Rules of
Department of Insurance
Division 400—Life, Annuities and Health
Chapter 4—Long-Term Care

Title 20—DEPARTMENT OF INSURANCE
Division 400—Life, Annuities and Health
Chapter 4—Long-Term Care

20 CSR 400-4.100 Long-Term Care

PURPOSE: This regulation implements sections 376.951–376.958, RSMo to promote the public interest, promote the availability of long-term care insurance coverage, protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, facilitate public understanding and comparison of long-term care insurance coverages and facilitate flexibility and innovation in the development of long-term care insurance.

(1) Scope. This regulation shall apply to all long-term care insurance policies delivered or issued for delivery in Missouri on or after the effective date of this regulation by insurers, fraternal benefit societies, health service corporations, prepaid health plans, health maintenance organizations and all similar organizations.

(2) Definitions. For the purpose of this regulation, the terms long-term care insurance, group long-term care insurance, director, applicant, policy and certificate shall have the meanings set forth in section 376.951, RSMo.

(3) Policy Definitions. No long-term care insurance policy delivered or issued for delivery in Missouri shall use the terms set forth in this rule, unless the terms are defined in the policy and the definitions satisfy the following requirements:

(A) Acute condition means that the individual is medically unstable. This individual requires frequent monitoring by medical professionals such as physicians and registered nurses in order to maintain his/her health status;

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

(C) Medicare shall be defined as the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, 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 or words of similar import;

(D) Mental or nervous disorder shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder;

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

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

(4) Policy Practices and Provisions.

(A) Renewability. The terms guaranteed renewable and noncancellable shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of section (5) of this regulation.

1. No long-term care insurance policy issued to an individual shall contain renewal provisions other than guaranteed renewable or noncancellable.

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

3. The term noncancellable may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

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

1. Preexisting conditions or diseases;

2. Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease or when the condition is the result of a demonstrable organic disease or physical injury;

3. Alcoholism and drug addiction;

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

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

B. Participation in a felony, riot or insurrection;

C. Service in the armed forces or units auxiliary to them;

D. Suicide or attempted suicide while sane or intentionally self-inflicted injury; or

E. Aviation (except for fare paying passengers);

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

6. Subsection (4)(B) is not intended to prohibit exclusions and limitations by type of provider or territorial limitations except as otherwise prohibited by statute or regulation; and

7. No policy provisions or conditions of coverage shall impose requirements upon facilities or define levels of care in a manner which is more restrictive than the applicable laws and regulations of this state.

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

(D) Continuation or Conversion.

1. Group long-term care insurance issued in this state on or after the effective date of section (4) shall provide covered individuals with a basis for continuation or conversion of coverage.

2. All group coverage must provide that it can be continued on a direct-billing basis, except for coverage for which the policyholder pays all or a portion of the premium. No additional premium may be charged for coverage continued in this manner which exceeds the actual additional cost due to the change in the method of billing.

3. For the purposes of this section, a basis for continuation of coverage means a

policy provision which maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies which restrict provision of benefits and services to, or contain incentives to use certain providers and/or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The director shall make a determination as to the substantial equivalency of benefits and in doing so shall take into consideration the differences between managed care and nonmanaged care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

4. For the purposes of this section, a basis for conversion of coverage means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced) for at least six (6) months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy s/he is covered, without evidence of insurability.

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

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

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

8. Continuation of coverage or issuance of a converted policy shall be mandatory except where—

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

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

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

(II) The premium for the replacement coverage is calculated in a manner consistent with the requirements of paragraph (4)(D)6. of this regulation.

9. Notwithstanding any other provision of section (4), a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than one hundred percent (100%) of incurred expenses. This provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

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

11. Notwithstanding any other provision of section (4), any insured individual whose eligibility for group long-term care coverage is based upon his/her relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

12. For the purposes of section (4), a managed-care plan is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

(E) Discontinuance and Replacement.

1. If a group long-term care insurance policy is replaced by another group long-term care insurance policy purchased by the same policyholder, and coverage under the policy is thereby discontinued, the succeeding insurer shall provide coverage to all persons for whom coverage under the prior group policy has not been continued, converted or extended. The replacing group insurer shall waive any time periods applicable to preexisting conditions to the extent that a similar exclusion has been satisfied under the original policy.

2. The group long-term care policy shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

(5) Required Contract Disclosure Provisions.

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

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

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

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

(E) Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those set out in section 376.955, RSMo shall set forth a description of the additional limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label the paragraph "Limitations or Conditions on Eligibility for Benefits."

(F) Disclosure of Tax Consequences.

1. With regard to life insurance policies which provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted. The disclosure statement shall state that receipt of the accelerated benefits may be taxable and that assistance should be sought from a personal tax advisor.

2. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.

(6) Prohibition Against Post-Claims Underwriting.

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

(B) Applications Containing Questions Designed to Ascertain Health Condition of Applicant.

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

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

(C) Except for policies or certificates which are guaranteed issue—

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

Caution: If your answers on this application are incorrect or untrue, (company) has the right to deny benefits or rescind your policy;

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

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

3. Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the insurer shall obtain one (1) of the following:

A. A report of a physical examination;

B. An assessment of functional capacity;

C. An attending physician's statement; or

D. Copies of medical records.

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

(E) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions both state and countrywide, except those which the insured voluntarily effectuated, and annually by June 30 shall furnish this information to the director in the format prescribed by the National Association of Insurance Commissioners.

(7) Minimum Standards for Home Health Care Benefits in Long-Term Care Insurance Policies.

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

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

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

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

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

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

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

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

(8) Requirement to Offer Inflation Protection.

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

1. Increases benefit levels annually (in a manner so that the increases are compounded annually), at a rate not less than five percent (5%);

2. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded

annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made;

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

4. The offer in subsection (8)(A) shall not be required of life insurance policies or riders containing accelerated long-term care benefits; and

5. Evidence of the offer and the applicant's response must be in writing.

(B) Where the policy is issued to a group, the required offer in subsection (8)(A) shall be made to the group policyholder. If the policy is issued to a group defined in section 376.951.2(4)(d), RSMo other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder.

(C) Insurers shall include the following information in or with the outline of coverage:

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

2. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages seventy-five (75) and eight-five (85) for benefit increases. An insurer may use a reasonable hypothetical or a graphic demonstration for the purposes of this disclosure.

(9) Requirements for Application Forms and Replacement Coverage.

(A) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and insurance producer, except where the coverage is sold without an insurance producer, containing these questions may be used. With regard to a replacement policy issued to a group as defined by section 376.951.2(4)(a), RSMo, 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:

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 twelve (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) Insurnace producers shall list any other health insurance policies they have sold to the applicant.

1. List policies sold which are still in force.

2. List policies sold in the past five (5) years which are no longer in force.

(C) Solicitations Other than Direct Response. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its insurance producer, 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 (1) copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice, which is included herein, shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF LONG-TERM CARE INSURANCE

(Insurance Company Name and Address)

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

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy or certificate to be issued by (company name) Insurance Company. Your new policy or certificate provides thirty (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 policy or certificate. You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY INSURANCE PRODUCER: (Use Additional Sheets, As Necessary)

I have reviewed your current medical or health or long-term care 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. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

2. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its insurance producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

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

_____ _____

(Signature of Insurance Producer) (Typed Name and Address of Insurance Producer)

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

_____ _____

(Date) (Applicant's Signature)

(D) Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a Notice Regarding Replacement of Long-Term Care Coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF LONG-TERM CARE INSURANCE

(Insurance company's name and address)

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

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by (company name) Insurance Company. Your new policy or certificate provides thirty (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 policy or certificate.

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 or certificate only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

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

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

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

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

_____
(Company Name)

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

(10) Reporting Requirements.

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

(B) Each insurer shall report annually by June 30 the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by subsection (10)(A).

(C) Reported replacement and lapse rates alone do not 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.

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

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

(F) For purposes of this section, policy and certificate shall mean only long-term care insurance and report means on a state-wide basis.

(11) Licensing. No agent is authorized to market, sell, solicit or otherwise contact any person for the purpose of marketing long-term care insurance unless the agent is authorized to write both life and accident and health lines of business.

(12) Discretionary Powers of Director. The director, upon written request and after an administrative hearing, may issue an order to modify or suspend a specific provision(s) of this regulation with respect to a specific long-term care insurance policy or certificate upon a written finding that—

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

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

(C) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care or—

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

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

(13) Reserve Standards.

(A) When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to those policies, policy reserves for the benefits shall be determined in accordance with section 376.380, RSMo. Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit. In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

1. Definition of insured events;
2. Covered long-term care facilities;
3. Existence of home convalescence care coverage;
4. Definition of facilities;
5. Existence or absence of barriers to eligibility;
6. Premium waiver provision;
7. Renewability;
8. Ability to raise premiums;
9. Marketing method;
10. Underwriting procedures;
11. Claims adjustment procedures;
12. Waiting period;
13. Maximum benefit;
14. Availability of eligible facilities;
15. Margins in claim costs;
16. Optional nature of benefit;
17. Delay in eligibility for benefit;
18. Inflation protection provisions; and
19. Guaranteed insurability option.

(B) When long-term care benefits are provided other than as in subsection (13)(A) reserves shall be determined in accordance with sections 376.370 and 376.380, RSMo.

(C) Notwithstanding any other provision to the contrary, claims payments made plus any increase in the claims reserves divided by the written premium less any increase in the policy reserves shall at least be equal to sixty percent (60%).

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

(14) Loss Ratio.

(A) Benefits under individual long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides for adequate reserving of the long-term care insurance risk and premiums computed to remain level throughout the term of coverage. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

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

(B) The minimum loss ratio standards shall not apply to long-term care coverage which is provided through a life insurance policy and the benefits for long-term care represent a prepayment of the life insurance proceeds.

(C) By March 1 of each year, loss ratio experience must be reported to the director for the prior year. This report must be in the format prescribed by the National Association of Insurance Commissioners or as prescribed by the director.

(15) Filing Requirement. Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state pursuant to section 376.953, RSMo, it shall file evidence with the director that the group policy or certificate under the policy has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

(16) Requirements for Advertising. All advertisements shall be retained by the insurer, health care service plan or other entity for at least three (3) years from the date the advertisement was first used.

(17) Standards for Marketing.

(A) Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall—

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

2. Establish marketing guidelines to assure excessive insurance is not sold or issued;

3. Display prominently by type, stamp or other appropriate means on the first page of the outline of coverage and policy or certificate the following:

"Notice to buyer: This policy or certificate may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy or certificate limitations.";

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

5. Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with subsection (17)(A).

(B) In addition to the practices prohibited in sections 375.930—375.949, RSMo, the following acts and practices are prohibited:

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

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

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.

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

(19) Prohibition Against Preexisting Conditions, Waiting Periods and Probationary Periods in Replacement Policies or Certificates. If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions, waiting periods and probationary periods in the new long-term care policy or certificate for similar benefits to the extent that similar exclusions have been satisfied under the original policy or certificate.

(20) Standard Format Outline of Coverage. This section interprets and makes specific, the provisions of sections 376.956 and 376.957, RSMo by prescribing a standard format and content of an outline of coverage.

(A) The outline of coverage shall be a free-standing document using no smaller than ten (10)-point type.

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

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

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

(E) Format for Outline of Coverage.

(COMPANY NAME)
(ADDRESS—CITY & STATE)
(TELEPHONE NUMBER)
LONG-TERM CARE INSURANCE
OUTLINE OF COVERAGE
(POLICY NUMBER OR GROUP MASTER POLICY AND CERTIFICATE NUMBER)

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

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

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

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

3) TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.
a) (Provide a brief description of the right to return—"free look" provision of the policy.)
b) (Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.)

4) THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.
a) (For agents) Neither (insert company name) nor its agents represent Medicare, the federal government or any state government.
b) (For direct response) (insert company name) is not representing Medicare, the federal government or any state government.

5) LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home. This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy (limitations) (waiting periods) and (coinsurance) requirements. (Modify this paragraph if the policy is not an indemnity policy.)

6) BENEFITS PROVIDED BY THIS POLICY.
a) (Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.)
b) (Institutional benefits, by skill level.)
c) (Noninstitutional benefits, by skill level.) (Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.)

7) LIMITATIONS AND EXCLUSIONS. Describe:
a) Preexisting conditions;
b) Noneligible facilities/provider;
c) Noneligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);
d) Exclusions/exceptions;
e) Limitations. (This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay or in any other manner operate to qualify payment of the benefits described in 6).)
THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

8) RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. As applicable, indicate the following:
a) That the benefit level will *not* increase over time;
b) Any automatic benefit adjustment provisions;
c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;
d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;
e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.

9) TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.
a) Describe the policy renewability provisions;
b) For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;
c) Describe waiver of premium provisions or state that there are not such provisions;
d) State whether or not the company has a right to change premium, and if such a right exists, describe clearly and concisely each circumstance under which premium may change.

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

11) PREMIUM.
a) State the total annual premium for the policy;
b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.

12) ADDITIONAL FEATURES.
a) Indicate if medical underwriting is used;
b) Describe other important features.

(21) Requirement to Deliver Shopper's Guide.

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

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

2. In the case of direct response solicitations, the buyer's guide must be presented in conjunction with the delivery of the contract or evidence of coverage.

(B) All shopper's guides shall contain the information required by section 660.551, RSMo, otherwise known as the ''Missouri Partnership for Long Term Care,'' if the policy being solicited is presented as a policy certified under the provisions of that law.

(C) Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the previously referenced guide, but shall furnish the policy summary required under section 376.957, RSMo.

AUTYHORITY: sections 374.045 and 660.551, RSMo 2000 and 376.951–376.958, RSMo 2000 and Supp. 2002. Original rule filed Jan. 28, 1991, effective Sept. 30, 1991. Amended: Filed July 12, 2002, effective Jan. 30, 2003.*

Original authority: 374.045, RSMo 1967, amended 1993, 1995; 376.951–376.958, see* ***Missouri Revised Statutes**, 2000 and Supp. 2002; and 660.551, RSMo 1990.*