DATE: **July 19, 2010**

TO: **IIPRC Product Standards Committee (PSC)**

FROM: **Industry Advisory Committee**

SUBJECT: **LTC Policy Standards Draft Dated July 13, 2010**

General Comments: State Variation Issues for Policy, Application and Outline of Coverage

Each of the 36 Compacting States could identify several requirements in their states that should be reflected in the LTC policy standards. But if these states each insisted on this, we would never get to the goal of ***one uniform national standard***. As we have noted during the rate standards hearings, we know that there are many state variations out there for the LTC policy and the filing preparation process today for the LTC policy is a cumbersome, time intensive and costly process. We believe that the standards deliberation process was a thorough, competent and fair one. For the most part, the standards reflect the Model, which was the logical approach to get to a uniform national standard since most states have adopted it.

To date we have done an admirable job of avoiding state variations to the extent possible in the other lines of business, and yet in the LTC standards there appears to be an intent to solve the state variation requests with a broad "you can have it your way" approach.

We are extremely disappointed at the number of changes that are being proposed to accommodate various one state variation requirements. It is our belief that these are not consumer protection issues and merely represent a ***different*** approach to requirements, not necessarily a ***better*** one.

We have supported the IIPRC concept as a tool for all of us to move away from the state variation approach and move toward a uniform national standards approach. We encourage the PSC to be mindful of the uniform national standards approach as the only way to make the IIPRC a viable alternative to today's state variation driven regulatory environment.

TABLE OF CONTENTS

The draft includes new sections and items that have not been included. We are presuming that these will be added when the draft is finalized.

Page 1, Partnership section, third paragraph

We applaud this suggestion, but seek clarification. We wish to confirm that the PSC offer is merely to accommodate the filing of the Issuer Certifications for those Compacting States that have operational Partnership programs. We are presuming this to be the case but wanted to confirm that the IIPRC does not intent to "approve".

If this is the case, the PSC may want to consider using the industry Issuer Certification prototype that we offered to the operational states and which all have adopted as a basis for the filing attachment. The text of the Certification is included at the end of these comments. We are available to work with you in developing the prototype into standards.

Page 1, Drafting Note (at end)

The paragraph is very problematic for us. Why should we allow the standards to accommodate state specific requirements in direct contradiction of the IIPRC goal of "uniform" national standards?

In the Drafting Note, the distinction between what is content and process is quite misleading – for example, "mandated offer" would include the 5% inflation protection requirement that is in the standards; for "disclosures", we have standards for these too in several places, such as page 1 of the policy; for "point-of-sales disclosures", we have the Potential Rate Increase Disclosure which are in the standards. Presumably, these pre-empt state specific requirements, right?

How are companies expected to make the distinctions when the examples given contradict what is in the standards?

In the reference to state law and regulation, "rule" is mentioned – is this different from a regulation? The word "practice" is also included - what is intended by this and how would companies know what each Compacting State intends by this?

If there are process state variations that must be complied with and the IIPRC standards would not pre-empt these, then the states having such variations should identify the specifics and industry and other states should have the right to vet these in a public forum. To date, some of the discussions have not taken place in public and it is frustrating to review proposed language changes not knowing the full meaning of the changes.

As is written, the current language and intent will not work for industry.

Page 2, Definition of "Long Term Care Insurance"

We note that the language preceding the proposed additional language is referring to "an acute care unit of a hospital." The proposed language would be acceptable if it was changed to say:

"unless ***the acute care unit of the hospital*** is licensed or certified to provide long-term care services and the insured is receiving such long-term care services."

The proposed changes broaden the definition of the Model: under the proposed changes, if a person who meets the triggers for long term care insurance while confined in a hospital for acute care hires a private duty nurse, LTC coverage would have to be provided. Under the Model, this service would not be considered LTC since the person was receiving acute care in a hospital.

Page 3, Drafting Note

We do not have standards for "clauses" or "papers" that describe long term care insurance, so it is not clear what this is intended to include that is currently missing. These words may be included in one state's statute, but in a practical sense they do not add anything meaningful.

From a legal perspective, a "clause" is a sentence, paragraph or stipulation in a written agreement. So in essence, riders, endorsements, amendments and even the policy itself already include "clauses", so it is redundant to refer to "clauses" in addition to having already included the policy, riders, endorsements and amendments.

Our guess is that the intent was to change the ***L. Entire Contract*** standards on page 13. All of the standards are somewhat non-specific about what will constitute the Entire Contract, and we recently proposed changing the standards for Group Life for the same reason and here is how the LTC version would read:

L. Entire Contract

The provision shall state that the policy, the insured's (owner's if there is an owner designated under the policy) application, and any riders, endorsements or amendments to the policy shall constitute the entire contract between the company and the insured (owner if there is one designated under the policy). No document may be included by reference.

If the PSC accepts this change, this would replace current items (1) and (2).

In the second sentence on page 3, add “these” after “because”.

Page 3, A. GENERAL, Item (1)

On page 1, under ***Self-Certification***, it is stated that LTC policies may never be filed on a self-certification basis, so why is self-certification addressed in this item?

Page 4, A. GENERAL, Item (10)

The change shown as deleted needs to be “accepted” to say “Include a”.

Page 8, E. BENEFITS, Drafting Note

The proposed change is very problematic for us since this another example of a one state requirement rising to the level of a uniform national standard. It should also be noted that such a variation also impacts the inflation protection benefit and other benefits that are presented as a percentage of the daily room and board amount.

We believe the Wisconsin requirement does not help consumers in that it overlooks affordability and consumer choice issues. Additionally, the health care reform legislation that was enacted by Congress includes the CLASS Act which provides a $50 benefit for affordability reasons. Since employers in Wisconsin will be offering a $50 benefit, how will the Wisconsin requirement be reconciled with this? While many would agree that a $50 benefit is not enough coverage, at the same time we all believe that some coverage is better than none.

We encourage the PSC to retain the previous language which established uniform national standards.

Page 10, Drafting Note at Top

Add a period at the end of the sentence.

Page 10, I. DEFINITIONS AND CONCEPTS, Item (c) “Adult Day Care”

The proposed changes are quite problematic – why was it deemed necessary to change the NAIC Model?

By removing the NAIC Model six life requirement, the liberalized standards would enable an individual to open up his home to care for a neighbor or a relative. More problematic is the indication that adult day care only needs to provide social services, which translated to unskilled care. The removal of "health related" may violate the tax qualification requirements for adult day care services.

It is curious that a state would add a licensure/certification requirement when the 2006 Model revisions, Section 5. Policy Definitions item Q and Section 6.B.(8), provide criteria for handling when states do not require licensing/certification.

We oppose the proposed change.

Page 11, I. DEFINITIONS AND CONCEPTS, Item (k) "Home health care services"

Why was it deemed necessary to change the NAIC Model and delete the word "may"?

By removing "may", the standards would require companies to cover the services listed and there is a price associated with such services, so we prefer that such decisions be made by the consumer.

Accordingly, we oppose the proposed change.

Page 11, I. DEFINITIONS AND CONCEPTS, Item (o) "Nursing Facility"

The proposed change is a deviation from the Model. Why was it deemed necessary to make this change? No other state requires this, and such a requirement ignores consumer affordability and choice.

The proposed change is quite significant since it will require assisted living facilities to be covered on the same basis as nursing homes, and in reality these two types of facilities operate in a totally different regulatory environment with regard to licensing and care provided. Nursing homes have to be licensed in all states; assisted living facilities do not. Nursing homes provide more skilled care and characteristically have a more intensive care environment. Assisted living facilities provide only custodial care. By equating the two, the currently cheaper assisted living facility benefit would have to also provide skilled care and this changes the distinct pricing for these two facilities.

Additionally, as stated above for the definition of "long term care insurance "on page 2 of the policy draft, with regard to coverage to be provided for care in a hospital, ***coverage should only be required for care in an acute care unit of a hospital licensed or certified to provide long term care services.***

We oppose the inclusion of this definition and the attempt to equate nursing home care with assisted living facility care.

Page 13, K. ELIGIBILITY FOR BENEFITS, end of item (3) at the top

The deletion of "retain the right to" is problematic for us. If a company has the right to verify, it should have the right to reserve that right in the policy and let Policyholders know this in advance of establishing a plan of care, so why is it a problem to leave the words in?

On page 6 of the policy, the "Caution" statement allows "the company has the right to deny or rescind….", so would it be acceptable here to say : "the company also has the right to verify…"?

Page 13, L. ENTIRE CONTRACT, Item (3)

Earlier in this comments we suggested better language for this standard.

Item (3) should be deleted. It is already included in the application standards, section K.(2)(b) on page 11. It is more critical to include this at the time of application since that is the first point of contact with an agent, so this is why it is here. To move this to the policy would make no sense since it may be too late after the policy issue date to let Policyholders know this. To say it in both places is overkill since the applications and the policy form the "entire contract."

Page 14, O. HOME HEALTH CARE AND COMMUNITY CARE BENEFITS, Item (2)(d)

The proposed changes are not in the NAIC Model, so we question the need for the change, and what it is trying to "fix".

The way it works today, companies do not require licensure or certification in those states where this is not required, and the lower cost for the care provided by aides and home care workers benefits both consumers and the companies.

Page 16, R. LIMITATIONS AND EXCLUSIONS, Item (f)

We question why this is an issue?

This item is verbatim from item (6) of Section 6.B. of the Model. It allows companies to coordinate benefits to be paid under their policy with those that may be payable under another LTC policy or a health insurance policy. The goal is to avoid duplication of coverage where an insured collects more than 100% of expenses incurred. Members

recall that there was also a fraud prevention element here – the objective was to avoid situations where people buy multiple policies with maximum benefits and use benefits regardless of need and have no incentive to use only services needed.

Page 16, T. NONFORFEITURE BENEFITS, Item (1)
[and BB. RIGHT TO REDUCE COVERAGE OR LOWER PREMIUMS item (1) on page 22]

Note that on page 2 under the definition of "Long term care insurance", first bullet, the term includes "rider, endorsements or amendments".

It has never been clear to us why the word has been omitted and we recommend that it be reinstated.

In Response To Tomasz Serbinowski's Comments:

Page 17, Item (2)(c)

We suggest the following language:

"A policy offered with the nonforfeiture benefit shall have coverage elements, eligibility, benefit triggers and benefit lengths that are the same as those offered in an otherwise similar policy offered without nonforfeiture benefits;"

Page 17, Item (2)(e)

There were two concerns here – one, that this only applies to qualified plans and at some point the standards extended the requirements to all plans; second, that the language appears to allow a company to change benefits once an owner has selected the nonforfeiture benefits under his policy; for example, if a rate schedule is changed after the policy went into nonforfeiture, that change should not affect the policy.

We suggest the following language:

"The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to the policy issue, as long as the policy is in force and a nonforfeiture benefit is not in effect, only as necessary to reflect changes in claims, persistency and interest as reflected in changes in claims and in the premium rate schedule for premium paying policies approved by the Interstate Insurance Product Regulation Commission for the same policy form; and"

Addition of Item DD. Termination

We agree with Tomasz's advice that "care needs to be taken to preserve any nonforfeiture benefits (contingent or not) ….".

Page 20, Drafting Note At the Bottom

This is already included in the middle of page 14 – should be deleted here.

Page 20, W. PAYMENT OF CLAIMS AND REVIEW OF BENEFIT DETERMINATIONS, Item (2)

Again, this appears to be an open invitation for state variations. Since the standard requires a description of the right to appeal, the IIPRC has the opportunity to use Section 31 of the Model Regulation as the standard. To date, only 4 states have adopted this section (IA, VT, PA and soon to be SD) and we already have state variations. The end result over the next few years could be hodge podge of state variations – the antithesis of what the IIPRC should be promoting.

We note that the proposed language states "where the policy is delivered or issued for delivery", and not "on the date the policy is delivered or issued for delivery". If a state has not adopted Section 31 as of the policy date of issue, and the company uses the Section 31 language on the date of issue, what happens several years later when the state finally adopts it own version?

We recommend that the IIPRC establish the NAIC Model section 31 as the uniform national standard.

Page 22, AA. RIGHT TO EXAMINE, Item (2)

Why is it deemed necessary to change the Model for the majority states that today believe 30 days is acceptable business practice? Is there evidence of abuse to warrant the change?

Mandating a 10 day refund process is not practical or reasonable. Although a return does not occur frequently, the company communicates with the insured/owner to affirm the intent (anyone can put the policy in an envelope and mail it back) and this takes time. When compared with other businesses' return policy, a 30 day allowance is reasonable.

We recommend that the PSC reinstate the NAIC Model requirement of 30 days.

Page 23, DD. TERMINATION

The proposed language uses "owner" at first and then "policy owner". The word "policy" should be deleted.

Based on how companies handle terminations today, the proposed language is not accurate:

For a monthly premium mode, if termination occurs in the middle of a month, the policy would not terminate until the end of that month. For premium modals other than monthly, if the owner terminates the policy before the end of a model period, the company refunds the premium for the portion of the modal period beyond the end of the current calendar month that has not yet occurred. There is no prorating by days.

We have previously noted support for the concerns raised by Tomasz Serbinowski.

Submitted by:

IIPRC Industry Advisory Committee:

Nicole Allen, CIAB
Bill Anderson, NAIFA
Maureen Adolf, Prudential
Steve Buhr, AEGON
Tom English, New York Life
Mary Keim, State Farm Insurance Company
Michael Lovendusky, ACLI
Amanda Mathiessen, AHIP

ISSUER CERTIFICATION FORM

(relating to Qualified State Long-Term Care Insurance Partnership)

Under section 1917(b)(5)(B)(iii) of the Social Security Act (42 U.S.C. 1396p(b)(5)(B)(iii)), the State insurance commissioner of a State implementing a qualified State long-term care insurance partnership ("Qualified Partnership") may 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 specified 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 each State insurance commissioner 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 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:

_____
_____
_____

Specimen copies of each of the above policy forms, including any riders and endorsements, shall be provided upon request.

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 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. The provisions of section 26 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. 7702B(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 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. The provisions of section 8 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 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 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