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 AND ANNUITY CONTRACTS, AND LIFE INSURANCE POLICIES THAT PROVIDE LONG-TERM CARE BENEFITS WITHIN THE POLICY

DIVISION 1. GENERAL PROVISIONS
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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

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DIVISION 4. PARTNERSHIP LONG-TERM CARE INSURANCE ONLY
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1. INTRODUCTION. The Commissioner of Insurance adopts 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. Sections 3.3803, 3.3804, 3.3826, 3.3829, 3.3830, 3.3837, 3.3839, 3.3842, 3.3844, 3.3848, 3.3849, 3.3860, 3,3870 - 3.3874, are adopted with changes to the proposed text published in the July 18, 2008 issue of the *Texas Register* (33

TexReg 5635). Sections §§3.3801, 3.3802, 3.3821, 3.3833, 3.3834, 3.3838, 3.3846, are adopted without changes. A correction of error was published in the *Texas Register* on August 8, 2008 (33 TexReg 6446) to correct an error in the July 18 published proposal of §3.3842(j). As published in the July 18 edition, the last sentence of §3.3843(j) reads: "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 requirements and procedures apply:". As corrected, the last sentence of subsection (j) reads: "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:".

The adoption of the proposed amendments and the proposed new sections were considered by the Commissioner in a public hearing held under Docket Number 2689, at 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.

2. REASONED JUSTIFICATION. The adopted amendments and new sections are necessary to implement the insurance related provisions of Senate Bill (SB) 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 with 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 (Pub. L. No. 109-171). This adoption 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 adopted 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 as amended by the Deficit Reduction Act (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 as amended by the Deficit Reduction Act (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 as amended by the Deficit Reduction Act (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 as amended by the Deficit Reduction Act (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 as amended by the Deficit Reduction Act (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 as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)).

Inflation Protection. Pursuant to §1917(b)(1)(C)(iii)(IV) of the Social Security Act as amended by the Deficit Reduction Act (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 as amended by the Deficit Reduction Act (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 rules regulating long-term care partnership certification and continuing education course and licensee requirements were adopted by Commissioner Order No. 08-0639, dated July 14, 2008, published in the August 1, 2008 edition of the *Texas Register* (33 *TexReg* 6138), and effective August 5, 2008.

In response to comments received on the published proposal for this rule, the Department has revised some of the proposed text in the published rule. Additionally, this adoption includes minor clarification changes to several proposed provisions. None of the changes made to the proposed text, either as a result of comments or as a result of necessary clarification, materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

Changes in the Proposed Text in Response to Comments. The Department received numerous comments on the proposed text. The following changes have been made to the proposed text as a result of those comments.

Exemptions from certain requirements. Three sections have been modified in the adoption in response to comments that there are various consumer protection requirements in the proposed text that do not apply to life policies that have acceleration riders and that exemptions from these requirements are necessary for consistency with the NAIC Model Regulations. These sections are (i) §3.3837(f) (Suitability Data Reporting Requirements), (ii) §3.3842 (Appropriateness of Recommended Purchase), and (iii) §3.3844 (Nonforfeiture and Contingent Nonforfeiture Benefits).

Exemption from the Requirement to Offer Inflation Protection. Section 3.3860 and the definition of “long-term care partnership insurance policy” in §3.3804(21) have been revised in the adoption in response to comments to exempt life insurance policies or riders containing accelerated long-term care benefits from the offering of inflation protection. Commenters recommended that this exemption, which is substantially similar to §13C of the NAIC Long-Term Care Insurance Model Regulations, be added to §3.3820. The Department agrees that certain "life insurance policies or riders containing accelerated long-term care benefits" should be exempt from the §3.3820 requirement to offer inflation protection. Existing §3.3820, however, was not proposed for amendment in the proposal published in the July 18, 2008 issue of the *Texas Register* (33 TexReg 5635). Therefore, no substantive change may be made to existing §3.3820. In lieu of adding the requested exemption language to §3.3820, the

Department is adopting (i) an addition to §3.3860 to address the requested exemption; and (ii) a clarification addition to the §3.3804(21) definition of "long-term care partnership insurance policy." New §3.3860 specifies the policy summary requirements for non-partnership life insurance policies and annuity contracts that provide long-term care benefits by rider. Section 3.3860(a) specifies that a policy summary must be provided with a life insurance policy or annuity contract that provides long-term care benefits by rider. Section 3.3860(a)(4) requires that the policy summary for this type of policy contain a statement that provides that any long-term care inflation option required by §3.3820 and §3.3872 is not available under this policy. The definition in §3.3804(21) defines a "long-term care partnership insurance policy" as a long-term care insurance policy that is established under the Human Resources Code Chapter 32 Subchapter C and that meets the requirements of the Federal Deficit Reduction Act of 2005, Pub. L. No. 109-171 and Chapter 1651 Subchapter C of the Insurance Code. Chapter 32, Subchapter C of the Human Resources Code addresses the establishment and operation of the Partnership for Long-Term Care Program in Texas. A life insurance policy or annuity contract that provides long-term care benefits by rider does not comply with the definition of "long-term care partnership insurance policy" in proposed §3.3804(21). A partnership policy must contain an inflation protection provision as required by §1917(b)(1)(C)(iii)(IV) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)). The DRA inflation protection provision is implemented in new §3.3872 (relating to long-term care partnership policies and certificates). Section 1651.104 of the Insurance Code requires that a long-term

care partnership 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 as amended by the Deficit Reduction Act (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 as amended by the Deficit Reduction Act (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. Section 3.3860 is consistent with the §6J and §6K requirements. It is also consistent with the definition of "long-term care partnership insurance policy" in §3.3804(21). Section 3.3820 addresses the requirement to offer inflation protection to all applicants for long-term care insurance. Therefore, to address the commenter's recommendation relating to the §3.3820 exemption, the Department is adopting an addition to proposed new §3.3860. A new subsection (d) is added to adopted §3.3860 to read: "The statement required in subsection (a)(4) of this section applies to: (1) life insurance policies (A) that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and (B) that provide the option of a lump-sum payment for those benefits, and (C) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care; and (2) riders for group and individual annuities and life insurance policies that provide long-term care insurance." In addition, for purposes of clarity and consistency, the following provision is added to the adopted §3.3804(21) definition of "long-term care partnership

insurance policy": "This term does not include a life insurance policy or annuity contract that provides long-term care benefits by rider." This addition simply clarifies the §3.3804(21) definition and is consistent with §3.3860(a)(4) and (d).

Exemption from Other Requirements. Sections 3.3837(f) (Suitability Data Reporting Requirements), 3.3842 (Appropriateness of Recommended Purchase), and 3.3844 (Nonforfeiture and Contingent Nonforfeiture Benefits) have been revised in the adoption in response to comments. Each of these sections as adopted exempts life policies that have acceleration riders from the requirements of each of the specified sections. Commenters stated that there are various consumer protection requirements in the proposed text that do not apply to life policies that have acceleration riders and that exemptions from these requirements are necessary for consistency with the NAIC Model Regulations. Some commenters recommended that §3.3837(f) be modified to include the NAIC Long-Term Care Insurance Model Regulation §24A which exempts life insurance policies that accelerate benefits for long-term care from the suitability reporting requirements in §24H of the NAIC Long-Term Care Insurance Model Regulations. The requested exemption reads: "This section shall not apply to life insurance policies that accelerate benefits for long-term care." Some commenters recommended that §3.3840 be modified to include the NAIC Long-Term Care Insurance Model Regulation §32B which exempts life insurance policies that accelerate benefits for long-term care from the requirement to deliver a Long-Term Care shopper's guide. The requested exemption reads: "Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced

guide, but shall furnish the policy summary required under §3.3860**.**" Some commenters recommended that §3.3842 be modified to include the NAIC Model Regulation §24A which exempts life insurance policies that accelerate benefits for long-term care from the suitability requirements. The requested exemption reads: "This section shall not apply to life insurance policies that accelerate benefits for long-term care." Some commenters recommended that §3.3844 be modified to include the NAIC Model Regulation §28A which exempts life insurance forms from the nonforfeiture and contingent nonforfeiture benefits requirements. The requested exemption reads: "This section does not apply to life insurance policies or riders containing accelerated long-term care benefits." While the Department agrees with the recommended exemptions, the Department does not agree with the commenter's recommended exemption language for the sections. The recommended exemption language for §§3.3837, 3.3840, 3.3842, and 3.3844 is not consistent with the definition of "long-term care insurance" in §3.3804(20). Each of these recommended exemption provision pertains to (i) life insurance policies that accelerate benefits for long-term care and/or (ii) life insurance policies or riders containing accelerated long-term care benefits. In the adopted text, it is necessary to more specifically identify the policies or riders subject to the exemptions. This is necessary for consistency with the definition of "long-term care insurance" in §3.3804(20). The definition of "long-term care insurance" in §3.3804(20) provides that "long-term care insurance" 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. Therefore, these types of life insurance policies are not defined as “long-term care insurance” for purposes of §3.3837, §3.3840, §3.3842, and §3.3844 and are properly exempt from the long-term care consumer protection requirements in those four sections. As a result, §3.3837(f)(2)(B), §3.3842(i), and §3.3844(h)(2) as adopted contain exemption language that is consistent with the definition of “long-term care insurance” in §3.3804(20). The definition of long-term care insurance in §3.3804(20) provides that riders for group and individual annuities and life insurance policies that provide long-term care insurance are long-term care insurance for purposes of the Subchapter Y rules, including §§3.3837, 3.3840, 3.3842, and 3.3844. Therefore, it is necessary that these types of policies be afforded the consumer protection requirements in the four sections. These types of riders cannot be subject to the requested exemption. Therefore, §§3.3837(f)(2)(A), 3.3842(k), and 3.3844(h)(1) as adopted provide that the specified requirements shall apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance. Adopted §3.3842(k) also addresses the applicability of the §3.3840 requirement of delivery of the shopper’s guide. Adopted §3.3842(k) provides that both the §3.3842 requirements relating to suitability and the delivery requirements for the shopper’s guide specified in §3.3840 shall apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance. Section 3.3840, relating to the requirement of the delivery of the Long-Term Care shopper’s guide, was not proposed

for amendment in the proposal published in the July 18, 2008 issue of the *Texas Register* (33 TexReg 5635). Therefore, no change may be made to existing §3.3840. Instead of modifying §3.3840 to address the requested exemption, the Department is adopting an exemption in §3.3842(l) for life insurance policies that under §3.3804(20) are eligible for the exemption. The booklet entitled "Long-Term Care Insurance" published by the Texas Department of Insurance is the current "shopper's guide" in accordance with §3.3840(3). Adopted §3.3842(l) exempts from the requirement of delivery of the shopper's guide (booklet) for life insurance policies that accelerate the death benefit 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. The adopted exemption provides that in those instances of agent solicitation, an agent is not required to deliver a copy of the booklet prior to the presentation of an application or enrollment form for such policies. The adopted exemption further provides that in the case of direct response solicitations, the insurer is not required to present the booklet in conjunction with any application or enrollment form for such policies. In accordance with the definition of "long-term care insurance" in §3.3804(20), riders for group and individual annuities and life insurance policies that provide long-term care insurance are "long-term care insurance" and cannot be exempt from the shopper's guide delivery requirement. Therefore, adopted §3.3842(k) provides that §3.3842 requirements and the delivery requirements for the shopper's guide

specified in §3.3840 of this subchapter shall apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance.

§3.3804(21). Definitions. The defined term in §3.3804(21) as adopted has been changed from "long-term care partnership insurance contract" to "long-term care partnership insurance policy." This change is made in response to commenters who indicated that the term "long-term care partnership insurance contract" as defined in §3.3804(21) is not used consistently throughout the text of the rules. The commenters noted that the only time this term is used in the proposal is in §3.3874(c) and that generally, the references in the rules are to "long-term care insurance or policy." Also, for purposes of clarification, two additional changes have been made to §3.3804(21) as adopted. The adopted definition states that the term may include an individual policy and/or a certificate. The adopted definition also provides that the term does not include a life insurance policy or annuity contract that provides long-term benefits by rider. Both of these clarifications are necessary to make the definition in §3.3804(21) consistent with the other rules.

§3.3826(b) – (c). Limitations and Exclusions. Section 3.3826 as adopted has been changed to conform to the NAIC Model Regulations §6B(8) and (9). Section 3.3826 as proposed is not entirely consistent with NAIC Model Regulations §6B(8) and (9). The proposed text combines the prohibitions against limitations by type of provider and territorial limitations into one subsection. The Model Regulations recognize that these are two separate prohibitions. To achieve uniformity with the Model Regulations in the adopted amendment to §3.3826, the Department is revising subsection (b) to

clarify that subsection (b) only applies to exclusions and limitations by type of provider. The first sentence of subsection (b) as adopted reads: "This section is not intended to prohibit exclusions and limitations by type of provider." Subsection (b) as adopted has further been changed to move the definition of "state of policy issue" from subsection (b) to new subparagraph (3) in subsection (b). To further clarify that there are separate prohibitions against limitations by type of provider and territorial limitations, subsection (c) as adopted has deleted the language "exclusions and limitations by type of provider" from subsection (c) to read: "Provisions of this section are not intended to prohibit territorial limitations." Therefore, subsection (c) as adopted conforms to the Model Regulation by limiting the scope of the subsection to only territorial limitations. These changes have been made in response to comments that the proposed language in §3.3826(b) regarding cross border limitations and exclusions is misplaced. While the commenters indicated agreement with the first sentence in §3.3826(b), they recommended that §3.3826(b)(1) and (b)(2) be moved to new §3.3826(c)(1) and (c)(2). While the Department agrees that the language regarding cross border limitations and exclusions is misplaced, it does not agree with the commenters' suggestion on how to correct the misplacement. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (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 as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership

policies include the provisions in §6B of the NAIC Long-Term Care Model Regulations relating to limitations and exclusions in a long-term care policy. Therefore, §3.3826 as adopted has been changed to conform to the NAIC Model Regulations §6B(8) and (9).

§3.3829(b)(2)(E). Rate Increase Disclosure. The phrase "individual or group" has been deleted from §3.3829(b)(2)(E) and (E)(i) as adopted. This change has been made because the Department has determined based on comments that the inclusion of the phrase caused unnecessary confusion. The deletion is a clarification consistent with the intent of the provision and is not a substantive change. Commenters requested clarification regarding the Department's intent with respect to the addition in the proposal of the phrase "individual or group" to §3.3829(b)(2)(E). The commenters expressed their understanding that if the Personal Worksheet is being used for individual insurance, a carrier only needs to disclose individual rate increases, not group rate increases. The Department agrees with the commenters' understanding that when offering long-term care insurance in the individual market, the "Rate Increase History" information is only required to pertain to policies offered in the individual market. Likewise, when offering long-term care insurance in the group market, the "Rate Increase History" information is only required to pertain to policies offered in the group market.

§3.3829(b)(8)(H). Long-Term Care Insurance Personal Worksheet. The Department has made changes to §3.3829(b)(8)(H) as proposed in response to a comment that requests removing the section in the Personal Worksheet titled "Questions Related to Your Needs" as proposed and replacing it with an alternative

section to read as follows: "You must be diagnosed with cognitive impairment or be unable to perform two (2) of the following six (6) activities of daily living (ADL's)-bathing, continence, dressing, eating, toileting, and moving around-prior to your long-term care benefits being paid. 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

Does Policy Form [insert policy form number] cover all of the services checked above?

If not, which of the above mentioned services are included?

Instructions to Company: Issuer must insert policy form number and list appropriate services. If demonstrating multiple policy forms, reproduce this section separately for each form." The Department agrees in part and disagrees in part with the recommended replacement section. The Department has changed the limitations on payment of policy benefits part of the "Questions Related to Your Needs" section in the adopted rules to follow the recommendation of the commenter except that the term "trigger" that was used in the proposal is being retained in the adopted rules in lieu of the suggested change to the term "paid." In addition, the Department has changed the terminology "moving around" that was used in the proposal to the term "transferring." The reason for this change is that the term "transferring" is the properly accepted term for describing the ADL's. Therefore, the pertinent part of the notice as adopted reads: "You must be diagnosed with cognitive impairment or be unable to perform two (2) of the following six (6) activities of daily living (ADL's)-bathing, continence, dressing,

eating, toileting, and transferring--prior to your long-term care benefits being triggered." This change will clarify that cognitive impairment can also trigger long-term care benefits. The Department, however, disagrees with adding the new questions recommended by the commenter. The questions concern whether the policy form that the agent is demonstrating to the applicant covers all of the long-term care services that the applicant has checked and if not, which of the services are included in the policy. The Department also disagrees with adding the recommended Instructions to Company that would require the insurer to reproduce these questions separately for each policy form being demonstrated if multiple policy forms are being demonstrated to an applicant. These recommended additions are redundant, and the Department, therefore, does not believe that they are necessary. The Outline of Coverage, which is required to be delivered to the applicant, includes the policy or certificate number and describes the benefits provided by the policy.

New §3.3829(c). Effective Dates for Use of the Long-Term Care Insurance Personal Worksheet and the Long-Term Care Insurance Potential Rate Increase Disclosure Form. Section 3.3829 as proposed is changed in the adoption to add a new subsection (c) to specify the effective dates and certain other requirements for use of the Long-Term Care Insurance Personal Worksheet and the Long-Term Care Insurance Potential Rate Increase Disclosure Form and to specify procedures that will provide insurers additional time to print and distribute the new forms. New subsection (c)(1) is added to §3.3829 as adopted to provide that in lieu of the Long-Term Care Insurance Personal Worksheet specified in adopted new §3.3829(b)(8)(H), insurers may

use, until December 31, 2009, the standard NAIC Long-Term Care Insurance Personal Worksheet and a Texas Supplement printed on a separate sheet that contains the "Questions Related to Your Needs." New subsection (c)(2) is added to §3.3829 as adopted to provide that in lieu of the Long-Term Care Insurance Potential Rate Increase Disclosure Form specified in §3.3829(b)(8)(I) insurers may use, until December 31, 2009, the "Texas" Long-Term Care Insurance Potential Rate Increase Disclosure Form (titled LTC RATE INCR DISC-01-2002) that is currently in use in Texas. Additionally, new subsection (c)(2) specifies that insurers are not required to include the "Rate Increase History" information on the "Texas" Long-Term Care Insurance Potential Rate Increase Disclosure Form but are required to include such information on the standard NAIC Long-Term Care Insurance Personal Worksheet. New subsection (c)(3) specifies that insurers are not required to file the standard NAIC Long-Term Care Insurance Personal Worksheet or the Texas Supplement for review and approval by the Department. New subsection (c)(4) requires that on and after January 1, 2010, all insurers must use the Long-Term Care Insurance Personal Worksheet specified in adopted new §3.3829(b)(8)(H) and the Long-Term Care Insurance Potential Rate Increase Disclosure Form specified in adopted new §3.3829(b)(8)(I) in accordance with all of the requirements for these forms that are specified in §3.3829. These changes are made in response to comments requesting that insurers have a one-year delay on use of the Personal Worksheet and the Potential Rate Increase Disclosure Form. According to the commenters, a year is needed to file the forms, have them approved, and moved into production. While the Department disagrees with the requested delay,

the Department understands that additional time may be needed to print and distribute the new Personal Worksheet and the new Potential Rate Increase Disclosure Form. The Personal Worksheet provides information for the insurer to use to assess the applicant's suitability to purchase a long-term care policy prior to the applicant's purchase of the policy. The Personal Worksheet provides the important consumer protection of assisting the applicant and the insurer in making an informed decision as to whether it is prudent for the applicant to purchase a long-term care policy given the financial circumstances of the applicant. Delaying the use of the Personal Worksheet as requested by the commenters would deprive long-term care policy applicants of these important consumer protections for a full year. Likewise, delaying the use of the Potential Rate Increase Disclosure Form would deprive long-term care policy applicants of important information concerning rate increases on specific policy forms for a full year. Therefore, the Department is adding a new subsection (c) to §3.3829 as adopted.

§3.3842(j). Appropriateness of Recommended Purchase. Section §3.3842(j) as adopted allows insurers to send the applicant a suitability letter in accordance with or similar to the letter specified in §3.3842(j). Adopted §3.3842(j) provides in the first sentence that 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 **or similar to** Form Number LHL568(LTC) Long-Term Care Insurance Suitability Letter. This change is made in response to commenters who requested greater "flexibility" in the language of the proposed suitability letter specified

in §3.3842(j). The commenters recommended amending the first sentence of §3.3842(j) to allow the issuer to send a letter similar to the letter specified in §3.3842(j). In addition, because of the change to the first sentence in §3.3842(j), conforming changes have been made to §3.3842(j)(1) and (j)(2). The modified language in §3.3842(j)(1) as adopted reads: “The issuer’s Suitability Letter must use the text in Form Number LHL568(LTC) as specified in adopted new §3.3842(j) or be similar to the text specified in §3.3842(j).” Additionally, the modified language in §3.3842(j)(2) as adopted deletes the requirement that the text must follow the order of the information presented in Figure: 28 TAC §3.3842(j).

§3.3848(a). Limited Premium Payment Requirements. Section 3.3848(a) as proposed has been changed in the adoption to add to the end of that subsection the following provision: “Nothing in this section prohibits a carrier from offering premium payment duration options in excess of 10 years and any such options are not subject to this section." Commenters asserted that it is not clear in §3.3848 that the requirements of the section apply only to policies with a payment period of 10 years or less. The commenters requested a clarifying statement to address this.

§3.3848(b)(1). Notice of Limited Premium Payment Option. Section 3.3848(b)(1) as proposed is changed in the adoption to allow for varying methods of disclosure of the notice of the limited premium payment option in limited pay period policies. Section 3.3848(b)(1) as adopted reads as follows: "Notice. A long-term care insurance policy or certificate with a limited premium payment option must accurately reflect a plan with a limited premium payment option." The proposal required that the

notice be on the face page of the policy. This change has been made in response to commenters who requested the language in §3.3848(b)(1) that is adopted.

§3.3848(b)(3), (4), and (5)(A). Requirements Concerning Single-Premium Payment Option, One-to-Four Year Premium Payment Options, and Five-to-Ten Year Premium Payment Options. Section 3.3848(b)(3), (4), and (5)(A) as adopted include the following provision: "In the alternative, the required renewability provision may be added to the policy via an endorsement and change to the schedule page." As proposed, these provisions required that the renewability provision be on the face page of the policy or certificate. Commenters objected because the provisions did not contain an alternative that would allow the required renewability provision to be added to the policy via an endorsement or change to the schedule page. The commenters pointed out that the rule has a requirement that the Department can only approve a limited pay plan on a separate policy series. The commenters stated that under §3.3848(b) the Department is essentially continuing that same mandate by requiring disclosure on the policy cover. According to the commenters, most carriers in virtually all states implement limited pay disclosures through an endorsement on the schedule page. The commenters requested that the following language be added to the end of each of the provisions in §3.3848(3), (4) and (5)(A): "In the alternative, the required renewability provision may be added to the policy via an endorsement or change to the schedule page." The Department disagrees with this recommended change. There is no requirement that only a limited pay plan on a separate policy series can be approved by the Department. Insurers are permitted to offer limited pay premium by endorsement

and proper disclosure on the cover page. Therefore, the Department has determined that the proper alternative is as stated in the adopted provisions.

§3.3870(a). Notification and Offer of Exchange Requirements. Section 3.3870(a) as adopted extends the requirement for insurers to implement an exchange program to 18 months from the date the insurer initiates its partnership program and limits the offer to exchange under a policy or certificate to a policy or certificate of the type certified by the insurer. Proposed §3.3870(a) required the insurer to offer the option to exchange by December 31, 2009. Proposed §3.3870(a) also required insurers to offer, on a one-time basis to all policyholders or 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. These changes are in response to commenters who requested that the requirement to offer exchanges be extended to allow insurers 18 months from the date the insurer initiates its partnership program to implement an exchange program. These commenters also requested that the offer to exchange be limited to insureds under a policy or certificate "of the type certified" by the insurer (e.g., if an insurer certifies an individual policy for partnership, certificate holders under a group policy should not be required to receive an offer of exchange for the individual partnership policy). These commenters recommended changing §3.3870(a) to read as follows: "(a) Notification and Offer of Exchange. *Within 18 months from the date that an insurer* [Any insurer that] begins to advertise, market, offer, *or* sell, [or issue] policies [that qualify] under the Texas Long-Term Care Partnership Program*, the insurer* is required to offer on a one-time basis*, in*

writing, to all policyholders [and] or certificate holders that were issued long-term care coverage *of the type certified* 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.]" Adopted §3.3870(a) is consistent with the commenters' requested changes.

§3.3870(b)(2)(C). Alternative Exchange Methodology or Program. Section §3.3870(b)(2) as adopted contains a new provision in subparagraph (C) to permit insurers to develop an alternative exchange methodology or program that may differ from the procedures and requirements specified in proposed §3.3870. Proposed §3.3870(b)(2) did not provide such an alternative. It required insurers to make the new coverage available in one of the ways specified in §3.3870(b). This change is in response to commenters who recommended that insurers be allowed to develop alternative exchange programs. These commenters specifically recommended that a new subparagraph (C) be added to §3.3870(b)(2) as follows: "(C) In lieu of paragraphs (A) and (B) above, an insurer may implement an alternative exchange methodology or program so long as such methodology or program meets the intent of this section and is filed with and approved by the Commissioner." While the Department agrees with the recommendation, the Department does not agree with the specific recommended language. The recommended language is vague and lacks sufficient specificity for rule implementation and compliance enforcement. Therefore, in lieu of the recommended language, the Department has adopted the following provision in §3.3870(b)(2)(C): *In lieu of subparagraphs (A) and (B) of this paragraph, an insurer may implement an*

alternative exchange methodology or program only for policies or certificates issued on and after February 8, 2006, and that is 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).

§3.3870(e). One-time Exchange Reporting Requirement. Section 3.3870(e) as adopted requires an insurer to report exchanges made pursuant to §3.3870 on a one-time basis for the reporting period in which the insurer begins to advertise, market, offer, or sell policies under the Texas Long-Term Care Partnership Program. Section 3.3870(e) as proposed required insurers to report exchanges made pursuant to §3.3870 on a one-time basis for the 2009 reporting period and to be reported by June 30, 2010. Some commenters objected to proposed 3.3870(e) because it required the carriers to report exchanges on the Long-Term Care Insurance Replacement and Lapse Reporting Form for calendar year 2009. According to the commenters, it is preferable to report exchanges separately because carriers will have to reprogram their replacement reporting systems for this onetime reporting requirement. Section 3.3870(a) as adopted provides each individual insurer with an 18-month time period from the date that the insurer initiates its partnership program to implement an exchange program. This modification to §3.3870(a) also requires a revision in the time frame for the reporting of exchanges specified in §3.3870(e).

§3.3871(a)(2)(B)(vii). Partnership Status Disclosure Notice. The proposed disclosure notice has been changed in the last sentence of the paragraph titled "What

Could Disqualify Your Policy Status as a Partnership Policy" to delete the incorrect reference to the term "Endorsement" and to substitute the words "Disclosure Notice." This change is in response to commenters who pointed out this inadvertent error in the disclosure notice specified in adopted new §3.3871(a)(2)(B)(vii).

Other Changes to the Proposed Text. The necessary clarification and other non-substantive changes to the proposed text are described in the following.

§3.3803(a)(3). Applicability and Severability. The Department has made a change to §3.3803(a)(3) as proposed to correct the inadvertent omission of “annuity contracts” from this paragraph. The purpose of §3.3803(a)(3) is to specify the applicability of §3.3860 to only non-partnership life insurance policies and annuity contracts that provide long-term care benefits by rider except as specified in §3.3803(a)(5). The proposal published in the July 18, 2008 issue of the *Texas Register* (33 TexReg 5635) inadvertently omitted the reference to “annuity contracts” in proposed §3.3803(a)(3). The Department has interpreted the §6J policy summary requirement and the §6J(4) prohibition to also apply to annuity contracts. While annuity contracts are not addressed in the NAIC Model Act §6J, the Department applies the §6J requirements to annuity contracts. There are two reasons for applying the §6J requirements to annuity contracts in Texas: (i) riders that meet the definition of long-term care are being attached to annuity contracts; and (ii) annuity products are regulated similarly to life insurance policies. Therefore, for purposes of clarity and consistency, §3.3803(a)(3) as adopted is changed to provide that §3.3860 applies not only to non-partnership life insurance policies, but also to annuity contracts, that provide

long-term care benefits by rider except as specified in §3.3803(a)(5). Section 3.3860 relates to the policy summary requirements for non-partnership life insurance policies and annuity contracts that provide long-term care benefits. Under these requirements, a policy summary must be delivered with a non-partnership life insurance policy or annuity contract that provides long-term care benefits by rider at the same time that the policy or contract is delivered.

§3.3804(15). Definition of "home health agency." In the definition of the term "home health agency" in proposed §3.3804(15), the reference to the Texas Department of Health has been revised to reflect that the Texas Department of Health is now a part of the Human Services Commission. The adopted definition references the Texas Health and Human Services Commission.

§3.3804(19). Definition of "long-term care benefit plan." Two revisions have been made to the definition of "long-term care benefit plan" in §3.3804(19) as adopted. First, the second sentence of the definition has been revised to add the statutory authorization. As adopted, the sentence reads: "Pursuant to the Insurance Code §1651.003(b), 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." Second, language has been added to the definition to specify the class of life insurance policies that will not be defined as a long-term care benefit plan. The reason for this change is to clarify for the users of these rules exactly which classes of life insurance policies are and are not included in

this definition. The clarifying language reads: "With regard to life insurance, this term does not include life insurance policies:

(A) 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

(B) that provide the option of a lump-sum payment for those benefits and

(C) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care."

§3.3804(20). Definition of "long-term care insurance." The proposed definition of "long-term care insurance" in §3.3804(20) is reformatted in the adoption for purposes of making the definition more user friendly. While there are no substantive changes in the proposed definition, the various components of this long and complicated definition have been reformatted into subparagraphs (A) - (D). Subparagraph (A) concerns the general definition of long-term care insurance, the types of policies that may be included in the category of long-term care insurance, and the entities that are authorized to issue long-term care insurance. Subparagraph (B) concerns the types of insurance policies that contain health benefits but are not classified as long-term care insurance. Subparagraph (C) concerns certain life insurance policies that accelerate death benefits that are not classified as long-term care insurance. Subparagraph (C) is further divided into clauses (i) - (iii).

Subparagraph (D) specifies that any product advertised, marketed, or offered as long-term care will be subject to the provisions to Subchapter Y.

§3.3804(21). Definition of "long-term care partnership insurance policy." The term defined in proposed §3.3804(21) was "long-term care partnership insurance contract." As a result of comments, the defined term has been changed in the adoption to "long-term care partnership insurance policy." The definition of "long-term care partnership insurance policy" is revised to include the necessary provision that the term "long-term care partnership insurance policy" does not include a life insurance policy or annuity contract that provides long-term benefits by rider. This clarification is non-substantive and is simply a re-statement of one of the principal elements of the long-term care partnership program in Texas. The re-statement in the definition is for purposes of making the definition more user friendly. This principal element is addressed in §3.3860(a)(4), (d)(1) and (2), and §3.3872(b).

§3.3849(e)(2). Initial Certification of Association's Compliance with Marketing Standards for Long-Term Care Policies and Certificates. In §3.3849(e)(2) as adopted, there is a change in the proposed time frame for the submission to the Department by insurers of Form Number LHL573(LTC), the initial Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form. Adopted §3.3849(e)(2) requires that the initial certification be submitted to the Department between January 1, 2010 and January 31, 2010, for the calendar year 2009. Section §3.3849(e)(2) as proposed required the initial certification to be submitted to the

Department between January 1, 2009 and January 31, 2009, for the calendar year 2008. The proposal was based on anticipated association activity during calendar year 2008 that would be subject to the rules. However, because the rules will not be effective until some time in early calendar year 2009, there will not be any association activity subject to this rule during calendar year 2008.

§3.3871(a)(1)(D). Standards and Reporting Requirements for Approved Long-Term Care Partnership Policies and Certificates. Section 3.3871(a)(1)(D) as adopted clarifies that the effective date of the newly issued partnership policy, which is shown on the policy schedule page, must be either the date that the partnership policy is issued or the date the application for the partnership policy was signed. The adopted provision further clarifies that the insurer has the option of using either date, but the insurer must use the same option in all partnership policies issued by that insurer. Section 3.3871(a)(1)(D) as proposed was unclear for the following reasons: (i) it did not indicate that the partnership policies that are addressed in §3.3871(a)(1)(D) are "newly issued" policies; (ii) it did not indicate that the effective date of the partnership policy is shown on the policy schedule page; (iii) it did not state that the choice of the effective date is at the option of the insurer, and (iv) it did not provide that while the insurer has the option of using either date, the insurer must use the same option in all partnership policies issued by that insurer. While all of these elements are implied, the clarifications remove the possibility of ambiguities in the reading and interpretation of the provision that could result in inconsistent compliance. Such inconsistent compliance

could result in disparate treatment of long-term care partnership policy holders and certificate holders.

§3.3872(a)(3). Inflation protection option for any person who has attained the age of 76. Section 3.3872(a)(3) as adopted clarifies that although inflation protection is not required for any applicant for a partnership policy who has attained the age of 76, the offer of the long-term care inflation protection option in §3.3820 is still required for any such applicants. While this requirement is implied, the clarification is necessary for purposes of making the rules relating to inflation protection in §3.3820 and §3.3872 more user friendly.

§3.3872. Inflation protection. Subsection (b) is added to §3.3872 as adopted to clarify the types of policies for which inflation protection is not available. This provision is necessary to conform §3.3872 with §3.3860(a)(4). Section 3.3860(a)(4) requires that the policy summary for the types of policies specified in §3.3872(b) contain a statement that provides that any long-term care inflation option required by §3.3820 and §3.3872 is not available under the policy. The clarifying subsection states that the inflation protection provisions in §3.3872 are not available (1) under riders for group and individual annuities and life insurance policies that provide long-term care insurance; and (2) under life insurance policies (A) that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement and (B) that provide the option of a lump-sum payment for those benefits and (C) where neither the

benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

§3.3874(c). Agent Training Certification Filing Requirements. The word "policies" has been added at the end of §3.3874(c) as adopted. The word was inadvertently omitted in proposed §3.3874(c). Adopted §3.3874(c) reads in pertinent part: "An insurer offering partnership policies or certificates in this state shall submit for the initial certification to the department . . . and how they relate to other public and private coverage of long-term care *policies."*

§3.3874(c)(1). Initial Agent Training Certification. Section 3.3874(c) specifies agent training certification filing requirements. It requires each insurer 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 policies. Insurers are required to submit the initial certification to the Department on Form Number LHL571(LTC), Long-Term Care Partnership Agent Training Certification Initial Reporting Form as specified in §3.3874(b)(6)(A) and the subsequent annual certifications to the Department on Form Number LHL572(LTC), Long-Term Care Partnership Agent Training Certification Form specified in §3.3874(b)(6)(B). Section 3.3874(c)(1) as adopted provides that insurers must file the initial agent training certification form, Form Number LHL571(LTC), between June 1, 2009 and June 30, 2009. Section 3.3874(c)(1) as proposed required that the initial certification Form Number LHL571(LTC) be submitted to the Department

between January 1, 2009 and January 31, 2009. In addition, a conforming change is made in adopted Form Number LHL571(LTC) Long-Term Care Partnership Agent Training Certification Initial Reporting Form in §3.3874(b)(6)(A) to specify that the form is to be submitted to the Department by June 30, 2009 instead of January 31, 2009 as proposed. The proposal was based on the rules being effective some time in 2008 with insurers filing the certification between January 1, 2009 and January 31, 2009 for those agents receiving the training in 2008. However, because the rules will not be effective until some time in early calendar year 2009, there will not be any certification necessary under this rule for calendar year 2008. Therefore, to give insurers and agents sufficient time for preparation to comply with the training and certification requirements, adopted §3.3874(c)(1) provides that insurers must file the initial agent training certification form, Form Number LHL571(LTC), between June 1, 2009 and June 30, 2009. There are no changes to Form Number LHL572(LTC), Long-Term Care Partnership Agent Training Certification Form, specified in §3.3874(b)(6)(B) for the annual certification.

Change of "title" to "subchapter." The incorrect reference to "title" has been changed to "subchapter" in the following sections as adopted: §§3.3826(a)(1), 3.3829(a)(1), 3.3829(a)(9), 3.3830(g), 3.3844(d)(6), and 3.3844(d)(8).

Section-by-Section Summary. The following is a section-by–section summary of the adopted amendments and new sections and the reasons for the adoption.

§3.3802. Purpose. The adopted 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. 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 adopted 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) has been repealed and the severability provisions have been relocated without change to §3.3803(b). The 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 adopted to be redesignated as subsection (a)(2). The adopted 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). Adopted new §3.3803(a)(3) specifies the applicability of §3.3860 to only non-partnership life insurance policies and annuity contracts that provide long-term care benefits by rider except as specified in §3.3803(a)(5). Adopted 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 re-designated as §3.3803(a)(5)(A) and (B). Additionally, the existing provision in §3.3803(2), which is re-designated as §3.3803(a)(5)(B), is 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 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 adopted amendments to §3.3803 also add new subsection (b) to relocate without change the existing §3.3850 severability provisions that are being repealed. The adopted repeal is also published in this edition of the *Texas Register*.

§3.3804. Definitions. The adopted 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. The adopted definition also specifies the class of life insurance policies that are not defined as a long-term care benefit plan. The adopted definition provides that with regard to life insurance, the term “long-term care benefit plan” does not include life insurance policies: (A) 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 (B) that provide the option of a lump-sum payment for those benefits and (C) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

Amendments are adopted to existing §3.3804(19), which is re-designated as paragraph (20). The adopted amendments to re-designated §3.3804(20) change the term from "long-term care insurance contract" to "long-term care insurance" to conform the term to the term used in the NAIC Model Regulations and Model Act. Adopted §3.3804(20) defines "long-term care insurance" as that term is defined by the NAIC but as modified for consistency with §1651.003 of the Insurance Code. Most of the existing and proposed regulations in Subchapter Y are based on the NAIC Model Regulations and Model Act. In §1651.003, the term long-term care benefit plan "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 loss of functional capacity" (emphasis added). The underlined language excludes a group or individual annuity or life insurance policy from being classified as long-term care insurance even if it provides for payment of benefits based on cognitive impairment or loss of functional capacity. Therefore, in order to conform the definition of "long-term care insurance" in Subchapter Y with the NAIC definition and for consistency with §1651.003 of the Insurance Code the definition is modified to specify that "the term includes riders for group and individual annuities and life insurance policies that provide long-term care insurance." To conform the adopted §3.3804(20) definition of "long-term care insurance" to the NAIC definition,

the following requirements are 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 adopted 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 adopted definition of “long-term care insurance” is reformatted into subparagraphs (A) - (D). Additionally, the components of subparagraph (C) are further divided into clauses (i) - (iii). The reformatting is necessary to make this definition more user friendly. Subparagraph (A) concerns the general definition of long-term care insurance, the types of policies that may be included in the category of long-term care insurance, and the entities that are authorized to issue long-term care insurance. Subparagraph (B) concerns the types of insurance policies that contain health benefits but are not classified as long-term care insurance. Subparagraph (C) concerns certain life insurance policies that accelerate death benefits that are not classified as long-term care insurance. Subparagraph (D) specifies that any

product advertised, marketed, or offered as long-term care will be subject to the provisions to Subchapter Y.

The adopted amendments to §3.3804 add new paragraph (21) to include a definition of "long-term care insurance partnership policy." The adopted definition provides that the term may include an individual policy and/or a certificate. The adopted definition also provides that the term does not include a life insurance policy or annuity contract that provides long-term benefits by rider. Adopted §3.3804(21) defines "long-term care insurance partnership policy" to mean a long-term care insurance policy established under the Human Resources Code Chapter 32 Subchapter C and that meets the requirements of the Federal Deficit Reduction Act of 2005, Pub. L. No. 109-171 and the Insurance Code Chapter 1651 Subchapter C. This new definition is necessary to clarify what constitutes a long-term care partnership insurance policy under the adopted amendments to Subchapter Y. The adopted amendments are necessary 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, in the adoption, paragraphs (20) - (30) are redesignated as paragraphs (22) - (32).

§3.3826. Limitations and Exclusions. The adopted amendments to §3.3826 (i) 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; (ii) clarify the applicability of 3.3826(b); and (iii) relocate the definition of "state of

policy issue" from subsection (b) to a new subparagraph (b)(3); and (iv) clarify in §3.3826(c) that the provisions of §3.3826 are not intended to prohibit territorial limitations." Section 3.3826(b) as adopted clarifies that subsection (b) only applies to exclusions and limitations by type of provider. The first sentence of subsection (b) as adopted reads: *This section is not intended to prohibit exclusions and limitations by type of provider.* Section 3.3826(b)(3) as adopted specifies the definition of "state of policy issue." Section 3.3826(c) as adopted provides that the provisions of §3.3826 are not intended to prohibit territorial limitations. This change to §3.3826(c) is necessary to conform the rules to the NAIC Model Regulation by limiting the scope of the subsection to only territorial limitations.

§3.3829. Required Disclosures. The adopted 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. Adopted §3.3829(b)(2)(E) and (E)(i) as adopted are the same as existing §3.3829(b)(2)(E) and (E)(i). The proposed amendments to specifically identify the policy form or similar policy forms as "individual or group" policy forms are not adopted. This is because some commenters requested clarification regarding the Department's intent with respect to the addition in the proposal of the phrase "individual or group" to existing §3.3829(b)(2)(E) and (E)(i). The

commenters expressed their understanding that if the Personal Worksheet is being used for individual insurance, a carrier only needs to disclose individual rate increases, not group rate increases. The Department agrees with the commenters' understanding that for offerings of long-term care insurance in the individual market, the "Rate Increase History" information is only required to pertain to policies offered in the individual market. Likewise, for offerings of long-term care insurance in the group market, the "Rate Increase History" information is only required to pertain to policies offered in the group market. Therefore, because the proposed amendments caused unnecessary confusion, the Department has deleted the phrase from §3.3829(b)(2)(E) and (E)(i) as adopted. This deletion does not result in any substantive change to §3.3829(b)(2)(E) and (E)(i). Adopted §3.3829(b)(2)(E) and (E)(i) require that the information regarding each premium rate increase on the policy form or similar policy forms over the past 10 years for this state or any other state must at a minimum, identify the policy forms for which premium rates have been increased.

Adopted 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 Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet is specified in new subparagraph (b)(8)(H). A representation of Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form is specified in new subparagraph (b)(8)(I). New Form Number LHL560(LTC) Long-Term Care Insurance 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. New Form Number LHL561(LTC) Long-Term Care Insurance 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 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 to 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. The adopted amendments to §3.3829(b)(2) add a new section to the Personal Worksheet titled "Questions Related to Your Needs." This new section explains that one must be diagnosed with cognitive

impairment or be unable to perform two of the six specified activities of daily living (ADL's) prior to long-term care benefits being triggered. The six activities are bathing, continence, dressing, eating, toileting, and transferring - prior to your long-term care benefits being triggered. The new section asks the applicant if the applicant understands this policy limitation. The next question is "What type of long-term care service do you anticipate utilizing?" and asks the applicant to check all that apply. The listed services are (i) Nursing home care, (ii) Assisted living care, (iii) Home health care, (iv) Adult day care, (v) Hospice care, (vi) Respite care and (vii) other services. The new section to the Personal Worksheet titled "Questions Related to Your Needs" adds consumer protection requirements in the form of additional disclosure statements and questions to Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet. These disclosure statements and questions are listed in the part of the form titled "Questions Related to Your Needs" and include disclosure statements and questions to applicants regarding: (i) awareness of the term "cognitive impairment" and the need for such a diagnosis to trigger benefits; (ii) awareness of ADL's and number of the ADL's that an applicant must be unable to perform to trigger long-term care benefits; (iii) a question concerning the applicant's understanding of policy limitations; and (iv) what type of long-term care service the applicant anticipates utilizing. These additional disclosure statements and questions are necessary to more prominently disclose some of the most important limitations that are currently contained in long-term care policies.

Adopted new §3.3829(c) specifies the effective dates and certain other requirements for use of Form Number LHL560(LTC) Long-Term Care Insurance

Personal Worksheet specified in §3.3829(b)(8)(H) and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form specified in §3.3829(b)(8)(l). Adopted new §3.3829(c) is necessary to provide sufficient time to insurers to print and distribute the new forms. Adopted §3.3829(c)(1) provides that in lieu of the Long-Term Care Insurance Personal Worksheet specified in §3.3829(b)(8)(H), insurers may use, until December 31, 2009, the standard NAIC Long-Term Care Insurance Personal Worksheet and a Texas Supplement printed on a separate sheet that contains the "Questions Related to Your Needs." Adopted to §3.3829(c)(2) provides that in lieu of the Long-Term Care Insurance Potential Rate Increase Disclosure Form specified in §3.3829(b)(8)(I) insurers may use, until December 31, 2009, the "Texas" Long-Term Care Insurance Potential Rate Increase Disclosure Form (titled LTC RATE INCR DISC-01-2002) that is currently in use in Texas. Additionally, adopted §3.3829(c)(2) specifies that insurers are not required to include the "Rate Increase History" information on the "Texas" Long-Term Care Insurance Potential Rate Increase Disclosure Form but are required to include such information on the standard NAIC Long-Term Care Insurance Personal Worksheet. Adopted §3.3829(c)(3) specifies that insurers are not required to file the standard NAIC Long-Term Care Insurance Personal Worksheet or the Texas Supplement for review and approval by the Department. Adopted §3.3829(c)(4) requires that on and after January 1, 2010, all insurers must use Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet specified in §3.3829(b)(8)(H) and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form

specified in §3.3829(b)(8)(l) in accordance with all of the requirements for these forms that are specified in §3.3829. The Personal Worksheet is necessary to provide information for the insurer to use to assess the applicant's suitability to purchase a long-term care policy prior to the applicant's purchase of the policy. The Personal Worksheet is necessary to provide the important consumer protection of assisting the applicant and the insurer in making an informed decision as to whether it is prudent for the applicant to purchase a long-term care policy given the financial circumstances of the applicant.

§3.3830. Requirements for Application Forms and Replacement Coverage.

The adopted 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 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 as amended by the Deficit Reduction Act (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 as amended by the Deficit Reduction Act (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 adopted new §3.3830(h).

§3.3837. Reporting Requirements. The adopted 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 re-designated as subsection (a)(1)(A). The adopted 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 adopted amendments; subsection (a)(3) relating to reporting the number of lapsed long-term care policies; this is existing subsection (a)(3) with adopted amendments; and subsection (a)(4) reporting number of replacement long-term care policies; this is existing subsection (a)(4) with adopted amendments.

Existing §3.3837(a)(2) is 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 adopted 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. 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 adopted 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 adopted amendments to §3.3837 further amend subsection (a)(3) and (4) to require insurers to use the part of 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 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 adopted amendments to subsection (a)(3) and (4), the required information must be submitted electronically in a format prescribed by the Department. The adopted 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 adopted amendments to subsection (a)(1), (2), (3), and (4). Existing §3.3837(a)(5) has been 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 moved to new §3.3837(g) for purposes of organizational clarity.

The adopted amendments to §3.3837(b), pertaining to insurer reporting requirements relating to rescissions, are necessary to require the use of 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 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 repealed, and the adopted repeal is also published in this edition of the *Texas Register*. The adopted 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 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 adopted amendments to §3.3837(b), the required information in new Form Number LHL563(LTC) must be submitted electronically in a format prescribed by the Department. The adopted amendments to §3.3837(b), including the 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 adopted 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 adopted to require insurers to use adopted 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 adopted 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 adopted 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 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 as amended by the Deficit Reduction Act (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 as amended by the Deficit Reduction Act (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 adopted new form specified in §3.3837(c)(2).

The adopted amendments to §3.3837(d), pertaining to reporting requirements for the long-term care partnership program, delete the existing subsection (d) and adopt new reporting requirements for all insurers that market partnership policies in Texas. 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 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 adopted new provisions in §3.3837 and is deleted.

The adopted 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 adopted 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. 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 adopted §3.3837(d) and non-partnership data as required pursuant to adopted §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 adopted new §3.3837(e) as well as the partnership data specified in the adopted 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.

Adopted 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 new Form Number LHL566(LTC) Long-

Term Care Suitability Reporting Form as specified in §3.3837(f)(1). The data is required to be reported to the Commissioner by no later than June 30 annually for the preceding calendar year. Under the 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. Adopted 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 reporting requirements require insurers to submit the data electronically in a format prescribed on the Department's website. Adopted §3.3837(f)(1) specifies the representation of Form Number LHL566(LTC) Long-Term Care Suitability Reporting Form. Adopted §3.3832(f)(2) is necessary to clarify the types of policies that are exempt from the requirements of §3.3837(f). Section 3.3837(f)(2)(A) provides that subsection (f) applies to riders for group and individual annuities and life insurance policies that provide long-term care insurance. Section 3.3837(f)(2)(B) exempts from the requirements of §3.3837(f) life insurance policies that accelerate the death benefit 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. 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 as amended by the Deficit Reduction Act (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 as amended by the Deficit Reduction Act (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 adopted new §3.3837(f). 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.

Adopted 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 redesignated as new §3.3837(g). Adopted §3.3837(g) clarifies 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). Adopted §3.3837(g) also mandates 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 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 adopted 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 Chapter 21 of Title 28 of the Texas Administrative Code (relating to Scope)) 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 continues to be subject to prior approval by the Commissioner, subject to the requirements in existing §3.3838. The adopted 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 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 adopted 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. Adopted 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 Insurance Personal Worksheet as specified in §3.3829(b)(8)(H) and the Long-Term Care Insurance Potential Rate Increase Disclosure Form as specified in §3.3829(b)(8)(I). These new requirements 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 means that more consumers are able to make more informed decisions regarding the purchase of long-term care insurance. Also, more consumers are 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 explains 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 are aware of the possible range of benefits that they 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 also assists 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 adopted §3.3829, provides 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 ensures that those consumers who do not need or cannot afford such a policy will be less likely to purchase one. Additionally, for marketing standards purposes, 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 adopted 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 redesignated as §3.3839(a)(11), specifies the requirements for providing the required notices to policyholders. No changes are adopted to the existing required notices or to the existing requirements for providing the notice to policyholders. The 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 adopted 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 as amended by the Deficit Reduction Act (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 as amended by the Deficit Reduction Act (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 adopted 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). The Department has determined that it is also necessary to apply the consumer protection requirements in the adopted 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 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.

Adopted new §3.3839(a)(8), (9) and (10) and the adopted amendments to existing §3.3839(b), which provide that the required inflation notices are also marketing procedure requirements that are subject to Department audit to verify compliance, 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 as amended by the Deficit Reduction Act (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 as amended by the Deficit Reduction Act (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 adopted new §3.3839(a)(8), (9) and

(10) and the adopted 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 redesignated as §3.3839(b) and (c) because of the redesignation of existing §3.3839(b) as §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 redesignated as §3.3842(a), constitutes the entirety of existing §3.3842. The adopted amendments to §3.3842 add several new requirements in adopted subsections (b) – (l) 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. Adopted 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.

Adopted 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: (i) the applicant's ability to pay for the

proposed coverage and other pertinent financial information; (ii) the applicant's goals and needs with respect to long-term care; and (iii) 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.

Adopted 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 adopted new §3.3842(c) and that the efforts shall include presentation to the applicant of the Long-Term Care Insurance Personal Worksheet that is adopted in new Form Number LHL560(LTC) specified in §3.3829(b)(8)(H). Under 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 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; and (iii) the filing should be submitted to the Filings Intake Division of the Department.

Adopted new §3.3842(e) requires the completed Long-Term Care Insurance 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. Adopted new §3.3842(f) prohibits the sale or dissemination of information obtained through completion of the Long-Term Care Insurance Personal

Worksheet. Adopted 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. Adopted new §3.3842(h) requires agents to use the suitability standards developed by the issuer in marketing the issuer's long-term care insurance.

Adopted new §3.3842(i) requires issuers to provide to the applicant at the same time the Personal Worksheet is provided the 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, adopted new §3.3842(i)(1) – (6) specify the requirements and procedures that apply to adopted new Form Number LHL567(LTC), including text size and content, recommended format, and filing and approval procedures as applicable. A representation of new Form Number LHL567(LTC) Things You Should Know Before You Buy Long-Term Care Insurance is in §3.3842(i)(7).

Adopted 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

adopted 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 or similar to the 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. 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. Adopted §3.3842(k) provides that §3.3842 and the delivery requirements for the shopper's guide in §3.3840 of this subchapter shall apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance. Adopted §3.3842(l) provides that §3.3842 and the delivery requirements for the shopper's guide in §3.3840 do not apply to life insurance policies: (1) that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement and (2) that provide the option of a lump-sum payment for those benefits and (3) where neither the

benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. New §3.3842(k) and (l) are necessary for consistency with the definition of "long-term care insurance" in §3.3804(20).

Adopted new §3.3842(b) – (l) 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 as amended by the Deficit Reduction Act (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 as amended by the Deficit Reduction Act (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 adopted new §3.3842(b) - (j). Section 24 requires the use of the 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 Suitability Letter specified in 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 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 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 adopted to existing §3.3844 (a), (b), (d), or (f). An adopted amendment to §3.3844(c)(3) corrects the erroneous word "shorten" to read

"shortened." No changes are made to §3.3844(g)(1); however, a new §3.3844(g)(2) is adopted.

Adopted 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 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 table in §3.3844(g)(2). This shall be based on (i) the insured's issue age, (ii) the policy or certificate lapsing within 120 days of the due date of the premium so increased, and (iii) the ratio specified in adopted §3.3844(g)(4)(B) is 40 percent or more. Adopted §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 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. 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.

Adopted 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.

Adopted 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 adopted 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 amendments also provide that subsection §3.3844(e) does not apply to contingent nonforfeiture benefits upon lapse in accordance with §3.3844(g)(2). Adopted §3.3844(g)(2) 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 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. Adopted §3.3844(h)(1) provides that §3.3844 applies to riders for group and individual annuities and life insurance policies that provide long-term care insurance. Adopted §3.3844(h)(2) provides that §3.3844

does not apply to life insurance policies: (A) that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement and (B) that provide the option of a lump-sum payment for those benefits and (C) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. New §3.3844(h)(1) and (2) are necessary for consistency with the definition of "long-term care insurance" in §3.3804(20).

The adopted amendments to §3.3844 that amend subsection (e), add new paragraphs (2) and (4) to subsection (g), and add new subsection (h)(1) and (2) 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 as amended by the Deficit Reduction Act (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 as amended by the Deficit Reduction Act (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 adopted amendments to §3.3844(e), (e)(3), (g)(2), and (4).

The Department has determined that it is also necessary to apply the new contingent nonforfeiture benefit requirements for limited premium payment policies in the adopted 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 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 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 adopted §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. Adopted new §3.3848(a) specifies the definition and applicability. Adopted new §3.3848(a) also provides that nothing in §3.3848 prohibits a carrier from offering premium payment duration options in excess of 10 years, and any such options are not subject to this section. Adopted 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 of Title 28 of the Texas Administrative Code and with the additional requirements specified in §3.3848(b).

The notice requirement in adopted new §3.3848(b)(1) requires that a long-term care insurance policy or certificate with a limited premium payment option must accurately reflect a plan with a limited premium payment option. The adopted requirement in §3.3848(b)(2) requires that 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. Adopted §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. Adopted §3.3848(b)(3) also provides that in the alternative, the required renewability provision may be added to the policy via an endorsement and change to the schedule page. 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. Adopted §3.3848(b)(4) also provides that in the alternative, the required renewability provision may be added to the policy via an endorsement and change to the schedule page.

Adopted §3.3848(b)(5) specifies the requirements for five-to-ten year premium payment option policies. A long-term care policy, certificate or rider with a five-to-ten year premium payment option must be guaranteed renewable as provided in adopted §3.3807(a). Adopted §3.3848(b)(5)(A) specifies the requirements for the renewability provision on the face page of a long-term care policy or certificate. Adopted §3.3848(b)(5)(A) also specifies that in the alternative, the required renewability provision may be added to the policy via an endorsement and change to the schedule page. Adopted §3.3848(b)(5)(B) requires that 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). Adopted §3.3848(b)(5)(C) requires those policies, certificates, and riders with a five-to-ten year premium payment option to 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. Adopted §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 adopted §3.3848 are not required by SB 22 or the DRA. The adopted requirements, which apply to both partnership and non-partnership policies, are necessary to protect Texas insureds who have limited premium payment plans from unfair cancellation, nonrenewal, and return of premium practices.

New §3.3848 is adopted 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 repealed, and the adopted repeal is also published in this edition of the *Texas Register*. Adopted 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 §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 Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form specified in §3.3849(e)(1)(F). A representation of Form Number LHL573(LTC) Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form is specified in adopted new §3.3849(e)(1)(F).

Adopted 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).

Adopted new §3.3849(e)(1)(A) – (D) specify the requirements and procedures that apply to the Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form, including text content, text font size, recommended format, and filing for approval as applicable. Adopted new §3.3849(e)(2) requires that the initial certification be submitted to the Department between January 1, 2010 and January 31, 2010, for the calendar year 2009, and thereafter be submitted annually between January 1 and January 31 for the preceding calendar year.

Adopted new §3.3849(e)(3) provides that the certification form is an informational filing pursuant to §3.5(b)(1) of Title 28 of the Texas Administrative Code (relating to Filing Authorities and Categories) and is subject to the requirements and procedures in Chapter 3, Subchapter A. Adopted 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 Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form. 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 certification form in §3.3849(e)(1)(F) will ensure timely and efficient filing of the required certification information with the Department.

Adopted 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.

Adopted §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 §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. These new requirements are necessary 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.

Adopted 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.

Adopted 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 as amended by the Deficit Reduction Act (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 as amended by the Deficit Reduction Act (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 adopted §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 adopted in §3.3849(a)(1)(C).

The Department has determined that it is also necessary to apply the consumer protection requirements in adopted 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. Requirements for Non-Partnership Life Insurance Policies and Annuity Contracts That Provide Long-Term Care Benefits. Adopted new §3.3860 sets forth the delivery and content requirements for the policy summary for non-partnership life insurance policies and annuity contracts that provide long-term care benefits by rider. The adopted requirements do not apply to any long-term care partnership policy. Adopted §3.3860(a) specifies that at the time of delivery of a life insurance policy or annuity contract that provides long-term care benefits by rider the insurer shall also deliver a policy summary. Adopted §3.3860(a) also provides requirements for policy summary delivery for direct response solicitations. Adopted §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. Adopted §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 of the Texas Administrative Code, relating to Life Insurance Illustrations. Adopted §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, adopted §3.3860(c) specifies the information the monthly report is required to contain. Adopted §3.3860(d) provides that the statement required in §3.3860(a)(4) applies to: (i) riders for group and individual annuities and life insurance policies that provide long-term care insurance and (ii) life insurance policies that (A) accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement and (B) provide the option of a lump-sum payment for those benefits and (C) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Adopted §3.3860(d) exempts the types of life insurance policies, annuity contracts, or riders containing accelerated long-term care benefits that are specified in §3.3860(d)(1) and (2) from the §3.3820 requirement to offer inflation protection and further provides that §3.3872 of this subchapter (relating to Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates) is not available for such policies.

The provisions in adopted §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 or annuity contract. Adopted §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 or annuity contract be consistent with the provisions in §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)). The policy or annuity 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 as amended by the Deficit Reduction Act (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. Adopted §3.3860 is consistent with the §6J and §6K requirements.

§3.3870. Exchange Requirements for Long-Term Care Partnership Policies. Adopted new §3.3870 specifies the requirements for the exchange of an existing long-term care policy for a new long-term care partnership policy. Adopted new §3.3870(a) addresses requirements for notification to policyholders eligible for exchange and the requirements for the offer of exchange. Adopted new §3.3870(a) provides that within 18 months from the date that an insurer begins to advertise, market, offer, or sell, policies under the Texas Long-Term Care Partnership Program, the insurer is required to offer, on a one-time basis to all policyholders or certificate holders that were issued long-term care coverage of the type certified by the insurer on or after February 8, 2006, the

option to exchange their existing policy or certificate for a partnership policy or certificate. Adopted new §3.3870(a) also requires that the offer be in writing.

Adopted new §3.3870(b) specifies the methods by which insurers may make the new coverage available, including: (i) by adding a rider or endorsement to the existing policy; (ii) by exchanging the existing policy or certificate for a new partnership policy or certificate; or (iii) in lieu of either of these, by implementing an alternative exchange methodology or program that is filed with the department and approved by the Commissioner. Adopted 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. Adopted 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. Adopted new §3.3870(b)(2)(C) provides that in lieu of subparagraphs (A) and (B), an insurer may implement an alternative exchange methodology or program only for policies or certificates issued on and after February 8, 2006, and that is filed with the department and approved by the commissioner in accordance with the requirements and procedures set forth in Subchapter A of this chapter.

Adopted 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 requirements which are specified in adopted §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.

Adopted new §3.3870(d) provides that policies issued pursuant to this section shall be considered exchanges and not replacements. Adopted new §3.3870(e) imposes a one-time reporting requirement. Under adopted new §3.3870(e), an insurer is required to report exchanges made pursuant to §3.3870 on a one-time basis for the reporting period in which the insurer begins to advertise, market, offer, or sell policies under the Texas Long-Term Care Partnership Program 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).

SB 22 establishes a partnership for long-term care program in Texas, and the Department is adopting 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 adopting 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. Adopted 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. Adopted §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 with 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.

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

Adopted §3.3871(a)(1)(D) provides that the effective date of a newly issued partnership policy, which is shown on the policy schedule page, must be either the date that the partnership policy is issued or the date that the application for the partnership policy was signed. The provision relating to the effective date being the date that the partnership policy is issued is consistent with the effective date provision 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 provision relating to the effective date being the date that the application for the partnership policy was signed is based on input from stakeholders. In the meetings that the Department held with stakeholders, insurer representatives indicated that some companies use the application date as the effective date of the policy. Adopted §3.3871(a)(1)(D) further clarifies that each insurer has the option of using either date, but provides that the insurer must use the same option in all partnership policies issued by that insurer.

A policy or certificate represented or marketed as a long-term care partnership policy or certificate must be accompanied by a disclosure notice that explains the benefits associated with the policy or certificate in accordance with the requirements in §3.3871(a)(2)(A) and (B). A representation of Form Number LHL569(LTC) (Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates) is specified in §3.3871(a)(2)(B)(vii). While 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 adopting these provisions pursuant to the Commissioner's rulemaking authority in the

Insurance Code §1651.004. Adopted §3.3871(a)(2)(A) and (B) are necessary to ensure that necessary information is provided 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 "Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates 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.

Adopted 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. Adopted 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 new §3.3871(a)(2)(B)(ix) and (x) are not required by SB 22 or the DRA, the Department is adopting 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.

Adopted 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 as amended by the Deficit Reduction Act (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 adopted §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. Adopted 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 as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(VI)) includes the requirements that are adopted in §3.3871(b). Adopted 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 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. Adopted new §3.3872(a) sets forth the inflation protection requirements for long-term care partnership policies and certificates. Adopted new §3.3872(a)(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. Adopted new §3.3872(a)(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. Adopted new §3.3872(a)(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). Adopted new §3.3872(a)(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(a)(2). Adopted new §3.3872(a)(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. Adopted new §3.3872(a)(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. Adopted new §3.3872(a)(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(a)(3). Adopted new §3.3872(a)(3) specifies that for a person who is 76 years old, inflation protection may be provided but is not required. Adopted new §3.3872(a)(3) clarifies that the long-term care inflation protection option specified in §3.3820 of this subchapter (relating to Requirement To Offer Inflation Protection) must be offered to any applicant for a partnership policy who has attained the age of 76. This clarification is necessary in order for users of these rules to clearly understand that although inflation protection is not required for any applicant for a partnership who has attained the age of 76, the offer of the long-term care inflation protection option in §3.3820 is still required for any applicant for a partnership policy who has attained the age of 76.

Adopted new §3.3872(a)(4) specifies that an option to purchase inflation protection in the future does not constitute compliance with the requirements in §3.3872(a)(1) and (a)(2). Adopted 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 as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)) includes the requirements that are adopted in §3.3872. Adopted new §3.3872(b) provides that the inflation protection provisions in §3.3872 are not available under the following policies: (1) riders for group and individual annuities and life insurance policies that provide long-term care insurance; and (2) life insurance policies: (A) that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement and (B) that provide the option of a lump-sum payment for those benefits and (C) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Adopted new §3.3872(b) is necessary to conform §3.3872 with §3.3860(a)(4). Section 3.3860(a)(4) requires that the policy summary for the types of policies specified in §3.3872(b) contain a statement that provides that any long-term care inflation option required by §3.3820 and §3.3872 is not available under the policy.

§3.3873. Filing Requirements for Long-Term Care Partnership Policies. Adopted 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. Adopted 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 (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings) and §3.3873(b) and (c) as applicable. Adopted 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). Adopted 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 adopted 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 (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 as amended by the Deficit Reduction Act (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.

Adopted new §3.3873(b) specifies 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 adopted 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 (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.

Adopted 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 adopted 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 (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.

Adopted 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 as amended by the Deficit Reduction Act (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. Adopted new §3.3873, including the information to be provided in the Long-Term Care Partnership Program Insurer Certification Form, is 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. Adopted new §3.3874 specifies insurer requirements for reporting information to the Department on agents that market long-term care partnership plans. Adopted new §3.3874(a)(1) - (3) specify training verification and certification requirements for insurers with agents who market partnership plans. These requirements are: (i) obtaining of verification that an agent has received the training specified in §19.1022 of Chapter 19 of Title 28 of the Texas Administrative Code (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) Long-Term Care Partnership Agent Training Certification Initial Reporting Form specified in §3.3874(b)(6)(A). Any subsequent certification must be submitted on Form Number LHL572(LTC) Long-Term Care Partnership Agent Training Certification Form specified in §3.3874(b)(6)(B).

Adopted new §3.3874(b) specifies the requirements and procedures that apply to 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.

Adopted 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) Long-Term Care Partnership Agent Training Certification Initial Reporting Form for the initial certification, and (ii) Form Number LHL572(LTC) 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. Adopted §3.3874(c)(1) requires the initial certification Form Number LHL571(LTC) to be submitted to the Department between June 1, 2009 and June 30, 2009, and the subsequent annual certification Form Number LHL572(LTC) to be submitted annually between January 1 and January 31 of each year for the preceding calendar year beginning in 2010. 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. 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. Adopted §3.3874(c)(2) provides that Form Number LHL571(LTC) and Form Number LHL572(LTC) are informational filings pursuant to §3.5(b)(1) (relating to Filing Authorities and Categories) and are subject to the requirements and procedures set forth in Subchapter A of Chapter 3. Adopted §3.3874(c)(3) requires any certification form submitted pursuant to §3.3874(c) to be filed with the Filings Intake Division of the Department and specifies the address. Adopted 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 as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(V)) and §1651.105 of the Insurance Code include the requirements that are adopted in §3.3874.

Update of Obsolete Statutory Citations. The Department is adopting 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.

3. HOW THE SECTIONS WILL FUNCTION.

§3.3801. Authority. The adopted amendment to §3.3801 updates obsolete Insurance Code citations as a result of the non-substantive Insurance Code revision.

§3.3802. Purpose. The adopted amendments to §3.3802 add new paragraph (7) to state the new purpose relating to the long-term care partnership program. Adopted 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 adopted amendments to §3.3803 clarify the different types of policies and certificates that are being regulated under Subchapter Y and 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 adopted amendments also specify the severability provisions. Specifically, the adopted amendments to §3.3803 amend the title of the section to read: "Applicability and Severability." Section 3.3850 (pertaining to Severability) is repealed and the severability provisions are relocated without change to §3.3803(b). 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 adopted and re-designated as subsection (a)(2). The adopted 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, adopted new subsection (a)(3) specifies that §3.3860 (relating to Policy Requirements for Non-Partnership Life Insurance Policies and Annuity Contracts That Provide Long-Term Care Benefits) applies only to non-partnership life insurance policies and annuity contracts that provide long-term care benefits by rider except as specified in §3.3803(a)(5). Adopted 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 re-designated as §3.3803(a)(5)(A) and (B). Additionally, the existing provision in §3.3803(2), which is re-designated as §3.3803(a)(5)(B), clarifies 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. The adopted amendments to §3.3803 also add new subsection (b) to relocate without change the existing §3.3850 severability provisions.

§3.3804. Definitions. Adopted §3.3804(19) defines the term “long-term care benefit plan.” This definition is consistent with the definition in §1651.003 of the Insurance Code. The adopted definition specifies the class of life insurance

Adopted §3.3804(20) defines the term “long-term care insurance.” The adopted definition specifies that “the term includes riders for group and individual annuities and life insurance policies that provide long-term care insurance.” The adopted definition specifies that (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, the adopted definition of "long-term care insurance" clarifies that the term does not include life insurance policies (i) 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 (ii) that provide the option of a lump-sum payment for those benefits and (iii) where neither the benefits nor the eligibility for benefits is conditioned upon the receipt of long-term care. Lastly, the definition specifies that any product advertised, marketed, or offered as long-term care will be subject to the rules in Subchapter Y.

Adopted new §3.3804(21) defines the term "long-term care partnership insurance policy." This definition defines the term to mean a long-term care insurance policy 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 new definition clarifies what constitutes a long-term care partnership insurance policy under the adopted amendments to Subchapter Y. The adopted amendments 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. The adopted definition specifies that the term does not include a life insurance policy or annuity contract that provides long-term benefits by rider.

§3.3826. Limitations and Exclusions. Adopted §3.3826(a)(6) permits exclusions and limitations for expenses for services or items paid under another long-

term care or health insurance policy. Adopted §3.3826(b) specifies that §3.3826 is not intended to prohibit exclusions and limitations by type of provider. Adopted §3.3826(b)(3) defines the phrase "state of policy issue" to mean the state in which the individual policy or certificate was originally issued.

Adopted §3.3826(c) limits the scope of the limitations and exclusions specified in §3.3826 to only territorial limitations. This limitation is consistent with NAIC Model Regulation §6B(9) that the provisions of §3.3826 are not intended to prohibit territorial limitations.

§3.3829. Required Disclosures. Adopted §3.3829(b)(2) specifies 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. Adopted §3.3829(b)(8) specifies 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 Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet is specified in new subparagraph (b)(8)(H). A representation of Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form is specified in new subparagraph (b)(8)(I). 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. 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. Adopted §3.3829(c) specifies the effective dates and certain other requirements for use of Form Number LHL560(LTC) Long-Term Care Personal Worksheet and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form. Under adopted §3.3829(c)(1), insurers are allowed to use until December 31, 2009, the standard NAIC Long-Term Care Insurance Personal Worksheet and a Texas Supplement printed on a separate sheet that contains the "Questions Related to Your Needs." Under adopted §3.3829(c)(2), insurers are allowed to use, until December 31, 2009, the "Texas" Long-Term Care Insurance Potential Rate Increase Disclosure Form (titled LTC RATE INCR DISC-01-2002) that is currently in use in Texas. Adopted §3.3829(c)(2) also provides that insurers are not required to include the "Rate Increase History" information on the "Texas" Long-Term Care Insurance Potential Rate Increase Disclosure Form but are required to include such information on the standard NAIC Long-Term Care Insurance Personal Worksheet. Under adopted §3.3829(c)(3), insurers are not required to file either the standard NAIC Long-Term Care Insurance Personal Worksheet or the Texas Supplement for review and approval by the

Department. Under adopted §3.3829(c)(4), on and after January 1, 2010, all insurers are required to use adopted Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet and adopted Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form in accordance with all of the requirements for these forms that are specified in §3.3829.

§3.3830. Requirements for Application Forms and Replacement Coverage. Adopted §3.3830(h) 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.

§3.3837. Reporting Requirements. Adopted §3.3837(a) states that the purpose of §3.3837 is 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. Section 3.3837(a)(1)(A) specifies existing insurer

requirements relating to agent records. Section 3.3837(a)(1)(B) re-adopts the provision in §3.3837(a)(2) (as it existed prior to this adoption). It provides that "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." Adopted new §3.3837(a)(2) addresses each insurer's reporting requirements for the 10 percent of its agents with the greatest percentages of policy or certificate lapses and replacements during the preceding calendar year. For these agents, each insurer is required to report by June 30 of each 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 adopted §3.3837(a)(2). Each insurer is required to submit the information electronically in a format prescribed by the department on the department's website. Adopted §3.3837(a)(3) addresses each insurer's reporting requirements for the number of lapsed long-term care policies. Each insurer is required to report by June 30 of each 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 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 adopted §3.3837(a)(2). Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website. Adopted §3.3837(a)(4) addresses each insurer's reporting requirements for replacement of long-

term care policies. Each insurer is required to report by June 30 of each 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 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 §3.3837(a)(2). Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website.

Adopted §3.3837(b) addresses insurer reporting requirements relating to rescissions. The section requires the use of 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 included in §3.3837(b) with a new form number but without changes to the form requirements. The adopted 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 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 adopted amendments to §3.3837(b), the required information in new Form Number LHL563(LTC) must be submitted electronically in a format prescribed by the

Department. The adopted amendments to §3.3837(b), including the new Form Number LHL563(LTC), result in all of the insurer reporting requirements in the subchapter being located in §3.3837. It is anticipated that this single-section location will result in more efficient organization and greater clarity that will facilitate implementation, compliance, and enforcement of the rules.

Section 3.3837 addresses insurer reporting requirements for claims denied by class of business. Adopted new §3.3837(c)(1) defines the terms “claim” and “denied.” The adopted amendments to subsection (c) require insurers to use adopted 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 adopted 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 adopted 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.

Adopted new §3.3837(d) addresses insurer reporting requirements for the long-term care partnership program. It applies to all insurers that market long-term care insurance in Texas. The new rule 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 the HHSC requirements under §32.107 of the Human Resources Code.

Adopted new §3.3837(e) addresses insurer reporting requirements for both partnership and non-partnership plans. It applies to all insurers that market long-term care insurance in Texas. Under §3.3837(e), all such insurers must 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 adopted 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. 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. In order to provide a meaningful, comprehensive report on the progress of the partnership program to the Legislature, insurers must report the non-partnership data specified in adopted new §3.3837(e) as well as the partnership data specified in adopted new §3.3837(d).

Adopted 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 new Form Number LHL566(LTC) Long-Term Care Suitability Reporting Form as specified in §3.3837(f)(1). The data is required

to be reported to the Commissioner by no later than June 30 annually for the preceding calendar year. Under the 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. 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 reporting requirements require insurers to submit the data electronically in a format prescribed on the Department's website. New §3.3837(f) requirements for reporting suitability data provide the Department with a mechanism for monitoring 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. Adopted new §3.3837(f)(2)(A) clarifies that the subsection (f) suitability reporting requirements apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance. Adopted new §3.3837(f)(2)(B) exempts from the subsection (f) suitability reporting requirements life insurance policies that accelerate the death benefit 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.

Adopted new §3.3837(g) contains the requirement in existing §3.3837(a)(5) that requires insurers to file an annual rate filing as required under the Insurance Code §1651.053(c) (former Insurance Code Article 3.70-12 §4(b)) 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. Adopted §3.3837(g) clarifies that the demonstration of compliance with applicable loss ratio standards that is in the current rule (existing §3.3837(a)(5) which is now included in §3.3837(g)) 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 requirements in §3.3837(g) clarify the information that an insurer must provide in order to demonstrate compliance with the Insurance Code 1651.053(c)(1).

§3.3838. Filing Requirements for Advertising. The adopted amendments to §3.3838(1) refine the requirements for the advertising of partnership and non-partnership long-term care insurance. Under the amendments, it is not necessary for

insurers to file institutional advertisements (as that term is defined in §21.102 of Chapter 21 of Title 28 of the Texas Administrative Code (relating to Scope)) if the advertisement only references long-term care insurance as a line of coverage. However, 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 continue to be subject to prior approval by the Commissioner and subject to the requirements in existing §3.3838. There are no changes to existing §3.3838(2) and (3).

§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. Adopted 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). The adopted amendments to §3.3839 also 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 redesignated as §3.3839(a)(11), specifies the requirements for providing the required notices to policyholders. No changes are adopted to the existing required notices or to the existing requirements for providing the notice to policyholders.

§3.3842. Appropriateness of Recommended Purchase. Adopted new §3.3842(b) – (l) add several new requirements to existing §3.3842. These requirements concern 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. These requirements are in addition to the requirement in existing §3.3842, which requires the company and the agent in recommending the purchase or replacement of any long-term care insurance policy or certificate, to make reasonable efforts to determine the appropriateness of the recommended purchase or replacement. This existing requirement, which is re-

designated as §3.3842(a), constitutes the entirety of existing §3.3842. Adopted new §3.3842(b)(1) – (3) requires each issuer to (1) 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, (2) train its agents in the use of the issuer's suitability standards, and (3) maintain a copy of its suitability standards that is available to the Commissioner for inspection upon request.

Adopted new §3.3842(c)(1) – (3) requires that the agent and issuer develop suitability procedures to determine whether the applicant meets the issuer's standards. In developing these procedures, the agent and issuer must consider the following factors: (1) the applicant's ability to pay for the proposed coverage and other pertinent financial information; (2) the applicant's goals and needs with respect to long-term care; and (3) 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.

Adopted 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 adopted new §3.3842(c) and that the efforts shall include presentation to the applicant of new Form Number LHL560(LTC) Long-Term Insurance Care Personal Worksheet that is specified in §3.3829(b)(8)(H). Under 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 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; and (iii) the filing should be submitted to the Filings Intake Division of the Department.

Adopted 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. Adopted new §3.3842(f) prohibits the sale or dissemination of information obtained through completion of the Long-Term Care Personal Worksheet. Adopted 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. Adopted new §3.3842(h) requires agents to use the suitability standards developed by the issuer in marketing the issuer's long-term care insurance.

Adopted new §3.3842(i) requires issuers to provide to the applicant at the same time the Personal Worksheet is provided the 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, adopted new §3.3842(i)(1) – (6) specify the requirements and procedures that apply to adopted new Form Number LHL567(LTC), including text size and content, recommended format, and filing and approval procedures as applicable. A representation of new Form Number LHL567(LTC) Things You Should Know Before You Buy Long-Term Care Insurance is specified in §3.3842(i)(7).

Adopted 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 adopted 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 or similar to new Form Number LHL568(LTC) Long-Term Care Insurance Suitability Letter. If the issuer elects to send the applicant a Suitability Letter to comply with the requirements of new §3.3842(j), the Suitability Letter must be in accordance with or similar to new Form Number LHL568(LTC) Long-Term Care Insurance Suitability Letter. The Suitability Letter must comply with the requirements and procedures specified in §3.3842(j)(1) – (4) which are as follows: (i) the Suitability Letter must use the text specified adopted §3.3842(j) or be similar to the text in such figure, (ii) the text must be in at least 12-point type, and (iii) the *Instructions to Company* and form number are not to be included in the letter sent to the applicant. 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. 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.

In accordance with the definition of "long-term care insurance" in §3.3804(20), adopted §3.3842(k) provides that §3.3842 and the delivery requirements for the shopper's guide in §3.3840 apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance. Existing §3.3840 requires that a long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners be provided to all prospective applicants of a long-term care insurance policy or certificate, as follows: (1) In the case of agent solicitation, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form; and (2) In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form. Adopted §3.3842(l) exempts certain life insurance policies from the §3.3842 requirements and the delivery requirements for the shopper's guide in §3.3840. In

accordance with the definition of “long-term care insurance” in §3.3804(20), adopted §3.3842(l) exempts from the requirement of delivery of the shopper’s guide (booklet) life insurance policies that accelerate the death benefit 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. The adopted exemption provides that in those instances of agent solicitation, an agent is not required to deliver a copy of the booklet prior to the presentation of an application or enrollment form for such policies. The adopted exemption further provides that in the case of direct response solicitations, the insurer is not required to present the booklet in conjunction with any application or enrollment form for such policies.

§3.3844. Nonforfeiture and Contingent Nonforfeiture Benefits. Existing §3.3844(a) – (g) specifies several requirements pertaining to nonforfeiture and contingent nonforfeiture benefits in long-term care policies and certificates. No changes are adopted to existing §3.3844 (a), (b), (d), or (f). An adopted amendment to §3.3844(c)(3) corrects the erroneous word “shorten” to read “shortened.” Existing §3.3844(g)(1) is unchanged in this adoption. However, a new §3.3844(g)(2) is adopted.

Adopted 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 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 specified in the table in §3.3844(g)(2). This will be 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 adopted §3.3844(g)(4)(B) is 40 percent or more. Adopted §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 revised contingent nonforfeiture benefit on lapse provision for policies with limited premium payment periods require insurers to include these protections in their policies. 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.

Adopted 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.

Adopted 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).

Adopted new §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). Section 3.3844(e) also provides that §3.3844(e) does not apply to contingent nonforfeiture benefits upon lapse in accordance with §3.3844(g)(2). Section 3.3844(g)(2) 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 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. Adopted new §3.3844(h) addresses the applicability of §3.3844. Under adopted §3.3844(h)(1), the requirements in §3.3844 apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance. Under adopted §3.3844(h)(2), the requirements in §3.3844 do not apply to life insurance policies that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement and 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.

§3.3848. Requirements for Limited Premium Payment Options in Long-Term Care Policies, Certificates, and Riders. Adopted §3.3848 specifies several regulatory requirements pertaining to limited premium payment options that apply to both partnership and non-partnership long-term care policies. These requirements govern noncancellation, guaranteed renewability, and return of premium practices for long-term care plans with limited premium payment options. Adopted new §3.3848(a) specifies that 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. Under adopted new §3.3848(a), limited premium payment policies, certificates, and riders must comply with the rules in Subchapter Y and Subchapter A of Chapter 3 of Title 28 of the Texas Administrative Code and the additional requirements specified in §3.3848(b). Also, 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 the §3.3848 requirements. Adopted new §3.3848(a) also provides that carriers are not prohibited from offering premium payment duration options in excess of 10 years, and if offered, the options are not subject to §3.3848.

Adopted new §3.3848(b)(1) requires a long-term care insurance policy or certificate with a limited premium payment option to accurately reflect a plan with a limited payment option. Adopted new §3.3848(b)(2) requires the provisions in long-term care policies, certificates, and riders with limited premium payment options to be at least as favorable as the requirements and provisions specified in §3.3848. Adopted §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. The renewability provision must be either on the face page of a policy or certificate or may be added to the policy via an endorsement and change to the schedule page.

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. The renewability provision must be either on the face page of a policy or certificate or may be added to the policy via an endorsement and change to the schedule page.

Five-to-ten year premium payment option policies must be guaranteed renewable, and the renewability provision in the policy must conform with the provision specified in §3.3848(b)(5)(A) that states the premiums are paid over a period of [n] (n may equal 5, 6, 7, 8, 9,or 10) 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. The renewability provision must be either on the face page of a policy or certificate or may be added to the policy via an endorsement and change to the schedule page.

Additionally, 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. Adopted

§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.

§3.3849. Requirements for Insurers that Issue Long-Term Care Policies to Associations and Marketing Standards for Associations that Market the Policies. Adopted 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 §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 Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form specified in §3.3849(e)(1)(F). A representation of 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 adopted new §3.3849(e)(1)(F).

Adopted 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).

Adopted new §3.3849(e)(1)(A) – (D) specify the requirements and procedures that apply to Form Number LHL573(LTC) Insurer Certification of Association

Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form specified in §3.3849(e)(1)(F), including text content, text font size, and recommended format. Adopted new §3.3849(e)(2) requires that insurers submit the initial certification to the Department between January 1, 2010 and January 31, 2010, for the calendar year 2009. Thereafter, they must submit the certification annually between January 1 and January 31 for the preceding calendar year.

Under adopted new §3.3849(e)(3), the certification form is an informational filing pursuant to §3.5(b)(1) and is subject to the requirements and procedures in Chapter 3, Subchapter A of Title 28 of the Texas Administrative Code. Adopted new §3.3849(e)(4) specifies where the annual completed certification form should be filed. The function of this subsection is 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 Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form. 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 certification form in §3.3849(e)(1)(F) will ensure timely and efficient filing of the required certification information with the Department.

Adopted 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 function of §3.3849(b) is 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.

Adopted §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 §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 function of these new requirements is 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, the function of these requirements is to provide information to more consumers 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.

Adopted 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.

§3.3860. Policy Summary Requirements for Non-Partnership Life Insurance Policies and Annuity Contracts That Provide Long-Term Care Benefits. Adopted new §3.3860 sets forth the delivery and content requirements for the policy summary for non-partnership life insurance policies and annuity contracts that provide long-term care benefits by rider. The adopted requirements do not apply to any long-term care partnership policy. Adopted §3.3860(a) specifies that at the time of delivery of a life insurance policy or annuity contract that provides long-term care benefits by rider the insurer shall also deliver a policy summary. Adopted §3.3860(a) also specifies requirements for policy summary delivery for direct response solicitations. Adopted §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. Adopted §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 (relating to Life Insurance Illustrations) of Title 28 of the Texas Administrative Code.. Adopted §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, adopted §3.3860(c) specifies the information the monthly report is required to contain. Adopted new §3.3860(d) requires that the statement required in §3.3860(a)(4) applies to: (i) riders for group and individual annuities and life insurance policies that provide long-term care insurance and (ii) life insurance policies that accelerate the death benefit 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; and (2) Adopted

§3.3860(a)(4) specifies one of the requirements that must be included in the policy summary for a non-partnership life insurance policy or annuity contract that provides long-term care benefits by rider. It requires that a statement be included in the policy summary 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. Adopted §3.3860 will function 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.

§3.3870. Exchange Requirements for Long-Term Care Partnership Policies. Adopted new §3.3870 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. Adopted new §3.3870(a) addresses requirements for notification to policyholders eligible for exchange and the requirements for the offer of exchange. Adopted new §3.3870(a) extends the requirement for insurers to implement an exchange program to 18 months from the date the insurer initiates its partnership program and limits the offer to exchange under a policy or certificate to a policy or certificate of the type certified by the insurer. This will provide each insurer with an 18-month time period from the date that the insurer initiates it partnership program in which to make the required offer of exchange. Additionally, the offer is limited to insureds under a policy of the type certified by the insurer (e.g., if an insurer certifies an individual

policy for partnership, certificate holders under a group policy are not required to receive an offer of exchange for the individual partnership policy. The function of the 18-month time frame is to allow each insurer sufficient time to take the necessary steps to have the partnership policies on the market and available to insureds who have already purchased non-partnership policies.

Adopted 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. Adopted 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. Adopted 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. Adopted §3.3870(b)(2)(C) permits insurers to develop an alternative exchange methodology or program that may differ from the procedures and requirements specified in §3.3870(b)(2)(A) and (B). Under adopted §3.3870(b)(2)(C), an insurer may implement an alternative exchange methodology or program only for policies or certificates issued on and after February 8, 2006, and that is filed with the Department and approved by the Commissioner in accordance with the requirements and procedures set forth in Subchapter A of Chapter 3 of Title 28 of the Texas Administrative Code.

Adopted 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.

Adopted §3.3870(c)(1) – (5) specify the following requirements: (1) All offers of policy exchanges must be made on a nondiscriminatory basis. (2) An exchange offer must 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.

Adopted new §3.3870(d) provides that policies issued pursuant to this section shall be considered exchanges and not replacements. Adopted new §3.3870(e) requires an insurer to report exchanges made pursuant to §3.3870 on a one-time basis for the reporting period in which the insurer begins to advertise, market, offer, or sell policies under the Texas Long-Term Care Partnership Program. The insurer must report the information 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).

§3.3871. Standards and Reporting Requirements for Approved Long-Term Care Partnership Policies. Adopted new §3.3871 applies only to newly issued 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, 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 newly issued partnership policy, which is shown on the policy schedule page, must be either the date that the partnership policy is issued or the date the application for the partnership policy was signed; the insurer has the option of using either date, but the insurer must use the same option in all partnership policies issued by that insurer.

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). The required disclosure notice, titled "Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates," 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 function of the 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.

Adopted §3.3871(a)(2)(B)(viii) requires insurers to furnish any policyholder that exchanges their policy for a partnership policy with the required Form Number

LHL569(LTC) Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates that is specified in §3.3871(a)(2)(B)(vii).

Adopted 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. Adopted 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

Adopted 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 as amended by the Deficit Reduction Act (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 adopted §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. Adopted 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 as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(VI)) includes the requirements that are adopted in §3.3871(b). Adopted new §3.3871(b) provides 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.

§3.3872. Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates. Adopted new §3.3872 applies only to long-term care partnership policies and specifies the inflation protection requirements for long-term care partnership policies and certificates. Adopted new §3.3872(a)(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. Adopted new §3.3872(a)(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. Adopted new §3.3872(a)(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). Adopted new §3.3872(a)(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(a)(2). Adopted new §3.3872(a)(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. Adopted new §3.3872(a)(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. Adopted new §3.3872(a)(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). Adopted new §3.3872(a)(3) specifies that for a person who is 76 years old, inflation protection may be provided but is not required. Section 3.3872(a)(3) also clarifies that although inflation protection is not required for any applicant for a partnership policy who has attained the age of 76, the offer of the long-term care inflation protection option in §3.3820 is still required for any such applicants.

Adopted new §3.3872(a)(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).

Adopted new §3.3872(b) clarifies the types of policies for which inflation protection is not available. Under §3.3872(b), the §3.3872 inflation protection provisions are not available (1) under riders for group and individual annuities and life insurance policies that provide long-term care insurance; and (2) under life insurance policies that accelerate the death benefit 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.

§3.3873. Filing Requirements for Long-Term Care Partnership Policies. Adopted new §3.3873 applies only to long-term care partnership policies and specifies the filing and prior approval requirements that apply to any partnership policy,

certificate, or endorsement that is to be delivered or issued for delivery in this state. Adopted new §3.3873(a)(1) requires that each partnership policy, certificate, or endorsement be filed with the Department and approved in accordance the procedures in Chapter 3, Subchapter A and §3.3873(b) and (c) as applicable. Adopted 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). Adopted 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 adopted 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 (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 as amended by the Deficit Reduction Act (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.

Adopted 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. Any such policy, certificate, or endorsement that is offered for sale in Texas as a partnership policy, must comply with the adopted 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; and (iv) and any policy form filing should be filed with the Filings Intake Division of the Texas Department of Insurance.

Adopted 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 adopted 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; and (vi) the filing should be submitted to the Filings Intake Division of the Texas Department of Insurance.

§3.3874. Insurer Requirements for Agents That Market Partnership Policies and Certificates. Adopted new §3.3874 applies only to long-term care partnership

policies and specifies insurer requirements for reporting information to the Department on agents that market long-term care partnership plans. Adopted new §3.3874(a)(1) - (3) specify training verification and certification requirements for insurers with agents who market partnership plans. These requirements are: (i) obtaining of verification that an agent has received the training specified in §19.1022 of Chapter 19 of Title 28 of the Texas Administrative Code (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 June 1, 2009) must be submitted on Form Number LHL571(LTC) Long-Term Care Partnership Agent Training Certification Initial Reporting Form specified in §3.3874(b)(6)(A). Any subsequent certification must be submitted on Form Number LHL572(LTC) Long-Term Care Partnership Agent Training Certification Form specified in §3.3874(b)(6)(B).

Adopted new §3.3874(b) specifies the requirements and procedures that apply to 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.

Adopted 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) Long-Term Care Partnership Agent Training Certification Initial Reporting Form for the initial certification, and (ii) Form Number LHL572(LTC) 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 June 1, 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. 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.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Exemptions from Certain Requirements

§3.3820. Requirement to Offer Inflation Protection
§3.3837(f). Suitability Data Reporting Requirements
§3.3840. Requirements to Deliver Shopper's Guide
§3.3842. Appropriateness of Recommended Purchase
§3.3844. Nonforfeiture and Contingent Nonforfeiture Benefits

Comment: Commenters assert that there are various consumer protection requirements in the proposed text that do not apply to life policies that have acceleration riders and that exemptions from these requirements are necessary for consistency with the NAIC Model Regulations. According to the commenters, these sections are (i)

§3.3820 (Requirement to Offer Inflation Protection), (ii) §3.3837(f) (Suitability Data Reporting Requirements), (iii) §3.3840 (Requirements to Deliver Shopper's Guide), (iv) §3.3842 (Appropriateness of Recommended Purchase), and (v) §3.3844 (Nonforfeiture and Contingent Nonforfeiture Benefits). The commenters point out that in the NAIC Model Regulations life insurance policies that have acceleration riders are exempt from these consumer protection requirements. The commenters further assert that under the NAIC Model Regulations the policy summary that is given to the policyholder at the time of policy delivery, in accordance with §3.3860, is in lieu of these consumer protection requirements. The commenters, therefore, request that the proposed text be modified to provide an exemption from the requirements of each of the specified sections for life policies that have acceleration riders.

Some commenters recommend that §3.3820 be modified to include the NAIC Long-Term Care Insurance Model Regulation exemption for inflation for life acceleration riders. The requested exemption reads: "The offer shall not be required of life insurance policies or riders containing accelerated long-term care benefits."

Some commenters recommend that §3.3837(f) be modified to include the NAIC Long-Term Care Insurance Model Regulation §24A which exempts life insurance policies that accelerate benefits for long-term care from the suitability reporting requirements in §24H of the NAIC Long-Term Care Insurance Model Regulations. The requested exemption reads: "This section shall not apply to life insurance policies that accelerate benefits for long-term care."

Some commenters recommend that §3.3840 be modified to include the NAIC Long-Term Care Insurance Model Regulation §32B which exempts life insurance policies that accelerate benefits for long-term care from the requirement to deliver a Long-Term Care shopper's guide. The requested exemption reads: "Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under §3.3860**.**"

Some commenters recommend that §3.3842 be modified to include the NAIC Model Regulation §24A which exempts life insurance policies that accelerate benefits for long-term care from the suitability requirements. The requested exemption reads: "This section shall not apply to life insurance policies that accelerate benefits for long-term care."

Some commenters recommend that §3.3844 be modified to include the NAIC Model Regulation §28A which exempts life insurance forms from the nonforfeiture and contingent nonforfeiture benefits requirements. The requested exemption reads: "This section does not apply to life insurance policies or riders containing accelerated long-term care benefits."

Agency Response: The Department agrees that certain life insurance policies that accelerate benefits for long-term care should be exempt from the requirements in §§3.3820, 3.3837, 3.3840, 3.3842, and 3.3844. The Department, however, does not agree with the commenter's recommended exemption language. The following

discusses the Department's reasoning and the changes made to the proposed text in response to the comments.

Section 3.3820 Exemption. The commenter's recommended exemption language for §3.3820 is substantially similar to §13C of the NAIC Long-Term Care Insurance Model Regulations. However, the consumer protection provisions required by the DRA do not include §13 or §13C of the NAIC Long-Term Care Model Regulations. The Department's existing long-term care rules in §3.3820 that relate to the requirement to offer inflation protection, however, do include the inflation protection provisions of Model Regulation §13 except for the §13C exemption requested by the commenters. While the Department agrees that certain "life insurance policies or riders containing accelerated long-term care benefits" should be exempt from the §3.3820 requirement to offer inflation protection, it is not possible to add the requested exemption to §3.3820 because such a change is substantive. Section 3.3820 was not proposed for amendment in the proposal published in the July 18, 2008 issue of the *Texas Register* (33 TexReg 5635). Therefore, a change as requested by the commenters may not be made to existing §3.3820. In lieu of adding the requested exemption language to §3.3820, the Department is making (i) an addition to §3.3860 to address the requested exemption; and (ii) a clarification addition to the §3.3804(21) definition of "long-term care partnership insurance policy." As previously stated, §3.3820 addresses the requirement to offer inflation protection to all applicants for long-term care insurance. Proposed new §3.3860 specifies the policy summary requirements for non-partnership life insurance policies and annuity contracts that

provide long-term care benefits by rider. The definition in proposed §3.3804(21) defines a “long-term care partnership insurance policy” as a long-term care insurance policy that is 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. Chapter 32, Subchapter C of the Human Resources Code addresses the establishment and operation of the Partnership for Long-Term Care Program in Texas. A life insurance policy or annuity contract that provides long-term care benefits by rider does not comply with the definition of “long-term care partnership insurance policy” in proposed §3.3804(21). A partnership policy must contain an inflation protection provision as required by §1917(b)(1)(C)(iii)(IV) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)). The DRA inflation protection provision is implemented in new §3.3872 (relating to long-term care partnership policies and certificates). Section 1651.104 of the Insurance Code requires that a long-term care partnership 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 as amended by the Deficit Reduction Act (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 as amended by the Deficit Reduction Act (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. It is also

consistent with the definition of “long-term care partnership insurance policy” in §3.3804(21).

Section 3.3860(a) specifies that a policy summary must be provided with a life insurance policy or annuity contract that provides long-term care benefits by rider. Section 3.3860(a)(4) requires that the policy summary for this type of policy contain a statement that provides that any long-term care inflation option required by §3.3820 and §3.3872 is not available under this policy. Therefore, to address the commenter’s recommendation relating to the §3.3820 exemption, the Department is adopting an addition to proposed new §3.3860. A new subsection (d) is added to adopted §3.3860 to read: “The statement required in subsection (a)(4) of this section applies to: (1) riders for group and individual annuities and life insurance policies that provide long-term care insurance; and (2) life insurance policies that accelerate the death benefit 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.” The provision exempts the life insurance policies, annuity contracts, and riders specified in adopted §3.3860(d)(1) and (2) from the §3.3820 requirement to offer inflation protection and further provides that §3.3872 of this subchapter (relating to Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates) is not available for such policies.

For purposes of clarity and consistency, the following provision is added to the adopted §3.3804(21) definition of "long-term care partnership insurance policy": "This term does not include a life insurance policy or annuity contract that provides long-term care benefits by rider." This addition simply clarifies the §3.3804(21) definition and is consistent with §3.3860(a)(4) and (d).

Sections 3.3837, 3.3840, 3.3842, and 3.3844 Exemptions. The commenter's recommended exemption language for §§3.3837, 3.3840, 3.3842, and 3.3844 is not consistent with the definition of "long-term care insurance" in §3.3804(20). Each of these recommended exemption provisions pertains to (i) life insurance policies that accelerate benefits for long-term care and/or (ii) life insurance policies or riders containing accelerated long-term care benefits. In the adopted text, however, it is necessary to more specifically identify the policies or riders subject to the exemptions. This is necessary for consistency with the definition of "long-term care insurance" in §3.3804(20).

The commenters request that life insurance policies or riders containing accelerated long-term care benefits be exempt from (i) the §3.3837(f) suitability reporting requirements; the NAIC Long-Term Care Insurance Model Regulation §24A exempts such policies; (ii) the §3.3840 requirement of the delivery of the Long-Term Care shopper's guide; NAIC Model Regulation §32B exempts such policies and riders; (iii) the §3.3842 suitability requirements; NAIC Model Regulation §24A exempts such policies; and (iv) the §3.3844 nonforfeiture and contingent nonforfeiture benefits requirements; NAIC Model Regulation §28A exempts such life insurance forms. The

definition of “long-term care insurance” in §3.3804(20) provides that “long-term care insurance” 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. Therefore, these types of life insurance policies are not defined as “long-term care insurance” for purposes of §§3.3837, 3.3840, 3.3842, and 3.3844 and are properly exempt from the long-term care consumer protection requirements in those four sections. As a result, §§3.3837(f)(2)(B), 3.3842(l), and 3.3844(h)(2) as adopted contain exemption language that is consistent with the definition of “long-term care insurance” in §3.3804(20). Adopted §3.3842(l) also addresses the exemption from the §3.3840 requirement of delivery of the shopper’s guide.

The definition of long-term care insurance in §3.3804(20) provides that riders for group and individual annuities and life insurance policies that provide long-term care insurance are long-term care insurance for purposes of the Subchapter Y rules, including §§3.3837, 3.3840, 3.3842, and 3.3844. Therefore, it is necessary that these types of policies be afforded the consumer protection requirements in the four sections. These types of riders cannot be subject to the requested exemption. Therefore, §§3.3837(f)(2)(A), 3.3842(k), and 3.3844(h)(1) as adopted provide that the specified requirements shall apply to riders for group and individual annuities and life insurance

policies that provide long-term care insurance. Adopted §3.3842(k) also addresses the applicability of the §3.3840 requirement of delivery of the shopper's guide. Adopted §3.3842(k) provides that both the §3.3842 requirements relating to suitability and the delivery requirements for the shopper's guide specified in §3.3840 shall apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance.

Section 3.3840, relating to the requirement of the delivery of the Long-Term Care shopper's guide, was not proposed for amendment in the proposal published in the July 18, 2008 issue of the *Texas Register* (33 TexReg 5635). Therefore, a change as requested by the commenters may not be made to existing §3.3840. Instead of modifying §3.3840 to address the requested exemption, the Department is adopting an exemption in §3.3842(l) for life insurance policies that under §3.3804(20) are eligible for the exemption. The booklet entitled "Long Term Care Insurance" published by the Texas Department of Insurance is the current "shopper's guide" in accordance with §3.3840(3). Adopted §3.3842(l) exempts from the requirement of delivery of the shopper's guide (booklet) for life insurance policies that accelerate the death benefit 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. The adopted exemption provides that in those instances of agent solicitation, an agent is not required to deliver a copy of the booklet prior to the presentation of an

application or enrollment form for such policies. The adopted exemption further provides that in the case of direct response solicitations, the insurer is not required to present the booklet in conjunction with any application or enrollment form for such policies. In accordance with the definition of "long-term care insurance" in §3.3804(20), riders for group and individual annuities and life insurance policies that provide long-term care insurance are "long-term care insurance" and cannot be exempt from the shopper's guide delivery requirement. Therefore, adopted §3.3842(k) provides that §3.3842 requirements and the delivery requirements for the shopper's guide specified in §3.3840 of this subchapter shall apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance.

§3.3803(a)(2) & (3). Applicability and Severability.

Comment: Commenters object to proposed §3.3803(a)(2) and (a)(3) for the following very similar and interrelated reasons: (i) the two provisions do not allow life and annuity products that provide long-term care coverage to be long-term care partnership policies while this is allowed under the Deficit Reduction Act of 2005; (ii) the two provisions are inconsistent with the requirements of the DRA because life and annuity products that provide long-term care benefits are able to meet all of the consumer protection requirements of the DRA; and (iii) the two provisions impose differing or additional standards on life and annuity products that provide long-term care coverage by precluding such plans from partnership status.

Some commenters state that §3.3803(a)(2) includes life and annuity products that provide long-term care coverage under the definition and scope of "long-term care." These commenters also parenthetically indicate that the definition of "long-term care insurance" in §3.3804(20) also includes such products. The commenters opine, however, that §3.3803(a)(3) implies that life policies and annuities that provide long-term care coverage cannot be partnership program policies. According to the comments, this is inconsistent with the DRA. The commenters state that the DRA allows life and annuity products that provide long-term care coverage to be long-term care partnership policies.

Some commenters also object to §3.3803(a)(2) and (a)(3) as proposed because they are inconsistent with the requirements of the DRA. The commenters note that the proposed partnership rules include the general requirement that all long-term care partnership insurance contracts must be "tax qualified" as defined in section 7702B of the Internal Revenue Code and must meet certain other requirements as specified in the DRA. These other requirements include the requirement to include certain types of inflation protection at certain ages. The commenters conclude that as long as life and annuity products that provide long-term care coverage meet all of the consumer protection standards of the DRA, a carrier must be allowed to offer such products as partnership policies.

Some commenters further object to §3.3803(a)(2) and (3) as proposed, asserting that the DRA does not permit states to impose differing or additional standards on partnership policies. According to these commenters, §3.3803(a)(2) and (a)(3) do

impose differing or additional standards on life and annuity products that provide long-term care coverage by precluding such plans from partnership status.

Agency Response: The Department disagrees with all three of the commenters' objections. Section 3.3803(a)(2) and (3) specify the applicability of the various sections of the long-term care rules. Section 3.3803(a)(2) specifies that §§3.3805 – 3.3849, which relate 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, except as specified in §3.3803(a)(5). Section 3.3803(a)(2) further provides that §§3.3805 – 3.3849 apply to 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). Section 3.3803(a)(3) specifies that §3.3860 applies only to non-partnership life insurance policies and annuity contracts that provide long-term care benefits by rider, except as specified in §3.3803(a)(5). Section 3.3860 specifies the policy summary requirements for non-partnership life insurance policies and annuity contracts that provide long-term care benefits. Section 3.3803(a)(2) and (3) do not impose any substantive requirements but rather summarize the organization of the rules in Subchapter Y. The two provisions simply indicate which long-term care rules apply to (i) non-partnership and partnership long-term care benefit plans; (ii) long-term care riders attached to life insurance policies or certificates or annuity contracts or certificates; and (iii) non-partnership life insurance policies that provide long-term care benefits by rider.

The Department disagrees with the commenters' assertion that, under the DRA, life and annuity products that provide long-term care coverage are allowed to be long-term care partnership policies. The Department also disagrees that proposed §3.3803(a)(2) and (a)(3) are inconsistent with the requirements of the DRA and that life and annuity products that provide long-term care benefits are able to meet all of the consumer protection requirements of the DRA. The reasoning for this disagreement is discussed in the following.

Section 3.3803(a)(2) specifies that §§3.3805 – 3.3849 relate to non-partnership and partnership long-term care insurance. It further specifies that §§3.3805 – 3.3849 apply, except as otherwise specified, to (i) non-partnership and partnership long-term care benefit plans as defined in the Insurance Code §1651.003 and §3.3804, and (ii) long-term care riders attached to life insurance policies or certificates or annuity contracts or certificates. Section 3.3803(a)(2) is consistent with the §3.3804(2) definition of "long-term care insurance" for the following reasons. The definition of "long-term care insurance" in §3.3804(20) defines which policies contain long-term care benefits, and of those policies, which are, and which are not, long-term care insurance for purposes of regulation in Texas. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), a 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 as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)). The Department's rules that implement the

partnership program are required to contain these NAIC consumer protection requirements in accordance with the DRA. The Department has determined that it is consistent with the intent and purpose of the DRA that the definition of "long-term care insurance" in these rules be as consistent as possible with the definition of that term in the NAIC Long-Term Care Model Regulations and Model Act. The definition, however, must also be consistent with Texas law, §1651.003 of the Insurance Code. The NAIC definition of "long-term care insurance" in §4A of the NAIC Model Act provides in pertinent part that the term "long-term care insurance" includes group and individual annuities and life insurance policies or riders that provide directly or supplement long-term care insurance. Section 1651.003, however, is not consistent with this part of the definition. Section 1651.003(b) provides that the term "long-term care benefit plan" 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 the loss of functional capacity. The language "other than a group or individual annuity or life insurance policy," in §1651.003(b) excludes a group or individual annuity or life insurance policy from being long-term care insurance even if it provides for payment of benefits based on cognitive impairment or loss of functional capacity. It is therefore necessary that the definition of "long-term care insurance" used in the Department's partnership rules be consistent with the Insurance Code §1651.003(b). As a result, the §3.3804(20) definition cannot be totally consistent with the NAIC Model Act §4A definition of "long-term care insurance." The §3.3804(20) definition, consistent with the NAIC Model Act §4A definition, further specifies that with respect to life insurance the

term “long-term care insurance” 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. Therefore, the definition of “long-care insurance” in §3.3804(20) is consistent with the NAIC definition of long-term care insurance as modified for consistency with the Insurance Code §1651.003. It is also consistent with the intent and purpose of the DRA.

Additionally, the preceding analysis indicates that the applicability of the sections as specified in §3.3803(a)(2) is consistent with the §3.3804(20) definition of “long-term care insurance.” Section 3.3803(a)(2) specifies that §§3.3805 – 3.3849 of the long-term care rules apply, except as otherwise specified, to (i) non-partnership and partnership long-term care benefit plans as defined in the Insurance Code §1651.003 and §3.3804, and (ii) to long-term care riders attached to life insurance policies or certificates or annuity contracts or certificates. Because §3.3803(a)(2) is consistent with the §3.3804(20) definition of “long-term care insurance," it is also consistent with the NAIC definition of long-term care insurance as modified for consistency with the Insurance Code §1651.003. For this same reason, it is also consistent with the intent and purpose of the DRA. Therefore, the Department disagrees with the commenter’s assertion that §3.3803(a)(2) is inconsistent with the requirements of the DRA.

As previously stated, the purpose of §3.3803(a)(3) is to specify the applicability of §3.3860 to only non-partnership life insurance policies and annuity contracts that provide long-term care benefits by rider except as specified in §3.3803(a)(5). The proposal published in the July 18, 2008 issue of the *Texas Register* (33 TexReg 5635) inadvertently omitted the reference to “annuity contracts” in proposed §3.3803(a)(3). Therefore, for purposes of clarity and consistency, §3.3803(a)(3) as adopted is changed to provide that §3.3860 applies not only to non-partnership life insurance policies, but also to annuity contracts, that provide long-term care benefits by rider except as specified in §3.3803(a)(5). Section 3.3860 relates to the policy summary requirements for non-partnership life insurance policies and annuity contracts that provide long-term care benefits. Under these requirements, a policy summary must be delivered with a non-partnership life insurance policy or annuity contract that provides long-term care benefits by rider at the same time that the policy or contract is delivered.

The DRA in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)) requires the provisions of the NAIC Model Act §6J to be included in the long-term care partnership rules. Section 6J provides "At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy that provides long-term care benefits within the policy or by rider..." Section 6J(4) further requires that such policy summary shall include "a statement that any long-term care inflation protection option required . . . is not available under this policy." Section 6J(4) prohibits the offering or including of inflation protection in a life insurance policy that provides long-term care benefits within the policy or by rider. The

Department has interpreted the §6J policy summary requirement and the §6J(4) prohibition to also apply to annuity contracts. Annuity contracts are not addressed in the NAIC Model Act §6J. Nevertheless, the Department's adopted rules apply the §6J policy summary requirement and the §6J(4) prohibition to annuity contracts in Texas. There are two reasons for this: (i) riders that meet the definition of long-term care are being attached to annuity contracts; and (ii) annuity products are regulated similarly to life insurance policies. Therefore, it is not possible for a life insurance policy or annuity contract that provides long-term care benefits within the policy or contract or by rider to meet the inflation protection requirements of the DRA. The definition of "long-term care insurance" in §3.3804(20) defines riders for group and individual annuities and life insurance policies that provide long-term care insurance as long-term care insurance. However, because of the NAIC Model Act §6J(4) prohibition, such policies and contracts cannot attain partnership status. Section 6J(4) is contained in §3.3860(a)(4) and §3.3820. Section 3.3803(a)(3), which specifies the applicability of §3.3860 to only non-partnership life insurance policies and annuity contracts that provide long-term care benefits by rider, is entirely consistent with the DRA. Therefore, the Department disagrees with the commenters' assertion that §3.3803(a)(3) is inconsistent with the requirements of the DRA. The Department also disagrees that the DRA allows life and annuity products to be long-term care partnership policies.

The Department agrees with the commenters' reasoning that the proposed partnership rules must include the general requirement that all long-term care partnership insurance contracts must be "tax qualified" as defined in section 7702B of

the Internal Revenue Code. The Department also agrees with the commenters' reasoning that the long-term care partnership policy must include certain types of inflation protection at certain ages. The Department, however, disagrees with the commenters' conclusion that life and annuity products are able to meet all of the consumer protection requirements necessary for partnership status just because these products provide long-term care benefits. As already discussed, one of the consumer protection requirements with which they cannot comply is the NAIC Model Act §6J(4) inflation protection requirement.

Therefore, the Department further disagrees with the commenters' objection to the rules because they impose differing or additional standards on life and annuity products that provide long-term care coverage by precluding such plans from partnership status. According to the commenters, this objection is based on the fact that the DRA prohibits states from imposing differing or additional standards on partnership policies. This prohibition is contained in §1917(b)(1)(C)(iii)(VII) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(VII)). It states: "The **State** does not impose any requirement affecting the terms or benefits of such a policy unless the State imposes such requirements on long-term care policies without regard to whether the policy is covered under the partnership or is offered in connection with such partnership." (emphasis added). Therefore, the Department agrees that the DRA does not permit states to impose differing or additional standards on life and annuity products that provide long-term care coverage. The standards, however, relating to life and annuity products in the

Department's long-term care rules simply reflect the standards imposed by the federal DRA.

§3.3804(21). Definitions.

Comment: Some commenters indicate that the term "long-term care partnership insurance contract" as it is defined in §3.3804(21) is not used consistently throughout the text of the rules. The commenters note that the only time this term is used in the proposal is in §3.3874(c) and that generally, the references in the rules are to "long-term care insurance or policy." Therefore, the commenters recommend that the defined term be changed to "long-term care partnership insurance policy."

Agency Response: The Department agrees. Therefore, the term defined in §3.3804(21) as adopted is "long-term care partnership insurance policy." For purposes of clarification, adopted §3.3804(21) is also changed to provide that the term may include an individual policy and/or a certificate and to provide that the term does not include a life insurance policy or annuity contract that provides long-term benefits by rider.

§3.3826(b) and (c). Limitations and Exclusions.

Comment: Commenters assert that the language regarding cross border limitations and exclusions is misplaced. While the commenters indicate agreement with the first sentence in §3.3826(b), they recommend that §3.3826(b)(1) and (b)(2) be moved to new §3.3826(c)(1) and (c)(2).

Agency Response: The Department agrees that the language regarding cross border limitations and exclusions is misplaced but does not agree with the commenters' suggestion on how to correct the misplacement. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (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 as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions in §6B of the NAIC Long-Term Care Model Regulations relating to limitations and exclusions in a long-term care policy. Section 3.3826 as adopted has been changed to conform to the NAIC Model Regulations §6B(8) and (9). Section 3.3826 as proposed is not entirely consistent with NAIC Model Regulations §6B(8) and (9). The proposed text combines the prohibitions against limitations by type of provider and territorial limitations into one subsection. The Model Regulations recognize that these are two separate prohibitions. Section 3.3826 as adopted also recognizes the separate prohibitions against limitations by type of provider and territorial limitations.

§3.3829(b)(2)(E). Rate Increase Disclosure.

Comment: Some commenters request clarification regarding the Department's intent with respect to the addition of the phrase "individual or group" to §3.3829(b)(2)(E). The commenters express their understanding that if the Personal Worksheet is being used

for individual insurance, a carrier only needs to disclose individual rate increases, not group rate increases.

Agency Response: The Department has determined from the comment received that the amendment to §3.3829(b)(2) adding the phrase "individual or group" has caused confusion and is deleting the phrase from §3.3829(b)(2) as adopted. The Department agrees with the commenters' understanding that when offering long-term care insurance in the individual market, the "Rate Increase History" information is only required to pertain to policies offered in the individual market. Likewise, when offering long-term care insurance in the group market, the "Rate Increase History" information is only required to pertain to policies offered in the group market.

§3.3829(b)(8)(H). Long-Term Care Insurance Personal Worksheet.

Comment: Some commenters support the use of the Personal Worksheet as detailed in the NAIC Model. However, the commenters object to the new section in the worksheet titled "Questions Related to Your Needs" and recommend that the entire section be removed from the worksheet due to its redundancy. According to the commenters, this new section is more appropriately and thoroughly addressed in multiple places including in the outline of coverage, the Shoppers Guide, and the disclosure form "Things You Should Know Before You Buy Long-Term Care Insurance." The commenters also assert that this section should be removed because it is inaccurately worded. For example, the second statement is incomplete as cognitive impairment can also trigger long-term care benefits.

Agency Response: The Department disagrees that the new section should be removed from the Personal Worksheet. The new section provides essential consumer information regarding the policy limitations on payment of long-term care benefits. The Department believes that this information is necessary for the applicant's careful consideration prior to purchasing a policy. Also, providing such information in the form of a question on the Personal Worksheet at the time the applicant is engaged in a dialogue with the agent is an extremely effective method of focusing the applicant's attention on matters directly relating to his/her purchase of the policy. The commenters are correct that this information is addressed in the multiple places listed in the comment. These sources, however, do not present the information in a question format that is more conducive to alerting and informing the potential purchaser. The other sources present the information in simple statements that are combined with many other important information items. This presentation makes the information less accessible to the consumer. Therefore, the Department disagrees that the new section should be deleted entirely. The Department, however, agrees with the comment that cognitive impairment can also trigger long-term care benefits. Therefore, the new section titled "Questions Related to Your Needs" has been changed accordingly in the Personal Worksheet as adopted.

Comment: One commenter requests removing the section in the Personal Worksheet titled "Questions Related to Your Needs" as proposed and replacing it with an alternative section. The alternative section would read in pertinent part:

Questions Related to Your Needs

You must be diagnosed with cognitive impairment or [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 *paid* [triggered]*. Do you understand this policy limitation*? ☐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

Does Policy Form [insert policy form number] cover all of the services checked above?

If not, which of the above mentioned services are included?

Instructions to Company: *Issuer must insert policy form number and list appropriate services. If demonstrating multiple policy forms, reproduce this section separately for each form."*

Agency Response: The Department agrees in part and disagrees in part with the recommended replacement section. The Department is changing the limitations on payment of policy benefits part of the "Questions Related to Your Needs" section in the adopted rules to follow the recommendation of the commenter except that the term “trigger” that was used in the proposal is being retained in the adopted rules in lieu of the suggested change to the term “paid.” This is because the term “trigger” more accurately describes the action. In addition, the Department is changing the

terminology “moving around” that was used in the proposal to the term “transferring.” The reason for this change is that the term “transferring” is the proper and commonly used term for describing that particular ADL. Therefore, the pertinent part of the notice as adopted reads: "You must be diagnosed with cognitive impairment or be unable to perform two (2) of the following six (6) activities of daily living (ADL’s)-bathing, continence, dressing, eating, toileting, and transferring--prior to your long-term care benefits being triggered. This will clarify that cognitive impairment can also trigger long-term care benefits. The Department, however, disagrees with adding the new questions recommended by the commenter. The questions concern whether the policy form that the agent is demonstrating to the applicant covers all of the long-term care services that the applicant has checked and if not, which of the services are included in the policy. The Department also disagrees with adding the recommended Instructions to Company that would require the insurer to reproduce these questions separately for each policy form being demonstrated if multiple policy forms are being demonstrated to an applicant. These recommended additions are redundant, and the Department, therefore, does not believe that they are necessary. The Outline of Coverage, which is required to be delivered to the applicant, includes the policy or certificate number and describes the benefits provided by the policy.

Comment: One commenter requests adding to the section of the Personal Worksheet on “Questions Related to Your Income” and prior to the questions concerning the elimination period an explanation of the "elimination period" for a long-term care policy. The commenter suggests the following language: "Most long-term care policies contain

an elimination period. An elimination period is the number of days you must receive and pay for the services that are covered under the policy before the policy will pay any benefits."

Agency Response: The Department disagrees that the requested addition to the Personal Worksheet is needed. The Personal Worksheet requires the applicant to consider the number of days that he/she is selecting and to evaluate how the applicant will pay for care during the elimination period. The key factors an applicant needs to be aware of with respect to an elimination period are: (i) knowing they have to pay for care during the elimination period; and (ii) evaluating whether they are able to do so. The addition of the requested definition will not assist an applicant in his/her awareness of these key factors for evaluating the elimination period for a long-term care policy.

§3.3829(b)(8)(H). Long-Term Care Insurance Personal Worksheet. §3.3829(b)(8)(I)Long-Term Care Insurance Potential Rate Increase Disclosure Form.

Comment: Some commenters request a delayed one-year effective date on use of the Personal Worksheet because a year is needed to file the form, have it approved, and moved into production. Some commenters request a one-year delayed effective date on use of the Potential Rate Increase Disclosure Form to allow insurers sufficient time to file the form, receive Department approval, and produce the form.

Agency Response: The Department disagrees with the requested delay. The Personal Worksheet provides information for the insurer to use to assess the applicant’s

suitability to purchase a long-term care policy prior to the applicant's purchase of the policy. The Personal Worksheet provides the important consumer protection of assisting the applicant and the insurer in making an informed decision as to whether it is prudent for the applicant to purchase a long-term care policy given the financial circumstances of the applicant. Delaying the use of the Personal Worksheet as requested by the commenters would deprive long-term care policy applicants of these important consumer protections for a full year. The Department, however, understands that insurers may need additional time to print and distribute the Personal Worksheet. Therefore, the Department is adopting new §3.3829(c) to specify the effective dates and certain other requirements for use of Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form. Adopted new §3.3829(c) also provides insurers with additional time to print and distribute the new forms. Adopted §3.3829(c)(1) provides that in lieu of Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form insurers may use until December 31, 2009 the standard NAIC Long-Term Care Insurance Personal Worksheet and a Texas Supplement printed on a separate sheet that contains the "Questions Related to Your Needs." New §3.3829(c)(3) specifies that insurers are not required to file the standard NAIC Long-Term Care Insurance Personal Worksheet or the Texas Supplement for review and approval by the Department. New §3.3829(c)(4) requires that on and after January 1, 2010, all insurers must use Form Number LHL561(LTC)

Long-Term Care Insurance Potential Rate Increase Disclosure Form specified in §3.3829(b)(8)(H) and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form specified in §3.3829(b)(8)(I) in accordance with all of the requirements specified for these two forms in §3.3829.

§3.3837(f). Reporting Requirements for Suitability Data.

Comment: Some of the commenters object to the requirement in §3.3837(f) for carriers to report suitability data on both Partnership and non-Partnership policies because it is overly burdensome. The commenters recommend that, if the Department elects to move forward with the additional suitability reporting requirements for non-Partnership policies, a delayed implementation is needed. The commenters recommend that the first data be reported in 2010 for calendar year 2009.

Agency Response: The new §3.3837(f) requirements for reporting suitability data are necessary for the Department to have an understanding of what is going on in 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 data will assist the Department in identifying possible improper marketing practices and will enable the Department to act more quickly and efficiently to resolve such problems before they result in harm to consumers. It appears that the commenters have misinterpreted §3.3837(f) concerning the time for the first suitability data to be reported. Under the

proposal and the adoption, the implementation of the suitability data reporting for both Partnership and non-Partnership policies is for calendar year 2009 with the Long-Term Care Suitability Reporting Form for the reporting year 2009 to be filed with the Commissioner by June 30, 2010. The Department's timeline for the first suitability reporting is the same as that recommended by the commenters.

§3.3842. Appropriateness of Recommended Purchase.

Comment: One commenter expresses concern that proposed §3.3842 allows each insurer to develop their own suitability standards. The commenter opines that the Department should specify additional suitability standards for insurers and also require each insurer to file their suitability standards for approval by the Department.

Agency Response: The Department disagrees with the commenter's recommendations. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (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 as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions in §24 of the NAIC Long-Term Care Model Regulations relating to suitability. The regulatory framework in §3.3842 is consistent with §24. Section 3.3842 provides specific guidelines to insurers for developing their suitability standards. Also, §3.3842 requires insurers to maintain a copy of their suitability

standards and to make them available for inspection upon request by the Commissioner.

§3.3842(i)(7). Long-Term Care Suitability Form ("Things You Should Know").

Comment: Some commenters request a delayed one-year effective date on use of the Long-Term Care Suitability Form entitled “Things You Should Know Before You Buy Long-Term Care Insurance” that is required in §3.3842(i)(7). The request is based on the fact that this is a new form not currently in use, and a year is needed to file the form, have it approved, and moved into production.

Agency Response: The Department disagrees that insurers need the requested delay of a one-year effective date. Under §3.3842(i)(7), there is no filing and approval requirement for the "Things You Should Know Before You Buy Long-Term Care Insurance" form unless the insurer changes the format of the mandated text. Insurers may print and use the form that is specified in §3.3929(i)(7) without having to file the form for approval. The DRA in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)) requires that insurers use this form and the disclosures contained in this form immediately upon marketing

Comment: One commenter recommends that to help consumers in evaluating the quality of potential long-term care services that a link to the Texas Department of Aging and Disability Services be included in the “Things You Should Know Before You Buy Long-Term Care Insurance” form. The link would refer one to the Long-Term Care

Quality Reporting System in the "Facilities" section on the website of the Aging and Disability Services Department. The commenter suggests the following language: "To find and compare long-term care providers, visit the Texas Department of Aging and Disability Services website at http://www.dads.state.tx.us/."

Agency Response: The Department declines to make the recommended change. The link refers one to the Long-Term Care Quality Reporting System which provides comparative individual provider information concerning facility inspections and results of complaint investigations for the various classifications of long-term care facilities that are located in each county of the state. This information is intended to assist individuals who are actively seeking to locate a long-term care facility for immediate occupancy. While the provider information on the Long-Term Care Quality Reporting System website is useful to an insured who may be actively seeking to locate a long-term care facility for immediate occupancy, it has limited value to applicants who probably will not need services for several years. The most appropriate resource for providing assistance to applicants in deciding whether or not to purchase long-term care insurance is the Texas Health Information Counseling and Advocacy Program (HICAP) that provides free one-to-one counseling concerning the applicant's suitability to purchase long-term care insurance. The (HICAP) information is contained in the Counseling section of the "Things You Should Know Before You Buy Long-Term Care Insurance" form.

§3.3842(j). Appropriateness of Recommended Purchase.

Comment: Several commenters request greater "flexibility" in the language of the proposed suitability letter specified in §3.3842(j). The commenters recommend amending the first sentence of §3.3842(j) to allow the issuer to send a letter similar to the letter specified in §3.3842(j).

Agency Response: The Department agrees, and §3.3842(j) as adopted allows insurers to send the applicant a suitability letter in accordance with or similar to the letter specified in §3.3842(j). Adopted §3.3842(j) provides in the first sentence that 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 **or similar to** Form Number LHL568(LTC) Long-Term Care Insurance Suitability Letter. In addition, because of the change to the first sentence in §3.3842(j),conforming changes have been made to §3.3842(j)(1) and (j)(2). The modified language in §3.3842(j)(1) as adopted reads: “The issuer’s Suitability Letter must use the text in Form Number LHL568(LTC) as specified in Figure: 28 TAC §3.3842(j) or be similar to the text specified in Figure: 28 TAC §3.3842(j).” Additionally, the modified language in §3.3842(j)(2) as adopted deletes the requirement that the text must follow the order of the information presented in Figure: 28 TAC §3.3842(j).

§3.3848. Limited Premium Payment Requirements.

Comment: Some commenters assert that it is not clear in §3.3848 that the requirements of the section apply only to policies with a payment period of 10 years or

less. The commenters request that to clarify this point the following statement be added to the end of subsection (a): "…Nothing in this section prohibits a carrier from offering premium payment duration options in excess of 10-years. Nor will such options be subject to this section."

Agency Response: The Department agrees with the comment, and the requested change has been made in §3.3848(a) as adopted.

Comment: Some commenters object to proposed §3.3848(b)(3), (4), and (5)(A) because they do not contain an alternative that will allow the required renewability provision to be added to the policy via an endorsement or change to the schedule page. The commenters point out that the rule has a requirement that the Department can only approve a limited pay plan on a separate policy series. The commenters state that under §3.3848(b) the Department is essentially continuing that same mandate by requiring disclosure on the policy cover. Most carriers in virtually all states implement limited pay disclosures through an endorsement on the schedule page. The commenters request that the following language be added to the end of each of the provisions in §3.3848(3), (4) and (5)(A): "In the alternative, the required renewability provision may be added to the policy via an endorsement or change to the schedule page."

Agency Response: The Department disagrees with this recommended change. There is no requirement that only a limited pay plan on a separate policy series can be approved by the Department. Insurers are permitted to offer limited pay premium by endorsement and proper disclosure on the cover page. Therefore, §3.3848(b)(3), (4),

and (5)(A) as adopted include the following provision: “In the alternative, the required renewability provision may be added to the policy via an endorsement and change to the schedule page.”

Comment: Some commenters request that varying methods of disclosure be allowed for use with limited pay period policies and recommend that §3.3848(b)(1) as proposed be changed as follows: "(1) Notice. [The face page of a] *A* long-term *care insurance* policy or certificate with a limited premium payment option must accurately reflect a plan with a limited premium payment option."

Agency Response: The Department agrees. Section 3.3848(b)(1) as adopted contains the requested change in language.

Comment: One commenter asserts that the consumer protections provided in §3.3848 against cancellation, changes in the policy, and return of premium when combined with the commenter’s alleged inadequacies of the suitability standards in the proposal may present difficulties in analyzing and detecting exploitive sales patterns. The commenter recommends a mechanism to detect whether agents are making inappropriate use of the limited pay options. The commenter states that the lack of certain information on the Personal Worksheet and the opportunity to prepay the policy may provide incentive for agents to inappropriately encourage applicants to use the limited pay options.

Agency Response: The Department understands the commenter’s concerns. The Department, however, does not agree with the recommendation to add a specific mechanism to detect whether agents are making inappropriate use of the limited pay options because such market conduct monitoring mechanisms are already in place.

The Department has several different tools to monitor insurers' market conduct to detect and analyze exploitive sales patterns. One of the most important tools is the new suitability reporting requirements in §3.3837(f) for all insurers that market long-term care insurance policies in Texas. It is anticipated that the new suitability reporting requirements and the new reporting 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. Another important tool for monitoring and detecting exploitive sales patterns is the ongoing monitoring of consumer complaints by the Department's Consumer Protection Division. If the Consumer Protection Division begins to see a pattern of complaints that involve a particular company then the company will be referred for further evaluation and a possible market conduct examination.

Comment: One commenter requests that an additional requirement be added to §3.3848 that provides that an applicant who is considering a limited premium payment policy be provided a comparison to a policy that provides a "regular" monthly premium.

Agency Response: The Department does not agree that such a requirement is necessary at this time. The Department is not aware of any circumstances that suggest

problems that would warrant such a requirement. However, if the Department receives complaints that indicate that such a comparison requirement is needed, the Department will consider an amendment to address the issue.

§3.3870. Partnership Exchanges.

Comment: Some commenters request that the requirement to offer exchanges be extended to allow insurers 18 months from the date the insurer initiates its partnership program to implement an exchange program. Proposed §3.3870 provides that the insurer is required to offer the option to exchange by December 31, 2009. These commenters also request that the offer to exchange be limited to insureds under a policy or certificate "of the type certified" by the insurer (e.g., if an insurer certifies an individual policy for partnership, certificate holders under a group policy should not be required to receive an offer of exchange for the individual partnership policy). These commenters recommend changing §3.3870(a) to read as follows:

"(a) Notification and Offer to Exchange. *Within 18 months from the date that an insurer* [Any insurer that] begins to advertise, market, offer *or* sell [or issue] policies [that qualify] under the Texas Long-Term Care Partnership Program*, the insurer* is required to offer on a one-time basis*, in writing,* to all policyholders [and] or certificate holders that were issued long-term care coverage *of the type certified* 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.]"

Agency Response: The Department agrees with the comments and §3.3870(a) as adopted is changed accordingly.

Comment: Some commenters recommend that carriers be allowed to develop exchange programs that may differ from the procedures and requirements specified in proposed §3.3870. These commenters recommend that a new subparagraph (C) be added to §3.3870(b)(2) as follows:

"(C) In lieu of paragraphs (A) and (B) above, an insurer may implement an alternative exchange methodology or program so long as such methodology or program meets the intent of this section and is filed with and approved by the Commissioner."

Agency Response: The Department agrees with the recommendation that carriers be allowed to develop alternative exchange programs. However, the Department does not agree with the specific recommended language. The recommended language is vague and lacks sufficient specificity for rule implementation and compliance enforcement. Therefore, in lieu of the recommended language, the Department is adopting the following provision in §3.3870(b)(2)(C): "In lieu of subparagraphs (A) and (B) of this paragraph, an insurer may implement an alternative exchange methodology or program only for policies or certificates issued on and after February 8, 2006, and that is 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)."

§3.3870(e). One-time Exchange Reporting Requirement.

Comment: Some commenters object to proposed §3.3870(e) which requires the carriers to report exchanges on the Long-Term Care Insurance Replacement and Lapse Reporting Form for calendar year 2009. According to the commenters, it is preferable to report exchanges separately because carriers will have to reprogram their replacement reporting systems for this onetime reporting requirement.

Agency Response: The Department has changed §3.3870(e) as adopted to require an insurer to report exchanges made pursuant to §3.3870 on a one-time basis for the reporting period in which the insurer begins to advertise, market, offer, or sell policies under the Texas Long-Term Care Partnership Program. This change is necessitated by the change to §3.3870(a) as adopted which provides each individual insurer with an 18-month time period from the date that the insurer initiates its partnership program to implement an exchange program. This modification to §3.3870(a) also requires a revision in the time frame for the reporting of exchanges specified in §3.3870(e). The purpose of the reporting requirements in §3.3870(e) is to ensure that exchanges are not reported as replacements.

§3.3871. Disclosure Notice.

Comment: Several commenters express concern that the statement in the last sentence of the first paragraph of the Disclosure Notice may be misleading. According to the commenters, the laws in Texas may change, and it would be clearer to

consumers if the statement is not absolute but that their rights are based on the current law. The commenters recommend that this statement be removed, or if included, that it be revised as follows:

"[In accordance with the] Texas Insurance Code [§1651.106], *1651.105 currently* provides that 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."

Agency Response: The Department disagrees that the statement may be misleading. The sentence states §1651.106 of the Insurance Code and is clear and readily understandable. It does not require any further explanation or refinement. Section 1651.105 is an incorrect citation. Section 1651.105 pertains to the required training for agents and does not address the effect of discontinuation of the partnership program on a partnership policy.

Comment: Several commenters point out that the disclosure notice in the last sentence of the paragraph titled "What Could Disqualify Your Policy Status as a Partnership Policy" incorrectly refers to the disclosure notice as an "Endorsement." The commenters recommend that the words "Disclosure Notice" be substituted for "Endorsement."

Agency Response: The Department agrees and the disclosure notice as adopted has been changed accordingly.

§3.3872. Inflation Protection Requirements.

Comment: One commenter opposes offering inflation protection at a rate of less than 3 percent and recommends requiring inflation protection of no less than 3 percent on all long-term care partnership policies.

Agency Response: The Department disagrees with the recommendation. The Department understands the commenter's concern that inflation will erode the utility of a long-term care policy over time. The Department, however, is also very concerned with maintaining the affordability of long-term care partnership policies. Inflation protection at any percentage is a costly feature of a long-term care policy. The inflation protection requirements in §3.3872 are intended to balance affordability of a long-term care policy with the need to protect consumers from the escalating costs of long-term care.

Comment: One commenter expresses concern that insureds have the option of dropping inflation protection for partnership policies when they reach the age of 76.

Agency Response: The Department understands the commenter’s concern. Section 1917(b)(1)(C)(iii)(IV)(cc) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(IV))cc)), however, clearly provides that if a partnership policy is sold to an individual who has attained age 76 as of such date, the policy may but is not required to provide some level of inflation protection. Affordability is a major concern with the purchase of a long-term care policy. Many individuals in retirement often have a lower income than they did during their working years. And in many instances, this income is a fixed income. The option of dropping inflation protection when an individual reaches the age of 76 will provide these individuals with

the flexibility to reduce their premiums at a time when a reduction might be most needed.

§3.3874. Insurer Requirements for Agents that Market Partnership Policies and Certificates.

Comment: Some commenters request an exemption from the agent training and certification requirements in §3.3874 that would also apply to financial advisors who refer applicants for long-term care policies to trained and certified agents. These requirements include an eight-hour training course and a subsequent continuing education course every two years. The commenters assert that the training and certification requirements are overly burdensome for financial advisors. The commenters state that financial advisors should not have to undergo the training and certification requirements if they are working with agents who are certified and trained. The financial advisor is not the agent of record but receives commissions.

Agency Response: Whether a financial advisor must be licensed as an insurance agent and comply with the agent training and certification requirements in §3.3874 is determined by the actual functions performed by the financial advisor. It is also based on the referral fee or commission arrangement of the individual financial advisor with the licensed insurance agent. Section 1651.105 of the Insurance Code specifies that each individual who sells a long-term care partnership policy must complete training and demonstrate evidence of an understanding of these policies and how they relate to other public and private coverage of long-term care. The statute further specifies that

each insurer that issues a long-term care partnership policy shall certify to the Commissioner that the individual who sells the policy has received the required training. A person who performs an act of an agent, as specified in the Insurance Code §4001.051, is required to hold the appropriate agent license. Section 4001.051(b) provides that regardless of whether the act is done at the request of or by the employment of an insurer, broker, or other person, a person is the agent of the insurer for which the act is done or risk is taken for purposes of the liabilities, duties, requirements, and penalties provided by the Insurance Code Title 13, Chapter 21, or a provision listed in §4001.009 if the person: (i) solicits insurance on behalf of the insurer; (ii) receives or transmits other than on the person's own behalf an application for insurance or an insurance policy to or from the insurer; (iii) advertises or otherwise gives notice that the person will receive or transmit an application for insurance or an insurance policy; (iv) receives or transmits an insurance policy of the insurer; (v) examines or inspects a risk; (vi) receives, collects, or transmits an insurance premium; (vii) makes or forwards a diagram of a building; (viii) takes any other action in the making or consummation of an insurance contract for or with the insurer other than on the person's own behalf; or (ix) examines into, adjusts, or aids in adjusting a loss for or on behalf of the insurer. Section 4001.051(d) provides that the referral by an unlicensed person of a customer or potential customer to an agent is not an act of an agent under this section unless the unlicensed person discusses specific insurance policy terms or conditions with the customer or potential customer. Under §4005.053(c)(2), an unlicensed person may receive a fee or other valuable consideration for referring a

customer who seeks to purchase an insurance product or seeks an opinion on or advice regarding an insurance product, so long as the fee or other valuable consideration is not based upon that customer's purchase of insurance. Therefore, certain financial advisors are required to be licensed as agents and to have the §3.3874 training and certification. These financial advisors include those who (i) receive referral fees or commissions based upon a customer's purchase of insurance; (ii) receive a fee or commission based on the percent of the policies sold; or (iii) discuss specific insurance policy terms or conditions with the customer or potential customer. Financial advisors who are not required to be licensed as agents and who are not required to have the §3.3874 training and certification include those who: (i) only advise a client to purchase a long-term care insurance policy; (ii) do not discuss the insurance policy terms and conditions; (iii) only provide the name of an agent or agents to the client; and (iv) either do not get paid based on the customer purchasing the policy or who receive only a flat fee for client referrals.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE SECTIONS.

For with changes: American Health Insurance Plans and American Council of Life insurers.

Neither for nor against: American Association of Retired Persons – Texas.

For with changes: Office of Public Insurance Counsel.

Neither for nor against: LTC Financial Partners.

6. STATUTORY AUTHORITY. The amendments and new sections are adopted pursuant to the Insurance Code §1651.004, §§1651.101 - 1651.107, and §36.001 and §1917(b) of the Social Security Act as amended by §6021 of the Deficit Reduction Act of 2005 (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 with 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 as amended by the Deficit Reduction Act (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 as amended by the Deficit Reduction Act (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 as amended by the Deficit Reduction Act (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 as amended by the Deficit Reduction Act (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 as amended by the Deficit Reduction Act (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 as amended by the Deficit Reduction Act (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.

7. TEXT.

DIVISION 1. GENERAL PROVISIONS

§3.3801. Authority. This subchapter of rules 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.

§3.3802. Purpose. The purpose of this subchapter is to implement the Insurance Code Chapter 1651:

(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;

(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.

(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, §§3.3805 - 3.3807, 3.3810 - 3.3812, 3.3815 and 3.3818 – 3.3849 of this subchapter (relating to Non-Partnership and Partnership Long-Term Care Insurance) apply to all non-partnership and partnership long-term care benefit plans as that term is 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 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 and annuity contracts 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) 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) a policy or certificate that 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) Except as otherwise provided by law or this subchapter, no long-term care insurance policy, certificate, group hospital service corporation subscriber contract, rider attached to a life insurance policy or certificate or annuity contract or certificate may be delivered or issued for delivery in this state, unless it complies with, and contains definitions in conformance with, this subchapter.

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

(1) Activities of daily living--Bathing, continence, dressing, eating, toileting and transferring, as those terms are defined in this subsection.

(2) Acute condition--The individual's medical condition is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

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

(4) Adult Day Care Facility--Provider of Adult Day Care services, operated pursuant to the provisions of the Human Resources Code, Chapter 103 (concerning licensing and quality of care requirements in the provision of adult day care).

(5) Applicant--The person who seeks to contract for benefits or services, in the instance of an individual long-term care insurance policy; or the proposed certificate holder or enrollee, in the instance of a group long-term care insurance policy.

(6) Attained age rating--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.

(7) Bathing--Washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.

(8) Care--Terms referring to care, such as "home health care," "intermediate care," "maintenance or personal care," "skilled nursing care," and other services, shall be defined in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.

(9) Certificate--Any certificate issued under a group long-term care insurance policy, which certificate has been delivered or issued for delivery in this state. For purposes of these sections, the term:

(A) Also includes any evidence of coverage issued pursuant to a group health maintenance organization contract for long-term care health coverage.

(B) Does not include certificates that are 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.

(10) Continence--The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

(11) Dressing--Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

(12) Eating--Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

(13) Exceptional premium rate increases--Increases filed by an insurer as exceptional and for which the department determines the need for the premium rate increase is justified:

(A) due to changes in laws or regulations applicable to long-term care coverage in this state; or

(B) due to increased and unexpected utilization that affects the majority of insurers of similar long term care products.

(14) Group long-term care insurance--A long-term care insurance policy or certificate of group long-term care insurance that 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), 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).

(15) Home health agency--A business which provides home health service and is licensed by the Texas Health and Human Services Commission.

(16) Home health care services--Medical or nonmedical services provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living, respite care services, case management services, and maintenance or personal care services.

(17) Level premium long-term care policy--A non-cancellable long-term care policy.

(18) Long-term care benefit classifications--Institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

(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. Pursuant to the Insurance Code §1651.003(b), 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. With regard to life insurance, this term does not include life insurance policies:

(A) 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

(B) that provide the option of a lump-sum payment for those benefits and

(C) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

(20) Long-term care insurance--

(A) Any insurance policy, group certificate, rider to such policy or certificate, or evidence of coverage that 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 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.

(B) The term "long-term care insurance" shall not include any insurance policy, group certificate, subscriber contract, or evidence of coverage that 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.

(C) With regard to life insurance, this term does not include life insurance policies:

(i) 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

(ii) that provide the option of a lump-sum payment for those benefits and

(iii) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

(D) 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.

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

Insurance Code. This term does not include a life insurance policy or annuity contract that provides long-term care benefits by rider.

(22) Maintenance or Personal Care Services--Any care the primary purpose of which is the provision of needed assistance under §3.3818 of this subchapter (relating to Standards for Eligibility for Benefits), including the protection from threats to health and safety due to impairment of cognitive ability.

(23) 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) Mental or Nervous Disorder--A neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

(25) 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 Insurance Code Chapter 843.

(26) 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) Qualified actuary--An actuary who is a member of either the Society of Actuaries or the American Academy of Actuaries.

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

(30) 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) Toileting--Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(32) 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 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, 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) a preexisting condition or disease, as defined in §3.3804(b) of this subchapter (relating to Definitions); and §3.3824 of this subchapter (relating to Preexisting Conditions Provisions);

(2) mental or nervous disorders; however, this shall not permit exclusion or limitations of benefits on the basis of the following:

(A) Alzheimer's disease or related disorders, where a clinical diagnosis of Alzheimer's disease by a physician licensed in this state, including history and physical, neurological, psychological and/or psychiatric evaluation, and laboratory studies, has been made to satisfy any requirement or demonstrable proof of organic disease or other proof under the coverage; or

(B) biologically based brain diseases/serious mental illness, including schizophrenia, paranoid and other psychotic disorders, bipolar disorders (mixed, manic, and depressive); major depressive disorders (single episode or recurrent); and schizo-affective disorders (bipolar or depressive);

(3) alcoholism and drug addiction;

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

(A) war or act of war, whether declared or undeclared;

(B) participation in a felony, riot, or insurrection;

(C) service in the armed forces or units auxiliary thereto;

(D) suicide, attempted suicide, or intentionally self-inflicted injury; or

(E) aviation activity as a nonfare-paying passenger;

(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) This section is not intended to prohibit exclusions and limitations by type of provider. However, 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 conditions specified in paragraphs (1) and (2) of this subsection:

(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.

(3) For purposes of this subsection, "state of policy issue" means the state in which the individual policy or certificate was originally issued.

(c) Provisions of this section are not intended to prohibit territorial limitations.

§3.3829. Required Disclosures.

(a) Required Disclosure of Policy Provisions.

(1) Long-term care insurance policies and certificates shall contain a renewability provision as required by §3.3822 of this subchapter (relating to Minimum

Standard for Renewability of Long-term Care Coverage). Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the coverage for which the policy is issued and for which it may be renewed.

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

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

(4) If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a

separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."

(5) Long-term care insurance applicants shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

(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 or §3.3824 of this subchapter (relating to Preexisting Conditions Provisions) shall set forth a description of such limitations or conditions in a separate paragraph of the policy or certificate and shall label each paragraph "Limitations or Conditions on Eligibility for Benefits."

(7) Long-term care insurance policies and certificates shall appropriately caption and describe the nonforfeiture benefit provision, if elected.

(8) Long-term care insurance policies and certificates shall contain a claim denial provision which shall be appropriately captioned. Such provision shall clearly state that if a claim is denied, the insurer shall make available all information directly relating to such denial within 60 days of the date of a written request by the

policyholder or certificate holder, unless such disclosure is prohibited under state or federal law.

(9) A long-term care insurance policy and certificate which includes benefit provisions under §3.3818(b) of this subchapter (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 the coverage described in §3.3818(b) of this subchapter. Criteria utilized to determine eligibility for benefits shall be disclosed in all long-term care insurance policies and certificates, in the manner prescribed by §3.3818 of this subchapter.

(10) If the insurer intends for a long-term care insurance policy or certificate to be a qualified long-term care insurance contract as defined by the Internal Revenue Code of 1986, §7702B(b), the policy or certificate shall include disclosure language substantially similar to the following. "This policy is intended to be a qualified long-term care contract as defined by the Internal Revenue Code of 1986, §7702B(b)."

(11) If the insurer does not intend for the policy to be a qualified long-term care insurance contract as defined by the Internal Revenue Code of 1986, §7702B(b), the policy or certificate shall include disclosure language substantially similar to the following. "This policy is not intended to be a qualified long-term care insurance contract. This long-term care insurance policy does not qualify the insured for the favorable tax treatment provided for in the Internal Revenue Code of 1986, §7702B."

(12) A long-term care policy or certificate which provides for increases in rates shall include a provision disclosing that notice of an upcoming premium rate

increase will be provided no later than the 45th day preceding the date of the implementation of the rate increase.

(b) Required Disclosure of Rating Practices.

(1) Other than non-cancellable policies or certificates, the required disclosures of rating practices 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 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) a statement that the policy may be subject to rate increases in the future;

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

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

(i) a description of when premium rate or rate schedule adjustments will become effective (e.g., next anniversary date, next billing date, etc.); and

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

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

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

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

(iii) the amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and also may be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(3) Subsequent to the information required by paragraph (2) of this subsection, insurers may, in a manner that is not misleading, provide in addition to the information required in paragraph (2)(E) of this subsection, explanatory information related to the rate increases.

(4) Insurers may exclude from the disclosure required by paragraph (2)(E) of this subsection premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

(5) If an acquiring insurer files for a rate increase either on a long-term care policy form acquired from a nonaffiliated insurer, or on a block of policy forms acquired from a nonaffiliated insurer on or before January 1, 2002 or the end of the 24-month period after the date of the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling insurer shall include the disclosure of that rate increase in accordance with paragraph (2)(E) of this subsection.

(6) If the acquiring insurer in paragraph (5) of this subsection files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from a nonaffiliated insurer or block of policy forms acquired from a

nonaffiliated insurer referenced in paragraph (5) of this subsection, the acquiring insurer shall make all disclosures required by paragraphs (2)(E), (3), (4) and (5) of this subsection.

(7) An applicant shall sign an acknowledgement at the time of application that the insurer has made the disclosure(s) required under paragraph (2) of this subsection. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

(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 paragraph (2)(A) and (E) of this subsection and Form Number LHL561(LTC) as specified in Figure: 28 TAC §3.3829(b)(8)(I) to comply with the requirements in paragraph (2)(B), (C), and (D) of this subsection. The effective dates for use of each form are specified in subsection (c) of this section. The following requirements and procedures apply to Form Number LHL560(LTC) and Form Number LHL561(LTC):

(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 website at www.tdi.state.tx.us.

(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

You must be diagnosed with cognitive impairment or be unable to perform two (2) of the following six (6) activities of daily living (ADLs) – bathing, continence, dressing, eating, toileting, and transferring – prior to your long-term care benefits being triggered. 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)

(l) 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.

(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) when the rate increase is implemented. The notice shall comply with the requirements specified in Figure: 28 TAC §3.3829(b)(8)(I).

(c) Effective Dates for Use of Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet, and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form.

(1) In lieu of Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet specified in Figure: 28 TAC §3.3829(b)(8)(H), insurers may use until December 31, 2009, the standard NAIC Long-Term Care Insurance Personal Worksheet and a Texas Supplement printed on a separate sheet that contains the "Questions Related to Your Needs."

(2) In lieu of Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form specified in Figure: 28 TAC §3.3829(b)(8)(I), insurers may use until December 31, 2009, the "Texas" Long-Term Care Insurance Potential Rate Increase Disclosure Form, LTC RATE INCR DISC-01-2002, that is currently being used in Texas. Insurers are not required to include the "Rate Increase History" information on the "Texas" Long-Term Care Insurance Potential Rate Increase

Disclosure Form but are required to include such information on the standard NAIC Long-Term Care Insurance Personal Worksheet.

(3) Insurers are not required to file the standard NAIC Long-Term Care Insurance Personal Worksheet or the Texas Supplement for review and approval by the Department.

(4) On and after January 1, 2010, all insurers must use Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet specified in Figure: 28 TAC §3.3829(b)(8)(H) and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form specified in Figure: 28 TAC §3.3829(b)(8)(I) in accordance with all of the requirements specified for these two forms in this section.

§3.3830. Requirements for Application Forms and Replacement Coverage.

(a) Individual, direct-response-solicited, and group long-term care insurance application forms shall include questions designed to elicit information as to whether, as of the date of application, the applicant has another long-term care insurance policy or certificate in force or the proposed insurance is intended to replace any other accident and sickness or long-term care insurance policy presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing such questions may be used. With regard to a replacement policy issued to an employer, labor union, or continuing care retirement community, the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other

than the group policy being replaced; provided, however, that the certificate holder has been notified of the replacement. The following questions shall be included in the application.

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

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

(A) If so, with which company?

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

(3) Are you covered by Medicaid?

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

(b) Agents shall list any other health insurance policies and certificates they have sold to the applicant and shall also:

(1) list policies and certificates sold which are still in force;

(2) list policies and certificates sold in the past five years which are no longer in force.

(c) Agents shall list any other health insurance policies or certificates the applicant has in force.

(d) Upon a determination that a sale will involve replacement, an insurer or its agent, if that insurer is other than one using direct-response solicitation methods, shall

furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner.

Figure: 28 TAC §3.3830(d):

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

(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

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

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

STATEMENT TO APPLICANT BY AGENT (OR OTHER REPRESENTATIVE):

(Use additional sheets, as necessary.)

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

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

2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions or probationary periods in the new policy or certificate (coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

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

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

_____
(Signature of Agent, Broker or Other Representative)
(Typed Name and Address of Agent)

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

_____
(Date)

_____
(Applicant’s Signature)

(e) Insurers using direct-response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the

applicant upon issuance of the policy or certificate. The required notice shall be provided in the following manner.

Figure: 28 TAC §3.3830(e):

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

(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE
IMPORTANT TO YOU IN THE FUTURE

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

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

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

(2) State law provides that your replacement policy or certificate may not contain new pre-existing conditions or probationary periods. Your insurer will waive any time periods applicable to pre-existing conditions or probationary periods in the new policy or certificate (coverage) for similar benefits to the extent such time was satisfied under the original coverage.

(3) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is

also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

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

_____
(Company Name)

(f) When replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy or certificate shall be identified by the insurer, name of the insured, and policy number or address including zip code. Such notice shall be made within five working days from the date the application is received by the replacing insurer at its home office, or the date the policy is issued, whichever is sooner.

(g) An application for a long-term care policy or certificate that contains benefits under §3.3818(b) of this subchapter (relating to Standards for Eligibility for Benefits) shall in equal prominence reflect the benefit levels payable for the inability to perform two activities of daily living, three activities of daily living, and cognitive impairment.

(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. Such outline of coverage shall be in a format identical to that which is required for individual long-term care insurance policies in §3.3832 of this subchapter (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) The text of the policy shall be organized so that it follows a logical sequence.

(b) Coverages shall be self-contained and independent.

(c) The use of provisions which refer the reader to another section shall be avoided to the extent possible.

(d) General policy provisions applying to all or several like coverages, such as defined words and terms, shall be located in a common area.

(e) Insurers may utilize a separate definition section for words used throughout the policy. If a separate definition section is used, it shall appear early in the policy format.

(f) Nonessential provisions shall be eliminated.

(g) Captions shall be of type size and style to clearly stand out.

(h) Type size and style must be legible and must comply with the requirements set forth in the Insurance Code §1201.054.

(i) Ample blank space shall separate the policy provisions.

(j) Ample blank space shall appear between the columns of printing and the border of the paper.

(k) A table of contents or index may be utilized to enable the policyholder to readily locate particular provisions.

§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 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) 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 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.

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)	

Form Number LHL562(LTC)

(3) Reporting number of lapsed long-term care policies. Each 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 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 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 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.

(b) Rescissions. Each 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 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.

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 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 expressed as a percentage of claims denied to the commissioner by June 30 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.

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

(1) Reporting Form. A representation of Form Number LHL566(LTC) Long-Term Care Suitability Reporting Form is as follows:

Figure: 28 TAC §3.3837(f)(1):

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

Long-term Care Non-Partnership Policies	**Total Number of Applications Received**	**Total Number of Applicants Who Declined to Provide Personal Worksheet Information**	**Total 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)				
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)

(2) Applicability.

(A) This subsection shall apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance.

(B) This subsection shall not apply to life insurance policies:

(i) that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement and

(ii) that provide the option of a lump-sum payment for those benefits and

(iii) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

(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 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. 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) All advertisements shall comply with all applicable federal and state laws and shall be submitted in accordance with §21.120 of this title (relating to Filing for Review). This section does not require prior approval of the advertisement. Nothing in

this section relieves any person from otherwise complying with all applicable laws or from any sanction imposed by law.

(3) The insurer or other entity providing long-term care insurance shall retain all advertisements relating to long-term care insurance as provided in §21.116 of this title (relating to Special Enforcement Procedures for Rules Governing Advertising and Solicitation of Insurance).

§3.3839. Standards for Marketing.

(a) Each 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) any comparison of policies by its agents or other producers will be fair and accurate;

(2) excessive insurance is not sold or issued;

(3) every reasonable effort is made to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance;

(4) no person shall, in selling or offering to sell a long-term care policy, misrepresent a material fact;

(5) the policy shall be delivered no later than 30 days after the application for the long-term care insurance policy or certificate is approved;

(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);

(7) auditable procedures are established 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) the notice required in subparagraph (A) or (B) of this paragraph, 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) 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) 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) The marketing of a long-term care insurance policy or certificate which includes benefits provisions under §3.3818(b) of this subchapter (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) of this subchapter.

(c) In addition to the practices prohibited in the Insurance Code Chapter 541, 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, 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-	• A long-term care insurance policy may pay most of the costs for your

Term Care Insurance	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 1-800-252-9240. 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 or similar to 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) or be similar to the text specified in Figure: 28 TAC §3.3842(j).

(2) The text must be in at least 12-point type.

(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.

(k) This section and the delivery requirements for the shopper's guide in §3.3840 of this subchapter (relating to Requirements to Deliver Shopper's Guide) shall apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance.

(l) This section and the delivery requirements for the shopper's guide in §3.3840 of this subchapter shall not apply to life insurance policies:

(1) that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement and

(2) that provide the option of a lump-sum payment for those benefits and

(3) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

§3.3844. Nonforfeiture and Contingent Nonforfeiture Benefits.

(a) Required Offering of Nonforfeiture Benefits and Contingent Benefits upon Lapse. No insurer or other entity may offer a long-term care insurance policy or certificate in this state unless such insurer or other entity also offers to the prospective insured, or to the group policyholder, the option to purchase a policy that contains nonforfeiture benefits. On or after July 1, 2002, in the event a policyholder or certificate holder declines the option to purchase a policy that contains nonforfeiture benefits, the insurer shall provide contingent benefits upon lapse as described in subsection (g) of this section. In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(b) Nonforfeiture Benefit Provisions.

(1) The nonforfeiture provision shall provide for a benefit available in the event of a default in the payment of any premiums. The amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in

claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the commissioner for the same contract form.

(2) The nonforfeiture provision shall be clearly and conspicuously captioned.

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

(1) reduced paid-up;

(2) extended term;

(3) shortened benefit period; or

(4) other offerings approved by the U.S. Secretary of Health and Human Services as provided by the Internal Revenue Code §7702B(g)(4)(B).

(d) Nonforfeiture and Contingent Benefit Standards/Requirements.

(1) Except as provided in paragraph (2) of this subsection, no policy or certificate shall begin a nonforfeiture benefit later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three years as well as thereafter.

(2) For a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

(A) The end of the tenth year following the policy or certificate issue date; or

(B) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

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

(4) All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would have been payable if the policy or certificate had remained in premium paying status.

(5) There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

(6) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit upon lapse shall be subject to the requirements of §3.3831 of this subchapter (relating to Standards and Rates) treating the policy as a whole.

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

(8) A qualified actuary shall certify as to the reasonability of rates charged for each nonforfeiture benefit and the reserving required by §3.3819 of this subchapter (relating to Requirement for Reserve) shall include reserving for the nonforfeiture options.

(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:

(1) The shortened benefit period shall provide paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in paragraph (2) of this subsection.

(2) The standard nonforfeiture credit will be equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limits specified in the policy or certificate.

(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) Disclosure of Nonforfeiture Benefits. The application or a separate form shall include an election to accept or reject the nonforfeiture benefit. The rejection notice

shall state: "I have reviewed the outline of coverage and the explanation of nonforfeiture benefits and I reject the nonforfeiture option." The agent shall provide information to assist the prospective policyholder in accurately completing the rejection statement.

(g) Contingent Nonforfeiture Benefits.

(1) The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in Triggers for a Substantial Premium Increase based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Policyholders shall be notified at least 45 days prior to the due date of the premium reflecting the rate increase.

Figure: 28 TAC §3.3844(g)(1):

Triggers for a Substantial Premium 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%

(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 paragraph (1) of this subsection 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) 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.

(h) Applicability.

(1) This section shall apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance.

(2) This section shall not apply to life insurance policies:

(A) that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement and

(B) that provide the option of a lump-sum payment for those benefits and

(C) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

§3.3846. Incontestability Period.

(a) For a policy or certificate that has been in force for less than two years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation and an intent to deceive by the insured in the application for insurance.

(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 for a group policy and the Insurance Code §1201.208 for an individual policy.

(c) No long-term care insurance policy or certificate may be field issued based on medical or health status. For purposes of this section, "field issued" means a policy or certificate issued by an agent or a third-party administrator pursuant to the underwriting authority granted to the agent or third-party administrator by an insurer.

§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. Nothing in this section prohibits a carrier from offering premium payment duration options in excess of 10 years, and any such options are not subject to this section.

(b) Requirements.

(1) Notice. A long-term care insurance 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." In the alternative, the required renewability provision may be added to the policy via an endorsement and change to the schedule page.

(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." In the alternative, the required renewability provision may be added to the policy via an endorsement and change to the schedule page.

(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 (relating 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." In the alternative, the required renewability provision may be added to the policy via an endorsement and change to the schedule page.

(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):

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 Figure: 28 TAC §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 clause (i) plus clause (ii) minus clause (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 Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form 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 Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form 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 Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form 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 Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form 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 Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form 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, 2010 and January 31, 2010, for the calendar year 2009, 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.

(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.

(d) The statement required in subsection (a)(4) of this section applies to:

(1) riders for group and individual annuities and life insurance policies that provide long-term care insurance;

(2) life insurance policies:

(A) that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement and

(B) that provide the option of a lump-sum payment for those benefits and

(C) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

DIVISION 4. PARTNERSHIP LONG-TERM CARE INSURANCE ONLY

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

(a) Notification and Offer of Exchange. Within 18 months from the date that an insurer begins to advertise, market, offer, or sell, policies under the Texas Long-Term Care Partnership Program the insurer is required to offer on a one-time basis, in writing, to all policyholders or certificate holders that were issued long-term care coverage of the type certified by the insurer on or after February 8, 2006, the option to exchange their existing policy or certificate for a partnership policy or certificate.

(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) In lieu of subparagraphs (A) and (B) of this paragraph, an insurer may implement an alternative exchange methodology or program only for policies or certificates issued on and after February 8, 2006, and that is 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).

(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 of this subchapter, 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 reporting period in which the insurer begins to advertise, market, offer, or sell policies under the Texas Long-Term Care Partnership Program 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 newly issued partnership policy, which is shown on the policy schedule page, must be either the date that the partnership policy is issued or the date the application for the partnership policy was signed. The insurer has the option of using either date, but the insurer must use the same option in all partnership policies issued by that insurer.

(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 Disclosure Notice 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.

(a) 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. However, the long-term care inflation protection option specified in §3.3820 of this subchapter (relating to Requirement To Offer Inflation Protection) must be offered to any applicant for a partnership policy who has attained the age of 76.

(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.

(b) The inflation protection provisions in this section are not available under these policies:

(1) riders for group and individual annuities and life insurance policies that provide long-term care insurance;

(2) life insurance policies:

(A) that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement and

(B) that provide the option of a lump-sum payment for those benefits and

(C) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

§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)(F) 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)(F) 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) Long-Term Care Partnership Agent Training Certification Initial Reporting Form as specified in Figure: 28 TAC §3.3874(b)(6)(A). Any subsequent certification must be submitted on Form Number LHL572(LTC) 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) Long-Term Care Partnership Agent Training Certification Initial Reporting Form as specified in Figure: 28 TAC §3.3874(b)(6)(A) and Form Number LHL572(LTC) 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 (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(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) Long-Term Care Partnership Agent Training Certification Initial Reporting Form and Form Number LHL572(LTC) 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 June 30, 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 policies.

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 Form
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 policies.

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) Long-Term Care Partnership Agent Training Certification Initial Reporting 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) 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 policies.

(1) The initial certification Form Number LHL571(LTC) must be submitted to the department between June 1, 2009 and June 30, 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.

CERTIFICATION. This agency hereby certifies that the adopted sections have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on _____, 2009.

_____
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance

IT IS THEREFORE THE ORDER of the Commissioner of Insurance that 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 specified herein, 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, are adopted.

AND IT IS SO ORDERED.

_____
MIKE GEESLIN
COMMISSIONER OF INSURANCE

ATTEST:

_____
Gene C. Jarmon
General Counsel and Chief Clerk

COMMISSIONER'S ORDER NO._____