care policies sold as a percentage of its total number of long-term care policies in force as of the end of the preceding year in accordance with the part of the Insurance Replacement and Lapse Reporting Form relating to Company Totals and in an electronic format prescribed by the Department. The anticipated public benefit from the reporting of the lapsed and replacement long-term care policy data specified in the Insurance Replacement and Lapse Reporting Form will be the provision of data to the Department that will assist in identifying possible market conduct problems and will thereby enable the Department to act more quickly and efficiently to resolve such problems before they result in harm to consumers. In the existing as well as the draft rules we state "Reported

replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The anticipated public benefit from the reporting of the lapsed and replacement long-term care policy data specified in the Insurance Replacement and Lapse Reporting Form will be the provision of data to the Department that will assist the Department in monitoring agent activities regarding the sale of long-term care. The anticipated public benefit resulting from the electronic submission of the required data will be increased efficiency in the Department's compiling and analyzing of data regarding lapsed and replacement long-term care policies. It should also be more efficient for insurers to report such data by electronic means.

The proposed amendments to §3.3837(a)(1) - (4) implement the provision of SB 22, codified as Insurance Code §1651.104. This section requires that a partnership policy be consistent with the provisions established under the DRA. The DRA requires a partnership policy to conform with specific reporting requirement provisions of the NAIC Long-Term Care Model Regulations and Model Act. These NAIC reporting requirements for partnership policies include the provisions of §15 of the NAIC Long-Term Care Model Regulations, which pertain to Reporting Requirements. Section 15 requires insurers to use the new form specified in §3.3837(a)(2) to report the data specified in proposed amendments to subsection (a)(1) - (4).

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3837(a) will incur no additional cost as a result of the amendments. Any such costs incurred by these

insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed amendments.

Those insurers that currently write or that opt to write non-partnership long-term care policies should not incur additional costs as a result of the proposed amendments to §3.3837(b) because this data is currently required to be reported on the NAIC form.

Insurers are required under the proposed amendments to §3.3837(b), pertaining to insurer reporting requirements relating to rescissions, to report the same information required in the existing form LTC RESCIND that is currently adopted by reference in §3.3848. The information, however, is required to be reported in accordance with the newly named Rescission Reporting Form for Long-Term Care Policies. There are no proposed changes to the existing reporting requirements relating to rescissions. The proposed amendments to §3.3837(b) require each insurer to report to the Commissioner, by no later than June 30 annually for the preceding calendar year, all rescissions of long-term care insurance policies or certificates except those rescissions voluntarily effectuated by an insured. Insurers are required to report for each rescission the policy form number, the policy and certificate number, the name of the insured, the date of the policy issuance, the date or dates that a claim or claims were submitted, the date of rescission, and a detailed reason for each rescission. The required information must be submitted electronically in a format prescribed by the Department. The data regarding rescissions of long-term care policies will assist the Department in monitoring insurers' activities regarding the sale of long-term care insurance. The anticipated public benefit resulting from the electronic submission of the required data will be

increased efficiency in the Department's compiling and analyzing of data regarding rescissions of long-term care insurance policies or certificates. It should also be more efficient for insurers to report such data by electronic means.

The proposed amendments to §3.3837(b) implement the provision of SB 22, codified as Insurance Code §1651.104. This section requires that a partnership policy be consistent with the provisions established under the DRA. The DRA requires a partnership policy to conform with specific reporting requirement provisions of the National Association of Insurance Commissioners' (NAIC) Long-Term Care Model Regulations and Model Act. These NAIC reporting requirements for partnership policies include the provisions of §15 of the NAIC Long-Term Care Model Regulations, which pertain to Reporting Requirements. Section 15 requires insurers to use the new form specified in §3.3837(b) to report the data specified in Figure: 28 TAC §3.3837(b).

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3837(b) will incur no additional cost as a result of the amendments. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed amendments.

Those insurers that continue to write or that opt to write non-partnership long-term care policies should not incur additional costs as a result of the proposed amendments to §3.3837(b) because this data is currently required to be reported in accordance with the existing form LTC RESCIND that is currently adopted by reference in §3.3848.

The proposed amendments to §3.3837(c), pertaining to reporting requirements for claims denied by class of business, define the terms “claim” and “denied” for purposes of reporting data relating to long-term care insurance claim denials. Proposed amendments to §3.3837(c)(2) require insurers to use the proposed new Long-Term Care Claim Denials Reporting Form to comply with the reporting requirements. Under the proposed amendments, each insurer is required to report 11 data elements for both state data and nationwide data for all long-term care insurance claim denials under in-force long-term care insurance policies, including total number of long-term care claims reported, total number of long-term care claims denied/not paid, number of claims not paid due to preexisting condition exclusion, and number of claims not paid due to waiting period not being met. The proposed amendments require the data to be submitted electronically in a format prescribed on the Department’s website. If an insurer has a particularly large percentage of long-term care claim denials, this may indicate improper or unfair claim settlement practices. The anticipated public benefit resulting from the use of the new form will be that the collection and reporting of such data will assist the Department in identifying possible improper claim settlement practices and will thereby enable the Department to act more quickly and efficiently to resolve such problems before they result in harm to consumers. The data will further assist the Department in conducting more efficient and thorough regulation of long-term care claim settlement practices by identifying insurers with claim settlement trends that may indicate improper or unfair claim settlement practices, thereby enabling the Department to focus market conduct examination resources on insurers displaying

problematic trends. The anticipated public benefit resulting from the electronic submission of the required data will be increased efficiency in the Department's compiling and analyzing of data regarding denials of claims filed under long-term care insurance policies or certificates. It should also be more efficient for insurers to report such data by electronic means.

The proposed amendments to §3.3837(c) implement the provision of SB 22, codified as Insurance Code §1651.104. This section requires that a partnership policy be consistent with the provisions established under the DRA. The DRA requires a partnership policy to conform with specific reporting requirement provisions of the National Association of Insurance Commissioners' (NAIC) Long-Term Care Model Regulations and Model Act. These NAIC reporting requirements for partnership policies include the provisions of §15 of the NAIC Long-Term Care Model Regulations, which pertain to Reporting Requirements. Section 15G contains the definitions in proposed new §3.3837(c)(1) and the requirement that insurers must report state and nationwide data relating to claim denials that is in the proposed new form specified in §3.3837(c)(2).

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3837(c) will incur no additional cost as a result of the amendments. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed amendments.

Those insurers that currently write or that opt to write non-partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3837(c), should not incur additional costs as a result of the proposed amendments to §3.3837(c) because this data is currently required to be reported on the NAIC form.

The proposed amendments to §3.3837(d) address additional reporting requirements for insurers marketing long-term care partnership policies in Texas. Proposed new §3.3837(d) requires each insurer to report to the Department by June 30 of each year the information required in §32.107 of the Human Resources Code. Each insurer must specify the number of approved partnership plans purchased in the state during the preceding calendar year and the average age of individuals purchasing approved partnership plans during the preceding calendar year. The required information must be reported in accordance with the Long-Term Care Policies Sold Reporting Form specified in §3.3837(e). The required information includes reporting for two long-term care partnership policy types: comprehensive (institutional and community care) and nursing home (institutional only). Each insurer must submit the required information electronically in a format prescribed on the Department's website. SB 22 enacted new §32.107 of the Human Resources Code that requires the Texas Health and Human Services Commission (HHSC) to report this information in a biennial report to the Legislature by not later than September 30 of each even-numbered year. The purpose of the report is to provide information to the Legislature on the progress of the partnership program for the preceding biennium. Section 32.107 also provides that the HHSC may request information from the Texas Department of Insurance as

necessary to prepare the biennial report. The Department will report this data to the HHSC for use in fulfilling HHSC's requirements under §32.107 of the Human Resources Code. The anticipated public benefit resulting from the new reporting requirements and the use of the new form will be that the collection and reporting of the data required in the new form regarding partnership policies will facilitate the timely completion and submission of the Health and Human Services Commission's biennial report to the Legislature as required by §32.107 of the Human Resources Code. The data collected under §32.107 and contained in the HHSC biennial report will assist the Legislature in determining whether to continue the long-term care partnership program as provided under §32.107. The anticipated public benefit resulting from the electronic submission of the required data will be increased efficiency in compiling and analyzing of data regarding the progress of the partnership program in the state. It should also be more efficient for insurers to report such data by electronic means.

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3837(d) will incur no additional cost as a result of the amendments. Any such costs for these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed amendments.

Proposed new §3.3837(e), pertaining to reporting requirements for non-partnership plans, requires that all insurers report to the Department by June 30 of each year the number of non-partnership plans sold in the state during the preceding calendar year and the average age of individuals purchasing the non-partnership plans

during the preceding calendar year. The required information must be reported in accordance with the Long-Term Care Policies Sold Reporting Form specified in §3.3837(e). The required information includes reporting for four long-term care non-partnership policy types: comprehensive (institutional and community care); nursing home (institutional only); home health care (community-based services); and riders (attached to life policies or annuity contracts.) Each insurer must submit the required information electronically in a format prescribed on the Department's website. Proposed new §3.3837(e) implements the provision of SB 22, codified as Human Resources Code §32.107. Section 32.107 requires that not later than September 30 of each even-numbered year the Texas Health and Human Services Commission (HHSC) shall submit a report to the Legislature on the progress of the partnership program for the preceding biennium. Section 32.107 also provides that the HHSC may request information from the Texas Department of Insurance as necessary to prepare the biennial report. Therefore, the Department has determined that the most effective approach to measuring the progress of the partnership program in Texas is to compare partnership data as required pursuant to proposed §3.3837(d) and non-partnership data as required pursuant to proposed §3.3837(e). While the Human Resources Code §32.107(a) requires the HHSC to submit the biennial report to the Legislature on the progress of the partnership program, any information that may be requested of the Department by the HHSC as provided in the Human Resources Code §32.107(b) will have to be requested from insurers by the Department pursuant to the Commissioner's rulemaking authority in the Insurance Code §1651.004. The anticipated public benefit

of collecting the required data on non-partnership plans will be the timely availability of data that will result in a more meaningful, comprehensive report to the Legislature on the progress of the partnership program that provides comparative information on both non-partnership and partnership policies.

Those insurers that currently write or that opt to write non-partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3837(e) will incur costs relating to the following: personnel, computer reprogramming, and printing and distribution. These actual costs will vary based on several factors that pertain to each individual insurer, including the size of the insurer; type of office equipment, including printers and computers; employee salaries; and number of forms that are needed. An insurer can calculate its estimated costs based on the company's own operation and needs.

Proposed new §3.3837(f) provides new suitability reporting requirements for all insurers that market long-term care insurance policies in Texas. Insurers are required to provide suitability data on both non-partnership and partnership policies sold in Texas in accordance with the requirements indicated in the proposed Long-Term Care Suitability Reporting Form specified in §3.3837(f). The data is required to be reported to the Commissioner by no later than June 30 annually for the preceding calendar year. Insurers are required to report suitability data for long-term care partnership comprehensive (institutional and community care) and nursing home (institutional only) policies that includes total number of applications received, total number of applicants who declined to provide the personal worksheet information, total number of applicants

who did not meet the suitability standards, and total number of applicants who chose to confirm after receiving a Suitability Letter. Proposed new §3.3837(f) requires insurers to report the same suitability data for long-term care non-partnership comprehensive, nursing home, and home health care policies, and riders attached to life policies and annuity contracts. The proposed reporting requirements require insurers to submit the data electronically in a format prescribed on the Department's website. The anticipated public benefit resulting from the new reporting requirements and the use of the new form will be that the collection and reporting of the data required in the new form will provide the Department with important information regarding the appropriateness of the marketing and sales of long-term care policies to Texas consumers. The data will provide an essential tool in the Department's monitoring of whether long-term care policies are being sold appropriately, i.e., to those who actually need the coverage. The data will assist the Department in identifying possible improper marketing practices and will thereby enable the Department to act more quickly and efficiently to resolve such problems before they result in harm to consumers. The anticipated public benefit resulting from the electronic submission of the required data will be increased efficiency in the Department's compiling and analyzing of data regarding the new suitability reporting requirements. The electronic reporting should also be more efficient for insurers to report such data by electronic means.

Proposed new §3.3837(f) requirements for reporting suitability data for partnership policies sold in Texas are necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership

policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C.§1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C.§1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions of §24 of the NAIC Long-Term Care Model Regulations, which pertain to Suitability. Section 24 contains the requirement that insurers must report the long-term care partnership data specified in proposed new §3.3837(f).

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with proposed new §3.3837(f) will incur no additional cost as a result of the amendments. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed amendments.

Those insurers that currently write or that opt to write non-partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3837(f) pertaining to non-partnership policies, will incur costs relating to the following: personnel, computer reprogramming, agent training, and printing and distribution. These actual costs will vary based on several factors that pertain to each individual insurer, including the size of the insurer; type of office equipment, including

printers and computers; employee salaries; and number of forms that are needed. An insurer can calculate its estimated costs based on the company's own operation and needs.

Proposed new §3.3837(g) contains the requirement in existing §3.3837(a)(5) that requires insurers to file an annual rate filing required under former Insurance Code Article 3.70-12 §4(b) (revised as Insurance Code §1651.053(c) as part of the non-substantive Insurance Code revision) to demonstrate compliance with the applicable loss ratios of this state and any other filing requirement adopted by the Commissioner relating to loss ratios. The requirement applies to both partnership and non-partnership long-term care policies. Existing §3.3837(a)(5) is proposed to be redesignated as new §3.3837(g) and amended to clarify that the demonstration of compliance with applicable loss ratio standards that is in the current rule is in addition to any demonstration required under §§3.3831(c)(2)(B) - 3.3831(c)(2)(D) and that compliance with the statutory requirement, includes providing the following information by calendar duration and separately by form number: (i) calendar duration; (ii) first year issued; (iii) actual earned premium by duration; (iv) actual incurred claims; (v) actual calendar duration loss ratio; (vi) anticipated calendar duration loss ratio; and (vii) number of insured lives. This also applies to partnership and non-partnership long-term care policies. The proposed requirements in re-designated §3.3837(g) are necessary to clarify the information a company must provide in order to demonstrate compliance with the Insurance Code 1651.053(c)(1). Therefore, those insurers that opt to write partnership long-term care policies and those insurers that currently write or that opt to write non-

partnership long-term care policies will not incur any additional cost as a result of the amendment.

Proposed Amendments to §3.3838. The proposed amendments to §3.3838(1), pertaining to Filing Requirements for Advertising, refine the requirements for the advertising of partnership and non-partnership long-term care insurance to exclude the necessity of filing institutional advertisements (as that term is defined in §21.102 of this title) if the advertisement only references long-term care insurance as a line of coverage. Institutional advertisements that provide details regarding the insurer's long-term care insurance products that go beyond merely identifying long-term care insurance as a line of coverage that is available from the insurer would continue to be subject to prior approval by the Commissioner, subject to the requirements in existing §3.3838. The proposed amendments to §3.3838(1) exclude from the filing and review requirements long-term care insurance advertisements that do not provide any details on the long-term care insurance product. Because these advertisements are not currently a source of false, misleading, or deceptive marketing practices, the Department has determined that the Commissioner's review is not necessary. The anticipated public benefit is more efficient and cost-effective advertising filing requirements for long-term care insurers. Also, the reduction in the number of institutional advertisements that are filed with the Department for review will enable the Department to more effectively utilize Departmental resources without compromising consumer protection. The Department will be able to redirect its resources to advertising practices that are a more frequent source of false, misleading, or deceptive

marketing practices. There are no changes proposed to existing §3.3838(2) and (3). The amendments to §3.3838(1), which apply to both partnership and non-partnership policies, are not required by SB 22 or any other state or federal legislation but rather are proposed pursuant to the Commissioner's rulemaking authority in the Insurance Code §1651.004. Chapter 1651 specifies the Department's regulatory functions with regard to long-term care benefit plans, including non-partnership and partnership plans. Those insurers that opt to write partnership long-term care policies and those insurers that currently write or that opt to write non-partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3838(1) will incur no additional cost as a result of the amendments. The amendments may be a cost savings measure for insurers because certain institutional advertisements that they are currently required to file will no longer be required to be filed.

Proposed Amendments to §3.3839. Section 3.3839, pertaining to Standards for Marketing, specifies the marketing procedures that must be established and implemented by each insurer, health care service plan, or other entity marketing, either directly or through its agents, partnership or non-partnership long-term care insurance in this state. Proposed new §3.3839(a)(8), (9) and (10) mandate three new requirements: (i) each insurer or other entity marketing long-term care insurance in this state must, at the time of solicitation, provide written notice to the prospective policyholder that a senior insurance counseling program is available; (ii) each insurer or other entity must provide to the applicant at the time of application an explanation of the contingent benefit upon lapse specified in §3.3844(g)(1), and if applicable, an explanation of the

additional contingent benefit upon lapse provided to policies with fixed or limited payment periods provided in §3.3844(g)(2); and (iii) each insurer or other entity must provide to the applicant, at the time of application, copies of the Long-Term Care Personal Worksheet as specified in §3.3829(b)(8)(H) and the Long-Term Care Potential Rate Increase Disclosure Form as specified in §3.3829(b)(8)(I). The anticipated public benefits will be more consumers who are better informed about the availability of the senior insurance counseling program and therefore, more consumers who will participate in the counseling program. The Health Information Counseling and Advocacy Program of Texas is the senior counseling program and is operated by the Department. The program provides consumer information on long-term care insurance, including planning, insurance basics, need for such coverage, costs, and methods of financing. This information will mean that more consumers will be able to make more informed decisions regarding the purchase of long-term care insurance. Another anticipated public benefit will be more consumers who are better informed about the contingent benefit on lapse provisions, including the additional contingent benefit upon lapse provided to policies with fixed or limited payment periods. A contingent lapse benefit allows the insured to either choose a reduced benefit amount to prevent premium increases or to convert their policy to a paid-up status. The required information will explain the different contingent benefit on lapse options that are available to a consumer if the consumer decides to allow their long-term care policy to lapse within 120 days of a substantial rate increase. With such information, more consumers will be aware of the possible range of benefits that they will have in the

event that they are unwilling or unable to pay the long-term care premium in the face of a substantial rate increase by the insurer. This type of information will also assist consumers in making more informed decisions regarding the purchase of long-term care insurance.

As previously stated, the anticipated public benefit resulting from the use of these new forms, which is also required under proposed §3.3829, is that the additional information obtained from the applicant on the Personal Worksheet and the information provided to the applicant regarding potential rate increases on the Potential Rate Disclosure Form, which may affect the applicant's ability to continue to pay the premiums for the long-term care insurance, will assist the insurer and the applicant to make an informed decision on whether it is prudent for the applicant to purchase the long-term care policy given the financial circumstances of the applicant. This will ensure that those consumers who do not need or cannot afford such a policy will be less likely to purchase one. From the perspective of marketing standards, the anticipated public benefit will be that each agent marketing long-term care insurance will have information pertaining to each applicant or potential applicant that will enable the agent to only sell long-term care insurance to individuals who are financially suitable to purchase such insurance.

The proposed amendments to §3.3839 provide that the required notices in existing §3.3839(b)(1) and (2), relating to the existence or non-existence of inflation protection provisions in each policyholder's policy, are also marketing procedure requirements, along with the other marketing procedure requirements specified in

§3.3839(a), that are subject to Department audit to verify compliance. These current notices, which are redesignated as §3.3839(a)(11)(A) and (B), respectively, must be provided to each policyholder who purchases a policy that contains inflation protection provisions and to each policyholder who purchases a policy that does not contain inflation protection provisions. Existing §3.3839(b), which is proposed to be redesignated as §3.3839(a)(11), specifies the current requirements for providing the required notices to policyholders. No changes are proposed to the wording of the existing required notices or to the existing requirements for providing the notice to policyholders. The anticipated public benefit of requiring that the inflation protection notices in existing §3.3839(b)(1) and (2) are marketing procedure requirements subject to Department audit to verify compliance will be that insurers and other regulated entities will be required to establish an auditable procedure for verifying that they have complied with these notice requirements. This will enable the Department to more easily verify each insurer's compliance and to take corrective action when appropriate. The required notices are significant because they provide insureds with important information concerning: (i) the fact that even if an insured's long-term care policy does contain an inflation protection provision, the policy still may not cover all of the costs associated with long-term care; and (ii) the fact that if the policy does not contain an inflation protection provision, then based on current health care cost trends, the policy benefits may be significantly diminished depending on the amount of time between when the policy is purchased and when the policyholder becomes eligible for benefits.

Proposed new §3.3839(a)(8), (9) and (10) and the proposed amendments to existing §3.3839(b) that provide that the required inflation notices are also marketing procedure requirements that are subject to Department audit to verify compliance, as applicable to partnership policies, implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C.§1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C.§1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions of §23 of the NAIC Long-Term Care Model Regulations, relating to Standards for Marketing. Included in §23 are the requirements specified in proposed new §3.3839(a)(8), (9) and (10) and the proposed amendments to existing §3.3839(b) that provide that the required inflation notices are also marketing procedure requirements that are subject to Department audit to verify compliance.

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3839 will incur no additional cost as a result of the amendments. Any such costs incurred by these

insurers are the result of legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed amendments.

Those insurers that currently write or that opt to write non-partnership long-term care policies and are therefore required to comply with the proposed new §3.3839(a)(8), (9) and (10) will incur costs relating to: personnel, computer reprogramming, agent training, and printing and distribution. These actual costs will vary based on several factors that pertain to each individual insurer, including the size of the insurer; type of office equipment, including printers and computers; employee salaries; number of agents; and number of forms that are needed. An insurer can calculate its estimated costs based on the company's own operation and needs. There will likely be other costs related to the requirement that the inflation notices are also marketing procedure requirements that are subject to Department audit to verify compliance. If agents are soliciting on behalf of an insurer, the agents will need some type of verifiable procedure to demonstrate that the required notice was provided to each prospective policyholder. This verification could be a signed form by the prospective policyholder indicating that the policyholder received the inflation notice. The insurer will incur minimal additional costs for paper and printing as a result of this verification form. The cost will vary depending on whether the insurer opts to have a single form for each prospective policyholder or a multiple-page form with several lines on which several prospective policyholders can sign (similar to a doctor's office patient sign-in sheet). Based on the Department's experience, an additional printed page costs approximately $0.05 per page. Insurers that opt to have a single form for each prospective policyholder will incur

greater paper and printing costs than the insurer that opts to have a multiple-page form with several lines on which several prospective policyholders can sign. An insurer, including an insurer that uses direct sales solicitations, can calculate its estimated costs based on the company's own operation and needs. There may also be record storage costs because the insurer will need to retain the forms for purposes of a Department audit. The total probable costs for maintaining such records will vary substantially based on business decisions made by individual insurers including choosing among numerous electronic forms of storage or various methods of physical storage. An insurer, however, has the information necessary to calculate its estimated costs based on the company's own operation and needs.

Proposed Amendments to §3.3842. Existing §3.3842, pertaining to Appropriateness of Recommended Purchase, requires that in recommending the purchase or replacement of any long-term care insurance policy or certificate, the company and the agent must make reasonable efforts to determine the appropriateness of the recommended purchase or replacement. This requirement, which is proposed to be redesignated as §3.3842(a), constitutes the entirety of existing §3.3842. The proposed amendments to §3.3842 add several new requirements relating to the suitability standards of the insurer, health service plan, or other entity marketing long-term care insurance (issuer). These requirements apply to both partnership and non-partnership long-term care insurance coverage. Proposed new §3.3842(b)(1) – (3) requires that each issuer develop and use suitability standards to determine whether the purchase or replacement of a long-term care policy is appropriate to the needs of the

applicant, train its agents in the use of the issuer's suitability standards, and maintain a copy of its suitability standards that is available to the Commissioner for inspection upon request.

Proposed new §3.3842(c) requires that the agent and issuer develop suitability procedures to determine whether the applicant meets the issuer's standards. These procedures must consider the following factors: the applicant's ability to pay for the proposed coverage and other pertinent financial information; the applicant's goals and needs with respect to long-term care; and the values, benefits, and costs of the applicant's existing insurance as compared to the values, benefits, and costs of the recommended purchase or replacement.

Proposed new §3.3842(d) requires the issuer or, if an agent is involved, the agent to make reasonable efforts to obtain the information required in proposed new §3.3842(c) and that the efforts shall include presentation to the applicant of the Long-Term Care Personal Worksheet that is specified in §3.3829(b)(8)(H). Under proposed new §3.3842(d), the issuer may request the applicant to provide additional information on the Personal Worksheet to comply with the issuer's suitability standards. However, if the issuer requests such additional information, the issuer must comply with the specified filing requirements: (i) a copy of the issuer's Personal Worksheet that includes the additional information must be filed with the Department for approval at least 60 days prior to use; (ii) the filing is subject to the requirements and procedures in Chapter 3, Subchapter A of this title; and (iii) the filing should be submitted to the Filings Intake Division of the Department. The Long-Term Care Personal Worksheet

requires the issuer to obtain detailed information from any individual who is considering the purchase of a long-term care policy. Such information includes the applicant's current insurance and premium payments, the applicant's income and net worth, the issuer's rate history, and also a disclosure of the insurer's right to increase premiums. The anticipated public benefit resulting from the use of this new form is that the additional information obtained from the applicant on the Personal Worksheet will assist the issuer and the applicant to make an informed decision on whether it is prudent for the applicant to purchase the long-term care policy given the financial circumstances of the applicant. This will ensure that those consumers who do not need or cannot afford such a policy will be less likely to purchase one. Also, the additional questions that have been added to the proposed Long-Term Care Personal Worksheet in the section titled "Questions Related to Your Needs" include questions to applicants regarding: (i) knowledge of what inabilities trigger long-term care benefits; (ii) awareness and meaning of the term "cognitive impairment"; (iii) understanding of policy limitations; and (iv) what type of long-term care service the applicant anticipates utilizing. The anticipated public benefit is that these direct questions to consumers are an effective method of more prominently disclosing and emphasizing some of the most important limitations that are currently in long-term care policies that need to be considered by consumers and issuers prior to a consumer purchasing a long-term care policy. This will result in more consumers being better informed about such limitations before making the important decision of whether to purchase a long-term care policy. Additionally, because the issuer may request the applicant to provide additional

information on the Personal Worksheet to comply with the issuer's suitability standards, the issuer is able to collect any additional specific information that the issuer has determined, based on the issuer's own experience, is necessary to ensure that each applicant purchases the appropriate product that is suitable to the applicant's goals and needs.

Proposed new §3.3842(e) requires the completed Long-Term Care Personal Worksheet to be returned to the issuer prior to the issuer's consideration of the applicant for coverage; however, this is not required for sales of employer group long-term care insurance.

Proposed new §3.3842(g) requires the issuer to use suitability standards that it has developed pursuant to §3.3842 in determining the appropriateness of issuing long-term care insurance to an applicant. Proposed new §3.3842(h) requires agents to use the suitability standards developed by the issuer in marketing the issuer's long-term care insurance.

The anticipated public benefit resulting from the proposed requirements in §3.3842(b), (c), (d), (e), (g) and (h) will be more purchasers of long-term care insurance who are financially and otherwise suitable to make such a purchase. The new requirements require issuers to use objective measures to evaluate an applicant's suitability to purchase long-term care insurance by collecting detailed information regarding the applicant's assets, current insurance in-force, and the applicant's probable future insurance needs. This information is to be carefully evaluated by the issuer in light of the issuer's established suitability standards to ensure that each

individual who purchases long-term care insurance is financially suitable to make such a purchase and that the product purchased is suitable to the individual's needs and goals.

Proposed new §3.3842(f) prohibits the sale or dissemination of information obtained through completion of the Long-Term Care Personal Worksheet. The anticipated public benefit resulting from this proposed prohibition is to provide reassurance of privacy of personal information to applicants who are being asked to provide to the issuer sensitive financial and personal information for purposes of the issuer making a suitability determination. The prohibition against the sale or dissemination of information should help allay the concerns that an applicant may have about providing the sensitive financial and personal information that is needed to evaluate the applicant's suitability for purchasing long-term care insurance and ensure that the individuals who purchase long-term care insurance are financially suitable to make such a purchase.

Proposed new §3.3842(i) requires issuers to provide to the applicant at the same time the Personal Worksheet is provided the proposed new disclosure Things You Should Know Before You Buy Qualified Long-Term Care Insurance. This form provides important information to the consumer concerning the general functions of a long-term care insurance policy, Medicare and Medicaid as those programs relate to long-term care insurance, the availability of a Shopper's Guide for Long-Term Care, the availability of a senior health insurance counseling program, and general information concerning long-term care facilities. This disclosure form is intended to help the applicant decide whether it is prudent to purchase a long-term care policy. Additionally, proposed new

§3.3842(i)(1) – (6) specify the requirements and procedures that apply to the proposed Things You Should Know disclosure form, including text size and content, recommended format, and filing and approval procedures as applicable. The anticipated public benefit resulting from the dissemination of the proposed new disclosure form is that the information provided will assist the consumer in determining whether it is prudent to purchase a long-term care policy. The anticipated public benefit of the requirements and procedures that pertain to the proposed Things You Should Know disclosure form are: (i) the 12-point type requirement will assist the consumer to more easily read and comprehend the information in the form, and (ii) while the text and order of presentation of the information in the form is mandated by the DRA, issuers will have flexibility with regard to the formatting of the form subject to Department approval.

Proposed new §3.3842(j) addresses actions to be taken if the issuer determines that the applicant does not meet its financial suitability standards or if the applicant has declined to provide the requested information. If either of these events occur, the issuer may either reject the application or, if the issuer does not opt to reject the application, the issuer is required to send the applicant a letter in accordance with the proposed new Long-Term Care Insurance Suitability Letter. However, only in the event that the applicant has declined to provide the requested financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned Suitability Letter containing the applicant's response or a record of the alternative method of verification must be made a part of the applicant's file. If the issuer elects to

send the applicant a Suitability Letter, the Suitability Letter must comply with the specified requirements and procedures, including mandated content and 12-point text. The letter will inform an applicant that the issuer has reviewed the financial information provided by the applicant on the Personal Worksheet and has determined that the applicant is not financially suitable to purchase long-term care insurance and that review of the application has been suspended or that the applicant has not provided any or has provided insufficient financial information for the issuer to make a determination as to the applicant's suitability to purchase a long-term care policy and that review of the application has been suspended. The anticipated public benefit resulting from the use of the Suitability Letter is that applicants will receive important information concerning the status of their application. This information will indicate either that the issuer has determined that the applicant is not financially suitable to purchase long-term care insurance or that the financial information provided by the applicant is not sufficient for the issuer to make a determination regarding the applicant's suitability to purchase a long-term care policy and that review of the application has been suspended. The Suitability Letter will further inform the applicant that the applicant may choose to continue the application process despite the determination that long-term care may not be a suitable purchase. This information is important because it alerts a consumer to the fact that their application for a long-term care policy is no longer being processed unless the consumer chooses to proceed with the purchase.

The proposed amendments to §3.3842 that add proposed new §3.3842(b) – (j) implement the provision of SB 22, codified as Insurance Code §1651.104. Section

1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C.§1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C.§1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions of §24 of the NAIC Long-Term Care Model Regulations, which pertain to Suitability and included in §24 are the requirements specified in proposed new §3.3842(b) - (j).

Those issuers that opt to write partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3842 will incur no additional cost as a result of the amendments. Any such costs, except those costs related to the information obtained in questions to the applicant on the Personal Worksheet that are in addition to those questions required in §9 (Required Disclosures of Rating Practices to Consumers) of the NAIC Long-Term Care Model Regulations, incurred by these issuers are the result of legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed amendments. The estimated probable costs for the additional questions in the Personal Worksheet are detailed in this Public Benefit/Cost Note in the section entitled “Proposed Amendments to §3.3829.”

Those issuers that are currently writing or that opt to write non-partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3842 will incur costs resulting from the adoption of the amendments. An issuer will incur costs to perform the following functions: (i) the development and use of suitability standards to determine whether the purchase or replacement of a long-term care policy is appropriate for the needs of the applicant; (ii) the training of its agents in the use of the issuer's suitability standards; (iii) maintaining a copy of its suitability standards that is available to the Commissioner for inspection upon request; (iv) the development of suitability procedures to determine whether the applicant meets the issuer's standards, including consideration of the following factors pertinent financial information of the applicant; the applicant's goals or needs for long-term care; benefits and costs of the applicant's existing insurance compared to the recommended replacement benefits and costs; (v) the making of reasonable efforts, or, if an agent is involved, the agent making reasonable efforts, to obtain the necessary information to determine whether the applicant meets the issuer's standards; (vi) the obtaining of the completed Long-Term Care Personal Worksheet from the applicant prior to the issuer's consideration of the applicant for coverage; (vii) the use of the issuer's suitability standards in determining the appropriateness of issuing long-term care insurance to an applicant; (viii) the provision to the applicant at the same time the Personal Worksheet is provided the proposed new disclosure Things You Should Know Before You Buy Long-Term Care Insurance; and (x) sending of the required Suitability Letter when appropriate. These costs may include personnel to develop the suitability standards if

the issuer has not already developed such standards or personnel to revise the issuer's suitability standards to conform to the new requirements and to develop suitability procedures to determine whether the applicant meets the issuer's standards These costs may also include personnel costs to train the issuer's agents in the use of the issuer's suitability standards if such training has not already been provided or if additional training is needed due to revised standards. There may be minimal personnel and storage costs for maintaining a copy of the issuer's suitability standards that is available to the Commissioner for inspection upon request. The estimated probable costs for the Personal Worksheet are detailed in this Public Benefit/Cost Note in the section entitled "Proposed Amendments to §3.3829." An issuer will incur costs for printing the required disclosure entitled Things You Should Know Before You Buy Long-Term Care Insurance. This disclosure printed in 12-point type is approximately one and one-half pages, and there will be costs for printing, envelopes, and postage. Based on the Department's experience, an additional printed page costs approximately $0.05 per page, an envelope and a return envelope cost approximately $0.05 each; postage for mailing the form to applicants will cost a maximum of $0.43 per applicant; and return postage for one to three pages of paper will cost a maximum of $0.43. The actual total costs for an issuer will vary based on factors that pertain to each individual issuer, including the size of the issuer; the type of office equipment, including printers and computers; and the number of forms that are needed. An issuer can calculate its estimated costs based on the company's own operation and needs. The Suitability Letter, which is required in certain specified circumstances under proposed §3.3842(j),

printed in 12-point type is approximately one and one-half pages, and there will be costs for printing, envelopes, and postage. These probable costs will include an estimated $0.05 per printed page, approximately $0.05 each for an envelope and a return envelope; a maximum of $0.43 per applicant for postage for mailing; and a maximum of $0.43 for return postage. Again, the actual total costs for an issuer will vary based on factors that pertain to each individual issuer, including the size of the issuer; the type of office equipment, including printers and computers; and the number of letters that are needed. An issuer can calculate its estimated costs based on the company's own operation and needs.

Proposed Amendments to §3.3844. Existing §3.3844 addresses nonforfeiture and contingent benefits in long-term care policies and certificates. The proposed amendments to §3.3844 also address contingent nonforfeiture benefits in long-term care policies and certificates, both partnership and non-partnership policies. Proposed new §3.3844(g)(2) provides that in addition to the provision in §3.3844(g)(1) for the triggering of contingent nonforfeiture benefits on lapse, such contingent nonforfeiture benefits shall be triggered for policies or certificates with a limited premium paying period every time an issuer 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 specified in the proposed table in §3.3844(g)(2) based on the insured's issue age, the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio specified in proposed §3.3844(g)(4)(B) is 40 percent or more. Proposed §3.3844(g)(2) also provides that

unless otherwise required, policyholders must be notified at least 45 days prior to the due date of the premium reflecting the rate increase. A contingent nonforfeiture benefit is a type of nonforfeiture benefit that becomes available to the policyholder when the contingency of a substantial rate increase occurs. The triggers for a substantial rate increase are contained in the tables in §3.3844(g)(1) and §3.3844(g)(2) that are expressed as a function of the issue age of the insured and the percent increase over initial premium that the insured paid. The anticipated public benefit resulting from the revised contingent nonforfeiture benefit on lapse provision for policies with fixed or limited premium payment periods is that insurers will be required to include these protections in their policies, and it is in the best interest of consumers who purchase policies on such payment plans to be able to receive greater protections if their policies lapse. The reasons for this are the following. The contingent nonforfeiture benefit on lapse is triggered every time an insurer increases the premium rate to a level that corresponds to the issue age of the insured at the time of the rate increase and the corresponding percent increase over the initial premium that the insured paid. Once the policyholder receives notice of a substantial rate increase the policyholder has 120 days to either pay the substantial rate increase or allow the policy to lapse and choose from the insurer's offer to: (i) reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that the required premium payments are not increased; or (ii) convert the coverage to a paid-up policy with a shortened benefit period. Therefore, another anticipated public benefit to consumers is that the contingent benefit on lapse provisions provide a safety net to policyholders who

are forced to allow their long-term care policies to lapse because they are unable to pay a substantial rate increase.

Proposed new §3.3844(g)(4)(A) and (B) require the insurer to make certain offers to the insured for a policy or certificate with a fixed or limited premium payment period when there is a substantial rate increase and the policy has lapsed within 120 days of the due date of the premium that was substantially increased. The insurer must offer to the policyholder the option to either: (i) reduce the policy or certificate benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased; or (ii) 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 prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. Proposed new §3.3844(g)(4)(C) requires the insurer to notify the policyholder that a lapse or default at any time during the 120-day period shall be deemed to be the insured's election of the offer to convert as set forth in §3.3844(g)(4)(B). The proposed amendments to §3.3844(e) limit the application of subsection (e) to contingent nonforfeiture benefits upon lapse in the event of a default in payment of premiums in accordance with §3.3844(g)(1). The proposed amendments also provide that subsection §3.3844(e) does not apply to contingent nonforfeiture benefits upon lapse in accordance with §3.3844(g)(2), which provides that a contingent nonforfeiture benefit on lapse is also triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative

increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium as set forth in the table Triggers for a Substantial Premium Increase in §3.3844(g)(2) based on certain specified factors. The anticipated public benefit resulting from the addition of this revised contingent nonforfeiture benefit on lapse provision for policies with fixed or limited premium payment periods is that consumers will receive greater protections if their policies lapse. This provision ensures that, in the event that an insured is unable to pay the substantial rate increase and is therefore forced to let their policy lapse, the insured will receive at least some benefits for the premiums he or she has paid in over the years. The proposed amendments to §3.3844 that amend subsection (e) and add new paragraphs (2) and (4) to subsection (g) implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C.§1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the nonforfeiture benefit requirements in the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C.§1396p(b)(5)(A)). These NAIC nonforfeiture benefit requirements for partnership policies are in §28D(4), D(6), E, and E(1) of the NAIC Long-Term Care Model Regulations, relating to Nonforfeiture Benefit Requirements. Section 28D(4), D(6), E, and E(1) are specified in the proposed amendments to §3.3844(e), (e)(3), (g)(2) and (4).

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3844 will incur no additional cost as a result of the amendments. Any such costs incurred by these insurers are the result of legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed amendments.

The proposal applies the proposed new nonforfeiture and contingent nonforfeiture benefit requirements to non-partnership policies and insureds for all long-term care insurance policies, not just partnership policies and insureds. The application of the proposed new nonforfeiture and contingent nonforfeiture benefit requirements to non-partnership policies and insureds is necessary to provide the same benefits to these insureds as is provided to partnership policy insureds. The anticipated public benefit is that those insureds covered by non-partnership policies will also receive some benefits if they are unable to pay the higher premiums and are required to allow their policies to lapse. The Department has determined that insureds covered under non-partnership policies should receive the same consumer protections and benefits as insureds covered under partnership policies. There is no regulatory or public interest reason to exempt non-partnership policy insureds from these consumer protection requirements and benefits. To the contrary, there are significant regulatory and public interest reasons for providing all long-term care insureds the same consumer protections and benefits. Providing the same consumer protections and benefits to all long-term care insureds will mean that all long-term care insurance policyholders in Texas will be uniformly treated in the event that an insured is unable to pay the

substantial rate increase and is therefore forced to let their policy lapse. Like the partnership policy insured, the non-partnership policy insured will receive at least some benefits for the premiums he or she has paid in over the years.

Those insurers that currently write or that opt to write non-partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3844, relating to the contingent nonforfeiture benefits on lapse that are available for a policy or certificate with a fixed or limited premium payment period will incur costs relating to the printing costs for modifying the existing policy forms to include these new provisions. Therefore, the Department anticipates that the costs associated with the proposed new nonforfeiture and contingent benefit requirements will involve the following cost components: personnel, computer reprogramming, and printing and distribution. These actual costs will vary based on several factors that pertain to each individual insurer, including the size of the insurer; type of office equipment, including printers and computers; employee salaries; and number of forms that are needed. An insurer can calculate its estimated costs based on the company's own operation and needs.

Proposed New §3.3848. The regulatory requirements in proposed §3.3848, pertaining to Requirements for Limited Premium Payment Options in Long-Term Care Policies, Certificates, and Riders, which apply to both partnership and non-partnership long-term care policies, govern noncancellation, guaranteed renewability, and return of premium practices for long-term care plans with limited premium payment options. Proposed new §3.3848(a) specifies the definition and applicability and proposed new

§3.3848(b) specifies the requirements for limited premium payment options in long-term care plans. Long-term care policies, certificates, and riders with limited premium payment options limit premium payments to a single payment or to a stated number of years not to exceed 10 years and must comply with Subchapter A and Subchapter Y of Chapter 3 in Title 28 of the Texas Administrative Code and with the additional requirements specified in §3.3848(b). The proposed requirements in §3.3848(b)(1) and (2) include: (i) notice on the face page of the policy or certificate that the plan has a limited premium payment option; and (ii) the provisions in long-term care policies, certificates, and riders with limited premium payment options must be at least as favorable as the requirements and provisions specified in §3.3848. Proposed §3.3848(b)(3) – (5) specify the requirements for three types of limited premium payment policies, certificates, and riders, including single-premium payment option, one-to-four-year premium payment options, and five-to-ten year premium payment options. Single-premium payment option policies must be noncancellable and the renewability provision in the policy must conform with the provision specified in §3.3848(b)(3) that states the premiums are paid by a single premium, that the policy cannot be cancelled by the insurer, and that no changes can be made to the policy unless requested by the insured. One-to-four year premium payment option policies must be noncancellable, and the renewability provision in the policy must conform with the provision specified in §3.3848(b)(4) that states the premiums are paid over a period of [n] (n may equal 1, 2, 3, or 4) years, that the policy cannot be cancelled by the insurer, and that no changes can be made to the policy unless requested by the insured. For those policies,

certificates, and riders with a five-to-ten year premium payment option, a provision must be included in the policy, certificate, or rider that provides for a return of premium upon cancellation, as provided in the Return of Premium Schedule in §3.3848(b)(5)(C)(ii) and must be accompanied by the disclosure notice specified in §3.3848(b)(5)(C)(i). The return of Premium Schedule chart in §3.3848(b)(5)(C)(ii) specifies the percentage of premium that the insurer is required to return to the insured expressed as a function of the premium payment option (5, 6, 7, 8, 9, and 10 year premium payment options) and of the number of completed years prior to the policy, certificate or rider being canceled and must comply with the requirements specified in §3.3848(b)(5)(C)(ii)(I) and (II), including text font size and format. Proposed §3.3848(b)(5)(D) and (E) provide a formula for using the Return of Premium chart to determine the total return of premium amount. The provisions in proposed §3.3848 are not required by SB 22 or the DRA. The proposed requirements, which apply to both partnership and non-partnership policies, are proposed to protect Texas insureds who have limited premium payment plans from unfair cancellation, nonrenewal, and return of premium practices.

Those insurers that are currently writing non-partnership long-term care policies with limited premium payment options will be required to amend their policy forms to include the applicable renewability provision and the return of premium chart, if applicable. Insurers currently writing limited premium payment option policies will incur costs relating to the following: personnel, computer reprogramming, and printing and distribution of the amended policy forms. These actual costs will vary based on several factors that pertain to each individual insurer, including the size of the insurer, type of

office equipment, including printers and computers, employee salaries; and the number of policy forms that are needed. An insured can calculate its estimated costs based on the company's own operation and needs.

Those insurers that opt to write partnership or non-partnership limited premium payment option long-term care policies in the future will be required to include the applicable renewability provision in their policies and the return of premium chart, if applicable. Because the requirements will be in effect at the time such insurers initially write their policies, they will not incur any additional costs related to amending policy forms or computer programming for amended policy forms. An individual insurer should be able to include any costs related to the proposed requirements into their start-up business operating costs.

Proposed New §3.3849. Proposed new §3.3849, pertaining to Requirements for Insurers that Issue Long-Term Care Policies to Associations and Marketing Standards for Associations That Market the Policies, specifies certification requirements for insurers that issue partnership and non-partnership policies to associations and marketing standards for associations, as defined in the Insurance Code §1251.052, that market partnership and non-partnership policies. Insurers that issue such policies to associations are required under proposed §3.3849(a)(1) to file with the Department the partnership and/or non-partnership policy and certificate, a corresponding outline of coverage, and an annual certification of the association's compliance with marketing standards for partnership and/or non-partnership policies and certificates in accordance with the Insurer Certification of Association Marketing Compliance specified in

§3.3849(e)(1)(F). Proposed new §3.3849(a)(2) provides that no group long-term care partnership and/or non-partnership policy or certificate may be issued to an association unless the insurer files with the Department the information required in §3.3849(a)(1). Proposed new §3.3849(e)(1)(A) – (D) specify the requirements and procedures that apply to the Insurer Certification of Association Marketing Compliance Form, including text content, text font size, recommended format, and filing for approval as applicable. Proposed new §3.3849(e)(2) requires that the initial certification be submitted to the Department between January 1, 2009 and January 31, 2009, for the calendar year 2008, and thereafter be submitted annually between January 1 and January 31 for the preceding calendar year. Proposed new §3.3849(e)(3) provides that the certification form is an informational filing pursuant to §3.5(b)(1) of this title and is subject to the requirements and procedures in Chapter 3, Subchapter A of this title. Proposed new §3.3849(e)(4) specifies where the annual completed certification form should be filed. The anticipated public benefit of the insurer filing the required information and certification relating to any association to which it has issued a long-term care partnership or non-partnership policy or certificate is that it provides necessary information to assist the Department in monitoring each association's compliance with the §3.3849 requirements, including an association's compliance with marketing standards for partnership and non-partnership policies and certificates in accordance with the Insurer Certification of Association Marketing Compliance. The monitoring will enable the Department to identify possible violations, including unfair marketing practices, in a timely manner so that the Department can take corrective action to

protect association members. Additionally, the proposed certification form in §3.3849(e)(1)(F) will ensure timely and efficient filing of the required certification information with the Department.

Proposed new §3.3849(b) requires advertisements for long-term care partnership and non-partnership insurance to be filed with the Department in accordance with §3.3838(1) (relating to Filing Requirements for Advertising). The anticipated public benefit is that the Department's review of long-term care partnership and non-partnership advertising by associations and to associations will enable the Department to timely identify and prevent unfair or deceptive advertising to association members who are considering applying for long-term care insurance coverage. This will help to ensure that association members are protected from unscrupulous and dishonest sales and enrollment practices.

Proposed §3.3849(c)(1) requires an association to disclose in any long-term care partnership and/or non-partnership insurance solicitation to its members: (i) the specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and (ii) a brief description of the process under which the policies and the insurer issuing the policies were selected. Under proposed §3.3849(c)(2), an association is required to disclose to its members the fact of any interlocking directorates or trustee arrangements between the association and the insurer. The anticipated public benefit is that more consumers will be aware of factors, such as the

financial arrangements between the insurer and the association and the extent of the insurer selection process, that will enable them to more effectively evaluate the pros and cons of the long-term care insurance solicitation. Also, more consumers will have information to enable them to more readily identify possible bias or deception in the marketing or solicitation of long-term care products by the association. These types of information will enable association members to be more than just pro forma participants in the purchase of their long-term care insurance if they so choose.

Proposed new §3.3849(d) requires an association's board of directors to review and approve the insurance policies and compensation arrangements the association has with the insurer. The anticipated public benefit of this requirement is that the association's board of directors will have the opportunity to examine and evaluate the long-term care benefits being purchased by the association's members and the financial arrangements between the insurer and the association to ensure that they are in the best interest of the members of the association.

Proposed new §3.3849(a) - (d) implements the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security

Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions in §23 of the NAIC Long-Term Care Model Regulations, relating to Standards for Marketing. The provisions in proposed §3.3849(a) - (d) are consistent with the provisions in §23 in the Model Regulations. While §23 of the Model Regulations does not specifically require a certification form, §23C(8) of the Model Regulations includes the requirement that insurers make the annual certification that is proposed in §3.3849(a)(1)(C).

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3849 will incur no additional cost as a result of the new requirements. Any such costs incurred by these insurers are the result of legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed requirements.

The Department has determined that it is also necessary to apply the consumer protection requirements in proposed new §3.3849 to insurers, their agents, and associations that market non-partnership long-term care policies, not just partnership policies. The Department has determined that members of associations being solicited for non-partnership policies should receive the same consumer protections as members of associations being solicited for partnership policies. There is no regulatory or public interest reason to exempt association member applicants for non-partnership policies from these consumer protection requirements. In fact, there are significant regulatory and public interest reasons for providing all association member applicants for long-term

care coverage the same consumer protections. Providing the same consumer protections to all long-term care association member applicants will mean that that all consumers who are members of associations in Texas will be uniformly protected from unscrupulous or dishonest marketing practices that can cause economic harm to the consumers.

Those insurers that currently write or that opt to write non-partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3849 will incur costs related to the following requirements: (i) filing with the Department the non-partnership policy and certificate, a corresponding outline of coverage, and an annual certification of the association's compliance with marketing standards for non-partnership policies and certificates in accordance with the Insurer Certification of Association Marketing Compliance specified in §3.3849(e)(1)(F); and (ii) the filing of advertisements for long-term care non-partnership insurance with the Department in accordance with §3.3838(1). The Department anticipates that the following costs will apply to the filing of the non-partnership policy and certificate and corresponding outline of coverage. These estimates are based on the Department's previous experience. A printed page costs approximately $0.05; an envelope, approximately $0.05 to $0.10 depending on the type used; and postage for mailing, $0.42 for a first class mailing with costs increasing depending on the size of the mailing. The Department estimates that insurers will incur costs for filing the annual certification form, which is approximately one page in length when printed in the minimal required 10-point type size, of approximately $0.52 per certification form ($0.05 for printed one-

page form, $0.05 for the envelope, and $0.42 for mailing cost). The total anticipated cost for insurers to file the policy and certificate and corresponding outline of coverage will vary based on the number of pages in the filing. Also, the total anticipated cost for insurers to advertisements will vary based on the number of ads filed during a calendar year and the number of pages in each of those advertisements.

Those associations that provide non-partnership long-term care policy solicitations to their members will incur costs related to the following requirements: (i) the disclosure in any long-term care non-partnership insurance solicitation to its members 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; (ii) a brief description of the process under which the policies and the insurer issuing the policies were selected; (iii) the disclosure to its members of the fact of any interlocking directorates or trustee arrangements between the association and the insurer; and (iv) the review and approval by the association's board of directors of the insurance policies and any compensation arrangements the association has with the insurer. The Department anticipates that the total estimated cost for an association to disclose in any long-term care non-partnership insurance solicitation to its members the required information will probably be a maximum of two additional pages at a cost of approximately $0.05 per printed page; the Department anticipates that postage cost for distributing the solicitation will either not increase or increase minimally because of the

additional information to be added to the solicitation as required under proposed §3.3849(c).

Proposed New §3.3860. Proposed new §3.3860, pertaining to Policy Summary Requirements for Non-Partnership Life Insurance Policies and Annuity Contracts that Provide Long-Term Care Benefits, applies to non-partnership long-term care policies only. The section sets forth the delivery and content requirements for the policy summary for non-partnership life insurance policies or annuity contracts that provide long-term care benefits by rider. The proposed requirements do not apply to any long-term care partnership policy. Proposed §3.3860(a) requires the insurer to deliver a policy summary at the time of delivery of the non-partnership life insurance policy or annuity contract. In the case of direct response solicitations, insurers are required to deliver the policy summary upon the applicant's request, but regardless of request, to deliver no later than at the time of the policy or annuity contract delivery. Proposed §3.3860(a)(1) – (5) specify the policy summary content requirements: (1) an explanation of how the benefits interact with other components of the policy; (2) an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefit; (3) any exclusions, reductions, and limitations on benefits; (4) a statement that the long-term care inflation protection option required by §3.3820 (relating to Requirement to Offer Inflation Protection) and the long-term care inflation protection provisions required for partnership policies by §3.3872 (relating to Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates) are not available under this policy; and (5) if applicable to the policy type, a disclosure of the

effects of exercising other rights under the policy; a disclosure of guarantees related to the cost of insurance charges, and a disclosure of current and projected lifetime benefits. Under §3.3860(b), insurers may incorporate the provisions of the policy summary into a basic life insurance illustration that is required to be delivered in accordance with Chapter 21 Subchapter N of Title 28, relating to Life Insurance Illustrations. Proposed §3.3860(c) requires insurers to provide a monthly report to each policyholder any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit by rider, is in benefit payment status. The information to be included in the monthly report is also specified in proposed §3.3860(c): (i) any long-term care benefits paid out during the month; (ii) an explanation of any changes in the policy, e.g., death benefits or cash values, due to long-term care benefits being paid out; and (iii) the amount of long-term care benefits existing or remaining.

The anticipated public benefit of §3.3860(a), which specifies the policy summary content requirements, will be more consumers who are informed about the various aspects (including how the different types of benefits interact; the exclusions, reductions, and limitations on the benefits; and the unavailability of the long-term care inflation protection option) of purchasing long-term care coverage through the purchase of a non-partnership life insurance policy or annuity contract that provides the long-term care benefits by rider. This information will assist consumers who are considering the purchase of such policies or annuity contracts to make a decision on whether this type of long-term care coverage is appropriate for them.

The anticipated public benefit of §3.3860(b), which allows insurers to incorporate the provisions of the policy summary into a basic life insurance illustration, is that those consumers who purchase a non-partnership life insurance policy or annuity contract that provides long-term care benefits by rider, will only be provided a single summary that includes both the life insurance or annuity contract benefits summary and the long-term care benefits summary. Currently, insureds receive two policy summaries, one for the life insurance or annuity contract benefits and one for the long-term care benefits. The single summary should be easier for insureds because they will only need to keep up with the one summary for the two types of insurance.

The anticipated public benefit of §3.3860(c), which requires insurers to provide a monthly report to each policyholder when the life insurance policy or annuity contract that also provides long-term care benefits is in benefit payment status is that each policyholder will receive in a timely manner important information that will enable the policyholder to more effectively monitor the status of their long-term care benefits. This information will relate to benefits paid out during the month, any policy changes, and the amount of long-term care benefits existing or remaining. The anticipated public benefits are that the monthly report will provide important information to the consumer concerning the interaction of the long-term care benefits with the life insurance benefits. The information provided in the monthly report will assist the policyholder to properly and timely monitor the two different types of benefits. This is important because as the long-term care benefits are paid the death benefit and cash surrender value of the life insurance policy are decreasing, and the timely information will assist the consumer in

planning his or her future insurance needs, both for life insurance and long-term care coverage.

Proposed new §3.3860 implements the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a long-term care policy that is funded by a life insurance policy be consistent with the provisions in §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)). The policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements include the provisions in §6J and §6K of the NAIC Long-Term Care Model Act. Proposed §3.3860 is consistent with the §6J and §6K requirements.

Those insurers that are currently writing or that opt to write non-partnership long-term care policies and are therefore required to comply with proposed new §3.3860 will incur no additional cost as a result of the proposed new section. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed new section.

Proposed New §3.3870. Proposed new §3.3870, pertaining to Exchange Requirements for Long-Term Care Partnership Policies, applies only to long-term care partnership policies and specifies the requirements for the exchange of an existing long-term care policy for a new long-term care partnership policy and one-time reporting

requirement. Section 3.3870(a) requires any insurer that begins to advertise, market, offer, sell, or issue policies that qualify under the Texas Long-Term Care Partnership Program to offer on a one-time basis to all policyholders and certificate holders that were issued long-term care coverage by the insurer on or after February 8, 2006, the option to exchange their existing policy or certificate for a partnership policy or certificate. The insurer is required to offer the option to exchange in writing by December 31, 2009.

Insurers may make the new coverage available by the methods that are specified in §3.3870(b). These methods are: (i) by adding a rider or endorsement to the existing policy; or (ii) by exchanging the existing policy or certificate for a new partnership policy or certificate. Proposed new §3.3870(b)(2)(A) specifies the conditions for exchange for new coverage that has an actuarial value of benefits equal to or lesser than the actuarial value of the benefits of the existing coverage: (i) If the new coverage has an actuarial value of benefits equal to or lesser than the actuarial value of benefits of the existing coverage, based on uniform assumptions as determined on the date of issue for a new insured, the insurer must comply with two requirements (the new policy cannot be underwritten and the rate charged for the new policy must be determined using the original issue age and risk class of the insured that was used to determine the rate of the existing policy. (ii) If the new coverage has an actuarial value of benefits exceeding the actuarial value of benefits of the existing coverage, based on uniform assumptions, as determined on the date of issue for a new insured, the insurer must comply with two requirements (the insurer must apply its new business, long-term care underwriting

guidelines to the increased benefits only and the rate charged for the new policy must be determined using the method specified in §3.3870(b)(2)(A)(ii) for the existing benefits, increased by the rate for the increased benefits using the current attained age and risk class of the insured for the increased benefits only).

Any exchange of an existing long-term care policy or certificate for a partnership policy or certificate must comply with the requirements specified in §3.3870(c): (i) All offers of policy exchanges must be made on a nondiscriminatory basis. (ii) An exchange offer shall be deferred to all policyholders who are currently eligible for benefits, within an elimination period on a claim, or who would not be eligible to apply for coverage due to issue age limitations under the new policy, until such time when such condition expires. (iii) All rates for exchanges must be in accordance with §3.3831 (relating to Standards and Rates); exchange policies may be underwritten and the premium may be increased in accordance with §3.3831 and subject to §3.3810. (iv) The new coverage offered must be on a currently approved form. (v) In the event of an exchange the insured shall not lose any rights, benefits, or built-up value under the original policy.

The anticipated public benefit resulting from the adoption of §3.3870(a) -(c) is that insureds who currently have non-partnership long-term care policies will have an opportunity to exchange their existing policies for a partnership policy. This will enable Texas residents to purchase long-term care policies that have the advantages of asset disregard and estate recovery benefits, which their existing non-partnership policies do not have. Additionally, §3.3870(a) - (c) provides procedures and guidelines for the

exchange of existing long-term care policies for partnership policies. This will provide uniformity in the implementation of such exchanges by insurers that will ensure that all insureds who avail themselves of such exchanges will be treated equally and in accordance with state-mandated guidelines.

Proposed §3.3870(a) - (c) implements the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires the Commissioner of Insurance, in consultation with the Texas Health and Human Services Commission, to adopt minimum standards for a long-term care benefit plan that may qualify as an approved plan under the partnership for long-term care program. The standards must be consistent with provisions governing the expansion of a state long-term care partnership program established under the federal Deficit Reduction Act of 2005 (Pub. L. No. 109-171). Under §1917(b)(1)(C)(iii)(VII) of the Social Security Act (SSA), as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(VII)), policies sold prior to the establishment of the partnership program may be exchanged for partnership policies, but the DRA does not provide any requirements or procedures for such exchanges. Therefore, the terms and requirements of such policy exchanges are left to the discretion of each individual state.

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with proposed new §3.3870(a) - (c) will incur no additional cost as a result of the proposed new subsections. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not

the result of the adoption, enforcement, or administration of the proposed new subsections.

Proposed new §3.3870(d) provides that policies issued pursuant to this section shall be considered exchanges and not replacements. Additionally, insurers are subject to a one-time reporting requirement under §3.3870(e). Insurers must report exchanges made pursuant to §3.3870 on a one-time basis for the 2009 reporting period (to be reported by June 30, 2010) on the Long-Term Care Insurance Replacement and Lapse Reporting Form specified in §3.3837(a)(2). The anticipated public benefit resulting from the reporting requirements in §3.3870(d) and (e) is that an insurer's replacement data for 2009 will not be artificially inflated by adding the number for the exchanges of existing long-term care policies for partnership into the replacement data. By reporting the exchanges as a separate data element on the 2009 report, confusion will be avoided regarding the insurer's actual number of replacement policies sold. This is important because a higher than normal percentage of replacement policies may indicate market conduct problems, such as misrepresentation or fraud in replacing existing policies. The data will thereby assist the Department in conducting more efficient regulation of long-term care marketing practices and enable the Department to focus market conduct examination resources only on those insurers that truly have a high percentage of replacement policies. The anticipated public benefit from the reporting of the exchange long-term care data will also assist the Department in assessing the progress and effectiveness of the partnership program in Texas. The number of exchange policies will be one factor in this assessment.

While proposed new §3.3870(d) and (e) are not required by SB 22 or the DRA, the Department is proposing these provisions pursuant to the Commissioner's rulemaking authority in the Insurance Code §1651.004 to obtain information important to monitoring the progress of the Texas partnership program. Pursuant to the Human Resources Code §32.107, the Health and Human Services Commission (HHSC) is required to submit a biennial report to the Legislature on the progress of the partnership program and the HHSC may request information from the Department to prepare this report. Additionally, the requirement that insurers report exchanges as a separate data element and not as part of replacement policy data will provide the Department with a more accurate measure of the actual number of replacement policies for each insurer. The number of replacement policies for an individual insurer may be used to identify problematic market trends that may require corrective measures by the Department.

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with proposed §3.3870(d), which provides that long-term care partnership policies issued pursuant to §3.3870 shall be considered exchanges and not replacements, will not incur any additional costs as a result of this proposed provision. However, the Department anticipates the insurers that opt to write partnership long-term care policies and are therefore required to comply with proposed §3.3870(e) will incur minimal costs because of the requirements relating to a one-time reporting requirement in which insurers must report exchanges made pursuant to §3.3870 for the 2009 reporting period (to be reported by June 30, 2010) on the Long-Term Care Insurance Replacement and Lapse Reporting Form specified in

§3.3837(a)(2). These additional costs will relate to the following: personnel, computer reprogramming, agent training, and printing and distribution. These actual costs will vary based on several factors that pertain to each individual insurer, including the size of the insurer; type of office equipment, including printers and computers; employee salaries; and number of forms that are needed. An insurer can calculate its estimated costs based on the company's own operation and needs.

Proposed New §3.3871. Proposed new §3.3871, pertaining to Standards and Reporting Requirements for Approved Long-Term Care Partnership Policies and Certificates, applies only to long-term care partnership policies and specifies the standards and reporting requirements for approved long-term care partnership policies. In addition to the required filing and approval pursuant to §3.3873 of this subchapter (relating to Filing Requirements for Long-Term Care Partnership Policies), any policy or certificate marketed or represented to qualify as a long-term care partnership policy or certificate must comply with the requirements specified in §3.3871(a)(1)(A) - (D): (i) the insured individual must be a resident of Texas when coverage first became effective under the policy, and if the policy or certificate is later exchanged for a different long-term care policy or certificate the individual was a resident of Texas when the coverage under the first policy became effective; (ii) a partnership policy must be a tax qualified policy under the provisions of §3.3847 (relating to Qualified Long-Term Care Insurance Contracts: Prohibited Representations); (iii) the policy is issued with and retains inflation protection coverage which meets the inflation standards based on the insured's attained age; and (iv) the effective date of the partnership policy must be the date that

the partnership policy is issued or the date the application for the partnership policy was signed. The anticipated public benefit resulting from proposed §3.3871(a)(1)(A) - (D) will be the establishment of a Partnership Program in Texas in accordance with the DRA and SB 22 enacted by the 80th Legislature. The state Partnership Program is intended to promote consumers' purchase of long-term care insurance from insurers by providing consumers access to Medicaid under special eligibility rules in the event that an individual consumer should ever need Medicaid long-term care coverage that is in addition to that provided by the purchased coverage. Adopted by the Texas Health and Human Services Commission, these special rules generally allow the individual to protect assets equal to the insurance benefits received from a partnership policy so that such assets will not be taken into account in determining financial eligibility for Medicaid and will not subsequently be subject to Medicaid liens and recoveries.

Proposed new §3.3871(a)(1)(A), (B) and (C) implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the DRA. Pursuant to §1917(b)(1)(C)(iii)(I), (II) and (IV) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(I), (II), and (IV)), the partnership policy must meet the general requirements of those sections in the DRA. Proposed §3.3871(a)(1)(A), (B) and (C) are consistent with §1917(b)(1)(C)(iii)(I), (II), and (IV) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(I), (II), and (IV)).

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with proposed new §3.3871(a)(1)(A), (B) and (C) will incur no additional cost as a result of the proposed new requirements. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed new requirements.

A policy or certificate represented or marketed as a long-term care partnership policy or certificate must be accompanied by a disclosure notice (a representation of which is specified in §3.3871(a)(2)(B)(vii)) that explains the benefits associated with the policy or certificate in accordance with the requirements in §3.3871(a)(2)(A) and (B). While proposed new §3.3871(a)(2)(A) and (B) pertaining to the required disclosure notice are not required by SB 22 or the DRA, the Department is proposing these provisions pursuant to the Commissioner's rulemaking authority in the Insurance Code §1651.004 to provide necessary information to the insured to protect the insured from inadvertently losing partnership status and to inform the insured of various essential facts relating to the partnership policy. The required disclosure notice, titled "Important Information Regarding the Texas Long-Term Care Insurance Partnership Program," provides essential information to the insured relating to certain disclosures, including: (i) the policy purchased qualifies for the Texas partnership program; (ii) the partnership policy may protect the insured's assets through "asset disregard" under the Texas Medicaid program; (iii) the meaning of "asset disregard" and the fact that the purchase of a partnership policy does not guarantee the ability to disregard assets and does not

automatically qualify the insured for Medicaid; (iv) the long-term care policy purchased confers partnership status as of the effective of the policy; (v) what could disqualify one's policy status as a partnership policy; and (vi) how the insured can obtain additional information on the partnership policy program. The notice, which is approximately one and one-half pages long, must be in at least 12-point type and must follow the order of the information presented in §3.3871(a)(2)(B)(vii). The text in the notice is mandated; the format for the form is a recommended format. An insurer may format the mandated text in a different format from that specified in §3.3871(a)(2)(B)(vii) if the insurer files the form for review and approval by the Commissioner in accordance with the procedures in §3.3871(a)(2)(B)(iii) and (vi). The anticipated public benefit of this disclosure notice is to ensure that individuals who purchase partnership policies have information in a separate document that accompanies the partnership policy that explains the benefits of the partnership program. Additionally, this notice will also be helpful in notifying family members or others who are administering the estate of the insured of the partnership status of the policy and of the estate recovery exemptions available for benefits paid under a partnership policy. The anticipated public benefit of the requirements and procedures related to the disclosure notice are: (i) the 12-point type requirement will assist the consumer to more easily read and comprehend the information in the notice; and (ii) while the text and order of presentation of the information in the forms is mandated by the DRA, insurers will have flexibility with regard to the formatting of the forms subject to Department approval.

Proposed new §3.3871(a)(2)(B)(ix) requires that when an insurer is made aware that a policyholder has initiated an action that will result in the loss of partnership status, the insurer must advise the policyholder in writing of how to retain the partnership status if possible. Proposed new §3.3871(a)(2)(B)(x) requires that when a partnership plan loses partnership status, the insurer must explain in writing to the policyholders the reason for the loss of status. While proposed new §3.3871(a)(2)(B)(ix) and (x) are not required by SB 22 or the DRA, the Department is proposing these provisions pursuant to the Commissioner's rulemaking authority in the Insurance Code §1651.004 to provide important information to the insured to enable the insured to retain the partnership status of the policy if possible and to explain to the insured why there has been a loss of partnership status. The anticipated public benefit is that these provisions will help to protect the insured from inadvertently losing partnership status and will provide vital information to the insured concerning any loss of partnership status by the insurer. Because of the important benefits of a partnership long-term care policy, including the advantages of asset disregard and estate recovery benefits, it is in the insured's interest to be informed about any possible loss of the partnership status of the long-term care policy. With this information, the insured may have the opportunity to take steps to either prevent the loss of partnership status or to replace the policy that has lost partnership status with another partnership policy.

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with the proposed requirements in new 3.3871(a)(2)(A) and (B) will incur costs relating to: (i) the printing and distribution of the required

disclosure notice Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates specified in §3.3871(a)(2)(B)(vii); (ii) the printing and distribution of the written explanation required to be sent to the insured when an insurer becomes aware that an insured has initiated action that will result in the loss of partnership status and a written explanation of how such action impacts the insured in writing; and (iii) the printing and distribution of an explanation advising the insured on how to retain partnership status if possible. The Department anticipates that the required disclosure notice Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates will be approximately one and one-half pages in length if printed in the minimum permissible 12-point type; that the written explanations concerning loss of partnership status and how such action impacts the insured in writing will be approximately one to one and one-half pages in length; and the explanation on how to retain partnership status will be approximately one page in length. Based on the Department's experience, a printed page costs approximately $0.05 per page. Therefore, it is anticipated that insurers that print the required disclosure notice Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates will incur approximately $0.10 per notice. It is anticipated that insurers that print the written explanations concerning loss of partnership status and how such action impacts the insured will incur approximately $0.10 per notice. And insurers that print the explanation on how to retain partnership status will incur approximately $0.05 per notice. Mailing costs for each of the required notices will be approximately $0.42 per notice. The Department anticipates that total estimated costs

will depend on several factors, including how many notices are required to be sent, the type of office equipment that is used (including computers, printers, and copiers), the size of the insurer, and salaries of personnel required to prepare the notices.

Proposed new §3.3871(b) specifies new reporting requirements for insurers that issue partnership policies. In accordance with §1917(b)(1)(C)(iii)(VI) and (v) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(VI) and (v)), all issuers of partnership policies or certificates must provide regular reports to the Secretary of the Department of Health and Human Services (Secretary) in accordance with regulations to be developed by the Secretary. As provided under proposed §3.3871(b)(1) – (3), such information shall include but not be limited to the following: (i) notification of when insurance benefits provided under a partnership policy have been paid and the amount of such benefits, (ii) notification regarding when such policies terminate, and (iii) any other information the Secretary determines is appropriate. Proposed new §3.3871(b) implements the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the DRA. Section 1917(b)(1)(C)(iii)(VI) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(VI)) includes the requirements that are proposed in §3.3871(b). The anticipated public benefit resulting from this proposed new §3.3871(b) will be Department rules that are consistent with the reporting requirements for insurers that issue long-term care partnership policies. The

information that insurers report to the Secretary of Health and Human Services will enable the Secretary to monitor the partnership program in Texas in accordance with the insurer reporting requirements established under the DRA.

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with proposed new §3.3871(b) will incur no additional cost as a result of the proposed new requirements. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed new requirements.

Proposed New §3.3872. Proposed new §3.3872, pertaining to Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates, specifies the inflation protection requirements for long-term care partnership policies and certificates. Under proposed §3.3872(1), a policy or certificate must provide, for a person who is less than 61 years of age as of the date of purchase, compound annual inflation protection from the date of purchase until the person attains age 61. An insurer is required under proposed §3.3872(1)(A) to offer to each applicant at the time of purchase the option to purchase compound annual inflation protection that automatically increases each year on a compounded basis at a rate of not less than 5.0 percent annually throughout the interval of coverage; the inflation protection is required to automatically increase benefits each year on a compounded basis. Proposed §3.3872(1)(B) specifies that if the applicant declines the offer of not less than 5.0 percent compound annual inflation protection, then the insurer must offer and the

applicant must purchase and retain compound annual inflation protection until the insured attains age 61 or goes on claim status, whichever comes first. The inflation protection is required to automatically increase benefits each year on a compounded basis at a rate that the insured elects which may be in a range of from one percent to four percent or tied to the Consumer Price Index for All Urban Consumers (CPI-U). Proposed new §3.3872(1)(C) specifies that a person who is less than 61 years of age who has purchased a long-term care partnership policy or certificate with the required compound inflation protection may upon attaining 61 years of age choose to amend the compound inflation protection provision in the policy or certificate in accordance with the requirements specified in §3.3872(2). Proposed new §3.3872(2) specifies that for a person who is between 61 and 76 years old, the policy must provide some acceptable level of inflation protection until the person attains 76 years of age. Proposed subparagraph (2)(A) specifies that regardless of the insured's health status the insurer must offer inflation protection and the insured must accept and retain inflation protection until the insured attains age 76 or goes on claim status. Proposed §3.3872(2)(A) – (D) specify that acceptable inflation protection includes: (i) regardless of the insured's health status, the insurer must offer and the insured must purchase and retain inflation protection until the insured attains age 76 or goes on claim status, whichever comes first; (ii) automatic annual inflation protection, either simple or compound, paid with either level or stepped premium; (iii) the Inflation protection may be in a range of from one percent to five percent or tied to the Consumer Price Index for All Urban Consumers (CPI-U); and (iv) a person who is less than 76 years of age who has

purchased a long-term care partnership policy or certificate with the required inflation protection may upon attaining 76 years of age choose to amend the inflation protection provision in the policy or certificate in accordance with the requirements specified in §3.3872(3). Proposed new §3.3872(3) specifies that for a person who is 76 years old, inflation protection may be provided but is not required. Proposed new §3.3872(4) specifies that an option to purchase inflation protection in the future does not constitute compliance with the requirements in §3.3872(1) and (2). Proposed new §3.3872 implements the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. The DRA in §1917(b)(1)(C)(iii)(IV) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)) includes the requirements that are proposed in §3.3872. The anticipated public benefit resulting from these inflation protection requirements will be that policyholders will be provided protection from escalating long-term care cost by increasing policy benefits each year in accordance with a fixed percentage or in accordance with the flexible measure of inflation (CPI-U).

Proposed new §3.3872 implements the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the DRA. Pursuant to §1917(b)(1)(C)(iii)(IV) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C.

§1396p(b)(1)(C)(iii)(IV)), the partnership policy must meet the general requirements of this section in the DRA. Proposed §3.3872 is consistent with §1917(b)(1)(C)(iii)(IV) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)).

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with proposed new §3.3872 will incur no additional cost as a result of the proposed inflation protection requirements. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed new section.

Proposed New §3.3873. Proposed new §3.3873(a), pertaining to Filing Requirements for Long-Term Care Partnership Policies, specifies the prior approval requirements that apply to any partnership policy, certificate, or endorsement that is to be delivered or issued for delivery in this state. Under proposed §3.3873(a)(1), each such partnership policy, certificate, or endorsement must be filed with the Department and approved in accordance the procedures in Chapter 3, Subchapter A of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings). Proposed new §3.3873(a)(2) requires that each partnership policy, certificate, or endorsement filing must include the Long-Term Care Partnership Program Insurer Certification Form specified in §3.3873(a)(2)(F). Proposed new §3.3873(a)(2)(A) – (F) specify the requirements and procedures that apply to the Insurer Certification Form, including text content and font size, order of information presented,

format requirements, and filing and approval requirements if applicable. The proposed certification form specifies the elements of information that are required to be provided to the Department by each insurer for each partnership policy, certificate, or endorsement that is filed by the insurer for approval by the Commissioner for use under the Qualified Partnership Program. Pursuant to §1917(b)(5)(B)(iii) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. 1396p(b)(5)(B)(iii)), the Commissioner of Insurance, when implementing a qualified state long-term care insurance partnership program, is authorized to certify that long-term care insurance policies (including certificates issued under a group insurance contract) covered under the Qualified Partnership meet certain consumer protection requirements, and policies so certified are deemed to satisfy such requirements. These consumer protection requirements are set forth in section 1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. 1396p(b)(5)(A)) and principally include certain specific provisions of the 2000 NAIC Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act. The certification form to be filed by the insurer requests information relating to: (i) in Section I, general information relating to the insurer's name and address, a contact person for information relating to the filing, the policy form number(s) or other identifying information; for a policy form not previously approved, copies of the policy forms including any riders or endorsements must be included; and for a policy form previously approved, only identifying policy information must be included; (ii) in Section II, the insurer's response regarding whether the specified requirements of the Model

Regulations and Model Act are met with respect to all policies and certificates that are intended to be included under the Qualified Partnership Program; and (iii) in Section III, the insurer's certification to the Commissioner that all of the attached or identified policy forms, riders and endorsements meet all of the requirements of the Model Regulations and Model Act that are specified in the Federal Deficit Reduction Act of 2005 and that all of the answers, accompanying information, and other information contained in the certification form are true, correct and complete.

Proposed new §3.3873(b) sets forth the requirements and procedures for the filing of a policy, certificate, or endorsement that has not been previously approved by the Commissioner. Prior to offering the policy for sale in Texas as a partnership policy, the policy, certificate, or endorsement must comply with the proposed requirements in §3.3873(b)(1) – (4), including: (i) the policy, certificate, or endorsement must be filed with the Department and approved by the Commissioner, and Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form must be submitted for each policy, certificate, or endorsement form submitted for partnership approval; (ii) the policy, certificate, or endorsement form must be in at least 10-point type; (iii) the policy form filing must be filed at least 60 days prior to use and is subject to the requirements and procedures in Chapter 3, Subchapter A of this title (relating to Submission Requirements For Filings and Departmental Actions Related to Such Filings); and (iv) and any policy form filing should be filed with the Filings Intake Division of the Texas Department of Insurance.

Proposed new §3.3873(c) specifies the requirements and procedures for insurers requesting to use a previously approved non-partnership long-term policy as a long-term care partnership policy. Prior to offering the policy for sale in Texas as a partnership policy, the policy, certificate, or endorsement must comply with the proposed requirements in §3.3873(c)(1) – (6), including: (i) the insurer must file Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form and a copy of any endorsement that is needed to comply with the partnership policy requirements; (ii) the policy form numbers or other identifying information must be included on Form Number LHL570(LTC); (iii) the filing must be approved by the Commissioner prior to the use of the form as a partnership policy; (iv) a previously approved policy or certificate does not have to be included in the filing; (v) the filing made must be made at least 60 days prior to use and is subject to the procedures in Chapter 3, Subchapter A of this title (relating to Submission Requirements For Filings and Departmental Actions Related to Such Filings); and (vi) the filing should be submitted to the Filings Intake Division of the Texas Department of Insurance.

The anticipated public benefit resulting from these proposed requirements will be to provide efficient, well defined procedures for insurers to file their partnership policies for approval with the Department. Additionally, the proposed section provides an efficient certification procedure for insurers to certify to the Commissioner that their policies meet all of the consumer protection requirements specified in the DRA. This will ensure that Texas consumers are offered and provided the opportunity to purchase only those long-term care partnership policies that have been approved by the

Commissioner as meeting all of the consumer protection requirements specified in the DRA.

Proposed new §3.3873 implements the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. The DRA in §1917(b)(5)(B)(iii) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. 1396p(b)(5)(B)(iii)) authorizes the Insurance Commissioner of a state implementing a qualified state long-term care insurance partnership ("Qualified Partnership") to certify to the state Medicaid agency that long-term care insurance policies (including certificates issued under a group insurance contract) covered under the Qualified Partnership meet certain consumer protection requirements, and policies so certified are deemed to satisfy such requirements. Proposed §3.3873, including the information to be provided in the proposed Long-Term Care Partnership Program Insurer Certification Form, are necessary to provide the Commissioner of Insurance with the information necessary to provide a certification for the policies.

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with proposed new §3.3873 will incur no additional cost as a result of the proposed new section. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed new section.

Proposed New §3.3874. Proposed new §3.3874, pertaining to Insurer Requirements for Agents That Market Partnership Policies and Certificates, specifies insurer requirements for reporting information to the Department on agents that market long-term care partnership plans. Proposed new §3.3874(a)(1) - (3) specify training verification and certification requirements for insurers with agents who market partnership plans. These proposed requirements are: (i) obtaining of verification that an agent has received the training specified in §19.1022 of this title (relating to Long-Term Care Partnership Certification Course); (ii) insurer certification to the Commissioner that each agent who sells partnership policies or certificates on behalf of the insurer complies with the training requirements of this subsection; and (iii) insurer's maintenance of verification records for at least four years; records are subject to review by the Department or its designee at any time. The initial certification (for the period from the effective date of the rules to January 31, 2009) must be submitted on the Initial Long-Term Care Partnership Agent Training Certification Form specified in §3.3874(b)(6)(A). Any subsequent certification must be submitted on the Annual Long-Term Care Partnership Agent Training Certification Form specified in §3.3874(b)(6)(B).

Proposed new §3.3874(b) specifies the requirements and procedures that apply to the proposed Initial Training Certification Form and the Annual Training Certification Form, including text content, text font size, recommended format, and filing and approval requirements and procedures as applicable.

Proposed new §3.3874(c)(1) – (3) specifies the filing requirements for the agent training certification by each insurer. An insurer offering partnership policies or

certificates must submit: (i) the Initial Long-Term Care Partnership Agent Training Certification Form for the initial certification, and (ii) the Annual Long-Term Care Partnership Agent Training Certification Form for each subsequent annual certification. The Initial Training Certification Form is to be used for certification by the insurer for the initial certification period (from the effective date of the rules to January 31, 2009). This form will be used by the insurer to certify that each individual who is currently selling partnership policies has completed training and demonstrated evidence of understanding long-term care partnership policies. There will be a grace period from the effective date of the rules to January 31, 2009, during which agents who have a license to sell accident and health insurance but may not have completed the specialized partnership training will be eligible to sell partnership policies. Insurers will file the Annual Training Certification annually with the Department beginning in January 2010 to certify that each individual who currently sells partnership policies for the insurer has completed the required training before the agent sells or solicits the insurer's partnership products.

The anticipated public benefit resulting from these proposed reporting requirements will be that insurers will have to certify to the Department that all agents who are marketing long-term care partnership policies have adequate training and understanding of these policies and how they relate to other public and private coverage of long-term care so that the agents are better able to adequately explain the coverage to applicants. This, in turn, should result in more consumers in Texas being aware of the information that is necessary to assist them in determining whether to purchase

long-term care insurance. Proposed new §3.3874 implements the provision of SB 22, codified as Insurance Code §§1651.104 and 1651.105. Section 1651.104 requires a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the DRA. Section 1651.105 requires that each long-term care benefit plan issuer that offers a plan under the partnership for long-term care program shall certify to the Commissioner, in the form required by the Commissioner that each individual who sells on behalf of the issuer has complied with the training requirements of §1651.105(a). The DRA in §1917(b)(1)(C)(iii)(V) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(V)) and §1651.105 of the Insurance Code include the requirements that are proposed in §3.3874.

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with proposed new §3.3874 will incur no additional cost as a result of the new requirements. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed new section.

4. ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES.

Insurers That Opt to Write Partnership Long-Term Care Policies. As required by the Government Code §2006.002(c), the Department has determined that there are no insurers currently writing long-term care insurance in Texas and that could opt to write

partnership long-term policies that qualify as small or micro businesses under the Government Code §2006.001. Additionally, the Department has determined that long-term care insurance is a capital intensive line of insurance and the Department does not anticipate that small or micro insurers will enter this market. However, as required by the Government Code §2006.002(c), the Department has determined that the proposed requirements will not have an adverse economic impact on these small or micro businesses that opt to write partnership policies. The Department has made this determination based on the following factors.

No insurer is required by law to write long-term care partnership insurance. The proposed rules, however, provide insurers an economic opportunity to engage in the long-term care partnership insurance market in Texas. The Department's analysis of any possible costs for compliance with the requirements for insurers writing partnership policies are detailed in the Public Benefit/Cost Note section of this proposal and apply to insurers that opt to utilize this opportunity.

As indicated in the Public Benefit/Cost Note analysis, those insurers that opt to write long-term care partnership policies pursuant to the Insurance Code Chapter 1651 Subchapter C and are therefore required to comply with the following proposed amendments and new sections will incur no additional costs as a result of the amendments and new sections because the amendments and new sections are the result of the legislative enactment of SB 22, and/or the federal Deficit Reduction Act of 2005 (DRA) (Pub. L. No. 109-171), and not from the adoption, enforcement, or administration of proposed §3.3826(a) and (b) relating to limitations and exclusions;

3.3829(b)(2), (b)(8), and (b)(9) relating to required disclosures; §3.3830(h) relating to requirements for application forms and replacement coverage; §3.3837(a) - (g) relating to reporting requirements; §3.3838(1) relating to filing requirements for advertising; §3.3839(a)(8) – (11) relating to standards for marketing; §3.3842(b) – (j) relating to appropriateness of recommended purchase (suitability standards); §3.3844(e), (e)(3), (g)(2), and (g)(4) relating to relating to nonforfeiture and contingent benefits; new §3.3848(a) - (b) relating to requirements for limited premium payment options in long-term care policies, certificates, and riders; new §3.3849(a) - (e) relating to requirements for insurers that issue long-term care policies to associations and marketing standards for association that market the policies; new §3.3870(a) – (e) relating to exchange requirements for long-term care partnership policies; new 3.3871(a) – (b) relating to standards and reporting requirements for approved long-term care partnership policies; new 3.3872 relating to inflation protection requirements for long term care partnership policies and certificates; new 3.3873(a) - (c) relating to filing requirements for long term care partnership policies; and new 3.3874(a) – (c) relating to insurer requirements for agents that market long term care partnership policies and certificates.

In accordance with the Government Code §2006.002(c), the Department has therefore determined that a regulatory flexibility analysis is not required because the proposal will not have an adverse impact on these small or micro businesses.

Insurers Currently Writing Non-Partnership Long-Term Care Policies or That Opt to Write Non-Partnership Long-Term Care Policies in the Future.

As required by the Government Code §2006.002(c), the Department has determined that there are no insurers currently writing long-term care non-partnership insurance in Texas that qualify as small or micro businesses under the Government Code §2006.001. No insurer is required by law to write long-term care non-partnership insurance. The proposed rules, however, provide insurers an economic opportunity to engage in the long-term care non-partnership insurance market in Texas. As required by the Government Code §2006.002(c), the Department has determined that the proposal may have an adverse economic effect on those small or micro businesses that opt to utilize such an opportunity. Adverse economic impact may result from costs relating to personnel, computer reprogramming, agent training, and printing and distribution costs that are associated with the insurer's compliance with the new consumer protection requirements for non-partnership policies. The Department's cost analysis and resulting estimated costs in the Public Benefit/Cost Note portion of this proposal is equally applicable to these small or micro businesses. The Public Benefit/Cost Note portion of this proposal indicates in a section by section analysis the amount of potential new costs that may be associated with the insurer's compliance with the new consumer protection requirements for non-partnership policies. The actual costs incurred will vary based on several factors that pertain to each individual insurer, including the size of the insurer; type of office equipment, including printers and computers; employee salaries; and the number of forms that are needed.

In accordance with the Government Code §2006.002(c-1), the Department has determined that even though proposed §3.3826(a) and (b) relating to limitations and

exclusions; 3.3829(b)(2), (b)(8), and (b)(9) relating to required disclosures; §3.3830(h) relating to requirements for application forms and replacement coverage; §3.3837(a) - (g) relating to reporting requirements; §3.3838(1) relating to filing requirements for advertising; §3.3839(a)(8) – (11) relating to standards for marketing; §3.3842(b) – (j) relating to appropriateness of recommended purchase (suitability standards); §3.3844(e), (e)(3), (g)(2), and (g)(4) relating to relating to nonforfeiture and contingent benefits; and proposed new §3.3848(a) - (b) relating to requirements for limited premium payment options in long-term care policies, certificates, and riders; new §3.3849(a) - (e) relating to requirements for insurers that issue long-term care policies to associations and marketing standards for association that market the policies; and new §3.3860 relating to policy summary requirements for life insurance policies that provide long-term care benefits may have an adverse economic effect on small or micro-businesses that are required to comply with these proposed requirements, the Department is not required to prepare a regulatory flexibility analysis as required in §2006.002(c)(2) of the Government Code. Section 2006.002(c)(2) requires a state agency, before adopting a rule that may have an adverse economic effect on small businesses, to prepare a regulatory flexibility analysis that includes the agency's consideration of alternative methods of achieving the purpose of the proposed rule. Section 2006.002(c-1) of the Government Code requires that the regulatory flexibility analysis "consider, if consistent with the health, safety, and environmental and economic welfare of the state, using regulatory methods that will accomplish the objectives of applicable rules while minimizing adverse impacts on small businesses."

Therefore, an agency is not required to consider alternatives that, while possibly minimizing adverse impacts on small and micro-businesses, would not be protective of the health, safety, and environmental and economic welfare of the state.

The Legislature in SB 22, codified as §1651.104 directs the Commissioner to "adopt minimum standards for a long-term care benefit plan that may qualify as an approved plan under the partnership for long-term care program. The standards must be consistent with provisions governing the expansion of a state long-tern care partnership program established under the federal Deficit Reduction Act of 2005 (Pub. L. No. 109-171)." The minimum standards for the partnership program are the new consumer protection requirements that are also being applied to non-partnership policies.

The proposal applies the minimum standards of the partnership program, which are the new consumer protection requirements contained in the proposal, to non-partnership long-term care policies. The new consumer protection requirements that are being applied to non-partnership policies are contained in the amended and new sections as follows: §3.3826(a) and (b); 3.3829(b)(2), (b)(8), and (b)(9); §3.3830(h); §3.3837(a) - (g); §3.3838(1); §3.3839(a)(8) – (11); §3.3842(b) – (j); §3.3844(e), (e)(3), (g)(2), and (g)(4); new §3.3848(a) - (b); new §3.3849(a) - (e); and new §3.3860. The Department has determined that individuals being solicited for non-partnership policies should receive the same consumer protections as individuals being solicited for partnership policies.

Some of the most important new consumer protection requirements that are being applied to non-partnership policies are those that relate to an applicant's suitability to purchase long-term care insurance. These new suitability requirements form a comprehensive regulatory scheme for determining an applicant's suitability to purchase long-term care insurance. Each issuer must develop and use suitability standards to determine whether the purchase or replacement of long-term care is appropriate to the needs of the applicant and train its agents in the use of the issuer's suitability standards. The new consumer protection provisions require the issuer to develop suitability procedures to determine whether the applicant meets the issuer's suitability standards. These procedures must consider the following factors: the applicant's ability to pay for the proposed coverage and other pertinent financial information; the applicant's goals and needs with respect to long-term care; and the values, benefits, and costs of the applicant's existing insurance as compared to the values, benefits, and costs of the recommended purchase or replacement. Additionally, the new consumer protection provisions require the issuer to make reasonable efforts to obtain the information specified in a new form titled the Long-Term Care Personal Worksheet. The Long-Term Care Personal Worksheet requires the issuer to obtain detailed information from any individual who is considering the purchase of a long-term care policy. Such information includes the applicant's current insurance and premium payments, the applicant's income and net worth, the issuer's rate history, and also a disclosure of the issuer's right to increase premiums. The public benefit resulting from the use of this new form is that the additional information obtained from the applicant on

the Personal Worksheet will assist the issuer and the applicant to make an informed decision on whether it is prudent for the applicant to purchase the long-term care policy given the financial circumstances of the applicant. This will ensure that those consumers who do not need or cannot afford such a policy will be less likely to purchase one. The public benefit resulting from the proposed new consumer protection requirements will be more purchasers of long-term care insurance who are financially and otherwise suitable to make such a purchase. The new requirements require issuers to use objective measures to evaluate an applicant's suitability to purchase long-term care insurance by collecting detailed information regarding the applicant's assets, current insurance in-force, and the applicant's probable future insurance needs. This information is to be carefully evaluated by the issuer in light of the issuer's established suitability standards to ensure that each individual who purchases long-term care insurance is financially suitable to make such a purchase and that the product purchased is suitable to the individual's needs and goals.

Additionally, the new suitability provisions require issuers to provide to the applicant at the same time the Personal Worksheet is provided the proposed new disclosure form titled Things You Should Know Before You Buy Qualified Long-Term Care Insurance. This form provides important information to the consumer concerning the general functions of a long-term care insurance policy, Medicare and Medicaid as those programs relate to long-term care insurance, the availability of a Shopper's Guide for Long-Term Care, the availability of a senior health insurance counseling program, and general information concerning long-term care facilities. This disclosure form is

intended to help the applicant decide whether it is prudent to purchase a long-term care policy.

The new consumer protection provisions relating to suitability further address actions to be taken if the issuer determines that the applicant does not meet its financial suitability standards or if the applicant has declined to provide the requested information. If either of these events occur, the issuer may either reject the application or, if the issuer does not opt to reject the application, the issuer is required to send the applicant a letter in accordance with the proposed new Long-Term Care Insurance Suitability Letter. However, only in the event that the applicant has declined to provide the requested financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned Suitability Letter containing the applicant's response or a record of the alternative method of verification must be made a part of the applicant's file. The letter will inform an applicant that the issuer has reviewed the financial information provided by the applicant on the Personal Worksheet and has determined that the applicant is not financially suitable to purchase long-term care insurance and that review of the application has been suspended or that the applicant has not provided any or has provided insufficient financial information for the issuer to make a determination as to the applicant's suitability to purchase a long-term care policy and that review of the application has been suspended. The public benefit resulting from the use of the Suitability Letter is that applicants will receive important information concerning the status of their application. This information will indicate either that the issuer has determined that the applicant is not financially suitable to

purchase long-term care insurance or that the financial information provided by the applicant is not sufficient for the issuer to make a determination regarding the applicant's suitability to purchase a long-term care policy and that review of the application has been suspended. The Suitability Letter will further inform the applicant that the applicant may choose to continue the application process despite the determination that long-term care may not be a suitable purchase. This information is important because it alerts a consumer to the fact that their application for a long-term care policy is no longer being processed unless the consumer chooses to proceed with the purchase.

The new consumer protection provisions require the dissemination of a new form titled The Long-Term Care Insurance Potential Rate Increase Disclosure Form to the applicant at the time of application or enrollment. The Long-Term Care Insurance Potential Rate Increase Disclosure Form provides detailed information to the applicant concerning the potential for a rate increase prior to the applicant purchasing a long-term care policy. The Long-Term Care Potential Rate Increase Disclosure Form requires the insurer to provide detailed information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policy options in the event of a rate increase. The public benefit resulting from the use of this new form is that the information provided to the applicant regarding potential rate increases on the Potential Rate Disclosure Form will assist the applicant in making an informed decision on whether it is prudent for the applicant to purchase the long-term care policy given the

financial circumstances of the applicant. This will ensure that those consumers who do not need or cannot afford such a policy will be less likely to purchase one.

The foregoing discussion of the suitability consumer protection provisions is not exhaustive of the new consumer protection requirements but it is clearly representative of the type and complexity of the regulatory scheme being proposed in these rules. The new consumer protection suitability requirements are protective of the health, safety, and economic welfare of the state because applying such standards will protect the members of this vulnerable group of consumers from purchasing long-term care insurance if they are not financially suitable to purchase such products. There are no alternative methods of achieving the consumer protection purposes of this rule due to the very complex and comprehensive nature of this regulatory scheme.

There is no regulatory or public interest reason to exempt individuals being solicited for non-partnership policies from these consumer protection requirements. In fact, there are significant regulatory and public interest reasons for providing all individuals being solicited for long-term care coverage the same consumer protections. Providing the same consumer protections to all individuals being solicited for long-term care means that that all consumers who are being solicited for long-term care insurance in Texas will be uniformly protected from unscrupulous or dishonest marketing practices that can cause economic harm to the consumers. The application of these new consumer protection requirements to non-partnership insurance solicitations is a vital part of the regulatory system that is designed to protect consumer economic interests and the state's welfare. These requirements collectively ensure that consumers who

are being solicited for non-partnership long-term care insurance are also being afforded the entire panoply of consumer protections that are available to partnership solicitations.

Therefore, the Department has determined, in accordance with §2006.002(c-1) of the Government Code, that because the purpose of proposed §3.3826(a) and (b); 3.3829(b)(2), (b)(8), and (b)(9); §3.3830(h); §3.3837(a) - (g); §3.3838(1); §3.3839(a)(8) – (11); §3.3842(b) – (j); §3.3844(e), (e)(3), (g)(2), and (g)(4); new §3.3848(a) - (b); new §3.3849(a) - (e); and new §3.3860 is to protect consumer economic interests and the state's welfare, there are no additional regulatory alternatives to the required comprehensive consumer protection requirements that will sufficiently protect the economic interests of consumers and the welfare of the state.

5. TAKINGS IMPACT ASSESSMENT. The Department has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking or require a takings impact assessment under the Government Code §2007.043.

6. REQUEST FOR PUBLIC COMMENT. To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on August 18, 2008, to Gene C. Jarmon, General Counsel and Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comment must be simultaneously submitted to Ana Smith-Daley, Deputy Commissioner

of the Life and Health Division, Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

The Commissioner will consider the adoption of amendments to §§3.3801 - 3.3804, 3.3821, 3.3826, 3.3829, 3.3830, 3.3833, 3.3834, 3.3837 - 3.3839, 3.3842, 3.3844 - 3.3846 and new 3.3848, 3.3849, 3.3860. and 3.3870-3.3874 in a public hearing under Docket Number 2689, scheduled for 9:30 a.m. on August 12, 2008, in Room 100 of the William P. Hobby, Jr. State Office Building, 333 Guadalupe Street, Austin, Texas. Written and oral comments presented at the hearing will be considered.

7. STATUTORY AUTHORITY. The amendments are proposed pursuant to the Insurance Code §1651.004, §§1651.101 - 1651.107, and §36.001 and §1917(b) of the Social Security Act (SSA) as amended by §6021 of the Deficit Reduction Act of 2005 (DRA) (pertaining to Expansion of State Long-Term Care Partnership Program) (42 U.S.C. §1396p(b)). Section 1651.004 provides that the Department may adopt reasonable rules that are necessary and proper to carry out Chapter 1651 concerning long-term care benefit plans. SB 22 enacted by the 80th Legislature, Regular Session, effective March 1, 2008, amended Chapter 1651 to add new Subchapter C concerning the Partnership for Long-Term Care Program. Section 1651.101 specifies the definitions that are specific to the Texas partnership program. Section 1651.102

specifies the applicability of Subchapters A (General Provisions) and B (Benefit Plan Standards), which were in effect prior to the enactment of SB 22, to the partnership policies issued in accordance with new Subchapter C. Section 1651.103 requires that the Department assist the Health and Human Services Commission as necessary for the Commission to perform its statutorily specified partnership program duties and functions, as provided in Chapter 32 Subchapter C. of the Human Resources Code. Section 1651.104 requires the Department to adopt, in consultation with the Texas Health and Human Services Commission, minimum standards for a long-term care benefit plan that qualifies as an approved plan under the partnership program and further requires that the standards be consistent with the provisions of the federal DRA. Section 1651.105 requires that each individual who sells a partnership policy must complete training and demonstrate an understanding of how partnership policies relate to other public and private coverage of long-term care and requires each insurer that offers partnership policies to certify to the Commissioner that its agents who sell partnership policies comply with the required training requirements. Section 1651.106 provides that, if the partnership program is discontinued, an individual who has purchased a partnership policy remains eligible to receive the benefits under the partnership policy. Section 1651.107 authorizes the Commissioner to adopt rules as necessary to implement Subchapter C. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The federal enabling legislation regulating qualified partnerships was enacted in the DRA of 2005; it was signed into law on February 8, 2006. Section 6021(a)(1)(A) of the DRA, expands State Long-Term Care Partnership Programs, which encourage individuals to purchase long-term care insurance. State partnership programs are intended to promote consumers' purchase of long-term care insurance from private insurers by providing consumers access to Medicaid under special eligibility rules in the event that an individual consumer should ever need Medicaid long-term care coverage that is in addition to that provided by the purchased partnership coverage. The DRA amends §1917(b)(1)(C) of the Social Security Act by adding new clause (iii) to permit states to exempt long-term care benefits from estate recovery, if the state has a state plan amendment filed with and approved by the Department of Health and Human Services Center for Medicaid and Medicare Services that provides for a qualified state long-term care insurance partnership. Additionally, §6021(a)(1)(A) of the DRA enacts several new provisions codified at §1917(b)(1)(C) of the Social Security Act that specify the requirements for partnership policies, including: (i) §1917(b)(1)(C)(iii)(II) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(II)) specifies that the policy must be a qualified long-term care insurance contract as defined in §7702B(b) of the Internal Revenue Code, (ii) §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)) specifies that the policy must meet the consumer protection requirements in §1917(b)(5)(A) of the Social Security Act

(SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)) which include meeting the requirements of specific portions of the National Association of Insurance Commissioners' Long-Term Care Insurance Model Regulations and Model Act, (iii) §1917(b)(1)(C)(iii)(I) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(I)) specifies that the policy must be issued not earlier than the effective date of the Qualified Partnership, (iv) §1917(b)(1)(C)(iii)(IV) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)) specifies that the policy must include inflation protection in accordance with the DRA, and (v) §1917(b)(1)(C)(iii)(I) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(I)) specifies that the policy must cover an insured who is a resident of the state when the coverage first became effective.

8. CROSS REFERENCE TO STATUTE. The following statutes are affected by this proposal:

Rule	Statute
§§3.3801 - 3.3804	Insurance Code §1651.004
§3.3821	Insurance Code §1651.004
§3.3826	Insurance Code §1651.104

§§3.3829 and 3.3830	Insurance Code §§1651.004 and 1651.104
§3.3833	Insurance Code §1651.004
§3.3834	Insurance Code §1651.004
§§3.3837, 3.3838, and 3.3839	Insurance Code §§1651.004 and 1651.104
§3.3842	Insurance Code §1651.104
§3.3844	Insurance Code §1651.104
§3.3845	Insurance Code §1651.004
§3.3846	Insurance Code §1651.004
§3.3848	Insurance Code §1651.004
§3.3849	Insurance Code §1651.004 and 1651.104
§3.3860	Insurance Code §1651.004
§3.3870	Insurance Code §§1651.004
§3.3871	Insurance Code §§1651.004 and 1651.104
§3.3872	Insurance Code § 1651.104
§3.3873	Insurance Code §1651.104
§3.3874	Insurance Code §§1651.004 and 1651.104

9. TEXT.

DIVISION 1. GENERAL PROVISIONS

§3.3801. Authority. This subchapter of rules [~~and regulations~~] of the Texas Department of Insurance is promulgated and adopted pursuant to the authority vested

in the commissioner under the Insurance Code Chapter 1651 and §36.001 [~~, Article 1.03A and Article 3.70-12~~].

§3.3802. Purpose. The purpose of this subchapter is to implement the Insurance Code Chapter 1651:[~~, Article 3.70-12,~~]

(1) to promote the public interest;[~~,~~]

(2) to promote the availability of long-term care insurance coverage;[~~,~~]

(3) to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices;[~~,~~]

(4) to facilitate public understanding and comparison of long-term care insurance coverages;[~~,~~]

(5) to facilitate flexibility and innovation in the development of long-term care insurance;[~~, and~~]

(6) to allow the sale of long-term care insurance contracts which will qualify insureds, under certain conditions, for favorable tax treatment under federal law; and

(7) to adopt, in consultation with the Texas Health and Human Services Commission, minimum standards for a long-term care benefit plan that may qualify as an approved plan under the long-term care partnership program.

§3.3803. Applicability and Severability [~~Scope~~].

(a) Applicability.

(1) In accordance with the Insurance Code Chapter 1651, §§3.3801 - 3.3804 of this subchapter (relating to General Provisions) apply to all long-term care insurance coverage that is regulated under this subchapter.

(2) In accordance with the Insurance Code Chapter 1651 [~~Article 3.70-12~~], §§3.3805 - 3.3849 of this subchapter (relating to Non-partnership and Partnership Long-Term Care Insurance) apply [~~applies~~] to all non-partnership and partnership long-term care benefit plans [~~insurance policies~~] as that term is defined in the Insurance Code §1651.003 and §3.3804 of this subchapter (relating to Definitions) [~~§2(4) of the article~~], and long-term care riders attached to life insurance policies or certificates or annuity contracts or certificates delivered or issued for delivery in this state except as specified in paragraph (5) of this subsection.[~~:~~]

(3) In accordance with the Insurance Code Chapter 1651 Subchapter C (relating to Partnership for Long-Term Care Program), §3.3860 of this subchapter (relating to Policy Summary Requirements for Non-partnership Life Insurance Policies and Annuity Contracts that Provide Long-Term Care Benefits) applies only to non-partnership life insurance policies that provide long-term care benefits by rider except as specified in paragraph (5) of this subsection.

(4) In accordance with the Insurance Code Chapter 1651 Subchapter C, §§3.3870 - 3.3874 of this subchapter (relating to Partnership Long-Term Care Insurance Only) apply only to long-term care partnership benefit plans as that term is defined in

the Insurance Code §1651.101 and §1651.104 delivered or issued for delivery in this state except as specified in paragraph (5) of this subsection.

(5) In accordance with the Insurance Code §1651.002, this subchapter does not apply to:

(A) [~~(1)~~] certificates delivered or issued for delivery in this state under a single employer or labor union group policy that is delivered or issued for delivery outside this state; or

(B) [~~(2)~~] a policy or certificate that [~~which~~] is not designed, advertised, marketed, or offered as long-term care or nursing home insurance.

(b) Severability. If any provision of the sections in this subchapter or its application to any person or circumstance is held to be invalid, such invalidity shall not affect other provisions or applications which can be given effect without the invalid provisions, and to this end, the provisions of each section are declared to be severable.

§3.3804. Definitions.

(a) (No change.)

(b) The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) – (13) (No change.)

(14) Group long-term care insurance--A long-term care insurance policy or certificate of group long-term care insurance that [~~which~~] is delivered or issued for delivery in this state[~~,~~] and issued to an eligible group as defined by the Insurance Code

Chapter 1251 Subchapter B (relating to Group Accident Health Insurance: Eligible Policyholders) but subject to the exemptions in the Insurance Code §1651.002 (relating to Exemptions) [~~Article 3.51-6, §1(a)~~], or a long-term care rider issued to an eligible group as defined by the Insurance Code §1131.002 (relating to Certain Group Life Insurance Authorized) [~~Article 3.50 §1~~].

(15) – (18) (No change.)

(19) Long-term care benefit plan--An insurance policy or group certificate, or rider to the policy or certificate, or evidence of coverage issued by a health maintenance organization subject to the Texas Health Maintenance Organization Act (Insurance Code Chapter 843) that is advertised or marketed as providing, or offered or designed to provide, coverage for not less than 12 consecutive months for each covered individual on an expense-incurred, indemnity, prepaid, or other basis 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. The term includes a plan or rider, other than a group or individual annuity or life insurance policy, that provides for payment of benefits based on cognitive impairment or for the loss of functional capacity. The term does not include an insurance policy, group certificate, or evidence of coverage that is offered primarily to provide Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident-only

coverage, specified disease or specified accident coverage, or limited benefit health coverage or basic or single health care services.

(20)[~~(19)~~] Long-term care insurance [~~contract~~]--Any insurance policy, group certificate, rider to such policy or certificate, or evidence of coverage that [~~issued by a health maintenance organization subject to the Texas Health Maintenance Organization Act (Texas Insurance Code, Chapter 20A)which~~] is advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, per diem or other basis[~~, and which provides insurance protection only~~] for one or more necessary or medically necessary services of the following types, administered in a setting other than an acute care unit of a hospital: diagnostic, preventive, therapeutic, curing, treating, mitigating, rehabilitative, maintenance, or personal care. The term includes riders for group and individual annuities and life insurance policies that provide long-term care insurance. The term also includes a policy, certificate, or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term shall also include qualified long-term care insurance contracts. Long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; and health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. The term "long-term care insurance [~~contract~~]" shall not include any insurance policy, group certificate, subscriber contract, or evidence of coverage that [~~which~~] is offered primarily to provide basic Medicare

supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or asset-related protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With regard to life insurance, this term does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision of this subchapter, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this subchapter. [~~The term includes a policy or rider, other than a group or individual annuity or life insurance policy that provides for payment of benefits based on the impairment of cognitive ability or the loss of functional capacity.~~]

(21) Long-term care partnership insurance contract--A long-term care insurance contract established under the Human Resources Code Chapter 32 Subchapter C and that meets the requirements of the Federal Deficit Reduction Act of 2005 (DRA), Pub. L. No. 109-171 and Chapter 1651 Subchapter C of the Insurance Code.

22 [~~(20)~~] Maintenance or Personal Care Services--Any care the primary purpose of which is the provision of needed assistance under §3.3818 of this

subchapter [~~title~~] (relating to Standards for Eligibility for Benefits), including the protection from threats to health and safety due to impairment of cognitive ability.

23 [~~(21)~~] Medicare--"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.

(24) [~~(22)~~] Mental or Nervous Disorder--A neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

(25) [~~(23)~~] Policy--Any policy, contract, subscriber agreement, rider, or endorsement, delivered or issued for delivery in this state by an insurer, fraternal benefit society, nonprofit group hospital service corporation, or health maintenance organization subject to the Texas Health Maintenance Organization Act ([~~Texas~~] Insurance Code[~~,~~] Chapter 843 [~~20A~~]).

(26) [~~(24)~~] Preexisting Condition--A condition for which medical advice was given or treatment was recommended by, or received from, a physician within six months before the effective date of coverage.

(27) [~~(25)~~] Qualified actuary--An actuary who is a member of either the Society of Actuaries or the American Academy of Actuaries.

(28) [~~(26)~~] Qualified long-term care insurance contract--A long-term care insurance contract meeting the requirements as contained in Internal Revenue Code of 1986, §7702B(b).

(29) [~~(27)~~] Qualified long-term care services--As the term is defined in Internal Revenue Code of 1986, §7702B(c).

(30) [~~(28)~~] Similar policy forms--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. Those certificates issued or delivered pursuant to one or more employers or labor union organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations, are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications.

(31) [~~(29)~~] Toileting--Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(32) [~~(30)~~] Transferring--Sufficient mobility to move into or out of a bed, chair or wheelchair or to move from place to place, either via walking, a wheelchair or other means.

DIVISION 2. NON-PARTNERSHIP AND PARTNERSHIP LONG-TERM CARE INSURANCE

§3.3821. Limits on Group Long-Term [~~term~~] Care Insurance. No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in the Insurance Code §1251.056 and §1131.064[~~, Article 3.51-6, §1(a)(6) and Article 3.50 §1(6)~~], unless the Texas Department of Insurance has made a determination that the group long-term care insurance requirements adopted by the State of Texas have been met, and the certificate for group long-term insurance coverage has been properly filed and approved by the department.

§3.3826. Limitations and Exclusions.

(a) No policy or certificate may be delivered or issued for delivery in this state as a long-term care insurance policy or certificate if such policy or certificate limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:

(1) - (3) (No change.)

(4) illness, treatment, or medical condition arising out of any of the following:

(A)-(D) (No change.)

(E) aviation activity as a nonfare-paying passenger; [~~or~~]

(5) treatment provided in a governmental facility (unless otherwise required by law); benefits provided 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 performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance; or [~~.~~]

(6) expenses for services or items available or paid under another long-term care insurance or health insurance policy.

(b) For purposes of this subsection, "state of policy issue" means the state in which the individual policy or certificate was originally issued. No long-term care insurer may deny a claim because services are provided in a state other than the state of policy issue under the following conditions:

(1) 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 in lieu of licensure, certification or registration; or

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

(c) [~~(b)~~] Provisions of this section are not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

§3.3829. Required Disclosures.

(a) Required Disclosure of Policy Provisions.

(1) - (5) (No change.)

(6) A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in the Insurance Code Chapter 1651[~~, Article 3.70-12,~~] or §3.3824 of this subchapter [~~title~~] (relating to Preexisting Conditions Provisions) shall set forth a description of such limitations or conditions in a separate paragraph of the policy or [~~and~~] certificate and shall label each paragraph "Limitations or Conditions on Eligibility for Benefits."

(7) – (12) (No change.)

(b) Required Disclosure [~~disclosure~~] of Rating Practices [~~rating practices~~].

(1) Other than non-cancellable policies or certificates, the required disclosures of rating practices[~~, as~~] set forth in paragraph (2) of this subsection[~~,~~] shall apply to any long-term care policy or certificate delivered or issued for delivery in this state on or after July 1, 2002, except for certificates issued under a group long-term care policy delivered or issued for delivery in this state and issued to one or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations that was in effect on January 1, 2002, in which case this subsection shall apply on the policy anniversary following January 1, 2003.

(2) Insurers shall provide the following information [~~in the same order~~] as set forth in this paragraph and Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet as specified in Figure: 28 TAC §3.3829(b)(8)(H) and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form as specified in Figure: 28 TAC §3.3829(b)(8)(I) to the applicant at the time of application or enrollment or, if the method of application does not allow for delivery at that time, the information shall be provided at the time of delivery of the policy or certificate:

(A) (No change.)

(B) an explanation of potential future premium rate revisions, including an explanation of contingent nonforfeiture benefit upon lapse, and the policyholder's or certificate holder's option in the event of a premium rate revision;

(C) (No change)

(D) a general explanation for applying premium rate or rate schedule adjustments that shall include:

(i) (No change.)

(ii) the right to a revised premium rate or rate schedule as provided in subparagraph (C) of this paragraph [~~subsection~~] if the premium rate or rate schedule is changed;

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

(i) the individual or group policy forms for which premium rates have been increased;

(ii)- (iii) (No change.)

(3) - (7) (No change.)

(8) An insurer shall use the text for Form Number LHL560(LTC) as specified in Figure: 28 TAC §3.3829(b)(8)(H) to comply with the requirements in subsection (b)(2)(A) and (E) of this section and Form Number LHL561(LTC) as specified in Figure: 28 TAC §3.3829(b)(8)(I) to comply with the requirements in subsection (b)(2)(B), (C), and (D) of this section. The following requirements and procedures apply to Form Number LHL560(LTC) and Form Number LHL561(LTC): [~~may use such form as the department prescribes to comply with the requirements of this section~~].

(A) The text in each form must be in at least 12-point type and must follow the order of the information presented in the form.

(B) The text and order of presentation of information in each form are mandated; the format for the forms is a recommended format. An insurer may format the mandated text in a different format from that specified in Figure: 28 TAC §3.3829(b)(8)(H) and Figure: 28 TAC §3.3829(b)(8)(I) if the insurer files the forms for review and approval by the commissioner as provided in subparagraphs (C) and (F) of this paragraph.

(C) Any form filed pursuant to subparagraph (B) of this paragraph must be filed no later than 60 days prior to use and is subject to the requirements and

procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(D) An insurer may add a company name and identifying form number to Form Number LHL560(LTC) and Form Number LHL561(LTC) as specified in Figure: 28 TAC §3.3829(b)(8)(H) and Figure: 28 TAC §3.3829(b)(8)(I) without obtaining commissioner approval.

(E) The *Instructions to Company* that are included in Figure: 28 TAC §3.3829(b)(8)(H) and Figure: 28 TAC §3.3829(b)(8)(I) are to aid the insurer in drafting the forms and should not be included in the text of the forms used by the insurer.

(F) The forms filed pursuant to subparagraph (B) of this paragraph should be filed with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104 or 333 Guadalupe, Austin, Texas, 78701

(G) Persons may obtain the required form by making a request to the Life/Health Division, Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9107 or 333 Guadalupe, Austin, Texas 78701, or by accessing the department's ~~[department]~~ website at www.tdi.state.tx.us. ~~[Insurers who elect not to use the prescribed form shall file the disclosure form with the Life/Health Division of the department for review 60 days prior to use.]~~

(H) A representation of Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet is as follows:

Figure: 28 TAC §3.3829(b)(8)(H):

Long-Term Care Insurance
Personal Worksheet

FOR THE STATE OF TEXAS

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.]

Instructions To Company: Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.

Rate Increase History

We have sold long-term care insurance since [year] and have sold this [policy/rider], Form No.[____] since (year). [We have never raised rates for any long-term care

(policy/rider) sold in this state or any other state.] [We have not raised rates for this (policy/rider) or a similar (policy/rider) in this state or any other state in the last ten years.] [We have raised rates on this (policy/rider) or a similar (policy/rider) in the last ten years. Following is a summary of the rate increases:]

Instructions To Company: A company may use the first bracketed sentence above only if it has never increased rates under any prior individual or group policy forms in this state or any other state. The issuer shall list each premium increase it has instituted on this or similar individual or group policy forms in this state or any other state during the last 10 years. The list shall specify the individual or group 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%?]

***Instructions To Company*:** 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

Instructions to Company: 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 ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

***Instructions to Company*:** 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)

☐No change ☐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.

Questions Related to Your Needs

Are you aware you need to be unable to perform two (2) of the following six (6) activities of daily living (ADLs) – bathing, continence, dressing, eating, toileting, and moving around – prior to your long-term care benefits being triggered? ☐YES ☐NO

Are you aware of the term “cognitive impairment:? ☐YES ☐NO

Companies selling long-term care policies must offer a policy that pays benefits based on your cognitive impairment or your inability to perform two (2) ADLs. Do you understand this policy limitation? ☐YES ☐NO

What type of long-term care service do you anticipate utilizing? (check all that apply)

□ Nursing home care □ Assisted living care □ Home health care □ Adult day care
□ Hospice care □ Respite care □ other services

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.** ***Instructions to Company:*** 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)

***Instructions to Company*:** Choose the appropriate sentences depending on whether this is a direct mail or agent sale.

The company may contact you to verify your answers.

***Instructions to Company*:** 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.

Form Number LHL560(LTC)

(I) A representation of Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form is as follows:

Figure: 28 TAC §3.3829(b)(8)(I):

Instructions to Company: This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

FOR THE STATE OF TEXAS

Long-Term Care Insurance Potential Rate Increase Disclosure Form

(Company Name, address & phone number)

1. (Premium rate/Premium rate schedules) that (is/are) applicable to you and that will be in effect until a request is made and filed with the Texas Department of Insurance for an increase (is/are) ($_____) shown on the application. The (premium/premium rate schedule) for this coverage will be (shown on the schedule page of/attached to) your (policy/rider).

2. If your rates are changed, the new rates will become effective on the (next anniversary date/next billing date, etc.). The new rates will remain in effect until another request is made and filed with the Texas Department of Insurance. You have the right to receive a revised (premium rate/premium rate schedule) if the (premium/premium rate schedule) is changed.

3. This long-term care coverage is Guaranteed Renewable. This means that the rates for this coverage may be increased in the future. Your rates CANNOT be increased due to (your increasing age or) declining health, but your rates may go up based on the experience of all insureds with a (policy/rider) similar to yours.

4. If you receive a (premium rate/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:

(a) Pay the increased premium and continue your coverage in force as is.

(b) Reduce your coverage benefits to a level such that your premiums will not increase.

(c) Exercise your long-term care nonforfeiture option, if purchased. This option is available for purchase for an additional premium.

(d) Exercise your contingent nonforfeiture rights - See No. 5. This option is available if you do not purchase a long-term care nonforfeiture option mentioned in (c) above.

5. Contingent Nonforfeiture Rights

If the premium rate for your (policy/rider) goes up in the future and you do not buy a long-term care nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

(a) You will keep some long-term care insurance coverage, if:

(1) Your premium after the increase exceeds your original premium by the percentage shown, or more, in the table (provided on the next page/below); and

(2) You do not pay your premium within 120 days of the increase causing your (policy/rider) to lapse.

(b) The amount of coverage, new lifetime maximum benefit amount, etc., you will keep will equal the total amount of premiums you have paid since your (policy/rider) was first issued. If you have already received benefits under the (policy/rider), so that the remaining maximum benefit amount is less than the total amount of premiums you have paid, the amount of coverage will be that remaining amount.

(c) Except for this reduced lifetime maximum benefit amount, all other (policy/rider) 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/rider), with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the (policy/rider) at age 65 and paid the $1,000 annual premium for ten years, so you have paid a total of $10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to not pay any more premiums causing your (policy/rider) to lapse.
- Your "paid-up" (policy/rider) benefits are $10,000, provided you have at least $10,000 of benefits remaining under your (policy/rider.)

Contingent Nonforfeiture Cumulative Premium Increase over Initial Premium That Qualifies for Contingent Nonforfeiture Table

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%

6. Fixed or Limited Premium Payment Period

In addition to the contingent nonforfeiture benefits described above, the following reduced “paid-up” contingent nonforfeiture benefit is an option in all policies or certificates 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 nonforfeiture 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:

(a) 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%

(b) You stop paying your premiums within 120 days of when the premium increase took effect; AND

(c) 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:

(1) The total lifetime amount of benefits your reduced paid up policy or certificate will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy or certificate 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.

(2) 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 or certificate 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 or certificate 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 or certificate.

Form Number LHL561(LTC)

(9) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, as applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by paragraph (2) (B), (C), and (D) of this subsection and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form as specified in Figure: 28 TAC §3.3829(b)(8)(I) [~~in the same order as set forth in paragraph (2)~~] when the rate increase is implemented. The notice shall comply with the requirements specified in Figure: 28 TAC §3.3829(b)(8)(I).

§3.3830. Requirements for Application Forms and Replacement Coverage.

(a) - (g) (No change.)

(h) Life Insurance policies with a long-term care rider that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of the Insurance Code Chapter 1114

(relating to Replacement of Certain Life Insurance Policies and Annuities), Subchapter NN of this chapter (relating to Consumer Notices for Life Insurance Policy and Annuity Contract Replacements), and any additional rules adopted by the department pursuant to the Insurance Code Chapter 1114. If a life insurance policy with a long-term care rider that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

§3.3833. Group Certificates; Outline of Coverage Required. An outline of coverage is required on any group certificate issued for group long-term care insurance issued to a group as defined in the Insurance Code Chapter 1251 Subchapter B, but subject to the exemptions in the Insurance Code §1651.002[~~, Article 3.51-6, §1(a)~~]. Such outline of coverage shall be in a format identical to that which is required for [~~of~~] individual long-term care insurance policies in §3.3832 of this subchapter [~~title~~] (relating to Outline of Coverage), and shall be delivered to prospective enrollees no later than the time that application for group benefits is made.

§3.3834. Organization of Policy Format for Readability.

(a) - (g) (No change.)

(h) Type size and style must [~~shall~~] be legible[~~,~~] and must [~~shall~~] comply with the requirements set forth in the Insurance Code §1201.054[~~, Article 3.70-2(A)(4)~~].

(i) - (k) (No change.)

§3.3837. Reporting Requirements.

(a) Policy or Certificate Replacements and Lapses. The purpose of this subsection is to specify requirements for insurers issuing long-term care insurance benefits in this state to report to the commissioner information on a statewide basis regarding long-term care insurance policy or certificate replacements and lapses.

(1) Agent records.

(A) Each [~~Every~~] insurer shall maintain records, for each agent, of that agent's number and dollar amount of replacement sales as a percentage of the agent's total number and amount of annual sales attributable to long-term care products, as well as the number and dollar amount of lapses of long-term care insurance policies sold by the agent and expressed as a percentage of the agent's total annual sales attributable to long-term care products.

(B) 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.

(2) [~~(1)~~] Reporting of 10 percent of agents. Each insurer shall report by June 30 of every year the information indicated in the parts of Form Number LHL562(LTC) Long-Term Care Insurance Replacement and Lapse Reporting Form on the listing of the 10 percent of agents data as specified in Figure: 28 TAC §3.3837(a)(2) for the 10 percent [~~10%~~] of its agents with the greatest percentages of policy or

certificate lapses and replacements during the preceding calendar year. Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website [~~as measured by this subsection; provided, however, that any agent with 20 or fewer sales of long-term care policies for any reporting period shall not be included in such report, even if such agent's replacement and lapse percentage rates would otherwise result in inclusion in such report~~].

Figure: 28 TAC §3.3837(a)(2):

Long-Term Care Insurance
Replacement and Lapse Reporting Form

FOR THE STATE OF TEXAS

Due: No later than June 30 annually for the preceding calendar year

For the State of _____ For the Reporting Year of _____

Company Name: _____

Company Address: _____

_____

Company NAIC Number: _____

Contact Person: _____ Phone Number: (____)_____

Instructions

The purpose of this form is to specify the information regarding long-term care insurance policy replacements and lapses that insurers are required to report to the Commissioner of Insurance on a statewide basis. Specifically, every insurer shall maintain records for each agent on that agent's amount of long-term care insurance 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. The following two tables indicate the information required in reporting the ten percent (10%) of the insurer's agents with the greatest percentages of replacements and lapses.

Listing of the 10% of Agents with the Greatest Percentage of Replacements

Agent's Name	Number of Policies Sold By This Agent	Number of Policies Replaced by This Agent	Number of Replacements As % of Number Sold By This Agent

Listing of the 10% of Agents with the Greatest Percentage of Lapses

Agent's Name	Number of Policies Sold By This Agent	Number of Policies Lapsed by This Agent	Number of Lapses As % of Number Sold By This Agent

The following table indicates the number of replacement long-term care policies sold as a percentage of the insurer's total annual sales of such policies and the number of lapsed long-term care policies as a percentage of the insurer's total annual sales of such policies.

Company Totals

Company Name: _____

Report Year _____

Replacement Policies Sold	

Annual Policies Sold	
Policies in Force (as of the end of the preceding calendar year)	
% of Replacement Policies Sold to Annual Policies Sold (as of the end of the preceding calendar year)	
% of Replacement Policies Sold to Policies in Force (as of the end of the preceding calendar year)	
Policies Lapsed	
% of Policies Lapsed to Annual Policies Sold (as of the end of the preceding calendar year)	
% of Policies Lapsed to Policies in Force (as of the end of the preceding calendar year)	

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[~~(2) 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.~~]

(3) Reporting number of lapsed long-term care policies. Each [~~Every~~] insurer shall report by June 30 of every year the number of lapsed long-term care policies as a percentage of its total annual sales of such policies and as a percentage of its total number of long-term care policies in force during [~~as of the end of~~] the preceding calendar year as indicated in the Company Totals part of Form Number LHL562(LTC) Long-Term Care Insurance Replacement and Lapse Reporting Form as specified in Figure: 28 TAC §3.3837(a)(2). Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website.

(4) Reporting number of replacement long-term care policies. Each [~~Every~~] insurer shall report by June 30 of every year the number of replacement long-term care policies sold as a percentage of its total annual sales of such products, and as a percentage of its total number of such policies in force during [~~as of~~] the preceding calendar year as indicated in the Company Totals part of Form Number LHL562(LTC) Long-Term Care Insurance Replacement and Lapse Reporting Form as specified in Figure: 28 TAC §3.3837(a)(2). Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website.

[~~(5) Every insurer by June 30 of each year shall file the annual rate filing required by Insurance Code Article 3.70-12, §4(b).~~]

(b) Rescissions. Each [~~Every~~] insurer issuing long-term care insurance benefits in this state shall maintain a record of all policy, contract, or certificate rescissions relating to such long-term care insurance benefits, both for coverage in this state and nationwide, except for those which the insured voluntarily effectuated, and shall report

this data for the preceding calendar year to the commissioner by June 30[~~30th~~] of every year as indicated on Form Number LHL563(LTC) Rescission Reporting Form for Long-Term Care Policies as specified in Figure: 28 TAC §3.3837(b). Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website [~~this information utilizing Form LTC RESCIND as referenced in §3.3848 of this title (relating to Adoption by Reference of Department Form Utilized in Reporting)~~].

Figure: 28 TAC §3.3837(b):

RESCISSION REPORTING FORM FOR
LONG-TERM CARE POLICIES

FOR THE STATE OF TEXAS

FOR THE REPORTING YEAR ____

Due: No later than June 30 annually for the preceding calendar year

Company Name: _____

Address: _____

_____

Phone Number _____

Instructions:

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates for the preceding calendar year. 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 print)

_____
Date

Form Number LHL563(LTC)

(c) Claims Denied by Class of Business.

(1) Definitions. For purposes of this subsection, the following terms shall have the following meanings.

(A) Claim--A request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.

(B) Denied--The insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

(2) Report of Claims Denied. Each

[~~(c) Every~~] insurer issuing long-term care insurance benefits in this state shall maintain a record by class of business of the number of long-term care claims for long-term care services denied during the preceding calendar year in this state. The insurer shall report the number of claims denied for each class of business [~~this information~~] expressed as a percentage of claims denied [~~(other than claims denied for failure to meet the waiting period or because of any applicable preexisting conditions or because the service for which the claim was submitted is not the type of service covered by a long-term care policy)~~] to the commissioner by June 30 [~~30th~~] of every year as indicated on Form Number LHL564(LTC) Long-Term Care Insurance Claim Denials Reporting Form as specified in Figure: 28 TAC §3.3837(c)(2). Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website.

Figure: 28 TAC §3.3837(c)(2):

Long-Term Care Insurance

Claim Denials Reporting Form

FOR THE STATE OF TEXAS

For the Reporting Year of _____

Due: No later than June 30 annually for the preceding calendar year

Company Name: _____
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. "Claim" means a request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.

Indicate the manner of reporting by checking one of the boxes below.

☐ Per Claimant - counts each individual who makes one or a series of claim requests

☐ Per Transaction - counts each claim request

"Denied" means a claim that is not paid for any reason other than for failure to meet the waiting period or because of an applicable preexisting condition. It does not include a request for payment that is in excess of the applicable contractual limits.

		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 Claims 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[5]		

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: (i) a benefit trigger not met; (ii) certification by a licensed health care practitioner not provided; (iii) no plan of care.
5. Examples: duplicate submission, incomplete claim submission, advance billing.

Form Number LHL564(LTC)

(d) Long-Term Care Partnership Program. Each insurer that markets partnership policies in this state shall report to the department by June 30 of each year the information required in §32.107 of the Human Resources Code, specifying the number of approved partnership plans sold in this state during the preceding calendar year and the average age of individuals purchasing approved partnership plans during the preceding calendar year in this state. The information required in this subsection shall be reported in accordance with Form Number LHL565(LTC) Long-Term Care Policies Sold Reporting Form as specified in Figure: 28 TAC §3.3837(e). Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website. [~~For purposes of this section, reporting~~

~~requirements relate only to long-term care insurance and coverage that are delivered or issued for delivery in this state.~~]

(e) Data Report for Non-Partnership Plans. Each insurer that markets long-term care insurance in this state shall report to the department by June 30 of each year the number of non-partnership plans sold in this state during the preceding calendar year and the average age of individuals purchasing such non-partnership plans. The information required in this subsection shall be reported in accordance with Form Number LHL565(LTC) Long-Term Care Policies Sold Reporting Form as specified in Figure: 28 TAC §3.3837(e). Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website.

Figure: 28 TAC §3.3837(e):

LONG-TERM CARE POLICIES SOLD REPORTING FORM
FOR THE REPORTING YEAR ____

FOR THE STATE OF TEXAS

Due: No later than June 30 annually for the preceding calendar year

Company Name: _____

NAIC ID Number: _____

TDI ID Number: _____

Instructions: Please include certificates and riders in the information reported below.

Long-Term Care Partnership Policy Type	Number Sold	Average Age

Comprehensive (institutional and community care)		
Nursing Home (institutional only)		

Long-Term Care Non-Partnership Policy Type	Number Sold	Average Age
Comprehensive (institutional and community care)		
Nursing Home (institutional only)		
Home Health Care (community-based services)		
Riders (attached to life policies, annuity contracts)		

Signature: _____

Name: _____

Title: _____

Address: _____

_____

City/State/Zip Code: _____

Phone Number: _____ EXT _____

E-mail Address: _____

Form Number LHL565(LTC)

(f) Suitability Data. Each insurer issuing long-term care benefits in this state shall report suitability data for this state for the preceding calendar year to the commissioner by June 30 of each year as indicated on Form Number LHL566(LTC) Long-Term Care Suitability Reporting Form as specified in Figure: 28 TAC §3.3837(f).

Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website.

Figure: 28 TAC §3.3837(f):

LONG-TERM CARE SUITABILITY REPORTING FORM
FOR THE REPORTING YEAR ____

FOR THE STATE OF TEXAS

Due: No later than June 30 annually for the preceding calendar year

Company Name: _____

NAIC ID Number: _____

TDI ID Number: _____

Suitability Data for Partnership Policies

Long-term Care Partnership Policies	Total Number of Applications Received	Total Number of Applicants Who Declined to Provide Personal Worksheet Information	Total Number of Applicants Who Did Not Meet Suitability Standards	Total Number of Applicants Who Chose to Confirm After Receiving a Suitability Letter
Comprehensive (institutional and community care)				
Nursing Home (institutional only)				

Suitability Data for Non-Partnership Policies

		Total Number		Total

Long-term Care Non-Partnership Policies	**Total Number of Applications Received**	**of Applicants Who Declined to Provide Personal Worksheet Information**	**Total of Applicants Who Did Not Meet Suitability Standards**	**Number of Applicants Who Chose to Confirm After Receiving a Suitability Letter**
Comprehensive (institutional and community care)				
Nursing Home (institutional only)				
Home Health Care (community-based services)				
Riders (attached to life policies, annuity contracts)				

Signature: _____

Name: _____

Title: _____

Address: _____

_____

City/State/Zip Code: _____

Phone Number: _____ EXT _____

E-mail Address: _____

Form Number LHL566(LTC)

(g) Demonstration of compliance with applicable loss ratio standards. Each insurer shall file by June 30 of each year the annual rate filing required by the Insurance Code §1651.053(c) to demonstrate compliance with the applicable loss ratios of this state and any other filing requirement adopted by the commissioner relating to loss ratios. The filing must be submitted to the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701. Such demonstration shall be in addition to any demonstration required under §3.3831(c)(2)(B) - (D) of this subchapter (relating to Standards and Rates) and shall include the following information by calendar duration, separately by form number:

(1) calendar duration;

(2) first year issued;

(3) actual earned premium by duration;

(4) actual incurred claims;

(5) actual calendar duration loss ratio;

(6) anticipated calendar duration loss ratio; and

(7) number of insured lives.

§3.3838. Filing Requirements for Advertising. A long-term care insurance policy shall not be deemed to meet the standards and requirements set forth in this subchapter unless the filing company has complied with the requirements of the following paragraphs.

(1) Each [~~Every~~] insurer or other entity providing long-term care insurance or benefits in this state shall provide to the commissioner for review a copy of any long-term care insurance advertisement, as defined in §21.102 of this title (relating to Scope of insurance advertising, certain trade practices, and solicitation), other than an institutional advertisement as defined in §21.102 of this title that only references long-term care insurance as a line of coverage offered, but which does not otherwise describe long-term care insurance or benefits [~~used to promote a policy which is approved under the provisions of this subchapter~~]. The copy of the advertisement shall be submitted to the commissioner no later than 60 days prior to its first use. At the expiration of the 60-day period provided by this paragraph, any advertisement filed with the commissioner shall be deemed acceptable, unless before the end of that 60-day period the commissioner has notified the entity of its nonacceptance.

(2)-(3) (NO CHANGE.)

§3.3839. Standards for Marketing.

(a) Each [~~Every~~] insurer, health care service plan, or other entity marketing long-term care insurance coverage in this state, directly or through its agents, shall establish and implement marketing procedures to assure that:

(1) - (5) (No change.)

(6) the terms non-cancellable and level premium are used only to describe a policy or certificate that conforms to §3.3810 of this subchapter (relating to Policy or Certificate Standards for Noncancellability); [~~and~~]

(7) auditable procedures are established [~~in place~~] to verify compliance with this subsection;[~~.~~]

(8) at time of solicitation, the insurer provides written notice to the prospective policyholder and certificate holder that a senior insurance counseling program is available from the department and the name, address and telephone number of the program;

(9) at the time of application, an explanation is provided to the applicant of the contingent nonforfeiture benefit upon lapse provided for in §3.3844(g)(1) of this subchapter (relating to Nonforfeiture and Contingent Nonforfeiture Benefits) and, if applicable, an explanation of the additional contingent nonforfeiture benefit upon lapse provided for policies or certificates with fixed or limited premium payment periods as specified in §3.3844(g)(2) of this subchapter;

(10) at the time of application, copies of the disclosure forms (Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet as specified in Figure: 28 TAC §3.3829(b)(8)(H) and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form as specified in Figure: 28 TAC §3.3829(b)(8)(I) are provided to the applicant; and

(11) [~~(b)~~] [~~Every insurer or other entity marketing long-term care insurance coverage in this state, directly or through its agents, shall ensure that~~] the notice required [~~provided~~] in subparagraph (A) or (B) [~~paragraph (1) or (2)~~] of this paragraph [~~subsection~~], as appropriate, is prominently displayed by type, stamp, or other

appropriate means on the first page of both the policy (or certificate) and the outline of coverage.

(A)[~~(1)~~] For any policy or certificate which contains inflation protection provisions, the notice shall read as follows: "Notice to buyer: This policy (or certificate) may not cover all of the costs associated with long-term care incurred by the policyholder (or certificate holder) during the period of coverage. The policyholder (or certificate holder) is advised to review carefully all policy limitations."

(B)[~~(2)~~] For any policy or certificate which does not contain inflation protection provisions, the notice shall read as follows: "Notice to buyer: This policy (or certificate) may not cover all of the costs associated with long-term care incurred by the policyholder (or certificate holder) during the period of coverage. The policyholder (or certificate holder) is advised to review carefully all policy limitations. In addition, the policyholder (or certificate holder) is advised that based on current health care cost trends, the benefits provided by this policy (or certificate) may be significantly diminished in terms of real value to the policyholder (or certificate holder), depending on the amount of time which elapses between the date of purchase and the date upon which the policyholder (or certificate holder) first becomes eligible for those benefits."

(b)[~~(c)~~] The marketing of a long-term care insurance policy or certificate which includes benefits provisions under §3.3818(b) of this subchapter [~~title~~] (relating to Standards for Eligibility for Benefits) shall disclose within a common location and in equal prominence a description of all benefit levels payable for coverage described in §3.3818(b).

(c)[~~(d)~~] In addition to the practices prohibited in the Insurance Code Chapter 541[~~, Article 21.21~~], the following acts and practices are unfair methods of competition or unfair or deceptive acts or practices in the marketing of long-term care policies or certificates in this state and are prohibited under §541.003 of the Insurance Code.

(1) Twisting--Knowingly making any misleading representation or incomplete or fraudulent comparisons 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.

(2) 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.

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

(4) Misrepresentation--Selling, marketing, offering, or advertising any insurance policy, certificate, or rider to such policy or certificate, which substantially meets the definition of long-term care insurance found in the Insurance Code §1651.003 [~~Article 3.70-12, §2~~], but which provides benefits for a period of fewer than 12 months.

§3.3842. Appropriateness of Recommended Purchase.

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

(b) Each insurer, health care service plan, or other entity marketing long-term care insurance (issuer) 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 agents 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) To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take the following factors into consideration:

(1) the applicant’s ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(2) 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

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

(d) The issuer and, where an agent is involved, the agent, shall make reasonable efforts to obtain the information set forth in subsection (c) of this section. The efforts shall include presentation to the applicant, at or prior to application, the Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet as specified in Figure: 28 TAC §3.3829(b)(8)(H). The issuer may request the applicant to provide additional information to comply with the issuer's suitability standards. The following requirements apply if the issuer requests such additional information on the personal worksheet:

(1) A copy of the issuer's Long-Term Care Insurance Personal Worksheet Form Number LHL560(LTC) that includes the additional information that is requested to comply with the issuer's suitability standards must be filed with the department for approval prior to use.

(2) Any form filed pursuant to paragraph (1) of this subsection must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(3) The filing should be submitted to the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104 or 333 Guadalupe, Austin, Texas, 78701.

(e) The issuer must receive the completed personal worksheet from the applicant prior to the issuer's consideration of the applicant for coverage, except the completed personal worksheet does not need to be received by the issuer prior to the

issuer's consideration of an applicant for coverage for employer group long-term care insurance for employees and their spouses.

(f) The sale or dissemination outside of the company or agency by the issuer or agent of information obtained through the completion of Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet, including any additional information provided to comply with the issuer's suitability standards, is prohibited.

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

(h) Agents must use the suitability standards developed by the issuer in marketing the issuer's long-term care insurance.

(i) At the same time that the personal worksheet is provided to the applicant, Form Number LHL567(LTC) Things You Should Know Before You Buy Long-Term Care Insurance, containing the text specified in Figure: 28 TAC §3.3842(i)(7) must also be provided to the applicant. The following requirements and procedures apply to this form:

(1) The text must be in at least 12-point type and must follow the order of the information presented in Figure: 28 TAC §3.3842 (i)(7).

(2) The text as specified in Figure: 28 TAC §3.3842(i)(7) is mandated; the format for the form is a recommended format. An insurer may format the mandated text in a different format from that specified in Figure: 28 TAC §3.3842(i)(7) if the insurer files the form for review and approval by the commissioner.

(3) The form must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter.

(4) An insurer may add a company name and identifying form number to Form Number LHL567(LTC) as specified in Figure: 28 TAC §3.3842(i)(7) without obtaining commissioner approval.

(5) The *Instructions to Company* that are included in Figure: 28 TAC §3.3842(i)(7) are to aid the insurer in drafting the form and should not be included in the text of the form used by the insurer.

(6) If filing the form for review and approval as provided under paragraphs (2) and (3) of this subsection, the insurer must file the form with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701.

(7) A representation of Form Number LHL567(LTC) Things You Should Know Before You Buy Long-Term Care Insurance is as follows:

Figure: 28 TAC §3.3842(i)(7):

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.]

Instructions to Company: For single premium policies, delete both of the sentences in the second bullet, and for noncancellable policies, delete the second sentence only in the second bullet.

	• 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 at 1-800-252-8263 or call 211. •
Shopper's Guide	• Make sure the insurance company or agent gives you a copy of a booklet entitled “Long-Term Care Insurance” published by the Texas Department of 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	• The Texas Health Information Counseling and Advocacy Program (HICAP) offers free one-to-one counseling services, concerning whether a long-term care insurance is a suitable option for you, that can be accessed through the toll free number 1-800-252-9250. For insurance agent, insurance company and any other long-term care insurance information, you may call the Consumer Help Line of the Texas Department of Insurance at 1-800-252-3439.
Facilities	• Some long-term care insurance contracts provide for benefit payments in certain facilities only if the facilities 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 into 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.

Form Number LHL567(LTC)

(j) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide all of the requested information, the issuer may reject the application or the issuer must send the applicant a letter in accordance with Form Number LHL568(LTC) Long-Term Care Insurance Suitability Letter. However, only in the event that the applicant has declined to provide the requested financial information, the issuer may use some other method to verify the applicant's intent. This method, at the option of the issuer, may include phone call, fax, U.S. mail, email or any combination of these methods. Either the applicant's returned Suitability Letter containing the applicant's response or a record of the alternative method of verification must be made a part of the applicant's file. If the issuer elects to send the applicant a Suitability Letter to comply with the requirements of this subsection, the following specifies the Suitability Letter and the requirements and procedures that apply:

Figure: 28 TAC §3.3842(j):

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 "Long-Term Care Insurance" published by the Texas Department of Insurance and the disclosure form entitled "Things You Should Know Before Buying Long-Term Care Insurance." The Texas Department of Insurance 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 may contact the Department at 1-800-252-3439 or you may go to the Department's web site at www.tdi.state.tx.us.

[You either did not provide any financial information or provided insufficient financial information for us to review.]

Instructions to Company: 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.

***Instructions to Company*:** Delete the phrase in brackets if the applicant did not answer the questions about income.

☐ **No.** I have decided not to buy a policy at this time.

_____ _____

APPLICANT'S SIGNATURE **DATE**

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

Form Number LHL568(LTC)

(1) The issuer's Suitability Letter must use the text in Form Number LHL568(LTC) as specified in Figure: 28 TAC §3.3842(j).

(2) The text must be in at least 12-point type and must follow the order of the information presented in Figure: 28 TAC §3.3842(j).

(3) The *Instructions to Company* that are included in Figure: 28 TAC §3.3842(j) are to aid the issuer in drafting the form and should not be included in the text of the letter sent to the applicant.

(4) The form number should not be included on the letter sent to the applicant.

§3.3844. Nonforfeiture and Contingent Nonforfeiture Benefits.

(a) – (b) (No change.)

(c) Nonforfeiture Benefit Options. Insurers shall offer at least one of the following nonforfeiture options:

(1) - (2) (No change.)

(3) shortened [~~shorten~~] benefit period; or

(4) (No change.)

(d) (No change.)

(e) Benefits Continued as Nonforfeiture Benefits. This subsection applies to contingent nonforfeiture benefits upon lapse in accordance with subsection (g)(1) of this section but does not apply to contingent nonforfeiture benefits upon lapse in accordance with subsection (g)(2) of this section: [~~Additional Requirements for Shortened Benefit Period An insurer offering a shorten benefit period shall comply with the following~~]:

(1) – (2) (No change.)

(3) For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases with age at least one percent per year prior to age 50 and at least three percent per year beyond age 50.

(f) (No change.)

(g) Contingent Nonforfeiture Benefits.

(1) (No change.)

(2) A contingent nonforfeiture benefit on lapse shall also be triggered for policies or certificates with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in Figure: 28 TAC §3.3844(g)(2) based on the insured's issue age, the policy or certificate lapses after notice of the rate increase is issued and within 120 days before or after notice of the due date of the premium so increased, and the ratio in paragraph (4)(B) of this subsection is 40 percent or more. Unless otherwise required,

policyholders must be notified at least 45 days prior to the due date of the premium reflecting the rate increase. The provision of this paragraph shall be in addition to the contingent nonforfeiture benefit provided by subsection (g)(1) of this section and where both are triggered, the benefit provided shall be at the option of the insured.

Figure: 28 TAC §3.3844(g)(2):

Triggers for a Substantial Premium Increase

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

(3) [~~(2)~~] On or after the effective date of a substantial premium increase as set forth in paragraph (1) of this subsection, 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 subsection (e) of this section. This option may be elected at any time during the 120-day period referenced in paragraph (1) of this subsection; and

(C) notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in paragraph (1) of this subsection shall be deemed to be the election of the offer to convert in subparagraph (B) of this paragraph.

(4) On or before the effective date of a substantial premium increase as defined in paragraph (2) of this subsection, the insurer shall:

(A) offer to reduce policy or certificate 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 prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in paragraph (2) of this subsection; and

(C) notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in paragraph (2) of this subsection shall be deemed to be the election of the offer to convert in subparagraph (B) of this paragraph if the ratio is 40 percent or more.

§3.3846. Incontestability Period.

(a) (No change.)

(b) After a policy or certificate has been in force for two years it is not contestable except for the grounds stated in the Insurance Code §1251.103 [~~Article 3.51-6, §1(d)(2)(ii)~~] for a group policy and the Insurance Code §1201.208 [~~Article 3.70-3(A)(2)~~] for an individual policy.

(c) (No change.)

§3.3848. Requirements for Limited Premium Payment Options in Long-Term Care Policies, Certificates, and Riders.

(a) Definition and Applicability. Long-term care policies, certificates, and riders with limited premium payment options limit premium payments to a single payment or to a stated number of years not to exceed 10 years. Limited premium payment policies, certificates, and riders must comply with this subchapter, Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings), and the additional requirements specified in subsection (b) of this section. Any policy, certificate or rider that contains a paid-up option at a specified age and becomes paid up in 10 years or less is subject to this section.

(b) Requirements.

(1) Notice. The face page of a long-term policy or certificate with a limited premium payment option must accurately reflect a plan with a limited premium payment option.

(2) Minimum Standards. The provisions in long-term care policies, certificates, and riders with limited premium payment options must be at least as favorable as the requirements and provisions specified in this section.

(3) Single-Premium Payment Option. A single-premium payment option policy, certificate, or rider must be noncancellable as provided in §3.3810(a) of this subchapter (relating to Policy or Certificate Standards for Noncancellability). The

renewability provision on the face page of the policy or certificate must conform with the following: "NONCANCELLATION PROVISION: This policy provides that premiums are paid by a single premium after which no additional premiums are due and your policy is fully paid-up and noncancellable. We cannot cancel your policy and we cannot make any changes unless requested by you, subject to the maximum benefits under the policy."

(4) One-to-Four Year Premium Payment Options. A long-term care policy, certificate, or rider with a one-to-four year premium payment option must be noncancellable as provided in §3.3810(a) of this subchapter. The renewability provision on the face page of a policy or certificate must conform with the following: “NONCANCELLATION PROVISION: This policy provides that your premiums may be paid over a period of [n] (n may equal 1, 2, 3, or 4) years, after which no additional premiums will be due and your policy is fully paid up and noncancellable. We cannot cancel your policy and we cannot make any changes unless requested by you, subject to the maximum benefits under the policy.”

(5) Five-to-Ten Year Premium Payment Options. A long-term care policy, certificate or rider with a five-to-ten year premium payment option must be guaranteed renewable as provided in §3.3807(a) of this subchapter (pertaining to Policy or Certificate Standards for Guaranteed Renewability) and must comply with the following requirements:

(A) The renewability provision on the face page of a long-term care policy or certificate must conform to the following: “This policy provides that your

premiums be paid over a period of [n] (n may equal 5, 6, 7, 8, 9 or 10) years, after which no additional premiums will be due and your policy is fully paid-up and noncancellable. We cannot cancel your policy and we cannot make any changes unless requested by you, subject to the maximum benefits under the policy."

(B) A provision must be included in the policy, certificate or rider that provides for a return of premium upon cancellation, as described in Figure: 28 TAC §3.3848(b)(5)(C)(ii).

(C) Each long-term care policy, certificate or rider must be accompanied by the disclosure specified in clause (i) of this subparagraph and the Return of Premium chart specified in Figure: 28 TAC §3.3848(b)(5)(C)(ii).

(i) Disclosure. The return of premium provision must conform with the following: "RETURN OF PREMIUM: Upon cancellation of this policy by you during the premium-paying period, we will return a portion of the total premiums paid less any benefits paid under the policy. The portion of the total premium paid will be determined in accordance with the accompanying chart, labeled Return of Premium Schedule."

(ii) Return of Premium Schedule. The return of Premium Schedule chart, which specifies the percentage of premium that the insurer is required to return to the insured expressed as a function of the premium payment option (5, 6, 7, 8, 9, and 10 year premium payment options) and of the number of completed years prior to the policy, certificate or rider being canceled, must comply with the following requirements:

Figure: 28 TAC §3.3848(b)(5)(C)(ii)[, and must be labeled "Return of Premium Schedule"].

Figure: 28 TAC §3.3848(b)(5)(C)(ii)

Return of Premium Schedule

Long Term Care policy, certificate, or rider with n-premium payment options where n = 5, 6, 7, 8, 9, 10

n = 10		n = 9		n = 8		n = 7		n = 6		n = 5	
Number of completed policy years	Percentage applied to the excess cumulative premium paid	Number of completed policy years	Percentage applied to the excess cumulative premium paid	Number of completed policy years	Percentage applied to the excess cumulative premium paid	Number of completed policy years	Percentage applied to the excess cumulative premium paid	Number of completed policy years	Percentage applied to the excess cumulative premium paid	Number of completed policy years	Percentage applied to the excess cumulative premium paid
1	0%	1	0%	1	0%	1	0%	1	0%	1	0%
2	5%	2	6%	2	7%	2	8%	2	9%	2	10%
3	10%	3	12%	3	14%	3	16%	3	18%	3	20%
4	15%	4	18%	4	21%	4	24%	4	27%	4	30%
5	20%	5	24%	5	28%	5	32%	5	36%	5	40%
6	25%	6	30%	6	35%	6	40%	6	45%		
7	30%	7	36%	7	42%	7	48%				
8	35%	8	42%	8	49%						
9	40%	9	48%								
10	45%										

Important Notice: After the end of the [nth] policy year, there will be no return of premium.

Source: Texas Department of Insurance

Form Number LHL574(LTC)

(I) The chart must be in not less than 12-point bold type.

(II) The chart must conform to the representation in Figure: 28 TAC §3.3848(b)(5)(c)(ii), and must be labeled "Return of Premium Schedule."

(iii) Under no circumstances shall the application of §3.3848(b)(5)(C)(ii) result in an amount that exceeds the aggregate premiums paid under the contract, when combined with any other provision of this chapter.

(D) Using the Return of Premium Chart specified in Figure: 28 TAC §3.3848(b)(5)(C)(ii), the return of premium amount must be at least as great as the sum of clauses (i) plus (ii) minus (iii) of this subparagraph:

(i) [(I) - (II)] X (III), where (I), (II) and (III) are as follows:

(I) the cumulative premium paid under the limited premium payment option specified in the policy, certificate, or rider;

(II) the cumulative premium that would have been paid under a lifetime premium payment option;

(III) the percentage specified in Figure: 28 TAC §3.3848(b)(5)(C)(ii), corresponding to the number of completed policy years and limited premium payment period specified in the policy, certificate, or rider;

(ii) the pro-rata unearned premium based on the premium paid for the year of cancellation;

(iii) any benefits paid under the policy.

(E) An example of the calculation of the return of premium required under this section is as follows:

(i) Given the facts provided in subclauses (I), (II), (III), and (IV) of this clause as follows:

(I) policy, certificate, or rider issue date: January 1, 2006;

(II) date of cancellation: April 1, 2008;

(III) 10-pay annual premium: $10,000;

(IV) annual lifetime premium: $1,000;

(ii) Portion of return of premium calculated under subparagraph (D)(i) of this paragraph is equal to .05 X [($10,000 + $10,000) - ($1,000 + $1,000)] = .05 X ($20,000 - $2,000) = .05 X $18,000 = $900;

(iii) Portion of return of premium calculated under subparagraph (D)(ii) of this paragraph is equal to $10,000 X 9/12 = $7,500;

(iv) Total return of premium due is equal to $900 + $7,500 = $8,400 less any benefits paid under the policy.

§3.3849. Requirements for Insurers that Issue Long-Term Care Policies to Associations and Marketing Standards for Associations that Market the Policies.

(a) Insurer Requirements.

(1) Any insurer issuing long-term care insurance to an association, as defined in the Insurance Code §1251.052, shall file with the department in accordance

with the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings) the following:

(A) the long-term care policy and certificate,

(B) a corresponding outline of coverage, and

(C) annual certification of the association's compliance with marketing standards for long-term care policies and certificates in accordance with Form Number LHL573(LTC) Insurer Certification of Association Marketing Compliance specified in Figure: 28 TAC §3.3849(e)(1)(F).

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

(b) Advertisements. Advertisements for long-term care insurance must be filed with the department in accordance with §3.3838(1) of this subchapter (relating to Filing Requirements for Advertising).

(c) Association Disclosure Requirements.

(1) An association must disclose in any long-term care insurance solicitation to its members:

(A) 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

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

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

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

(e) Insurer Certification Form.

(1) The following requirements and procedures apply to Form Number LHL573(LTC) Insurer Certification of Association Marketing Compliance specified in Figure: 28 TAC §3.3849(e)(1)(F):

(A) The text must be in at least 10-point type and must follow the order of the information presented in Figure: 28 TAC §3.3849(e)(1)(F).

(B) The text of Form Number LHL573(LTC) Insurer Certification of Association Marketing Compliance as specified in Figure: 28 TAC §3.3849(e)(1)(F) is mandated; the format for the form is a recommended format. An insurer may format the mandated text in a different format from that specified in Figure: 28 TAC §3.3849(e)(1)(F) if the insurer files the reformatted certification form for review and approval by the commissioner.

(C) Any reformatted certification form that is filed for approval pursuant to paragraph (2) of this subsection must be filed no later than 60 days prior to

use and is subject to the requirements and procedures set forth in Subchapter A of this chapter.

(D) Any reformatted certification form filed pursuant to paragraph (2) of this subsection should be filed with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701.

(E) Form Number LHL573(LTC) Insurer Certification of Association Marketing Compliance may be obtained from the Life/Health Division, Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9107 or 333 Guadalupe, Austin, Texas 78701, or from the department's website at www.tdi.state.tx.us.

(F) A representation of Form Number LHL573(LTC) Insurer Certification of Association Marketing Compliance is as follows:

Figure: 28 TAC §3.3849(e)(1)(F):

Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates

Due annually between January 1 and January 31 for the preceding calendar year

Company Name _____

NAIC ID Number _____

For Calendar Year _____

Date Submitted _____

TDI ID Number _____

I hereby certify that:

Each association as defined in the Insurance Code §1251.052 to whom (company name) has issued a long-term care partnership policy or certificate or non-partnership policy or certificate during (calendar year) has met the requirements of the Texas Administrative Code §3.3849 (relating to Requirements for Insurers that Issue Long-Term Care Policies to Associations and Marketing Standards for Associations that Market the Policies).

Signature: _____

Name: _____

Title: _____

Address: _____

_____

City/State/Zip Code: _____

Phone Number: _____ EXT _____

E-mail Address: _____

Form Number LHL573(LTC)

(2) The initial certification shall be submitted to the department between January 1, 2009 and January 31, 2009, for the calendar year 2008, and thereafter shall be submitted annually between January 1 and January 31 for the preceding calendar year.

(3) Form Number LHL573(LTC) is an informational filing pursuant to §3.5(b)(1) of this chapter (relating to Filing Authorities and Categories) and is subject to the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(4) The annual completed certification form submitted pursuant to paragraphs (2) and (3) of this subsection should be filed with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104 or 333 Guadalupe, Austin, Texas, 78701.

DIVISION 3. NON-PARTNERSHIP LONG-TERM CARE INSURANCE ONLY

§3.3860. Policy Summary Requirements for Non-partnership Life Insurance Policies and Annuity Contracts that Provide Long-Term Care Benefits.

(a) At the time of delivery of a non-partnership life insurance policy or annuity contract that provides long-term care benefits by rider, a policy summary shall be delivered. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make delivery no later than at the time of policy delivery. The policy summary must comply with all applicable requirements of this section and must include:

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

(2) an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;

(3) any exclusions, reductions and limitations on benefits of long-term care;

(4) a statement that any long-term care inflation protection option required by §3.3820 of this subchapter (relating to Requirement to Offer Inflation Protection) and §3.3872 of this subchapter (relating to Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates) is not available under this policy;

(5) if applicable to the policy type:

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

(B) a disclosure of guarantees related to long-term care costs of insurance charges; and

(C) a disclosure of current and projected maximum lifetime benefits.

(b) The provisions of the policy summary required in subsection (a) of this section may be incorporated into a basic illustration that is required to be delivered in accordance with Chapter 21, Subchapter N of this title (relating to Life Insurance Illustrations).

(c) During the entire time that a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include:

(1) any long-term care benefits paid out during the month;

(2) an explanation of any changes in the policy, e.g., death benefits or cash values, due to long-term care benefits being paid out; and

(3) the amount of long-term care benefits existing or remaining.

DIVISION 4. PARTNERSHIP LONG-TERM CARE INSURANCE ONLY

§3.3870. Exchange Requirements for Long-Term Care Partnership Policies.

(a) Notification and Offer of Exchange. Any insurer that begins to advertise, market, offer, sell, or issue policies that qualify under the Texas Long-Term Care Partnership Program is required to offer on a one-time basis to all policyholders and certificate holders that were issued long-term care coverage by the insurer on or after February 8, 2006, the option to exchange their existing policy or certificate for a partnership policy or certificate. The insurer is required to offer the option to exchange in writing by December 31, 2009.

(b) New Coverage. The insurer shall make the new coverage available in one of the following ways:

(1) by adding a rider or endorsement to the existing policy and charging a separate premium for the new rider or endorsement based on the insured's attained age if an additional premium is appropriate; or

(2) by exchanging the existing policy or certificate for a new partnership policy or certificate.

(A) If the new coverage has an actuarial value of benefits equal to or lesser than the actuarial value of benefits of the existing coverage, based on uniform

assumptions as determined on the date of issue for a new insured, then the following two requirements apply:

(i) the new policy shall not be underwritten; and

(ii) the rate charged for the new policy shall be determined using the original issue age and risk class of the insured that was used to determine the rate of the existing policy.

(B) If the new coverage has an actuarial value of benefits exceeding the actuarial value of benefits of the existing coverage, based on uniform assumptions, as determined on the date of issue for a new insured, then the following two requirements apply:

(i) the insurer shall apply its new business, long-term care underwriting guidelines to the increased benefits only; and

(ii) the rate charged for the new policy shall be determined using the method set forth in subparagraph (A)(ii) of this paragraph for the existing benefits, increased by the rate for the increased benefits using the current attained age and risk class of the insured for the increased benefits only.

(c) Exchange Requirements. Any exchange of an existing long-term care policy or certificate for a partnership policy or certificate must comply with the following requirements:

(1) Any offer of exchange shall be made to all policyholders on a nondiscriminatory basis.

(2) An exchange offer shall be deferred to all policyholders who are currently eligible for benefits, within an elimination period on a claim, or who would not be eligible to apply for coverage due to issue age limitations under the new policy, until such time when such condition expires.

(3) All rates for exchanges must meet the requirements specified in §3.3831 of this subchapter (relating to Standards and Rates). In accordance with §3.3831, exchange policies may be underwritten, and the premium may be increased, subject to §3.3810 of this subchapter (relating to Policy or Certificate Standards for Noncancellability).

(4) The new coverage offered shall be on a form that is currently approved for sale in the general market.

(5) In the event of an exchange, the insured shall not lose any rights, benefits or built-up value that have accrued under the original policy with respect to the benefits provided under the original policy, including, but not limited to, rights established because of the lapse of time related to pre-existing condition exclusions, elimination periods, or incontestability clauses.

(d) Exchanges and Not Replacements. Policies issued pursuant to this section shall be considered exchanges and not replacements.

(e) One-time Reporting Requirement. An insurer is required to report exchanges made pursuant to this section on a one-time basis for the 2009 reporting period (to be reported by June 30, 2010) on Form Number LHL562(LTC) Long-Term Care Insurance Replacement and Lapse Reporting Form in accordance with the procedures and

requirements specified in §3.3837(a)(4) of this subchapter (relating to Reporting Requirements).

§3.3871. Standards and Reporting Requirements for Approved Long-Term Care Partnership Policies and Certificates.

(a) Standards.

(1) General requirements. In addition to the required filing and approval pursuant to §3.3873 of this subchapter (relating to Filing Requirements for Long-Term Care Partnership Policies), any policy or certificate marketed or represented to qualify as a long-term care partnership policy or certificate must comply with the following requirements:

(A) the insured individual was a resident of Texas when coverage first became effective under the policy. If the policy or certificate is later exchanged for a different long-term care policy or certificate, the individual was a resident of Texas when coverage under the first policy became effective;

(B) the policy is intended to be a qualified long-term care insurance policy under the provisions of §3.3847 of this subchapter (relating to Qualified Long-Term Care Insurance Contracts; Prohibited Representations);

(C) the policy or certificate is issued with and retains inflation coverage that meets the inflation standards specified in §3.3872 of this subchapter (relating to Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates) based on the insured's then attained age;

(D) the effective date of the partnership policy shall be the date that the partnership policy is issued or the date the application for the partnership policy was signed.

(2) Required disclosure notice.

(A) A policy or certificate represented or marketed as a long-term care partnership policy or certificate shall be accompanied by a disclosure notice that explains the benefits associated with the policy or certificate. The required disclosure notice is set forth in Form Number LHL569(LTC) Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates as specified in Figure: 28 TAC §3.3871(a)(2)(B)(vii).

(B) The following requirements and procedures apply to Form Number LHL569(LTC):

(i) The text in the notice must be in at least 12-point type and must follow the order of the information presented in Figure: 28 TAC §3.3871(a)(2)(B)(vii).

(ii) The text in the notice as specified in Figure: 28 TAC §3.3871(a)(2)(B)(vii) is mandated; the format for the form is a recommended format. An insurer may format the mandated text in a different format from that specified in Figure: 28 TAC §3.3871(a)(2)(B)(vii) if the insurer files the form for review and approval by the commissioner.

(iii) Any form filed pursuant to clause (ii) of this subparagraph must be filed no later than 60 days prior to use and is subject to the

requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(iv) An insurer may add a company name and identifying form number to Form Number LHL569(LTC) as specified in Figure: 28 TAC §3.3871(a)(2)(B)(vii) without obtaining commissioner approval.

(v) The *Instructions to Company* that are included in Figure: 28 TAC §3.3871(a)(2)(B)(vii) are to aid the insurer in drafting the form and should not be included in the disclosure notice provided by the insurer.

(vi) Any form filed pursuant to clause (ii) of this subparagraph should be filed with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701.

(vii) A representation of Form Number LHL569(LTC) Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates is as follows:

Figure: 28 TAC §3.3871(a)(2)(B)(vii):

Partnership Status Disclosure Notice for Long Term Care Partnership Policies/Certificates

Important Information Regarding the Texas Long-Term Care Insurance Partnership Program

Note: It is very important that you keep this Disclosure Notice with your Long-Term Care insurance Policy or Certificate.

Insured Name: _____

Policy Name: _____

Date of Issue: _____

The long-term care insurance policy [certificate] that you have purchased currently qualifies for the Texas Long-Term Care Insurance Partnership Program. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance policies [certificates] may protect your assets through a feature known as an "Asset Disregard," under the Texas Medicaid program. In accordance with the Texas Insurance Code §1651.106, if the partnership for long-term care program is discontinued, an individual who purchased an approved plan before the date the partnership program is discontinued remains eligible to receive dollar–for–dollar asset disregard and asset protection under the Texas Medicaid program.

Asset Disregard means that the amount of the policyholder's [certificate holder's] assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy [Certificate] will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified partnership Policy [Certificate] without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply. Asset Disregard is not available under a long-term care insurance policy [certificate] that is not a Partnership Policy [Certificate]. ***The purchase of a Partnership policy, however, does not guarantee you the ability to disregard assets. In addition, the purchase of a Partnership Policy does not automatically qualify you for Medicaid.***

Partnership Policy [Certificate] Status. Your long-term care insurance policy [certificate] is intended to qualify as a Partnership Policy [Certificate] under the Texas Long-Term Care Partnership Program as of your Policy's [Certificate's] effective date.

What Could Disqualify Your Policy [Certificate] Status as a Partnership Policy. If you make any changes to your policy [certificate], such changes could affect whether your policy][certificate] continues to be a Partnership Policy. **Before you make any changes, you should consult with [insert name of insurance company] to determine the effect of a proposed change.** In addition, if you move to a State that does not maintain a Partnership Program or does not recognize your policy [certificate] as a Partnership Policy [Certificate], you may not receive beneficial treatment of your policy [certificate] such as asset disregard under the Medicaid program of that State.

The information contained in this Endorsement is based on current Texas and Federal laws. These laws are subject to change.

Additional Information. If you have questions regarding your insurance policy [certificate] please contact [insert the name of insurer]. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Texas Health and Human Services Commission by calling 1-800-252-8263 or 211.

Form Number LHL569(LTC)

(viii) Any policyholder that exchanges their policy for a partnership policy must be provided with the required Form Number LHL569(LTC) Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates as specified in Figure: 28 TAC §3.3871(a)(2)(B)(vii).

(ix) When an insurer is made aware that a policyholder or certificate holder has initiated action that will result in the loss of partnership status, the insurer must provide an explanation of how such action impacts the insured in writing. The insurer must also advise the policyholder or certificate holder on how to retain partnership status if possible.

(x) If a partnership plan subsequently loses partnership status, the insurer must explain to the policyholders or certificate holders in writing the reason for the loss of status.

(3) Commissioner certification. Under §1917(b)(5)(B)(iii) of the Social Security Act (42 U.S.C. §1396p(b)(5)(B)(iii)), the Commissioner of Insurance, in implementing the Texas Long-Term Care Partnership Insurance Program ("Partnership Program"), may certify that long-term care insurance policies and certificates covered

under the Partnership Program meet certain consumer protection requirements, and policies so certified are deemed to satisfy such requirements. These consumer protection requirements are set forth in §1917(b)(5)(A) of the Social Security Act and principally include certain specified provisions of the NAIC Long-Term Care Model Act and Model Regulations (adopted as of October 2000). In providing this certification, the commissioner may reasonably rely upon the certification by insurers of the policy forms that is made in accordance Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form as specified in Figure: 28 TAC §3.3873(a)(2)(F).

(b) Reporting Requirements. In accordance with §1917(b)(1)(C)(iii)(VI) and (v) of the Social Security Act, all issuers of partnership policies or certificates shall provide regular reports to the Secretary of the Department of Health and Human Services (Secretary) in accordance with regulations to be developed by the Secretary. Such information shall include but not be limited to the following:

(1) notification regarding when insurance benefits provided under partnership policies or certificates have been paid and the amount of such benefits paid;

(2) notification regarding when such policies or certificates otherwise terminate; and

(3) any other information the Secretary determines is appropriate.

§3.3872. Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates. Pursuant to §1917(b)(1)(C)(iii)(IV) of the Social Security Act (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)), an insurer shall not issue a policy or certificate

marketed or represented to qualify as an approved long-term care partnership policy unless the policy or certificate complies with the following inflation protection requirements:

(1) For a person who is less than 61 years of age, as of the date of purchase, the policy or certificate must provide compound annual inflation protection from the date of purchase until the person attains 61 years of age.

(A) At the time of purchase, insurers must offer to each applicant the option to purchase compound annual inflation protection that automatically increases each year on a compounded basis at a rate of not less than 5.0 percent annually throughout the interval of coverage. The inflation protection is required to automatically increase benefits each year on a compounded basis.

(B) If the applicant declines the offer of inflation protection specified in subparagraph (A) of this paragraph, then the insurer must offer and the applicant must purchase and retain compound annual inflation protection until the insured attains age 61 or goes on claim status, whichever comes first. The inflation protection is required to automatically increase benefits each year on a compounded basis at a rate that the insured elects which may be in a range of from one percent to four percent or tied to the Consumer Price Index for All Urban Consumers (CPI-U).

(C) A person who is less than 61 years of age that has purchased a long-term care partnership policy or certificate with the required compound inflation protection specified in this paragraph may upon attaining 61 years of age choose to

amend the compound inflation protection provision in the policy or certificate in accordance with the requirements specified in paragraph (2) of this subsection.

(2) For a person who is at least 61 years of age but less than 76 years of age, the policy or certificate must provide an acceptable level of inflation protection until the person attains 76 of years age. Acceptable inflation protection includes the following:

(A) Regardless of the insured's health status, the insurer must offer and the insured must purchase and retain inflation protection until the insured attains age 76 or goes on claim status, whichever comes first.

(B) Acceptable coverage includes automatic annual inflation protection, either simple or compound, paid with either level or stepped premium.

(C) Inflation protection as required by this paragraph may be in a range of from one percent to five percent or tied to the Consumer Price Index for All Urban Consumers (CPI-U).

(D) A person who is less than 76 years of age that has purchased a long-term care partnership policy or certificate with the required inflation protection specified in this paragraph may upon attaining 76 years of age choose to amend the inflation protection provision in the policy or certificate in accordance with the requirements specified in paragraph (3) of this subsection.

(3) For any person who has attained the age of 76, inflation protection may be provided but is not required.

(4) An option to purchase inflation protection at a future time does not constitute compliance with the inflation protection requirements set forth in paragraphs (1) and (2) of this subsection.

§3.3873. Filing Requirements for Long-Term Care Partnership Policies.

(a) Prior Approval Requirements. Each long-term partnership policy or certificate, including any long-term care partnership endorsement, that is to be delivered or issued for delivery in this state must comply with the requirements specified in paragraphs (1) and (2) of this subsection before being delivered or issued in this state.

(1) Each long-term care partnership policy, certificate, or endorsement must be filed with the department and approved by the commissioner in accordance with the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings) and subsections (b) and (c) of this section, as applicable.

(2) Each long-term care partnership policy, certificate, or endorsement filing must include Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form, as specified in Figure: 28 TAC §3.3873(a)(2)(F). The following requirements and procedures apply to this certification form:

(A) The text in the certification form must be in at least 10-point type and must follow the order of the information presented in Figure: 28 TAC §3.3873(a)(2)(F).

(B) The text in the certification form as specified in Figure: 28 TAC §3.3873(a)(2)(F) is mandated; the format for the form is a recommended format. An insurer may format the mandated text in a different format from that specified in Figure: 28 TAC §3.3873(a)(2)(F) if the insurer files the certification form for review and approval by the commissioner.

(C) Any certification form that is filed for approval pursuant to subparagraph (B) of this paragraph must be filed no later than 60 days prior to use in any filing of a policy, certificate or endorsement submitted pursuant to subsection (c) or (d) of this section and is subject to the requirements and procedures set forth in Subchapter A of this chapter.

(D) Any certification form filed pursuant to subparagraph (B) of this paragraph should be filed with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701.

(E) Form Number LHL570(LTC) may be obtained from the Life/Health Division, Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9107 or 333 Guadalupe, Austin, Texas 78701, or from the department's website at www.tdi.state.tx.us.

(F) A representation of Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form is as follows:

Figure: 28 TAC §3.3873(a)(2)(F):

Long-Term Care Partnership Program Insurer Certification Form

Section 1917(b)(5)(B)(iii) of the Social Security Act (42 U.S.C. 1396p(b)(5)(B)(iii)), authorizes the Texas Commissioner of Insurance upon implementing a qualified State long-term care insurance partnership program ("Qualified Partnership") to certify that long-term care insurance policies (including certificates issued under a group insurance contract) covered under the Qualified Partnership meet certain consumer protection requirements, and policies so certified are deemed to satisfy such requirements. These consumer protection requirements are set forth in section 1917(b)(5)(A) of the Social Security Act (42 U.S.C. 1396p(b)(5)(A)) and principally include certain specific provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) (referred to herein as the "2000 Model Regulation" and "2000 Model Act" respectively).

In order to provide the Commissioner of Insurance with information necessary to provide a certification for policies, this Issuer Certification Form requests information and a certification from issuers of long-term care insurance policies with respect to policy forms that may be covered under the Qualified Partnership Program of the State.

An insurance company may request certification of policies from time to time and, accordingly, may supplement this issuer certification form, *e.g.*, as it introduces new long-term care insurance policy forms for issuance.

I. GENERAL INFORMATION

A. Name, address and telephone number of issuer:

_____
_____
_____

B. Name, address, telephone number, and email address (if available) of an employee of issuer who will be the contact person for information relating to this form:

_____
_____
_____

C. Policy form number(s) (or other identifying information, such as certificate series) for policies covered by this Issuer Certification Form:

_____
_____
_____

Copies of each of the above referenced policy forms, including any riders and endorsements, shall be provided if required under the provisions of 28 TAC §3.3873 (pertaining to Filing Requirements For Long-Term Care Partnership Policies).

II. QUESTIONS REGARDING APPLICABLE PROVISIONS OF THE 2000 MODEL REGULATION AND 2000 MODEL ACT

Please answer each of the questions below with respect to the policy forms identified in section I.C above. For purposes of answering the questions below, any provision of the 2000 Model Regulation or 2000 Model Act listed below shall be treated as including any other provision of the 2000 Model Regulation or 2000 Model Act necessary to implement the provision.

Are the following requirements of the 2000 Model Regulation met with respect to all policies (including certificates issued under a group insurance contract) intended to be covered under the Qualified Partnership Program that are issued on each of the policy forms identified in Section I.C above?

Yes___ No___ N/A___ A. Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the 2000 Model Act relating to such section 6A.

Yes___ No___ N/A___ B. Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

Yes___ No___ N/A___ C. Section 6C (relating to extension of benefits).

Yes___ No___ N/A___ D. Section 6D (relating to continuation or conversion of coverage).

Yes___ No___ N/A___ E. Section 6E (relating to discontinuance and replacement of policies).

Yes___ No___ N/A___ F. Section 7 (relating to unintentional lapse).

Yes___ No___ N/A___ G. Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.

Yes___ No___ N/A___ H. Section 9 (relating to required disclosure of rating practices to consumer).

Yes___ No___ N/A___ I. Section 11 (relating to prohibitions against post-claims underwriting).

Yes___ No___ N/A___ J. Section 12 (relating to minimum standards).

Yes___ No___ N/A___ K. Section 14 (relating to application forms and replacement coverage).

Yes___ No___ N/A___ L. Section 15 (relating to reporting requirements).

Yes___ No___ N/A___ M. Section 22 (relating to filing requirements for marketing).

Yes___ No___ N/A___ N. Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.

Yes___ No___ N/A___ O. Section 24 (relating to suitability).

Yes___ No___ N/A___ P. Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

Yes___ No___ N/A___ Q. Section 26 (the provisions relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in section 7702B(g)(4) of the Internal Revenue Code of 1986 (26 U.S.C. 7702BJ(g)(4)).

Yes___ No___ N/A___ R. Section 29 (relating to standard format outline of coverage).

Yes___ No___ N/A___ S. Section 30 (relating to requirement to deliver shopper's guide).

Are the following requirements of the 2000 Model Act met with respect to all policies (including certificates issued under a group insurance contract) intended to be covered under the Qualified Partnership Program that are issued on each of the policy forms identified in section I.C above?

Yes___ No___ N/A___ A. Section 6C (relating to preexisting conditions).

Yes___ No___ N/A___ B. Section 6D (relating to prior hospitalization).

Yes___ No___ N/A___ C. Section 8 (provisions relating to contingent nonforfeiture benefits).

Yes___ No___ N/A___ D. Section 6F (relating to right to return).

Yes___ No___ N/A___ E. Section 6G (relating to outline of coverage).

Yes___ No___ N/A___ F. Section 6H (relating to requirements for certificates under group plans).

Yes___ No___ N/A___ G. Section 6J (relating to policy summary).

Yes___ No___ N/A___ H. Section 6K (relating to monthly reports on accelerated death benefits).

Yes___ No___ N/A___ I. Section 7 (relating to incontestability period).

In order for a policy to be covered under the Qualified Partnership Program of the State, the answers to all questions above should be "yes" (or "N/A" where all requirements with respect to a provision above are not applicable). If answers differ between policy forms (*e.g.*, a requirement would be answered "Yes" for one form and "N/A" for another), you should use separate Issuer Certification Forms for such policies.

III. CERTIFICATION

I hereby certify that the policy forms and endorsements identified in Section C above meet all of the requirements of the 2000 National Association of Insurance Commissioners' Long-Term Care Model Act and Model Regulations that are specified in the Federal Deficit Reduction Act of 2005 (Pub. L. No. 109-171) and further certify that the answers, accompanying documents, and other information set forth herein are, to the best of my knowledge and belief, true, correct, and complete.

_____ _____

Date

Name and Title of Officer of the Issuer

_____
Signature of Officer of the Issuer

Form Number LHL570(LTC)

(b) Policies Not Previously Approved. Any policy or certificate, including any endorsement, that has not been previously approved by the commissioner must comply with the requirements specified in paragraphs (1) – (4) of this subsection prior to an insurer offering the policy for sale in Texas as a partnership policy:

(1) The policy, certificate, or endorsement must be filed with the department and approved by the commissioner, and Form Number LHL570(LTC) as specified in subsection (a)(2) of this section must be filed for each policy, certificate, or endorsement form submitted for partnership policy approval.

(2) The policy, certificate, or endorsement form must be in at least 10-point type.

(3) Any filing made pursuant to paragraph (1) of this subsection must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter.

(4) The filing should be submitted to the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104 or 333 Guadalupe, Austin, Texas, 78701.

(c) Previously Approved Policies. Insurers requesting to use a previously approved non-partnership policy form as a long-term care partnership policy must comply with the requirements specified in paragraphs (1) – (6) of this subsection prior to offering the policy for sale in Texas as a partnership policy:

(1) The insurer must file Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form as specified in subsection (a)(2) of this section and must include a copy of any endorsement that is needed to comply with partnership policy requirements.

(2) The policy form number(s) or other identifying information, such as certificate series, must be provided on Form Number LHL570(LTC) as a part of the filing.

(3) The filing must be approved by the commissioner prior to an insurer offering the policy for sale in Texas as a partnership policy.

(4) The policy or certificate does not have to be included in the filing if it has been previously filed and approved by the commissioner.

(5) Any filing made pursuant to this subsection must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter.

(6) The filing should be submitted to the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104 or 333 Guadalupe, Austin, Texas, 78701.

§3.3874. Insurer Requirements for Agents That Market Partnership Policies and Certificates.

(a) Insurer Training Verification and Certification Requirements for Agents. The following requirements apply to an insurer that is offering partnership policies or certificates in this state.

(1) The insurer is required to obtain verification that an agent has received the training specified in §19.1022 of this title (relating to Long-Term Care Partnership Certification Course).

(2) Pursuant to the Insurance Code §1651.105(b), the insurer is required to certify to the commissioner that each agent who sells partnership policies or certificates on behalf of the insurer complies with the training requirements of this subsection. The initial certification must be submitted on Form Number LHL571(LTC) Initial Long-Term Care Partnership Agent Training Certification Form as specified in Figure: 28 TAC §3.3874(b)(6)(A). Any subsequent certification must be submitted on Form Number LHL572(LTC) Annual Long-Term Care Partnership Agent Training Certification Form, as specified in Figure: 28 TAC §3.3874(b)(6)(B).

(3) The insurer is required to maintain records of the verification required in paragraph (1) of this subsection for at least four years from the date the verification is received, and the department or its designee may review these records at any time.

(b) Agent Training Certification Form Requirements. The following requirements and procedures apply to Form Number LHL571(LTC) Initial Long-Term Care

Partnership Agent Training Certification Form as specified in Figure: 28 TAC §3.3874(b)(6)(A) and Form Number LHL572(LTC) Annual Long-Term Care Partnership Agent Training Certification Form, as specified in Figure: 28 TAC §3.3874(b)(6)(B):

(1) The text must be in at least 10-point type and must follow the order of the information presented in Figure: 28 TAC §3.3874(b)(6)(A) and in Figure: 28 TAC §3.3874(b)(6)(B).

(2) The text of Form Number LHL571(LTC) as specified in Figure: 28 TAC §3.3874(b)(6)(A) and the text of Form Number LHL572(LTC) as specified in Figure: 28 TAC §3.3874(b)(6)(B) are mandated; the format for the forms is a recommended format. An insurer may format the mandated text in a different format from that specified in Figure: 28 TAC §3.3874(b)(6)(A) and Figure: 28 TAC §3.3874(b)(6)(B) if the insurer files the reformatted certification form for review and approval by the commissioner.

(3) Any reformatted certification form that is filed for approval pursuant to paragraph (2) of this subsection must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter.

(4) Any reformatted certification form filed pursuant to paragraph (2) of this subsection should be filed with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701.

(5) Form Number LHL571(LTC) and Form Number LHL572(LTC) may be obtained from the Life/Health Division, Mail Code 106-1A, Texas Department of

Insurance, P.O. Box 149104, Austin, Texas 78714-9107 or 333 Guadalupe, Austin, Texas 78701, or from the department's website at www.tdi.state.tx.us.

(6) Representations of Form Number LHL571(LTC) Initial Long-Term Care Partnership Agent Training Certification Form and Form Number LHL572(LTC) Annual Long-Term Care Partnership Agent Training Certification Form are specified in subparagraphs (A) and (B) of this paragraph.

(A) A representation of Form Number LHL571(LTC) is as follows:

Figure: 28 TAC §3.3874(b)(6)(A):

Long-Term Care Partnership Agent Training Certification
Initial Reporting Form
To be submitted to the Department by January 31, 2009

Company Name _____

NAIC ID Number _____

Date Report Submitted _____

TDI ID Number _____

I hereby certify that:

Each individual who currently sells a long-term care benefit plan for (company name) under the Long-Term Care Partnership Program has completed training and demonstrated evidence of understanding long-term care partnership policies and how they relate to other public and private coverage of long-term care.

Signature: _____

Name: _____

Title: _____

Address: _____

_____

City/State/Zip Code: _____

Phone Number: _____ EXT _____

E-mail Address: _____

Form Number LHL571(LTC)

(B) A representation of Form Number LHL572(LTC) is as follows:

Figure: 28 TAC §3.3874(b)(6)(B):

Long-Term Care Partnership Agent Training Certification
To be submitted to the Department annually between January 1 and January 31 for the preceding year beginning in 2010

Company Name _____

Reporting for Year _____

NAIC ID Number _____

Date Report Submitted _____

TDI ID Number _____

I hereby certify that for the annual period specified above:

Each individual who currently sells or who has sold a long-term care benefit plan for (company name) under the Long-term care Partnership Program completed training and demonstrated evidence of understanding long-term care partnership policies and how they relate to other public and private coverage of long-term care.

Signature: _____

Name: _____

Title: _____

Address: _____

_____

City/State/Zip Code: _____

Phone Number: _____ EXT _____

E-mail Address: _____

Form Number LHL572(LTC)

(c) Agent Training Certification Filing Requirements. An insurer offering partnership policies or certificates in this state shall submit for the initial certification to the department Form Number LHL571(LTC) Initial Long-Term Care Partnership Agent Training Certification Form containing the text as specified in Figure: 28 TAC §3.3874(b)(6)(A) and shall submit for the subsequent annual certifications to the department Form Number LHL572(LTC) Annual Long-Term Care Partnership Agent Training Certification Form, containing the text as specified in Figure: 28 TAC §3.3874(b)(6)(B), to certify that each individual who sells a long-term care benefit plan

for the insurer under the Long-Term Care Partnership Program has completed training and demonstrated evidence of understanding long-term care partnership insurance contracts and how they relate to other public and private coverage of long-term care.

(1) The initial certification Form Number LHL571(LTC) must be submitted to the department between January 1, 2009 and January 31, 2009, and the subsequent annual certification Form Number LHL572(LTC) must be submitted annually between January 1 and January 31 of each year for the preceding calendar year beginning in 2010.

(2) Form Number LHL571(LTC) and Form Number LHL572(LTC) are informational filings pursuant to §3.5(b)(1) of this chapter (relating to Filing Authorities and Categories) and are subject to the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(3) Any certification form submitted pursuant to this subsection should be filed with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104 or 333 Guadalupe, Austin, Texas, 78701.

10. CERTIFICATION. This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued at Austin, Texas, on _____, 2008.

_____
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance