CHAPTER 39
LONG-TERM CARE INSURANCE

Chapter exempt from chapter rescission pursuant to Iowa Code section 17A.7

DIVISION I
GENERAL PROVISIONS

191—39.1(514G) Purpose. The purpose of this chapter is to implement Iowa Code chapter 514G, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance.

191—39.2(514G) Authority. This chapter is issued pursuant to the authority vested in the commissioner under Iowa Code section 514G.105 in accordance with the procedures set forth in Iowa Code chapter 17A.
[**ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.3(514G) Applicability and scope. Except as otherwise specifically provided, this chapter applies to all long-term care insurance policies and long-term care coverage arrangements delivered or issued for delivery in this state on or after the effective date hereof, by insurers, fraternal benefit societies, nonprofit health, hospital and medical service corporations, prepaid health plans, health maintenance organizations and all similar organizations.

191—39.4(514G) Definitions. For the purpose of these rules, the terms *"Group long-term care insurance," "Commissioner," "Applicant," "Policy," "Preexisting condition"* and *"Certificate"* shall have the meanings set forth in Iowa Code chapter 514G, "Long-Term Care Insurance Act."

"Long-term care insurance" means an insurance policy, insurance contract, insurance certificate, or rider, which is advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care service provided in a setting other than an acute care unit of a hospital. This definition also encompasses group and individual annuities and life insurance policies or riders that provide directly for or supplement long-term care insurance as well as a policy or rider providing for payment of benefits based upon cognitive impairment or the loss of functional capacity.

Long-term care insurance may be issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations or any similar organizations to the extent they are otherwise authorized to issue life or health insurance.

Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare Supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, disability income or related asset-protection coverage, or accident-only coverage, specific disease or specified accident coverage, or limited benefit health coverage. The definition does not include life insurance policies which 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 which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor eligibility for those benefits is conditional upon the receipt of long-term care. Notwithstanding any other provision contained herein, any product advertised, marketed, or offered as long-term care insurance shall be subject to the provisions of 191—Chapter 39.

"Long-term care coverage arrangement" is a promise that long-term care will be delivered to a person upon need and the meeting of certain contractual requirements. The arrangement is offered to the general

public or a sector of the general public at a cost determined by the use of sound actuarial principles based upon the probability of use. This definition does not include self-insurance.

"Qualified long-term care insurance contract" or *"federally tax-qualified long-term care insurance contract"* means an individual or group insurance contract that meets the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as follows:

1. The only insurance protection provided under the contract is coverage of qualified long-term care services. A contract shall not fail to satisfy the requirements of this paragraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

2. The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this paragraph do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payor. A contract shall not fail to satisfy the requirements of this paragraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

3. The contract is guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986;

4. The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed;

5. All refunds of premiums, and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract; and

6. The contract meets the consumer protection provisions set forth in Section 7702B(g) of the Internal Revenue Code of 1986.

"Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" also means the portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of Sections 7702B(b) and (e) of the Internal Revenue Code of 1986.

191—39.5(514G) Policy definitions. No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

39.5(1) *"Medicare"* shall be defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

39.5(2) *"Mental or nervous disorder"* shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

39.5(3) *Nursing care.*

a. *"Skilled nursing care"* shall not be defined more restrictively than one or more professional services performed for the benefit of the insured on a daily basis, by or under the supervision of a registered nurse, prescribed by a physician, appropriate and consistent with the diagnosis and conditions requiring care.

b. *"Intermediate nursing care"* shall not be defined more restrictively than care which meets all of the above when professional nursing services are delivered on a regular basis but less often than daily.

c. *"Custodial nursing care"* shall not be defined more restrictively than that level of care required to assist an individual in activities of daily living when, due to age complicated by sickness or injury, such care is required. This level of care can be performed by persons without professional skills or training.

39.5(4) *"Nursing facility"* shall be defined in relation to its status, facilities, and available services.

a. A definition of such home or facility shall not be more restrictive than one requiring that it:

(1) Be operated pursuant to law; be appropriately licensed or certified;

(2) Be primarily engaged in providing, in addition to room and board accommodations, skilled or intermediate nursing care under the supervision of a duly licensed physician;

(3) Provide nursing service by or under the supervision of a registered nurse (R.N.); and

(4) Maintain a daily medical record of each patient.

b. The definition of such home or facility may provide that the term shall not include:

(1) Any home, facility or part thereof used primarily for rest;

(2) A home or facility for the aged or for the care of drug addicts or alcoholics; or

(3) A home or facility primarily used for the care and treatment of mental diseases, or disorders, or custodial or educational care.

39.5(5) *"Acute condition"* means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain the individual's health status.

39.5(6) *"Home health care services"* means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

39.5(7) *"Activities of daily living"* means at least bathing, continence, dressing, eating, toileting and transferring.

39.5(8) *"Adult day care"* means a program for six or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

39.5(9) *"Bathing"* means 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.

39.5(10) *"Cognitive impairment"* means a deficiency in a person's short- or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

39.5(11) *"Continence"* means 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).

39.5(12) *"Dressing"* means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

39.5(13) *"Eating"* means 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.

39.5(14) *"Exceptional increase"* means only those increases filed by an insurer as exceptional for which the commissioner determines that the need for the premium rate increase is justified due to changes in laws or regulations applicable to long-term care coverage in this state or due to increased and unexpected utilization that affects the majority of insurers of similar products. Except as provided in rule 191—39.28(514G), exceptional increases are subject to the same requirements as other premium rate schedule increases.

The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase. The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

39.5(15) *"Hands-on assistance"* means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activities of daily living.

39.5(16) *"Incidental,"* as used in subrule 39.28(10), means that the value of the long-term care benefits provided is less than 10 percent of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

39.5(17) *"Personal care"* means the provision of hands-on services to assist an individual with activities of daily living.

39.5(18) *"Qualified actuary"* means a member in good standing of the American Academy of Actuaries.

39.5(19) *"Similar policy forms"* means 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. Certificates of groups that meet the definition of group long-term care insurance in Iowa Code section 514G.103 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. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, noninstitutional long-term care benefits only, or comprehensive long-term care benefits.

39.5(20) *"Toileting"* means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

39.5(21) *"Transferring"* means moving into or out of a bed, chair or wheelchair.

[**ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.6(514G) Policy practices and provisions.

39.6(1) *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 this chapter. No such policy issued to an individual shall contain renewal provisions other than "guaranteed renewable" or "noncancellable."

a. 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. Rates may be revised by the insurer on a class basis.

b. 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.

c. Notwithstanding the provisions in 191—subrule 36.5(4), long-term care insurance policies may contain a return of premium or cash value benefit so long as:

(1) The return of premium or cash value benefit is not reduced by an amount greater than the aggregate of any claims paid under the policy; and

(2) The insurer demonstrates in its filings that the reserve basis for the policies is adequate.

Any advertisement or sales presentation of a long-term care insurance policy with a return of premium or cash value benefit provision shall include a side-by-side comparison of premiums for the same policy with and without the return of premium or cash value benefit provision.

d. The term "level premium" may be used only when the insurer does not have the right to change the premium.

e. In addition to the other requirements of this subrule, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986.

39.6(2) *Limitations and exclusions.*

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

(1) Preexisting conditions or disease;

(2) Mental or nervous disorders (however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease or similar forms of irreversible dementia nor limit coverage for Alzheimer's disease to the skilled or intermediate level of care);

(3) Alcoholism and drug addiction;

(4) Illness, treatment or medical condition arising out of:

1. War or act of war (whether declared or undeclared);
2. Participation in a felony, riot or insurrection;
3. Service in the armed forces or units auxiliary thereto;
4. Attempted suicide (sane or insane) or intentional self-inflicted injury;
5. Aviation (this exclusion applies only to non-fare-paying passengers).

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

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

(7) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.

Paragraph *"a"* is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

b. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in Iowa Code section 514G.105(3)*"b"* expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in Iowa Code section 514G.105(3)*"b."*

c. No long-term care insurance policy may be delivered or issued for delivery in this state if the policy conditions eligibility for any benefits other than waiver of premium, postconfinement, postacute care or recuperative benefits on a prior institutionalization requirement.

39.6(3) *Extension of benefits.* Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

39.6(4) *Continuation or conversion.*

a. Group long-term care insurance issued in this state on or after January 1, 1992, shall provide covered individuals with a basis for continuation or conversion of coverage.

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

c. For the purposes of this rule, *"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 months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy the individual is covered, without evidence of insurability.

d. For the purposes of this rule, *"converted policy"* means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use, certain providers or facilities, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and

nonmanaged care plans including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

e. 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 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.

f. 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.

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

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

(2) The terminating coverage is replaced not later than 31 days after termination, by group coverage, effective on the day following termination of coverage, that provides benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage, and for which the premium is calculated in a manner consistent with the requirements of paragraph *"f"* of this subrule.

h. Notwithstanding any other provision of this rule, 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 100 percent of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

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

j. Notwithstanding any other provision of this rule, any insured individual whose eligibility for long-term care coverage is based upon the individual's 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.

k. For the purpose of this rule: 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.

39.6(5) *Discontinuance and replacement.* If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

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

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

39.6(6) *Premiums.*

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

(1) The increasing age of the insured at ages beyond 65; or

(2) The duration the insured has been covered under the policy.

b. The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under subrule 39.29(6), the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

c. A reduction in benefits shall not be considered a premium change, but for purposes of the calculation required under subrule 39.29(6), the initial annual premium shall be based on the reduced benefits.

39.6(7) *Electronic enrollment for group policies.* In the case of group long-term care insurance, any requirement that a signature of an insured be obtained by a producer or insurer shall be deemed satisfied if:

a. The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

b. The telephonic or electronic enrollment provides necessary and reasonable safeguards to ensure the accuracy, retention and prompt retrieval of records; and

c. The telephonic or electronic enrollment provides necessary and reasonable safeguards to ensure that the confidentiality of individually identifiable information and privileged information is maintained.

The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09; **ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.7(514G) Required disclosure provisions.

39.7(1) *Renewability.*

a. Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state 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. A long-term care insurance policy or certificate, other than one in which the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

39.7(2) *Riders and endorsements.* Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured or exercises a specifically reserved right under an individual long-term care insurance policy, no riders or endorsements may be 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. 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 is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

39.7(3) *Payment of benefits.* A long-term care insurance policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

39.7(4) *Limitations.* If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitation shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."

39.7(5) *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 prohibited in Iowa Code section 514G.105(3)*"b,"* shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

39.7(6) *Disclosure of tax consequences.* 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 that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This subrule shall not apply to qualified long-term care insurance contracts.

39.7(7) *Benefit triggers.* Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the policy or certificate in a separate

paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this paragraph. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of the insured's functional dependency in order for the insured to be eligible for benefits, this too shall be specified.

39.7(8) *Qualified long-term care contracts.* A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986.

39.7(9) *Nonqualified long-term care contracts.* A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage that the policy is not intended to be a qualified long-term care insurance contract.

[**ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.8(514G) Prohibition against postclaims underwriting.

39.8(1) 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.

39.8(2) 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.

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

39.8(3) Except for policies or certificates which are guaranteed issue:

a. 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.

b. 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]

39.8(4) 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.

39.8(5) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated and shall annually furnish this information to the insurance commissioner in the format prescribed by the National Association of Insurance Commissioners, substantially similar to Appendix A.

[**ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.9(514D,514G) Minimum standards for home health care benefits in long-term care insurance policies.

39.9(1) A long-term care insurance policy or certificate may not, if it provides benefits for home health care services, limit or exclude benefits:

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

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

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

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

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

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

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

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

i. By excluding coverage for adult day care services.

39.9(2) Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

This rule is intended to implement Iowa Code section 514D.9 and chapter 514G.

191—39.10(514D,514G) Requirement to offer inflation protection.

39.10(1) No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder, in addition to any other inflation protection offers, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

a. Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than 5 percent;

b. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5 percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

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

39.10(2) Where the policy is issued to a group, the required offer in subrule 39.10(1) shall be made to the group policyholder; except, if the policy is issued to a group defined in Iowa Code section 514G.103(9) *"d,"* other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder.

39.10(3) The offer in subrule 39.10(1) shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

39.10(4) Insurers shall include the following information in or with the outline of coverage:

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

b. 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 75 and 85 for benefit increases.

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

39.10(5) Inflation protection benefit increases under a policy which contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

39.10(6) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

39.10(7) Inflation protection as provided in this subrule shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subrule. The rejection may be either in the application or on a separate form. The rejection shall be considered a part of the application and shall state:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection.

This rule is intended to implement Iowa Code section 514D.9 and chapter 514G.

[**ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.11(514D,514G) Requirements for application forms and replacement coverage.

39.11(1) Application forms shall include the following questions designed to elicit information 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 producer, except where the coverage is sold without a producer, containing such questions may be used. With regard to a replacement policy issued to a group defined by Iowa Code section 514G.103(9)*"a,"* the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced; provided, however, that the certificate holder has been notified of the replacement.

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

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

(1) If so, with which company?

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

c. Are you covered by Medicaid?

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

39.11(2) Producers shall list any other health insurance policies they have sold to the applicant.

a. List policies sold which are still in force.

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

39.11(3) Solicitations other than direct response. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its 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 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:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE
[Insurance company's name and address]
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name]. Your new policy provides ten days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

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

STATEMENT TO APPLICANT BY PRODUCER
[BROKER OR OTHER REPRESENTATIVE]:

(Use additional sheets, as necessary.)

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

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

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

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its 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.

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

_____

(Signature of Producer, Broker or Other Representative)

[Typed Name and Address of Producer or Broker]

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

_____

(Date)

_____

(Applicant's Signature)

39.11(4) Direct response solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE
[Insurance company's name and address]
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

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

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

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

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

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its 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.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within 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)

39.11(5) Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Such notice shall be made within five working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

39.11(6) Life insurance policies that accelerate benefits for long-term care shall comply with this subrule 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 191—Chapter 16. If a life insurance policy 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.

This rule is intended to implement Iowa Code section 514D.9 and chapter 514G.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09; **ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.12(514G) Reserve standards.

39.12(1) When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for such benefits shall be determined in accordance with Iowa Code section 508.36(3)*"a"*(7). Claim reserves must also be established when such policy or rider is in claim status.

Reserves for policies and riders subject to this subrule 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 the subrule, 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:

a. Definition of insured events;
b. Covered long-term care facilities;
c. Existence of home convalescence care coverage;
d. Definition of facilities;
e. Existence or absence of barriers to eligibility;
f. Premium waiver provision;
g. Renewability;
h. Ability to raise premiums;
i. Marketing method;
j. Underwriting procedures;
k. Claims adjustment procedures;
l. Waiting period;

m. Maximum benefit;
n. Availability of eligible facilities;
o. Margins in claim costs;
p. Optional nature of benefit;
q. Delay in eligibility for benefit;
r. Inflation protection provisions; and
s. Guaranteed insurability option.

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

39.12(2) When long-term care benefits are provided other than as in subrule 39.12(1), reserves shall be determined in accordance with sound actuarial standards, applied consistently and accepted by the commissioner of insurance.

191—39.13(514D) Loss ratio.

39.13(1) *Applicability.* This rule shall apply to all long-term care insurance policies or certificates except those covered under rules 191—39.26(514G) and 191—39.28(514G).

39.13(2) *Minimum loss ratio.* Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least 60 percent, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors including:

a. Statistical credibility of incurred claims experience and earned premiums.
b. The period for which rates are computed to provide coverage.
c. Experienced and projected trends.
d. Concentration of experience within early policy duration.
e. Expected claim fluctuation.
f. Experience refunds, adjustments or dividends.
g. Renewability features.
h. All appropriate expense factors.
i. Interest.
j. Experimental nature of the coverage.
k. Policy reserves.
l. Mix of business by risk classification.
m. Product features such as long elimination periods, high deductibles and high maximum limits.

39.13(3) *Accelerated benefits.* Subrule 39.13(2) shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

a. The interest credited internally to determine cash value accumulations, including long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

b. The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of Iowa Code section 508.37;

c. The policy meets the disclosure requirements of rules 191—39.20(514G) and 191—39.21(514G);

d. The policy illustration meets the applicable requirements of 191—Chapter 14 regarding illustrations; and

e. An actuarial memorandum is filed with the insurance division that includes:

(1) A description of the basis on which the long-term care rates were determined;

(2) A description of the basis for the reserves;

(3) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(4) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(5) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(6) The estimated average annual premium per policy and the average issue age;

(7) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(8) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

191—39.14(514G) Filing requirement. Prior to an insurer or similar organization's offering group long-term care insurance to a resident of this state pursuant to Iowa Code section 514G.103(9)*"d,"* it shall file with the commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

[**ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.15(514D,514G) Standards for marketing.

39.15(1) Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

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

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

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

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

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

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

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

g. For long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to paragraph 39.6(1)*"b."*

h. Provide an explanation of contingent benefit upon lapse provided for in 39.29(6)*"c."*

39.15(2) In addition to the practices prohibited in Iowa Code chapter 507B, the following acts and practices are prohibited:

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

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

c. Cold-lead advertising. Making use directly or indirectly of any method of marketing 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 producer or insurance company.

d. Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

39.15(3) Association marketing.

a. When a group long-term care insurance policy is issued to an association or a trust or the trustees of a fund established, created or maintained for the benefit of members of one or more associations, the association or associations, or the insurer of the association or associations, shall, prior to advertising, marketing or offering the policy within this state, file evidence with the commissioner that the association or associations have at the outset a minimum of 100 persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws that provide that:

(1) The association or associations hold regular meetings not less than annually to further purposes of the members;

(2) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(3) The members have voting privileges and representation on the governing board and committees.

Thirty days after the filing, the association or associations will be deemed to satisfy the organizational requirements, unless the commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

b. When a professional, trade, or occupational association is issued a group long-term care policy for its members or retired members or combination thereof, the association shall have as its primary responsibility, when endorsing or selling long-term care insurance, to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

(1) The insurer shall file with the insurance division the following material:

1. The policy and certificate;
2. A corresponding outline of coverage; and
3. All advertisements requested by the insurance division.

(2) The association shall disclose in any long-term care insurance solicitation 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 a brief description of the process under which the policies and the insurer issuing the policies were selected.

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

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

(5) The association shall also:

1. At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance who is not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change;
2. Actively monitor the marketing efforts of the insurer and its producers; and
3. Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

Numbered paragraphs "1" through "3" shall not apply to qualified long-term care insurance contracts.

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

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

(8) Failure to comply with the filing and certification requirements of this subrule constitutes an unfair trade practice in violation of Iowa Code chapter 507B.

39.15(4) *Producer training requirements.*

a. Purpose. The purpose of this subrule is to require certain specific minimum training for insurance producers who wish to sell long-term care insurance or long-term care partnership insurance in Iowa. This additional training is necessary due to the complex nature of long-term care insurance and long-term care partnership insurance products. This additional training is also necessary to ensure that insurance producers are able to determine whether long-term care insurance or long-term care partnership insurance products are suitable for consumers and that producers are able to adequately explain to consumers how the long-term care insurance and long-term care partnership insurance products work. The ultimate goal of this subrule is to ensure that purchasers of long-term care insurance and long-term care partnership insurance products understand basic features of the products.

(1) This subrule applies to all long-term care insurance and long-term care partnership insurance products sold on or after January 1, 2010.

(2) For purposes of this subrule, "CE," "CE provider," "CE term" and "credit" shall mean the same as defined in rule 191—11.2(505,522B).

b. Required training.

(1) An individual may not sell, solicit or negotiate long-term care insurance or long-term care partnership insurance products unless the individual is licensed as an insurance producer with an accident and health or sickness line of authority and has completed a one-time training course and ongoing training every CE term thereafter. The training shall meet the requirements set forth in paragraph 39.15(4)*"c."*

(2) The training content of paragraph 39.15(4)*"c"* must be approved as continuing education courses under 191—Chapter 11, except that the one-time training required under subparagraph 39.15(4)*"b"*(1) must be classroom training. However, a CE provider may apply directly to the division and request that a self-study or on-line course be approved as a substitute. Ongoing training may be by any means allowable under 191—Chapter 11.

c. Training content.

(1) The one-time training required by this subrule shall be no less than eight credits and the ongoing training required by this subrule shall be no less than four credits, except that producers who have completed four credits of long-term care insurance training prior to January 1, 2010, shall complete only four credits of one-time training specifically related to the long-term care partnership program and Iowa-specific Medicaid requirements.

(2) The training required under subparagraph (1) shall consist of topics related to long-term care insurance, long-term care services and qualified state long-term care insurance partnership programs, including, but not limited to:

1. State and federal regulations and requirements and the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services, including Medicaid requirements;
2. Available long-term care services and providers;
3. Changes or improvements in long-term care services or providers;
4. Alternatives to the purchase of private long-term care insurance or long-term care partnership insurance;
5. The effect of inflation on benefits and the importance of inflation protection;
6. Consumer suitability standards and guidelines;
7. The Deficit Reduction Act;
8. Iowa's laws regarding the long-term care partnership program;
9. The Iowa Medicaid program;
10. Miller trusts;
11. Spousal protection;

12. Transfer of assets;
13. Estate recovery; and
14. Eligibility.

(3) Unless otherwise required by state or federal law, the training required by this subrule shall not include training that is specific to a single insurer or company product and shall not include any sales or marketing information, materials, or training, other than those required by state or federal law.

d. Requirements for insurers.

(1) Insurers subject to this chapter shall obtain verification that a producer has received training required by subparagraph 39.15(4)*"b"*(1) before a producer is permitted to sell, solicit or negotiate the insurer's long-term care insurance or long-term care partnership insurance products; shall make verifications available to the division upon request; and shall maintain records subject to the state's record retention requirements.

(2) Each insurer subject to this chapter shall maintain records with respect to the training of its producers concerning the distribution of its partnership policies that will allow the division to provide assurance to the Iowa department of human services that producers have received the training set forth in subparagraph 39.15(4)*"c"*(2), numbered paragraph "1," as required by subparagraph 39.15(4)*"b"*(1) and that producers have demonstrated an understanding of the partnership policies and the policies' relationship to public and private coverage of long-term care, including Medicaid, in this state. These records shall be maintained in accordance with the state's record retention requirements and shall be made available to the division upon request.

e. Training obtained in other states. The satisfaction of the training requirements in any state shall be deemed to satisfy the training requirements in this state.

f. Requirements for continuing education providers to provide long-term care partnership insurance training. In addition to having been approved as a CE provider under rule 191—11.9(505,522B), a CE provider intending to provide either the initial training or the ongoing continuing education required under subrule 39.15(4) shall:

(1) Provide only classroom training for the initial one-time training for providers. However, the CE provider may apply directly to the division and request that a self-study or on-line course be approved as a substitute. Ongoing training may be by any means allowable under 191—Chapter 11.

(2) If approved, comply with rules 191—11.10(505,522B) and 191—11.11(505,522B).

This rule is intended to implement Iowa Code section 514D.9 and chapter 514G.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.16(514D,514G) Suitability.

39.16(1) This rule shall not apply to life insurance policies that accelerate benefits for long-term care.

39.16(2) Every insurer, health care service plan or other entity marketing long-term care insurance (the "issuer") shall:

a. 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;

b. Train its producers in the use of its suitability standards; and

c. Maintain a copy of its suitability standards and make it available for inspection upon request by the commissioner.

39.16(3) To determine whether the applicant meets the standards developed by the issuer, the producer and issuer shall develop procedures that take into consideration the following:

a. The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

b. 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

c. 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.

39.16(4) The issuer, and, when a producer is involved, the producer, shall make reasonable efforts to obtain the information set out in subrule 39.16(3). The efforts shall include presentation of the "Long-Term Care Insurance Personal Worksheet" to the applicant, at the time of or prior to application. The personal

worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix B, in not less than 12-point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the commissioner.

A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

The sale or dissemination outside the company or agency by the issuer or producer of information obtained through the personal worksheet in Appendix B is prohibited.

39.16(5) The issuer shall use the suitability standards it has developed pursuant to this rule in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

39.16(6) Producers shall use the suitability standards developed by the issuer in marketing long-term care insurance.

39.16(7) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix C, in not less than 12-point type.

39.16(8) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

39.16(9) The issuer shall report annually to the commissioner the total number of applications received from residents of this state, the number of applicants who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of applicants who chose to confirm after receiving a suitability letter.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.17(514G) Prohibition against preexisting conditions 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 and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

191—39.18(514G) Standard format outline of coverage. This rule, which is not applicable to life policies with long-term care riders attached, implements, interprets and makes specific the provisions of Iowa Code section 514G.105 in prescribing a standard format and the content of an outline of coverage.

39.18(1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

39.18(2) In the case of producer solicitations, a producer must deliver the outline of coverage prior to the presentation of an application or enrollment form.

39.18(3) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

39.18(4) The commissioner shall prescribe the standard format, including style, arrangement, and overall appearance and content of an outline of coverage.

39.18(5) The outline of coverage shall be a freestanding document, using no smaller than 10-point type.

39.18(6) The outline of coverage shall contain no material of an advertising nature.

39.18(7) Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.

39.18(8) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

39.18(9) 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 substantially similar language, must appear as follows in the outline of coverage.]

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

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

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

3. FEDERAL TAX CONSEQUENCES.

This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986.

OR

Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

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

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

(1)

[Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS [POLICY] [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your [policy] [certificate], to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2)

[Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS [POLICY] [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

(c) [Describe waiver of premium provisions or state that there are not such provisions.]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium and, if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

6. 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.]

7. 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 producers] Neither [insert company name] nor its producers 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.

8. 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.]

9. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductibles, waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Noninstitutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.]

[Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of the insured's functional dependency in order for the insured to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Noneligible facilities and provider;

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

(d) Exclusions and exceptions;

(e) Limitations.]

[This section should provide a brief, specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in "6" above.]

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

11. 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.]

12. 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.]

13. 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.]

14. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

15. CONTACT THE STATE SENIOR HEALTH INSURANCE INFORMATION PROGRAM (800-351-4664) IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09; **ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.19(514G) Requirement to deliver shopper's guide.

39.19(1) A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, the Blue Cross and Blue Shield Association, the Health Insurance Association of America or the senior health insurance information program of the insurance division shall be provided to all prospective applicants of a long-term care insurance policy or certificate or life insurance policy or certificate that includes a long-term care rider.

a. In the case of producer solicitations, a producer must deliver the shopper's guide to the applicant at the time of application.

b. In the case of direct response solicitations, the shopper's guide must be presented to the applicant at the time the policy is delivered.

39.19(2) Insurers offering life insurance policies or riders containing accelerated long-term care benefits are not required to comply with 39.19(1), but shall furnish the policy summary required under rule 191—39.20(514G).

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.20(514G) Policy summary and delivery of life insurance policies with long-term care riders.

39.20(1) If an application for a long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than 30 days after the date of approval.

39.20(2) At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. 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 such delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

a. An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

b. An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits, if any, for each covered person;

c. Any exclusions, reductions, and limitations on benefits of long-term care;

d. If applicable to the policy type, the summary shall also include a disclosure of the effects of exercising other rights under the policy, a disclosure of guarantees related to long-term care costs of insurance charges, and current and projected maximum lifetime benefits; and

e. A statement that any long-term care inflation protection option required by rule 191—39.10(514D,514G) is not available under this policy.

The provisions of the policy summary listed above may be incorporated into a basic illustration required to be delivered in accordance with 191—Chapter 14 or into the life insurance policy summary which is required to be delivered in accordance with rule 191—15.4(507B).

191—39.21(514G) Reporting requirement for long-term care benefits funded through life insurance by acceleration of the death benefit. Any time a long-term care benefit, funded through life insurance which 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.

191—39.22(514G) Unintentional lapse.

39.22(1) Notice before lapse or termination. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either: a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium; or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate any person to receive such notice."

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

39.22(2) When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in subrule 39.22(1) need not be met until 60 days after the policyholder or certificate holder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

39.22(3) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to subrule 39.22(1) at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first-class United States mail, postage prepaid; and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.

39.22(4) Reinstatement. In addition to the requirement in subrule 39.22(1), a long-term care insurance policy or certificate shall include a provision which provides for reinstatement of coverage in the event of lapse if the insurer is provided proof of cognitive impairment or the loss of functional capacity. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss

of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity, if any, contained in the policy and certificate.

191—39.23(514G) Denial of claims. If a claim under a long-term care insurance contract is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificate holder, or a representative thereof, provide a written explanation of the reasons for the denial; and make available all information directly related to the denial.

191—39.24(514G) Incontestability period.

39.24(1) For a policy or certificate that has been in force for less than six months, 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 that is material to the acceptance for coverage.

39.24(2) For a policy or certificate that has been in force for at least six months but 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 that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.

39.24(3) After a policy or certificate has been in force for two years, it is not contestable upon the grounds of misrepresentation alone; such policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

39.24(4) No long-term care insurance policy or certificate may be field-issued based on medical or health status. For purposes of this subrule, "field-issued" means a policy or certificate issued by a producer or a third-party administrator pursuant to the underwriting authority granted to the producer or third-party administrator by an insurer.

39.24(5) If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

39.24(6) In the event of the death of the insured, this rule shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies shall be governed by Iowa Code section 508.28. In all other situations, this rule shall apply to life insurance policies that accelerate benefits for long-term care.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.25(514G) Required disclosure of rating practices to consumers.

39.25(1) *Applicability.* This rule applies to any new long-term care policy or certificate issued in this state on or after February 1, 2003. For certificates issued under a group long-term care insurance policy which policy was in force prior to February 1, 2003, the provisions of this rule shall apply on the policy anniversary following February 1, 2003.

39.25(2) *Contents of disclosure.* Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subrule to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this subrule to the applicant no later than 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, 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:

(1) A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and

(2) The right to a revised premium rate or rate schedule as provided in paragraph 39.25(2)*"c"* 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 ten years for this state or any other state.

(1) The following, at a minimum, shall be included:

1. The policy forms for which premium rates have been increased;

2. The calendar years when the form was available for purchase; and

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

(2) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

(3) An insurer shall have the right to exclude from the disclosure 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.

(4) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or on a block of policy forms acquired from nonaffiliated insurers on or before the later of February 1, 2003, or the end of a 24-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the non-affiliated selling company shall include the disclosure of that rate increase in accordance with paragraph *"e."*

(5) If the acquiring insurer in subparagraph (4) above files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in subparagraph (4), the acquiring insurer shall make all disclosures required by paragraph *"e,"* including disclosure of the earlier rate increase referenced in subparagraph (4).

39.25(3) *Acknowledgment.* An applicant shall sign an acknowledgment at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under 39.25(2)*"a"* and 39.25(2)*"e."* If due to the method of application the applicant cannot sign an acknowledgment at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

39.25(4) *Required format.* An insurer shall use the forms in Appendices B and F to comply with the requirements of this rule.

39.25(5) *Notice of rate increase.* An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, if 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 subrule 39.25(2) when the rate increase is implemented.

191—39.26(514G) Initial filing requirements.

39.26(1) *Effective date.* This rule applies to any long-term care policy issued in this state on or after February 1, 2003.

39.26(2) *Required filing.* An insurer shall provide the information listed in this subrule to the commissioner pursuant to rule 191—20.1(505,509,514A,515,515A,515F) 30 days prior to making a long-term care insurance form available for sale.

a. A copy of the disclosure documents required in rule 191—39.25(514G); and

b. An actuarial certification consisting of at least the following:

(1) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(2) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(3) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(4) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

1. Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

2. A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

3. A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and

4. A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur;

● An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;

● If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under subrule 39.26(3) based on a standard age distribution; and

(5) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or a comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

39.26(3) *Demonstration on request.*

a. The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

b. In the event the commissioner asks for additional information under this provision, the period in subrule 39.26(2) does not include the period during which the insurer is preparing the requested information.

191—39.27(514G) Reporting requirements.

39.27(1) Every insurer shall maintain for each producer records of that producer's amount of replacement sales as a percent of the producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the producer as a percent of the producer's total annual sales.

39.27(2) Every insurer shall report annually by June 30 the 10 percent of its producers with the greatest percentages of lapses and replacements as measured by subrule 39.27(1) in the format prescribed in Appendix G.

39.27(3) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely producer activities regarding the sale of long-term care insurance.

39.27(4) Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year in the format prescribed in Appendix G.

39.27(5) Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year in the format prescribed in Appendix G.

39.27(6) Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied in the format prescribed in Appendix E.

39.27(7) For purposes of rule 191—39.27(514G):

a. "Policy" means only long-term care insurance;

b. Subject to paragraph *"c"* below, "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;

c. "Denied" means 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; and

d. "Report" means on a statewide basis.

39.27(8) Reports required under this rule shall be filed with the commissioner. The first reports under this rule are due June 30, 2004.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.28(514G) Premium rate schedule increases.

39.28(1) This rule applies to any long-term care policy or certificate issued in this state on or after February 1, 2003. For certificates issued under a group long-term care insurance policy which policy was in force on February 1, 2003, the provisions of this rule shall apply on the policy anniversary following July 1, 2003.

39.28(2) An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least 30 days prior to the notice to the policyholders and shall include:

a. Information required by rule 191—39.25(514G);

b. Certification by a qualified actuary that:

(1) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

(2) The premium rate filing is in compliance with the provisions of this rule;

c. An actuarial memorandum justifying the rate schedule change request that includes:

(1) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

1. Annual values for the five years preceding and the three years following the valuation date shall be provided separately;

2. The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

3. The projections shall demonstrate compliance with subrule 39.28(3); and

4. For exceptional increases,

- The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and
- In the event the commissioner determines that offsets may exist, the insurer shall use appropriate net projected experience;

(2) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(3) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

(4) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

(5) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates;

d. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

e. Sufficient information for review of the premium rate schedule increase by the commissioner.

39.28(3) All premium rate schedule increases shall be determined in accordance with the following requirements:

a. Exceptional increases shall provide that 70 percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

b. Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(1) The accumulated value of the initial earned premium multiplied by 58 percent;

(2) Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis;

(3) The present value of future projected initial earned premiums multiplied by 58 percent; and

(4) Eighty-five percent of the present value of future projected premiums not in subparagraph (3) above on an earned basis;

c. In the event that a policy form has both exceptional and other increases, the values in subparagraphs 39.28(3)*"b"*(2) and (4) will also include 70 percent for exceptional rate increase amounts; and

d. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as recommended by the NAIC Financial Examiners Handbook. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

39.28(4) For each rate increase that is implemented, the insurer shall file for review by the commissioner updated projections, as defined in subparagraph 39.28(2)*"c"*(1), annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subrule 39.28(11), the projections required by this subrule shall be provided to the policyholder in lieu of filing with the commissioner.

39.28(5) If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in subparagraph 39.28(2)*"c"*(1), shall be filed for review by the commissioner every five years following the end of the required period in subrule 39.28(4). For group insurance policies that meet the conditions in subrule 39.28(11), the projections required by this paragraph shall be provided to the policyholder in lieu of filing with the commissioner.

39.28(6) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subrule 39.28(3), the commissioner may require the insurer to implement any of the following:

a. Premium rate schedule adjustments; or

b. Other measures to reduce the difference between the projected and actual experience.

In determining whether the actual experience adequately matches the projected experience, consideration should be given to subparagraph 39.28(2)*"c"*(5), if applicable.

39.28(7) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

a. A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise, the commissioner may impose the condition in subrule 39.28(8); and

b. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subrule 39.28(3) had the greater of the original anticipated lifetime loss ratio or 58 percent been used in the calculations described in subparagraphs 39.28(3)*"b"*(1) and (3).

39.28(8) Review of lapse rates.

a. For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(1) The rate increase is not the first rate increase requested for the specific policy form or forms;

(2) The rate increase is not an exceptional increase; and

(3) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

b. In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(1) The offer shall:

1. Be subject to the approval of the commissioner;
2. Be based on actuarially sound principles, but not be based on attained age; and
3. Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

(2) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

1. The maximum rate increase determined based on the combined experience; and
2. The maximum rate increase determined based only on the experience of the insureds originally issued the form plus 10 percent.

39.28(9) If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of subrule 39.28(8), prohibit the insurer from either of the following:

a. Filing and marketing comparable coverage for a period of up to five years; or

b. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

39.28(10) Subrules 39.28(1) through 39.28(9) shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in subrule 39.5(16), if the policy complies with all of the following provisions:

a. The interest credited internally to determine cash value accumulations, including long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

b. The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

(1) Iowa Code section 508.37, regarding nonforfeiture standards for life insurance;

(2) Iowa Code section 508.38, regarding nonforfeiture standards for individual deferred annuities; and

(3) Iowa Code section 508A.5 and 191—subrule 31.3(8), regarding variable annuities;

c. The policy meets the disclosure requirements of rules 191—39.20(514G) and 191—39.21(514G);

d. The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

(1) Policy illustrations as required by 191—Chapter 14;

(2) Disclosure requirements for annuities as required by the commissioner; and

(3) Disclosure requirements for variable annuities as required by 191—Chapter 31;

e. An actuarial memorandum is filed with the insurance division that includes:

(1) A description of the basis on which the long-term care rates were determined;

(2) A description of the basis for the reserves;

(3) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(4) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(5) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(6) The estimated average annual premium per policy and the average issue age;

(7) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if underwriting is used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(8) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

39.28(11) Subrules 39.28(6) and 39.28(8) shall not apply to group insurance policies where:

a. The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

b. The policyholder, and not the certificate holders, pays a material portion of the premium, which shall not be less than 20 percent of the total premium for the group in the calendar year prior to the year a rate increase is filed.

191—39.29(514G) Nonforfeiture.

39.29(1) Except as provided in subrule 39.29(2), a long-term care insurance policy may not be delivered or issued for delivery in this state unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. In the event the policyholder or certificate holder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates.

39.29(2) When a group long-term care insurance policy is issued, the offer required in subrule 39.29(1) shall be made to the group policyholder. However, if the policy is issued as group long-term care insurance to a group as defined in Iowa Code section 514G.103(9)*"d,"* other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificate holder.

39.29(3) This rule does not apply to life insurance policies or riders containing accelerated long-term care benefits.

39.29(4) To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of subrule 39.29(1):

a. A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subrule 39.29(7); and

b. The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

39.29(5) If the offer required to be made under subrule 39.29(1) is rejected, the insurer shall provide the contingent benefit upon lapse described in this rule.

39.29(6) Benefit triggers.

a. After rejection of the offer required under subrule 39.29(1), for individual and group policies without nonforfeiture benefits issued after February 1, 2003, the insurer shall provide a contingent benefit upon lapse.

b. 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.

c. The contingent benefit upon 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 below 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. Unless otherwise required, policyholders shall be notified at least 30 days prior to the due date of the premium reflecting the rate increase.

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%

d. On or before the effective date of a substantial premium increase as defined in paragraph 39.29(6)*"c,"* the insurer shall:

(1) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(2) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subrule 39.29(7). This option may be elected at any time during the 120-day period referenced in paragraph 39.29(6)*"c"*; and

(3) Notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in paragraph 39.29(6)*"c"* shall be deemed to be the election of the offer to convert in subparagraph (2) above.

39.29(7) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in this subrule.

a. For purposes of this subrule, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least 1 percent per year prior to age 50, and at least 3 percent per year beyond age 50.

b. For purposes of this subrule, the nonforfeiture benefit shall be of a shortened benefit period providing 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 *"c."*

c. 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 limitation of subrule 39.29(8).

d. Benefit dates.

(1) The nonforfeiture benefit shall begin not 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) Notwithstanding subparagraph (1), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

1. The end of the tenth year following the policy or certificate issue date; or

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

e. 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.

39.29(8) All benefits paid by the insurer while the policy or certificate is in premium-paying status and in paid-up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium-paying status.

39.29(9) There shall be no difference in the minimum nonforfeiture benefits as required under this rule for group and individual policies.

39.29(10) The requirements set forth in this rule shall become effective July 1, 2003, and shall apply as follows:

a. Except as provided in paragraph *"b,"* the provisions of this rule apply to any long-term care policy issued on or after February 1, 2003.

b. For certificates issued on or after July 1, 2003, under a group long-term care insurance policy which policy was in force on February 1, 2003, the provisions of this rule shall not apply.

39.29(11) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of 39.13(2) or 191—39.28(514G), whichever applies, treating the policy as a whole.

39.29(12) To determine whether contingent nonforfeiture upon lapse provisions are triggered under paragraph 39.29(6)*"c,"* 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.

39.29(13) A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

a. The nonforfeiture provision shall be appropriately captioned;

b. 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 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; and

c. The nonforfeiture provision shall provide at least one of the following:

(1) Reduced paid-up insurance;

(2) Extended term insurance;
(3) Shortened benefit period; or
(4) Other similar offerings approved by the commissioner.

39.29(14) Notwithstanding subrule 39.29(10), if an insurer requests a premium rate increase on any long-term care policy issued prior to February 1, 2003, the commissioner shall require as a condition of approval of such premium rate increase that the insurer provide notice to all affected policyholders and certificate holders that, in lieu of the requested premium rate increase, the insured may opt for one of the following:

a. A reduced benefit. The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable. The age used to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force. The reduced benefit offered may include one or more of the following:

(1) A reduced daily, weekly, or monthly benefit;
(2) A longer waiting period;
(3) A reduced benefit period or a reduced maximum lifetime benefit; or
(4) Any other benefit or coverage reduction option consistent with the policy or certificate design or the carrier's administrative processes.

b. A contingent benefit upon lapse as described in subrules 39.29(7), 39.29(8), 39.29(9), and 39.29(12) if the requested premium rate increase 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 paragraph 39.29(6)*"c."*

c. Any other alternative mechanism filed by the insurer and approved by the commissioner.

[**ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.30(514G) Standards for benefit triggers.

39.30(1) A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

39.30(2) Activities of daily living.

a. Activities of daily living shall include at least the following as defined in rule 191—39.5(514G) and in the policy:

(1) Bathing;
(2) Continence;
(3) Dressing;
(4) Eating;
(5) Toileting; and
(6) Transferring.

b. Insurers may use other activities of daily living to trigger covered benefits as long as the activities are defined in the policy.

39.30(3) An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however, the provisions shall not restrict, and are not in lieu of, the requirements contained in subrules 39.30(1) and 39.30(2).

39.30(4) For purposes of this rule, the determination of a deficiency shall not be more restrictive than:

a. Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

b. If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cuing by another person is needed in order to protect the insured or others.

39.30(5) Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

39.30(6) Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

39.30(7) The requirements set forth in this rule shall be effective July 1, 2003, and shall apply as follows:

a. Except as provided in paragraph *"b,"* the provisions of this rule apply to a long-term care policy issued in this state on or after February 1, 2003.

b. For certificates issued on or after July 1, 2003, under group long-term care insurance as defined in Iowa Code section 514G.103 that was in force on February 1, 2003, the provisions of this rule shall not apply.

[**ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.31(514G) Additional standards for benefit triggers for qualified long-term care insurance contracts.

39.31(1) For purposes of this rule, the following definitions apply:

"Chronically ill individual" has the meaning prescribed for this term by Section 7702B(c)(2) of the Internal Revenue Code of 1986. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

1. Being unable to perform (without substantial assistance from another individual) at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity; or

2. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

The term "chronically ill individual" shall not include an individual otherwise meeting these requirements unless within the preceding 12-month period a licensed health care practitioner has certified that the individual meets these requirements.

"Licensed health care practitioner" means a physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the Secretary of the Treasury.

"Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

"Qualified long-term care services" means services that meet the requirements of Section 7702(c)(1) of the Internal Revenue Code of 1986, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

39.31(2) A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

39.31(3) A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.

39.31(4) Certifications regarding activities of daily living and cognitive impairment required pursuant to subrule 39.31(3) shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury.

39.31(5) Certifications required pursuant to subrule 39.31(3) may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the 90-day period.

39.31(6) Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

191—39.32(514G) Penalties. Violations of this chapter shall be subject to the penalties imposed under Iowa Code chapter 507B.

191—39.33(514G) Notice of cancellation, nonrenewal or termination of long-term care insurance.

39.33(1) *Purpose and definitions.*

a. Purpose. The purpose of this rule is to clarify the authorized methods of delivery for notices of cancellation, nonrenewal or termination by an insurer, so as to implement the various policyholder protections intended by Iowa Code section 514G.111 and rule 191—39.22(514G).

b. Definitions. As used in Iowa Code section 505B.1 and this rule:

"Commissioner" means the Iowa insurance commissioner or insurance division.

"Notice of cancellation, nonrenewal or termination" means:

1. Notice of an insurance company's termination of an insurance policy at the end of a term or before the termination date;

2. Notice of an insurance company's decision or intention not to renew a policy; and

3. For purposes of notices required by Iowa Code section 514G.111 and rule 191—39.22(514G), at a minimum, an insurance company's notice of lapse or termination of a long-term care insurance policy.

39.33(2) *Scope.* This rule shall apply to all insurance companies holding a certificate of authority to transact the business of insurance under the provisions of Iowa Code chapter 508 or 515.

39.33(3) *Delivery.* For any notice of cancellation, nonrenewal or termination by an insurer under Iowa Code section 514G.111 and rule 191—39.22(514G) to be effective, an insurer must, within the time frame established by law, deliver the notice to the person to whom notice is required to be provided either in person or by mail through the U.S. Postal Service to the last-known address of the person to whom notice is required to be provided. The use of U.S. Postal Service Intelligent Mail® fulfills any requirement in Iowa Code section 514G.111 and rule 191—39.22(514G) for certified mail or certificate of mailing as proof of mailing.

39.33(4) *Electronic transmissions.* Notwithstanding the requirements of subrule 39.33(3), if an insurer receives, pursuant to 191—subrule 4.24(2), approval from the commissioner of a manner of electronic delivery of a notice of cancellation, nonrenewal or termination of a policy, the approved manner shall satisfy the notice requirements of Iowa Code section 514G.111 and rule 191—39.22(514G).

This rule is intended to implement Iowa Code chapter 505B.

[**ARC 1999C**, IAB 5/27/15, effective 7/1/15; **ARC 2415C**, IAB 2/17/16, effective 3/23/16]

191—39.34 to **39.40** Reserved.

DIVISION II
INDEPENDENT REVIEW OF BENEFIT TRIGGER DETERMINATIONS

191—39.41(514G) Purpose. This division is intended to implement Iowa Code chapter 514G to provide a uniform process for insureds covered under long-term care insurance to request an independent review of a denial of coverage based on a benefit trigger determination.

[**ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.42(514G) Effective date. The rules contained in this division shall apply to all requests for benefit trigger determinations made on or after January 1, 2009.

191—39.43(514G) Definitions. For purposes of this division, the definitions found in Iowa Code section 514G.103 shall apply.

[**ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.44(514G) Notice of benefit trigger determination and content. The notice required by Iowa Code section 514G.109 shall contain the following information:

1. The reason that the insurer determined that the policy benefit trigger has not been met by the insured.

2. A description of the internal appeal mechanism provided under the long-term care policy.

3. A description of how the insured, after exhausting the insurer's internal appeal process, has the right to have the benefit trigger determination reviewed under the independent review process required by Iowa Code section 514G.110.

[**ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.45(514G) Notice of internal appeal decision and right to independent review. Upon the conclusion of the internal appeal mechanism specified in Iowa Code section 514G.109(2), the notice required in Iowa Code section 514G.110(2)*"b"* and *"c"* shall contain the following information:

39.45(1) A description of additional internal appeal rights, if any, offered by the insurer.

39.45(2) A description of how the insured can request independent review of the benefit trigger determination. Such description must specify the following:

a. The insured must submit a written request within 60 days of the insured's receiving written notice of the insurer's internal appeal decision;

b. The request must be made to the Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315;

c. A copy of the insurer's benefit trigger determination letter must accompany the written request for an independent review.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09; **ARC 3683C**, IAB 3/14/18, effective 4/18/18; Editorial change: IAC Supplement 9/23/20]

191—39.46(514G) Independent review request. The insured shall send a copy of the insurer's notice explaining why the benefit trigger has not been met, with the insured's request for an independent review, to the insurance commissioner within 60 days of receipt of the benefit trigger determination. The notice shall be sent to the commissioner at the Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315.

[**ARC 3683C**, IAB 3/14/18, effective 4/18/18; Editorial change: IAC Supplement 9/23/20; **ARC 0001Z**, IAB 9/23/20, effective 10/28/20]

191—39.47(514G) Certification process.

39.47(1) The commissioner shall provide written notice of the certification decision to the insurer and the insured within the two-business-day period specified in Iowa Code section 514G.110.

39.47(2) The insurer may appeal the commissioner's certification decision within three business days after receiving notice of the decision. The commissioner shall review any such appeal and promptly notify the insured and the insurer of the commissioner's decision.

[**ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.48(514G) Selection of independent review entity.

39.48(1) Within three business days of receiving the commissioner's certification decision, the insurer shall:

a. Select an independent review entity from the list certified by the commissioner;

b. Notify the insured in writing of the name, address, and telephone number of the independent review entity;

c. Notify the independent review entity of its selection and provide the independent review entity with sufficient information to allow selection of qualified licensed health care professionals to conduct the independent review;

d. Provide the commissioner with copies of the notices required by this subrule.

39.48(2) Within three business days of receiving the notice specified in subrule 39.48(1), the independent review entity shall do one of the following:

a. Accept its selection, designate a qualified licensed health care professional to perform the independent review, and notify the insured and insurer, with a copy to the commissioner, of the designation, the qualifications of the qualified licensed health care professional, and the reasons why the licensed health care professional is qualified to conduct the independent review;

b. Decline its selection and provide notice to the commissioner, the insured, and the insurer of the declination. The insurer shall have three business days after receipt of the declination notice to designate a different independent review entity pursuant to subrule 39.48(1); or

c. Request that the commissioner grant the independent review entity additional time to have a qualified licensed health care professional certified and provide notice of such request to the insured, the insurer, and the commissioner. Within three business days of such a request, the commissioner shall notify the insured, the insurer, and the independent review entity how to proceed.

39.48(3) Within ten days of receiving the notice specified in paragraph 39.48(1)*"b,"* an insured may object to the independent review entity selected by the insurer or the licensed health care professional selected by the independent review entity. Such an objection shall state the reasons for the objection with particularity. The objection shall be sent to the commissioner, and a copy shall be sent to the insurer. The commissioner shall notify the insured, the insurer, and the independent review entity of the commissioner's decision within two business days of receipt of the objection.

191—39.49(514G) Independent review process.

39.49(1) Within five business days of receiving either the notice provided in paragraph 39.48(1)*"b,"* or the denial of an objection made pursuant to subrule 39.48(3), whichever is later, the insured may submit any additional information or documentation in support of the insured's claim to both the independent review entity and the insurer.

39.49(2) Within 15 days of receiving the notice provided in paragraph 39.48(1)*"b,"* or within three business days of receiving notice of the denial of an objection made pursuant to subrule 39.48(3), whichever is later, an insurer shall:

a. Provide the independent review entity with any information submitted to the insurer by the insured during the insurer's internal appeal process relating to the benefit trigger determination that is the subject of the independent review proceeding;

b. Provide the independent review entity with any other relevant documents used by the insurer in making its benefit trigger determination; and

c. Provide the commissioner and the insured with confirmation that the information required by this subrule was submitted to the independent review entity, including the date such information was submitted.

39.49(3) The independent review entity shall not commence its review of the insurer's benefit trigger determination until 15 business days after either the independent review entity receives the notice of its selection specified in paragraph 39.48(1)*"c"* or the resolution of any objection made pursuant to subrule 39.48(3), whichever is later.

39.49(4) During the time period specified in subrule 39.48(3), the insurer may consider any information provided by the insured pursuant to subrule 39.49(1) and affirm or overturn the insurer's benefit trigger determination. If the insurer overturns its benefit trigger determination:

a. The insurer shall provide notice to the independent review entity, the commissioner, and the insured of the insurer's decision; and

b. The independent review process shall immediately cease.

191—39.50(514G) Decision notification.

39.50(1) The independent review entity shall immediately notify the insurer, the insured, and the commissioner of the independent review decision either affirming or overturning the insurer's benefit trigger determination. The initial notification shall be delivered by telephone or fax transmission, and a written copy of the decision notification delivered by regular mail. The written copy of the decision shall include a description of the basis for the independent review entity's decision.

39.50(2) If the independent review entity overturns the insurer's decision, the independent review entity shall include all of the following in the decision:

a. The precise date that the benefit trigger was deemed to have been met;

b. The specific period of time under review for which the insurer declined eligibility but during which the independent review entity determined that the benefit trigger was met;

c. For qualified long-term care insurance contracts, a certification made only by a licensed health care practitioner that the insured is a chronically ill individual.

191—39.51(514G) Insurer information.

39.51(1) No later than January 1, 2009, each insurer delivering or issuing for delivery long-term care insurance policies in this state on or after July 1, 2008, and each insurer that has active long-term care policies or riders under which claims for benefits may be made on or after July 1, 2008, shall provide the commissioner the name or title, telephone and fax numbers and email address of an individual who shall be the insurer's contact person for independent review procedures and matters. Any changes in personnel or communication numbers shall be immediately communicated to the commissioner.

39.51(2) Each insurer shall provide the commissioner a detailed description of the process that the insurer has in place to ensure compliance with the requirements of this division and of Iowa Code sections 514G.109 and 514G.110. The description required by this subrule shall be filed in a format as directed by the commissioner on or before March 1, 2009, and thereafter as requested by the commissioner. The description shall include:

a. An explanation of how the insurer determines when an insured has qualified for independent review of the benefit trigger decision and should receive a notice from the insurer,

b. A copy of the notice sent to insureds who fall within the scope of the law, and

c. An explanation of the internal appeal process.

[**ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.52(514G) Certification of independent review entity. The following minimum standards are required for certification as an independent review entity:

39.52(1) The entity shall ensure that any licensed health care professional on its staff who participates in an independent review proceeding holds a current unrestricted license or certification to practice a health care profession in the United States.

39.52(2) The entity shall ensure that any licensed health care professional on its staff who participates in an independent review proceeding and who is a physician holds a current certification by a recognized American medical specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

39.52(3) The entity shall ensure that any licensed health care professional on its staff who participates in an independent review proceeding and who is not a physician holds a current certification in the specialty in which that person is licensed by a recognized American specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

39.52(4) The entity shall ensure that any licensed health care professionals on its staff who participate in an independent review proceeding have no history of disciplinary actions or sanctions including, but not limited to, the loss of staff privileges or any participation restriction taken or pending by any hospital or state or federal government regulatory agency for wrongdoing by the health care professional.

39.52(5) The entity shall ensure that neither the entity, nor any of its employees, agents, or licensed health care professionals utilized, receive compensation of any type that is dependent on the outcome of the review.

39.52(6) The entity shall ensure that neither the entity, nor any of its employees, agents, or licensed health care professionals utilized, are in any manner related to, employed by, or affiliated with the insured or with a person who previously provided medical care to the insured.

39.52(7) The entity shall provide a description of the qualifications of the reviewers retained to conduct independent review of long-term care insurance benefit trigger decisions, including the reviewers' employment histories and practice affiliations for at least the prior ten years, and a description of past experience with decisions relating to long-term care, functional capacity, and dependency in activities of daily living, or in assessing cognitive impairment.

39.52(8) The entity shall provide a description of the procedures employed to ensure that reviewers conducting independent reviews are appropriately: licensed, registered or certified; trained in the principles, procedures and standards of the independent review entity; knowledgeable about the functional or cognitive impairments associated with the diagnosis and disease staging processes, including expected duration of such impairment; and knowledgeable and experienced in diagnosing a person as a "chronically ill individual" as defined in Section 7702B(c)(2) of the Internal Revenue Code.

39.52(9) The entity shall provide a description of the evaluation tools the entity would use to conduct a review of a long-term care insurance benefit trigger decision.

39.52(10) The entity shall provide a description of the methods of recruiting and selecting impartial reviewers and matching such reviewers to specific cases.

39.52(11) The entity shall provide the number of reviewers retained by the independent review entity and a description of the areas of expertise available from such reviewers and the types of cases such reviewers are qualified to review (e.g., assessment of cognitive impairment or inability to perform activities of daily living due to a loss of functional capacity).

39.52(12) The entity shall provide a description of the policies and procedures employed to protect confidentiality of individual personally identifiable health information in accordance with applicable state and federal laws.

39.52(13) The entity shall provide a description of the quality assurance program established by the independent review entity.

39.52(14) The entity shall provide the names of all corporations and organizations owned or controlled by the independent review entity or which own or control the entity, and the nature and extent of any such ownership or control. The entity must ensure that neither the entity, nor any of its employees, agents, or licensed health care professionals utilized, are a subsidiary of, or owned or controlled by, an insurer or by a trade association of insurers of which the insurer is a member.

39.52(15) The entity shall provide the names and résumés of all directors, officers and executives of the entity.

39.52(16) The entity shall provide a description of the fees to be charged by the entity for independent reviews of a long-term care insurance benefit trigger decision.

39.52(17) The entity shall provide the name of the medical director or health professional director responsible for the supervision and oversight of the independent review procedure.

39.52(18) The entity must have on staff or contract with a licensed health care practitioner who is qualified to certify that an individual is chronically ill for purposes of a qualified long-term care insurance contract.

191—39.53(514G) Additional requirements. The independent review entity shall develop and maintain written policies and procedures governing all aspects of the independent review process. The written policies and procedures include, but are not limited to, the following:

39.53(1) Procedures to ensure that independent reviews are conducted within the time frames specified in this division and Iowa Code chapter 514G as amended by 2008 Iowa Acts, House File 2694, and that any required notices are provided in a timely manner.

39.53(2) Procedures to ensure the selection of qualified and impartial reviewers. The reviewers shall be qualified to render impartial determinations relating to the benefit trigger which is the subject of the benefit trigger decision under review (e.g., assessment of cognitive impairment or inability to perform activities of daily living due to a loss of functional capacity) and be deemed experts in the assessment of such benefit trigger.

39.53(3) Procedures to ensure that the insured is notified in writing of the insured's right to object to the independent review entity selected by the insurer or to the licensed health care professional designated by the independent review entity to conduct the review by filing a notice of objection, along with the reasons for the objection, with the commissioner at the Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315, within ten days of the receipt of a notice from the independent review entity.

39.53(4) Procedures to ensure the confidentiality of protected health information records and review materials, in accordance with federal and state law.

39.53(5) Procedures to ensure adherence to the requirements of this division and Iowa Code chapter 514G by any contractor, subcontractor, subvendor, agent or employee affiliated with the independent review entity.

39.53(6) Policies and procedures establishing a quality assurance program. The program shall include a written description to be provided to all individuals involved in the program, the organizational arrangements, and the ongoing procedures for the identification, evaluation, resolution and follow-up of

potential and actual problems in independent reviews performed by the independent review entity and procedures to ensure the maintenance of program standards pursuant to this requirement.
[**ARC 4780C**, IAB 11/20/19, effective 12/25/19; Editorial change: IAC Supplement 9/23/20; **ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.54(514G) Toll-free telephone number. The independent review entity shall establish a toll-free telephone service to receive information relating to independent reviews pursuant to this division and Iowa Code chapter 514G. The system shall include a procedure to ensure the capability of accepting, recording, or providing instruction to respond to incoming telephone calls during other than normal business hours. The independent review entity shall also establish a facsimile and electronic mail service.
[**ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.55(514G) Division application and reports. The independent review entity shall provide the commissioner such data, information, and reports as the commissioner determines necessary to evaluate the independent review process established under Iowa Code chapter 514G. An application for certification as an independent review entity must be submitted in duplicate to the Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315. An application must be submitted in full to be considered. Every applicant will be notified of the certification decision. A list of certified independent review entities shall be maintained at the division and shall be available through the division's website.
[**ARC 4780C**, IAB 11/20/19, effective 12/25/19; Editorial change: IAC Supplement 9/23/20]

191—39.56 to **39.74** Reserved.

DIVISION III
LONG-TERM CARE PARTNERSHIP PROGRAM

191—39.75(514H) Purpose.

39.75(1) This division is intended to implement Iowa Code chapter 514H and Section 6021 of the federal Deficit Reduction Act of 2005, Public Law 109-171, to establish, in conjunction with the department of human services, a long-term care partnership program in Iowa to provide for financing of long-term care through a combination of private insurance and Iowa Medicaid. This program is also known as the long-term care asset disregard incentive program.

39.75(2) The Iowa long-term care partnership program shall:

a. Provide incentive for individuals to insure against the costs of providing for long-term care needs;

b. Provide a mechanism for individuals to qualify for coverage under Iowa Medicaid while having certain assets disregarded for eligibility determinations and recovery; and

c. Reduce the financial burden on the state's Medicaid program by encouraging the pursuit of private initiatives using qualified long-term care partnership policies or certificates.
[**ARC 8271B**, IAB 11/4/09, effective 12/9/09; **ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.76(514H) Effective date. The rules in this division shall apply to all long-term care partnership policies or certificates sold or issued for delivery on or after January 1, 2010.
[**ARC 8271B**, IAB 11/4/09, effective 12/9/09; **ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.77(514H) Definitions. For purposes of this division, the definitions in Iowa Code chapter 514H and rule 191—39.4(514G) shall apply. In addition, the following definitions shall apply:

"Asset disregard" means, with regard to the state's Medicaid program, disregarding assets in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified long-term care partnership policy.

"Division" means the Iowa insurance division.

"Iowa long-term care partnership policy" or *"partnership policy"* means an insurance policy that meets the following requirements:

1. The policy covers an insured who, when coverage first became effective under the policy, was a resident of Iowa or was an individual eligible under subrule 39.78(2).

2. The policy is a qualified long-term care insurance policy as defined in Section 7702B(b) of the Internal Revenue Code of 1986 and was issued no earlier than January 1, 2010.

3. The policy meets all of the applicable requirements of this chapter and Iowa Code chapter 514H.

4. The division has certified the policy as meeting the requirements of the following: Section 1917(b) of the Social Security Act, 42 U.S.C. 1396p; Section 6021 of the federal Deficit Reduction Act of 2005, Public Law 109-171; and any applicable federal regulations or guidelines.

5. The policy provides the following inflation protections:

- For a person who is less than 61 years of age as of the date of purchase of the policy or date of issuance of the certificate, the policy provides either annual compounded inflation protection of not less than 3 percent or annual compounded inflation protection of not less than a rate based on changes in the consumer price index. "Consumer price index" means consumer price index for all urban consumers, U.S. city average, all items, as determined by the Bureau of Labor Statistics of the United States Department of Labor.
- For a person who is at least 61 years of age but less than 76 years of age as of the date of purchase of the policy or date of issuance of the certificate, the policy provides either an inflation feature that meets the requirements of this definition, paragraph "5," first bulleted paragraph, or an automatic inflation feature that provides annual simple inflation increases at a rate of not less than 3 percent.
- For a person who is at least 76 years of age as of the date of purchase of the policy or date of issuance of the certificate, an inflation protection feature may be included in the policy but is not required.

"Long-term care partnership program" means a qualified state long-term care insurance partnership as defined in Section 1917(b) of the Social Security Act, 42 U.S.C. 1396p; Section 6021 of the federal Deficit Reduction Act of 2005, Public Law 109-171; and Iowa Code chapter 514H as amended by 2009 Iowa Acts, House File 723.

"Medicaid" means the program of medical assistance operated by the Iowa department of human services under Title XIX of the federal Social Security Act, 42 U.S.C. 1396 et seq., and amendments thereto.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09; **ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.78(514H) Eligibility.

39.78(1) An individual who is a beneficiary of an Iowa long-term care partnership policy or certificate may be eligible for assistance under the state's Medicaid program using the asset disregard as provided under Iowa Code chapter 514H as amended by 2009 Iowa Acts, House File 723.

39.78(2) An individual who is a beneficiary of a long-term care partnership policy or certificate issued in another state which grants reciprocity to an Iowan who moves to that state is eligible for benefits under Iowa's Medicaid program using the asset disregard as provided in Iowa Code chapter 514H as amended by 2009 Iowa Acts, House File 723. For purposes of this subrule, "reciprocity" means the granting of all the benefits by one state to an individual who becomes a resident of that state but who purchased a long-term care partnership policy while residing in another state.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09; **ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.79(514H) Discontinuance of partnership program. If the Iowa long-term care partnership program established by this division and Iowa Code chapter 514H as amended by 2009 Iowa Acts, House File 723, is discontinued, any individual who purchased an Iowa long-term care partnership policy or certificate before the date the program was discontinued shall be eligible to receive asset disregard if allowed as provided by Title VI, Section 6021 of the federal Deficit Reduction Act of 2005, Public Law 109-171.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09; **ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.80(514H) Required disclosures.

39.80(1) An insurer or a producer soliciting or offering to sell a partnership policy shall provide to each prospective applicant a Partnership Program Notice. The notice must be substantially similar to

Appendix H of this chapter. The Partnership Program Notice shall be provided with the required outline of coverage.

39.80(2) An insurer or a producer soliciting or offering to sell a partnership policy shall provide to each prospective applicant a copy of the Iowa Long-Term Care Partnership Program Consumer Guide. The Iowa Long-Term Care Partnership Program Consumer Guide may be found at shiip.iowa.gov.

39.80(3) A partnership policy or certificate issued or issued for delivery in Iowa shall be accompanied by a Partnership Status Disclosure Notice (Appendix I). A similar notice may be used if filed with and approved by the division.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09; **ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.81(514H) Form filings.

39.81(1) A partnership policy shall not be issued or issued for delivery in Iowa unless filed with and approved by the division. Any policy submitted for certification as a partnership policy shall be accompanied by a Partnership Issuer Certification. The Partnership Issuer Certification form may be found on the division's website, www.iid.state.ia.us. Insurance companies required to file rates or forms with the division shall submit required rate and form filings and any fees required for the filings electronically using the System for Electronic Rate and Form Filing (SERFF). Insurance companies must comply with the division's requirements, including both the Iowa general instructions and the specific submission requirements for the type of insurance for which the companies are submitting forms or rates, as set forth on the SERFF website at www.serff.org.

39.81(2) Insurers may request to make use of a previously approved policy form as a qualified state long-term care partnership policy. Requests shall be filed electronically via SERFF and according to instructions on the SERFF website.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09; **ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.82(514H) Exchanges.

39.82(1) An insurer must offer, on a one-time basis, in writing, to all existing policyholders that were issued long-term care policies between February 1, 2003, and January 1, 2010, the option to exchange their existing long-term care policies for an Iowa long-term care partnership policy. The insurer must make this offer within 18 months of the date the insurer begins the first marketing efforts for any long-term care partnership insurance product.

39.82(2) Under an exchange program, an insurer must comply with all of the following:

a. The mandatory offer of an exchange shall apply only to products issued by the insurer that are comparable to the type of policy, such as group policies and individual policies, and to the policy series that the company has certified as partnership-qualified.

b. An insurer must provide the insured a minimum of 90 days from the date of mailing of the offer by the insurer to accept or reject the offer.

c. An insurer must make the offer on a nondiscriminatory basis without regard to the age or health status of the insured. However, the insurer may underwrite if the policy is amended to provide additional benefits or if the exchange would require the issuance of a new policy, except as described in paragraph 39.82(2)*"d"* below. Any portion of the policy that was issued prior to the exchange date shall be priced based on the policyholder's age when the policy was originally issued. Any portion of the policy that is added as a result of the exchange may be priced based on the policyholder's age at the time of the exchange.

d. If there is no change in coverage that is material to the risk, policies exchanged under this rule shall not be subject to any medical underwriting.

e. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the policy or certificate being replaced.

f. Any portion of the policy that was issued prior to the exchange date shall maintain the policy's original price based on the policyholder's age when the policy was originally issued. Any portion of the policy that is added as a result of the exchange may be priced based on the policyholder's age at the time of the exchange.

g. When the policy is issued to a group, the offer required in subrule 39.82(1) shall be made to the group policyholder.

h. Notwithstanding paragraphs 39.82(2)*"a"* and *"c,"* an insurer is not required to offer an exchange to an individual who is eligible for benefits within an elimination period, who is or who has been in claim status, or who would not be eligible to apply for coverage due to issue age or plan design limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including plan design, underwriting, if applicable, and payment of the required premium.

39.82(3) Policies issued pursuant to this rule shall be considered exchanges and not replacements and are not subject to rule 191—39.11(514D,514G).

39.82(4) A policy received in an exchange after January 1, 2010, is treated as newly issued and is eligible for long-term care partnership policy status. For purposes of applying the Medicaid rules relating to Iowa's long-term care partnership program, the addition of a rider, endorsement or change in schedule page for a policy may be treated as giving rise to an exchange.

39.82(5) An insurer or a producer offering an exchange shall provide to each prospective applicant a Partnership Program Notice, as required by subrule 39.80(1), and a copy of the Iowa Long-Term Care Partnership Program Consumer Guide, as required by subrule 39.80(2). An insurer issuing or issuing for delivery in Iowa an exchange shall provide the policyholder or certificate holder a Partnership Status Disclosure Notice, as required by subrule 39.80(3).

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09; **ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.83(514H) Required policy terms and disclosures.

39.83(1) A policy or certificate designed or marketed as a long-term care insurance policy or certificate must prominently disclose on the schedule page the following statements:

"Some long-term care insurance [policies or certificates] may qualify under the state's Long-Term Care Partnership Program. Under this Program the [policyholder or certificate holder] may be able to protect some of the [policyholder's or certificate holder's] assets from Medicaid spend-down requirements through a feature known as 'Asset Disregard.' Nothing in this [policy or certificate] is a guarantee of Medicaid eligibility nor is it a guarantee of any ability to disregard assets for purposes of Medicaid eligibility. If you have questions about whether or not your policy currently qualifies under the Long-Term Care Partnership Program, please contact [the insurer at ###-###-####] and request a long-term care partnership program policy summary."

39.83(2) If a policyholder or certificate holder or that person's representative requests a long-term care partnership program policy summary, as provided in subrule 39.83(1), the information the insurer shall provide and the format of the long-term care partnership program policy summary shall be as set forth in Appendix J. An insurer may submit a form substantially similar to Appendix J to the commissioner for approval to use as a substitute for Appendix J.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09; **ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.84(514H) Standards for marketing and suitability. The standards for marketing found in rule 191—39.15(514D,514G) and the suitability requirements of rule 191—39.16(514D,514G) shall apply to the marketing and sale of long-term care partnership policies.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09; **ARC 5598C**, IAB 5/5/21, effective 6/9/21]

191—39.85(514H) Required reports.

39.85(1) Each issuer of partnership-qualified long-term care insurance in this state shall provide regular reports to the Secretary of the United States Department of Health and Human Services in accordance with federal law and regulations and to the Iowa department of human services and the division as provided in Section 6021 of the federal Deficit Reduction Act of 2005, Public Law 109-171. The report shall include information as required by the United States Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Submission of the report to the Iowa department of human services or the division is not required if the issuer files the report through the Centers for Medicare and Medicaid Services filing system.

39.85(2) When a policyholder or certificate holder begins receiving any benefits under a policy, the issuer shall begin providing to the policyholder or certificate holder statements of benefits either monthly or within a reasonable time after benefits have been paid. The statements of benefits shall include, at a minimum, detailed information regarding benefits paid and dates of service.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09; **ARC 5598C**, IAB 5/5/21, effective 6/9/21]

These rules are intended to implement Iowa Code section 514D.9 and chapters 514G and 514H.

[Filed 4/28/88, Notice 1/13/88—published 5/18/88, effective 7/1/88]
[Filed 1/19/90, Notice 11/29/89—published 2/7/90, effective 3/14/90]
[Filed 10/25/91, Notice 9/18/91—published 11/13/91, effective 1/1/92]
[Filed 12/3/93, Notice 8/18/93—published 12/22/93, effective 1/26/94]
[Filed 6/5/02, Notice 5/1/02—published 6/26/02, effective 7/31/02]
[Filed 3/9/07, Notice 1/31/07—published 3/28/07, effective 5/2/07]
[Filed 8/10/07, Notice 7/4/07—published 8/29/07, effective 10/3/07][1]
[Filed emergency 12/12/07—published 1/2/08, effective 12/12/07]
[Filed 10/30/08, Notice 9/24/08—published 11/19/08, effective 1/1/09][◊]
[Filed emergency 12/24/08—published 1/14/09, effective 1/1/09]
[Filed ARC 8271B (Notice ARC 8132B, IAB 9/9/09), IAB 11/4/09, effective 12/9/09]
[Filed ARC 1999C (Notice ARC 1943C, IAB 4/1/15), IAB 5/27/15, effective 7/1/15]
[Filed ARC 2415C (Notice ARC 2078C, IAB 8/5/15), IAB 2/17/16, effective 3/23/16]
[Filed ARC 3683C (Notice ARC 3570C, IAB 1/17/18), IAB 3/14/18, effective 4/18/18]
[Filed ARC 4780C (Notice ARC 4660C, IAB 9/25/19), IAB 11/20/19, effective 12/25/19]
[Editorial change: IAC Supplement 9/23/20]
[Filed ARC 5598C (Notice ARC 5472C, IAB 2/24/21), IAB 5/5/21, effective 6/9/21]

APPENDIX A

RESCISSION REPORTING FORM FOR
LONG-TERM CARE POLICIES
FOR THE STATE OF IOWA
FOR THE REPORTING YEAR 20[ ]

Company Name: _____
Address: _____
_____
Phone Number: _____

Due: March 1 annually

Instructions:
The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those 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 type)

_____
Date

APPENDIX B

Long-Term Care Insurance
Personal Worksheet

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.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.]

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

Drafting Note: 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

Drafting Note: 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.

Drafting Note: 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 ten years? (check one)
□ Stay about the same □ 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.

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 producer (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.** (This box must be checked.)

Signed: _____ _____
(Applicant) (Date)

[□ I explained to the applicant the importance of completing this information.]

Signed: _____ _____
(Producer) (Date)

Producer'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 producer 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)

Drafting Note: Choose the appropriate sentences depending on whether this is a direct mail or producer sale.

The company may contact you to verify your answers.

Drafting Note: 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.

APPENDIX C

Things You Should Know Before You Buy

Long-Term Care Insurance

Long-Term Care Insurance

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.

- [You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

Drafting Note: For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.

- 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.

Shopper's Guide

- Make sure the insurance company or producer gives you a copy of a booklet called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care 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

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

APPENDIX D

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 "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department 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 chose not to provide any financial information for us to review.]

Drafting Note: 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.

Drafting Note: 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].

APPENDIX E

Claims Denial Reporting Form
Long-Term Care Insurance

For the State of Iowa
For the Reporting Year of_____

Company Name: _____ Due: June 30 annually
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. "Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

		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		

[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—a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

APPENDIX F

Instructions:

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.

Insurers shall provide all of the following information to the applicant:

Long-Term Care Insurance
Potential Rate Increase Disclosure Form

1. **[Premium Rate] [Premium Rate Schedules]:** [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [filed][approved] for an increase [is][are] [on the application][$_____].

Drafting Note: Use "approved" in states requiring prior approval of rates.

2. **The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.**

3. **Rate Schedule Adjustments:**

   The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): _____.

4. **Potential Rate Revisions:**

   This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

   If you receive a premium rate or 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:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

Turn the Page

***Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

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

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

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

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

Example:

- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premiums.
- 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 lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your policy).

Turn the Page

Contingent Nonforfeiture
Cumulative Premium Increase Over Initial Premium
That Qualifies for Contingent Nonforfeiture

(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%

APPENDIX G

Long-Term Care Insurance

Replacement and Lapse Reporting Form

For the State of _____ For the Reporting Year of_____

Company Name: _____ Due: June 30 annually
Company Address: _____ Company NAIC Number: _____
Contact Person: _____ Phone Number: (_____)_____

Instructions

The purpose of this form is to report on a statewide basis information regarding long-term care insurance policy replacements and lapses. Specifically, every insurer shall maintain records for each producer on that producer's amount of long-term care insurance replacement sales as a percent of the producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the producer as a percent of the producer's total annual sales. The tables below should be used to report the ten percent (10%) of the insurer's producers with the greatest percentages of replacements and lapses.

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

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

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

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

Company Totals

Percentage of Replacement Policies Sold to Total Annual Sales ____%
Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year) ____%
Percentage of Lapsed Policies to Total Annual Sales _____%
Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) _____%

APPENDIX H

Partnership Program Notice

Important Consumer Information Regarding the
Iowa Long-Term Care Partnership Program

Some long-term care insurance policies or certificates sold in Iowa may qualify for the Iowa Long-Term Care Partnership Program (the Partnership Program). The Partnership Program is a partnership between state government and private insurance companies to assist individuals in planning their long-term care needs. 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 or certificates that qualify as partnership policies or certificates may protect the policyholder's or certificate holder's assets through a feature known as "Asset Disregard" under Iowa's Medicaid program.

Asset Disregard means that an amount of the policyholder's or certificate holder's assets equal to the amount of long-term care insurance benefits received under a qualified partnership policy or 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 or certificate without affecting the person's eligibility for Medicaid.

All other Medicaid eligibility criteria will apply, and special rules may apply to persons whose home equity exceeds $500,000. Asset Disregard is not available under a long-term care insurance policy or certificate that is not a partnership policy or certificate. Therefore, you should consider if Asset Disregard is important to you and whether a partnership policy or certificate meets your needs. The purchase of a partnership policy or certificate does not automatically qualify you for Medicaid. There are other eligibility requirements you must meet, including resource and income requirements.

What Are the Requirements for a Partnership Policy or Certificate?

In order for a policy or certificate to qualify as a partnership policy or certificate, it must, among other requirements:

- Be issued to an individual on or after January 1, 2010;
- Be issued to an individual who is an Iowa resident when coverage first becomes effective under the policy;
- Be a tax-qualified policy under Section 7702B(b) of the Internal Revenue Code of 1986;
- Meet the following inflation protection requirements:

→ For a person less than 61 years of age – provides compound annual inflation protection
→ For a person at least 61 but less than 76 years of age – provides 3 percent inflation protection
→ For a person at least 76 years of age – inflation protection may be offered but is not required

If you apply and are approved for long-term care insurance coverage, [carrier name] will provide you with written documentation as to whether or not your policy or certificate qualifies as a partnership policy or certificate.

What Could Disqualify a Policy or Certificate as a Partnership Policy or Certificate?

Certain types of changes to a partnership policy or certificate could affect whether or not such policy or certificate continues to be a partnership policy or certificate. If you purchase a partnership policy or certificate and later decide to make *any* changes, you should first consult with your insurance producer or insurance company to determine the effect of a proposed change. If you move to a state that does not have a Partnership Program or does not recognize your policy or certificate as a partnership policy or certificate, you would not receive beneficial treatment of your policy or certificate under the Medicaid program of that state. The information contained in this disclosure is based on current Iowa and federal laws. These laws

may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your policy or certificate under Iowa's Medicaid program.

Additional Information

If you have questions regarding the long-term care insurance policies or certificates, please contact [carrier name]. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Iowa Department of Human Services (Sally Oudekerk, Medicaid Policy Specialist, Bureau of Medical Support, telephone number (515)281-3709, email address soudeke@dhs.state.ia.us).

APPENDIX I

Partnership Status Disclosure Notice

Important Information Regarding Your Policy's or Certificate's

Long-Term Care Partnership Status

This disclosure notice is issued in conjunction with your long-term care policy.

Some long-term care insurance policies or certificates sold in Iowa qualify for the Iowa Long-Term Care Partnership Program. Long-term care insurance policies or certificates that qualify as partnership policies or certificates may be entitled to special treatment, in particular as "Asset Disregard" under Iowa's Medicaid program.

Asset Disregard means that an amount of the policyholder's or certificate holder's assets equal to the amount of long-term care insurance benefits received under a qualified partnership policy or 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 or certificate without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply, and special rules may apply to persons whose home equity exceeds $500,000. Asset Disregard is not available under a long-term care insurance policy or certificate that is not a partnership policy or certificate. The purchase of a partnership policy or certificate does not automatically qualify you for Medicaid. There are other eligibility requirements you must meet, including resource and income requirements.

Partnership Policy or Certificate Status

Your long-term care insurance policy or certificate is intended to qualify as a partnership policy or certificate under the Iowa Long-Term Care Partnership Program as of your policy's or certificate's effective date.

What Could Disqualify a Policy or Certificate as a Partnership Policy or Certificate?

Certain types of changes to a partnership policy or certificate could affect whether or not such policy or certificate continues to be a partnership policy or certificate. If you purchase a partnership policy or certificate and later decide to make *any* changes, you should first consult with your insurance producer or your insurance company to determine the effect of a proposed change. If you move to a state that does not maintain a Partnership Program or does not recognize your policy or certificate as a partnership policy or certificate, you would not receive beneficial treatment of your policy or certificate under the Medicaid program of that state. The information contained in this disclosure is based on current Iowa and federal laws. These laws may be subject to change. Any change on law could reduce or eliminate the beneficial treatment of your policy or certificate under Iowa's Medicaid program.

Additional Information

If you have questions regarding the long-term care insurance policies or certificates, please contact [carrier name]. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Iowa Department of Human Services (Allison Scott, Medicaid Program Manager, telephone number (515)418-3497, email address ascott@dhs.state.ia.us).

APPENDIX J

Long-Time Care Partnership Program Policy Summary

1. Name of insured _____
2. Policy/certificate number _____
3. Effective date of coverage _____
4. The policy/certificate was issued in the state of _____
5. Issue age of the insured at the time the coverage was issued _____
6. The policy/certificate was issued □ With inflation protection coverage
   □ Without inflation protection coverage
7. The inflation protection coverage is □ Simple Inflation □ Compound Inflation □ None
8. The inflation protection coverage is currently in effect on the coverage □ Yes □ No
   If no, the date inflation protection coverage ceased _____
9. The policy is intended to meet the standards of a tax-qualified long-term care policy
   □ Yes □ No
10. The cumulative dollar amount of insurance benefits paid $_____
    (NOTE: The indicated amount does not include any payments for cash surrender, return of premium death benefits, or waiver of premium, and if joint coverage, the amount is for the indicated insured only.)
11. The total dollar amount of insurance benefits remaining available under the policy $_____
12. This information is correct as of the date this form was completed, which date was _____
13. The name, telephone number and email address of the person completing this form

_____
Name

_____
Telephone Number

_____
E-mail Address

◊ Two or more ARCs

1 Effective date of subrule 39.15(4) delayed 70 days by the Administrative Rules Review Committee at its meeting held September 11, 2007.