# **02 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION**

**031 BUREAU OF INSURANCE**

**Chapter 420: NURSING HOME CARE INSURANCE AND LONG-TERM CARE INSURANCE**

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**Section 1. Purpose**

The purpose of this rule is to set forth ongoing requirements applicable to nursing home and long term care insurance policies issued prior to October 1, 2004.

*(Drafting Note: Maine Insurance Rule Chapter 425 establishes rating standards and requirements applicable to long-term care insurance policies issued on and after October 1, 2004.)*

**Section 2. Authority**

This rule is promulgated pursuant to the authority vested in the Superintendent of Insurance under Title 24-A M.R.S.A. §§ 212, 5052, 5053, 5078, and 5083.

**Section 3. Applicability and scope**

This rule shall apply to all Nursing Home Care and Long-Term Care insurance policies as defined in Title 24-A M.R.S.A. §§ 5051 and 5071 issued prior to October 1, 2004. It does not apply to any rate filing that is subject to Sections 9, 10, or 20 of Rule 425. The provisions of this rule do not apply to certain long-term care insurance policies issued prior to October 1, 1990 to employer, labor union, and association groups or to individuals pursuant to group conversion privileges.

*(Drafting Note: See 24-A M.R.S.A. §5051 for specifics.)*

The provisions of this rule do not apply to a group nursing home care or long-term care insurance policy offered to a resident of Maine under a group policy issued in another state.

*(Drafting Note: This rule does not apply to contracts issued or issued for delivery in other states even if the insured becomes a resident of this state.)*

**Section 4. Definitions**

1. “Adverse benefit trigger determination” means a claims denial determining that the insured has not satisfied a required clinical standard for benefit eligibility, including, when applicable under the contract, the existence or degree of cognitive impairment, chronic illness, or inability to perform one or more specified activities of daily living. The term is described more fully in Bureau of Insurance Rule 425, Sections 27 and 28.
2. “Authorized representative” means:
3. A person to whom an insured has given express written consent to represent the insured in a standard appeal or an external review;
4. A person authorized by law to provide consent to request in an internal appeal or an external review for an insured; or
5. A family member of an insured or an insured’s treating health care professional when the insured is unable to provide consent to request an internal appeal or an external review
6. “Bureau” means the Maine Bureau of Insurance.
7. “Claims denial” means any reduction of a benefit, termination of a benefit, or failure to provide or make payment (in whole or in part) for a benefit, including a determination of an insured’s ineligibility for benefits. The term “claims denial” includes both clinical decisions and benefit determinations that do not involve clinical decisions.
8. “Claims denial eligible for external review” means an adverse benefit trigger determination or a claims denial that requires the exercise of professional judgment within the scope of practice of a health care professional on the applicability of the following policy limitations or exclusions:
9. A preexisting condition or disease;
10. Mental or nervous disorders;
11. Alcoholism and drug addiction;
12. Illness, medical condition or treatment arising from:
13. War or act of war (whether declared or undeclared);
14. Participation in a felony, riot or insurrection;
15. Service in the armed forces or units auxiliary thereto;
16. Suicide, attempted suicide or any intentionally self-inflicted injury; or
17. Aviation.
18. “Substantive issue” means a matter that is integral to the determination of whether the insured is eligible for benefits under a policy and that involves information essential for the insurer to have prior to paying the claim. A substantive issue includes the issues generated by the items described in Sections 9(A)(1) through 9(A)(5). A substantive issue also includes information necessary to pay the claim that the insurer is unable to obtain because the provider refuses to provide it or because it is not available from sources other than the insured or the insured’s authorized representative.
19. “Technical issue” means a matter that is procedural in nature or not integral to the determination of whether the insured is entitled to benefits under the policy. Examples of a technical issue are an insurer’s lack of receipt of completed forms that duplicate information that the insurer already has or the license number for a long-term care facility.

**Section 5. Rating standards prior to May 1, 2008**

A. Prior to May 1, 2008, benefits under long-term care and nursing home 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:

1. Statistical credibility of incurred claims experience and earned premiums;

2. The period for which rates are computed to provide coverage;

3. Experienced and projected trends;

4. Concentration of experience within early policy duration;

5. Expected claim fluctuation;

6. Experience refunds, adjustments or dividends;

7. Renewability features;

8. All appropriate expense factors;

9. Interest;

10. Experimental nature of the coverage;

11. Policy reserves;

12. Mix of business by risk classification; and

13. Product features such as long elimination periods, high deductibles and high maximum limits.

**Section 6. Rating standards on or after May 1, 2008**

The requirements of this section apply to rates in effect on or after May 1, 2008, for policies subject to this rule pursuant to Section 3.

A. Rate filings may be filed electronically, using the System for Electronic Rate and Form Filing (SERFF), or on paper. Paper filings must include two copies of the cover letter. If the filing is found to be in compliance with the law, one copy of the cover letter (and any other materials sent in duplicate) will be returned to the insurer stamped to confirm that the rates are acceptable. Every rate submission must contain the following information:

 1. **Insurer Information**: Include the name and address of the insurer. The name, title, email address, and direct phone number of the person responsible for the filing must also be included.

 2. **Description of Benefits**: Include a brief description of the benefits provided by each policy form and any attached riders or endorsements.

 3. **Dates of Issue**: State the period during which the policy form was issued in Maine.

 4. **In Force Business**: State the policy or certificate count and annualized premium of Maine policyholders or certificate holders who will be affected by the proposed rate revision.

 5. **Proposed Effective Date**: State the proposed effective date and method of the proposed rate revision implementation (e.g. next anniversary or next premium due date).

 6. **History of Rate Adjustments**: List the approval dates and average percentage rate adjustments for the form both nationwide and in Maine since inception of the policy form.

 7. **Maine and National Experience on the Form** (Past and Future Anticipated): Experience from inception for each calendar year and, where appropriate, each policy year must be displayed. If there have been prior rate adjustments, past experience must be presented on both an actual basis and a current premium rate basis. Show experience separately for Maine and for all states in which the form is or was sold. State whether the proposed rates are based on Maine experience, national experience, or a combination and explain the reasons this basis was used. If nationwide experience is used, premiums must be adjusted to the Maine rate level.

 8. **Waiver of Premium**: Specify whether waived premiums are included in earned premiums and incurred claims.

 a. If waived premiums are included, include the following:

(i) Specify the amount of waived premiums over the last 12 months.

(ii) Specify the amount of reserves held for future waived premiums.

(iii) Indicate the effect of the proposed rate increase on future waived premiums and reserves.

b. If waived premiums are not included, specify the amount of waived premiums in each year.

9. **Supporting Information**: The filing must include sufficient supporting information to demonstrate that the rates are not excessive, inadequate, or unfairly discriminatory. At a minimum, the filing must include an analysis of actual and projected experience with respect to morbidity, mortality, lapsation, and any other relevant factors. Include a comparison to original pricing assumptions and to the assumptions at the time of any previous rate adjustment. Include a demonstration that the actual and projected experience meets the standards of subsection B.

10. **Premium breakdown**: Separately for the future period and for the lifetime of the form, show the following items as a percentage of earned premium. Past experience must be accumulated with interest. Future experience must be on a present value basis.

 a. Initial contract reserves (applies to future period only; zero for lifetime);

 b. Incurred claims;

 c. Commissions;

 d. Administrative expenses other than commissions that are a percentage of premium (e.g., premium tax);

 e. Fixed administrative expenses; and

 f. Profit = 100% + (a) - (b) - (c) - (d) - (e).

 For purposes of this section, incurred claims do not include any active life reserves, claim adjustment expenses, or cost containment expenses.

 11. **Similar forms**

 a. If the form is no longer actively marketed, a statement must be included as to whether a similar form is actively marketed and, if so, a discussion of equity between the two forms, including a comparison of the benefits and premium rates, must also be included. “Similar forms” means all of the long-term care or nursing home care policies and certificates issued by an insurer in the same benefit classification as the policy form being considered. Certificates of employee groups as defined in 24-A M.R.S.A. §2804, labor union groups as defined in 24-A M.R.S.A. §2805, or trustee groups as defined in 24-A M.R.S.A. §2806 are not considered similar to certificates or policies otherwise issued as long-term care or nursing home care insurance but are similar to other comparable certificates with the same benefit classifications. The different benefit classifications are: institutional benefits only, non-institutional benefits only, and comprehensive (institutional and non-institutional) benefits.

 b. Rates for individual policy forms for closed blocks must not exceed rates for an open block, unless the difference is justified by differences in benefits or other conditions, or unless the fact that renewal rates would exceed new business rates was disclosed at issue. The Superintendent may approve exceptions to this requirement, if the enrollees are permitted to change to the new form based on original issue age and the Superintendent determines that the change would be in the best interest of the enrollees.

 12. **Actuarial Certification**: There must be certification by a qualified actuary that, to the best of the actuary’s knowledge and judgment, the entire rate filing is in compliance with the applicable laws of the State of Maine and with the rules of the Bureau of Insurance. “Qualified actuary,” as used herein, means a member in good standing of the American Academy of Actuaries.

 13. Any additional information that the Superintendent deems necessary.

 B.

 1. For purposes of this subsection, the following definitions apply:

 a. “Future” means the period after the proposed rate increase takes effect.

 b. “Past” means the period beginning when the first policy was issued and ending on the date the proposed rate increase takes effect. Past experience includes actual experience plus projected experience for the portion of the period beyond which actual experience is available;

 c. “Past adjusted earned premiums” means past earned premiums adjusted to the proposed rate level.

 d. “Initial premium” means the premium at the rate initially filed for the form, before any rate increases.

 e. “Increased portion of premium” means the total premium minus the initial premium.

 2. Except as provided in subsection C, no rate increase will be approved unless the actual and projected experience submitted pursuant to subsection A meets the terms of this paragraph. The accumulated value of past incurred claims plus the present value of future incurred claims must not be less than the sum of the following:

 a. Sixty percent of the accumulated value of past adjusted earned premiums plus the present value of future projected earned premiums; and

*(Drafting Note: Past premiums are adjusted to the current rate level in order to ensure that the proposed increase does not recoup past losses.*

*This methodology is set forth as the “Variation in Future Loss Ratio Approach” in the article entitled “Long-Term Care Insurance Rate Increase Considerations” published by the Society of Actuaries in the December 2003 edition of the Long-Term Care News.)*

 b. Twenty-five percent of the accumulated value of the increased portion of past adjusted earned premiums plus the present value of the increased portion of future projected earned premiums;

*(Drafting Note: The addition of 25% of the increased portion of the premiums reflects the lack of first-year expenses associated with this portion of the premium. This assumes that 15% of premium will cover renewal expenses. If this is not the case, the insurer may request an exception under subsection C.)*

 C. An insurer will be granted an exception to the requirements of subsection B if it demonstrates that its reasonable renewal expenses exceed 15% of the increased premium. In that case, the 25% in subparagraph B(2)(b) will be replaced by 40% minus the demonstrated reasonable renewal expenses as a percentage of the increased premium.

 D. All present and accumulated values used to determine rate increases must use the maximum valuation interest rate for contract reserves as specified in Bureau of Insurance Rule Chapter 130. The filing must disclose the use of any appropriate averages.

 E. If the policy form affects policies issued both before and after October 1, 2004, separate filings must be submitted. The filing for policies issued prior to October 1, 2004 must meet the standards of this rule. The filing for policies issued on or after October 1, 2004 must meet the standards of Rule 425.

**Section 7. Contingent Nonforfeiture Benefit Upon Lapse**

 A. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

 B. The insurer shall provide a contingent nonforfeiture benefit upon lapse every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured’s initial annual premium set forth in Appendix A, 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 90 days prior to the due date of the premium reflecting the rate increase.

 C. Benefits continued as contingent nonforfeiture benefits upon lapse are described in this subsection:

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

 2. For purposes of this subsection, the contingent nonforfeiture benefit shall be for 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 3.

 3. The standard nonforfeiture credit will be equal to 100% 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 subsection D.

 4. a. The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent nonforfeiture benefit upon lapse shall be effective immediately on the policy or certificate issue date.

 b. Notwithstanding subparagraph a, for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

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

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

 5. 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.

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

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

 F. To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection B, 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.

 G. The Superintendent may also approve any other alternative mechanism filed by the insurer in lieu of the contingent benefit upon lapse.

**Section 8. Notice of Rate Increase**

 The insurer shall provide written notice by first class mail of a rate increase to all affected policyholders and to group certificate holders who are directly billed for coverage at least 90 days before the effective date of any increase in premium rates. An increase in premium rates may not be implemented until 90 days after the notice is provided.

**Section 9. Payment of Claims**

Upon receipt of a notice of claim for benefits under a policy or certificate of long-term care insurance delivered or issued for delivery in this State, and after the insurer has sent the written statement required by 24-A M.R.S.A. §5083(1) and received the information identified in 24-A M.R.S.A. §5083(2), a long-term care insurer shall pay or deny the claim within 30 days, except as otherwise permitted by this section. If the insurer is unable to decide the claim because more information is needed, it may request necessary additional documentation, consistent with Subsection A, with sufficient detail to permit the insured to understand and respond. The written request must be provided by the insurer within 10 business days after receipt of the notice of claim. For purposes of this section, “insured” includes the insured’s authorized representative.

1. **Documentation**

The documentation an insurer may require of an insured following the submission of a claim for benefits under a policy or certificate of long-term care insurance is as follows:

1. A brief statement by or on behalf of the insured describing the basis of the claim for benefits;
2. A signed release permitting the insurer to obtain personal health information about the insured pursuant to the federal *Health Insurance Portability and Accountability Act of 1996*;
3. A statement from the insured’s physician, including the appropriate diagnosis and a treatment and care plan for the insured;
4. A statement from the long-term care provider rendering services to the insured, including an itemized bill for services, the provider’s license number, and any daily nursing notes;
5. A copy of any power of attorney executed by the insured; and
6. Other information that the insurer determines is reasonably necessary to evaluate before making a determination on the claim and is not readily available from sources other than the insured.
7. **Burden on Insurer**

Except for information solely in the possession of the insured, the burden is on the insurer to obtain any information other than that described in Paragraphs (A)(1) to (A)(6) that is reasonably necessary to pay or continue paying the claim.

1. **Delay or Denial of Claim**

If the insurer denies a claim in whole or part, the insurer shall promptly issue a written notice to the insured explaining the specific reason or reasons for the denial. If the insurer cannot pay the claim within 30 days because it does not have sufficient information to make a decision, the insurer shall decide the claim and notify the insured in accordance with the following requirements.

1. An insurer may not extend the time for resolution of a claim beyond 30 days after receipt of documentation and information related to a technical issue. The insurer may not extend the time period beyond 30 days for documentation that the insurer already possesses.

2. An insurer may not extend the time for resolution of a claim beyond 30 days after receipt of all documentation and information initially requested from the insured unless the insurer determines, as a result of its review of that information, that the insurer cannot reasonably decide the claim without additional information relating to a substantive issue.

a. The insurer may not delay the resolution of the claim any longer than is reasonably necessary and must act expeditiously to obtain all necessary information.

b. If the resolution of the claim is being delayed because a source other than the insured is failing to provide necessary information, the insurer shall notify the insured of the reason for the delay and the nature of the missing information, unless such notice might prejudice the insurer’s investigation of suspected fraud or other misconduct.

1. **Ongoing Claim**

Except for information solely in the possession of the insured, if, during the course of an ongoing claim for benefits paid on a monthly or recurring basis, the insurer identifies additional documentation that is reasonably necessary to verify that the insured remains entitled to benefits under the policy or certificate of long-term care insurance, the burden is on the insurer to obtain that information.

1. **Appeals of Claims Denials**

An insured who receives a claims denial has the right to internal appeal. In addition, if the claims denial is eligible for external review, the insured has the right to request an external review under Section 11 of this rule. The written notice to the insured of the claims denial as required by Subsection C must include: a statement informing the insured of the insured’s right to internal appeal, and of the right to external review in the case of a claims denial eligible for external review; a statement of the insured’s right to seek assistance or file a complaint with the Superintendent; and contact information for the Bureau, including its toll-free telephone number and Internet address.

*(****Drafting Note****: Although this section does not apply to contracts issued or issued for delivery in other states even if the insured becomes a resident of this state, insurers are encouraged to voluntarily adopt these standards for insureds who obtain long-term care services in this state. Nothing in this rule prohibits insurers from voluntarily complying with this section.)*

**Section 10. Appealing a Claims Denial**

1. **Representation**. For purposes of this section and for section 11, “insured” includes the insured’s authorized representative.
2. **Notice**. An insurer shall provide clear written notice to the insured of any claims denial. The notice shall include:
3. The reason or reasons for the decision;
4. Reference to the specific contract provision on which the decision is based;
5. A description of any additional material or information necessary for the insured to perfect the claim and an explanation of why such material or information is necessary;
6. The insured’s right to internal appeal in accordance with subsection C, including instructions and time limits for initiating the appeal, and the right to submit new or additional information relating to the claims denial with the appeal request;
7. The insured’s right, after completion of the insurer’s internal appeal process, to have the claims denial reviewed under the independent review process in accordance with Section 11 if the claims denial is eligible for external review, and the right to file a complaint with the Superintendent after completion of at least one level of the insurer’s internal review process.
8. **Standard Appeal**. The insured may appeal the claims denial by sending a written request to the insurer within 120 days after receipt of the claims denial along with any additional supporting information. The internal appeal shall be considered by a panel of one or more qualified individuals, designated by the insurer, who did not participate in making the initial benefit determination.
9. **Timeline for Appeal**. The internal appeal shall be completed and written notice of the internal appeal decision shall be sent to the insured within thirty (30) calendar days after the insurer’s receipt of all necessary information upon which a final determination can be made. Additional time is permitted when the insurer can establish the 30-day time frame cannot reasonably be met due to the insurer’s inability to obtain necessary information from a person not affiliated with or under contract with the insurer. The insurer shall provide written notice of the delay to the insured. In such instances, decisions must be issued within 30 days after the insurer’s receipt of all necessary information.
10. **Notice of Decision**. If the claims denial appeal decision is adverse to the insured, the written decision shall contain:
	1. The qualifying credentials of the person or persons evaluating the appeal;
	2. A statement of the reviewers’ understanding of the reason for the insured’s request for an appeal;
	3. Reference to the specific policy provisions upon which the decision is based;
	4. The reviewers’ decision in clear terms and the rationale in sufficient detail for the insured to respond further to the insurer’s position;
	5. A reference to the evidence or documentation used as the basis for the decision, including any clinical review criteria used to make the determination. The decision shall include instructions for requesting copies, free of charge, of information relevant to the claim, including any referenced evidence, documentation, or clinical review criteria not previously provided to the insured.
	6. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the claims denial decision, either the specific rule, guideline, protocol or other similar criterion that was relied upon in making the claims denial decision or an explanation that a copy will be provided free of charge to the insured upon request;
	7. Notice of any subsequent appeal rights and the procedure and time limitation for exercising those rights. Notice of external review rights must be provided for decisions on claims denials eligible for external review.
	8. Notice of the insured’s right to contact the Superintendent’s office. The notice shall contain the toll free telephone number, website address and mailing address of the Bureau of Insurance.
11. **Second Level Review**
12. An insurer shall provide a second level appeal process to an insured who is dissatisfied with a first level review determination under Subsection C. The insured has the right to appear before authorized representatives of the insurer and shall be provided adequate notice of that option by the insurer. The insured may appeal the standard appeal decision by sending a written request to the insurer within 120 days after receipt of the standard appeal decision letter.
13. The insurer shall appoint a second level appeal review panel for each appeal subject to review under this subsection. A majority of the panel shall consist of employees or representatives of the insurer who were not previously involved in the appeal.
14. If an insured initiates a second level appeal without requesting to appear before authorized representatives of the insurer, the second level appeal shall be completed and written notice of the final internal appeal decision shall be sent to the insured within thirty (30) calendar days after the insurer’s receipt of all necessary information upon which a final determination can be made. Additional time is permitted when the insurer can establish that the 30-day time frame cannot reasonably be met due to the insurer’s inability to obtain necessary information from a person not affiliated with or under contract with the insurer. The insurer shall provide written notice of the delay to the insured. In such instances, decisions must be issued within 30 days after the insurer’s receipt of all necessary information. A decision adverse to the insured shall include the information specified in Subparagraph C(2).
15. Whenever an insured has requested the opportunity to appear before authorized representatives of the insurer, an insurer’s procedures for conducting a second level panel review shall include the following:
16. The review panel shall schedule and hold a review meeting within 45 days after receiving a request from the insured for a second level review. The review meeting shall be held at a time reasonably accessible to the insured. The insurer shall offer the insured the opportunity to appear before the review panel, at the insurer’s expense, by conference call, video conferencing, or other appropriate technology. The insured shall be notified in writing at least 15 days in advance of the review date. The insurer shall not unreasonably deny a request for postponement of the review made by the insured.
17. Upon the request of an insured, the insurer shall provide to the insured, free of charge, all relevant information that is not confidential and privileged from disclosure to the insured.
18. The insured has the right to:
	1. Attend the second level review by conference call, video conferencing, or other appropriate technology;
	2. Present his or her case to the review panel;
	3. Submit supporting material both before and at the review meeting;
	4. Ask questions of any representative of the insurer who has provided information to the review panel; and
	5. Be assisted or represented by a person of his or her choice.
19. If the insurer will have an attorney present to argue its case against the insured, the insurer shall so notify the insured at least 15 days in advance of the review and shall advise the insured of his or her right to obtain legal representation.
20. The insured’s right to a fair review shall not be made conditional on his or her appearance at the review.
21. The review panel shall issue a written decision to the insured within 5 working days after completing the review meeting. A decision adverse to the insured shall include the information specified in Subparagraph C(2).

**Section 11. External Review**

A. **Notice of External Review**. If the insurer’s claims denial eligible for external review is upheld after completion of the insurer’s internal appeal process outlined in section 10, the insurer shall provide a written description of the insured’s right to request an external review. The notice must include:

1. A description of the external review procedure and the requirements for making a request for external review;
2. A statement informing the insured how to request assistance from the insurer in filing a request for external review;
3. A statement informing the insured of the right to participate in the external review proceeding by teleconference or other reasonable means, to obtain and submit material in support of the claim, to ask questions of the insurer, and to have outside assistance; and
4. A statement informing the insured of the right to seek assistance or file a complaint with the Bureau and the toll-free number for the Bureau.

B. **Request**. The insured may request an external review of the claims denial eligible for external review after completion of both levels of the insurer’s internal appeal process outlined in Section 10. A written request for external review may be made by the insured to the Bureau within 120 days after the insurer’s written notice of the final internal appeal decision is received by the insured. The insured may not be required to pay any filing fee as a condition of processing a request for external review.

C. **Cost**. The cost of the external review shall be borne by the insurer.

D. **Insured’s Right to Alternative Formats**. The insurer shall provide auxiliary telecommunications devices or qualified interpreter services by a person proficient in American Sign Language, when requested by an insured who is deaf or hard-of-hearing; shall provide printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader, when requested by an insured who is visually impaired; and shall make such other reasonable accommodations as may be necessary to allow an insured to exercise the right to external review under this section.

1. **Bureau Oversight**. The Bureau shall oversee the external review process and shall contract with approved independent review organizations to conduct external reviews and render external review decisions. At a minimum, an independent review organization approved by the Bureau shall ensure the selection of qualified and impartial reviewers who have no professional, familial, or financial conflict of interest relating to the insurer, the insured, or the insured’s authorized representative or long-term care provider involved in the external review.
2. **Independent External Review Decision; Timelines**. An external review decision must be made in accordance with the following requirements.
3. In rendering an external review decision, the independent review organization must give consideration to the following:
4. All relevant clinical information relating to the insured’s physical and mental condition, including any competing clinical information;
5. All relevant clinical standards and guidelines, including, but not limited to, those standards and guidelines relied upon by the insurer.
6. If the independent review organization rules in favor of the claimant in a dispute arising out of a federally tax-qualified contract, it shall provide a certification by a licensed health care practitioner (as defined in Section 7702B(c)(4) of the Internal Revenue Code) that the insured is chronically ill.
7. An external review decision must be rendered by an independent review organization within 30 days of receipt of a completed request for external review from the Bureau.
8. **Binding nature of decision.** An external review decision is binding on the insurer. An insured may not file a request for a subsequent external review involving the same claims denial for which the insured has already received an external review decision pursuant to this section. An external review decision made under this section is not considered final agency action pursuant to Title 5, chapter 375, subchapter II.
9. **Additional Rights**. Nothing contained in this section shall limit the ability of an insurer to assert any rights an insurer may have under the policy related to:
10. An insured’s misrepresentation;
11. Changes in the insured’s benefit eligibility; and
12. Terms, conditions, and exclusions of the policy, other than the failure to meet the requirements to pay the claim.
13. **Long-Term Care Insurance Independent Review Organizations**. The Superintendent shall contract with qualified long-term care insurance independent review organizations. To be considered qualified, the organization must meet the following criteria:
14. Have on staff, or contract with, a qualified and licensed health care professional in an appropriate field for determining an insured’s functional or cognitive impairment (e.g., physical therapy, occupational therapy, neurology, physical medicine and rehabilitation), to conduct the review.
15. Neither it nor any of its licensed health care professionals may, in any manner, be related to or affiliated with a person or entity that previously provided medical care to the insured.
16. Utilize a licensed health care professional who is not an employee of the insurer or related in any manner to the insured.
17. Neither it nor its licensed health care professional who conducts the reviews may receive compensation of any type that is dependent on the outcome of the review.
18. Provide a description of the fees it charges for external reviews of a long-term care insurance adverse benefit determination. Such fees shall be reasonable and customary for the type of long-term care insurance adverse benefit determination under review.
19. Provide the name of the medical director or health care professional responsible for the supervision and oversight of the external review procedure.
20. 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.

*(****Drafting Note****: Although this section does not apply to contracts issued or issued for delivery in other states even if the insured becomes a resident of this state, insurers are encouraged to voluntarily adopt these standards for insureds who obtain long-term care services in this state. Nothing in this rule prohibits insurers from voluntarily complying with this section.)*

**Section 12. Transition**

1. Within four months after the effective date of the 2015 amendments to this Rule, every insurer shall file with the Superintendent any new forms or contract provisions, and all revisions to existing forms or contracts, which it will be using as a result of the amendments.
2. Every insurer required to file forms with the Superintendent and subject to this rule shall send all applicable forms and amended contract provisions to existing individual and group contract holders within 60 days after the first billing date after the form or contract provision has been approved by the Superintendent.

**Section 13. Effective date**

This rule is effective October 1, 2004. The 2008 amendments are effective May 1, 2008. The 2015 amendments are effective March 30, 2015.

EFFECTIVE DATE (ELECTRONIC CONVERSION):

 January 14., 1997

NON-SUBSTANTIVE CORRECTIONS:

 August 22, 2002 - format and numbering

REPEALED AND REPLACED:

 October 1, 2004 - filing 2004-111

AMENDED:

 May 1, 2008 – filing 2008-60

 March 30, 2015 – filing 2015-051

CORRECTION:

 Section 3 title (spelling) – December 2, 2021

APAO WORD VERSION CONVERSION (IF NEEDED) AND ACCESSIBILITY CHECK: July 18, 2025

**APPENDIX A**

**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% |

\* See Section 6(F)