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3 AAC 28 is amended by adding a new article to read:

Article 7. Long-term Care Insurance

Section

550. Applicability

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552. Policy practices and provisions.

554. Unintentional lapse.

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556. Required disclosure of rating practices to consumers.

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3 AAC 28.550. Applicability. (a) Except as otherwise specifically provided, the

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provisions of 3 AAC 28.250 – 3 AAC 28.599 applies to all long-term care insurance policies, including qualified long-term care contracts and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in this state on or after the effective date by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations. Certain provisions of this chapter apply only to qualified long-term care insurance contracts as noted.

(b) The provisions of this chapter are intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if:

(1) the benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;

(2) the disability income policy is advertised, marketed or offered as insurance for long-term care services; or

(3) benefits under the policy may begin after the policyholder has reached Social Security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.53.090

3 AAC 28.551. Policy definitions. Long-term care insurance policies delivered or issued for delivery in this state may not use the terms set out below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

(1) “activities of daily living” means at least bathing, continence, dressing, eating, toileting and transferring;

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(2) “acute condition” means that the individual is medically unstable. The individual requires frequent monitoring by medical professionals, including physicians and registered nurses, to maintain his or her health status;

(3) “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;

(4) “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;

(5) “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;

(6) “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 a catheter or colostomy bag;

(7) “dressing” means putting on and taking off all items of clothing and necessary braces, fasteners or artificial limbs;

(8) “eating” means feeding oneself by getting food into the body from a receptacle, like a plate, cup or table or by a feeding tube or intravenously;

(9) “hands-on assistance” means physical assistance, whether minimal, moderate or maximal, without which the individual would not be able to perform the activity of daily living;

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

(11) “Medicare” means “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;

(12) “mental or nervous disorder” may not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder;

(13) “personal care” means the provision of hands-on services to assist an individual with activities of daily living;

(14) “skilled nursing care,” “personal care,” “home care,” “specialized care,” “assisted living care” and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered;

(15) “toileting” means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene;

(16) “transferring” means moving into or out of a bed, chair or wheelchair;

(17) all providers of services, including “skilled nursing facility,” “extended care facility,” “convalescent nursing home,” “personal care facility,” “specialized care providers,” “assisted living facility,” and “home care agency” shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration or degree status of

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those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified or registered, it shall also state what requirements a provider must meet instead of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or when the state licenses, certifies or registers the provider of services under another name. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.53.050 AS 21.53.090

3 AAC 28.552. Policy practices and provisions. (a) The terms “guaranteed renewable” and “noncancellable” may not be used in an individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of 3 AAC 28.555 and subject to the following restrictions:

(1) a policy issued to an individual may not contain renewal provisions other than “guaranteed renewable” or “noncancellable;”

(2) the term “guaranteed renewable” may only be used 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 a change in a provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis;

(3) the term “noncancellable” may only be used 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 a change in a provision of the insurance or in

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the premium rate;

(4) the term “level premium” may only be used when the insurer does not have the right to change the premium; and

(5) in addition to the other requirements of this subsection, 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, as amended.

(b) A policy may not be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

(1) preexisting conditions or diseases;

(2) mental or nervous disorders; however, this may not permit exclusion or limitation of benefits on the basis of Alzheimer’s Disease;

(3) alcoholism and drug addiction;

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

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

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

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

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

(E) 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

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Medicaid, a state or federal workers' compensation, employer's liability or occupational disease law, or a 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.

(8) This subsection does not prohibit exclusions and limitations by type of provider. However, no long-term care issuer may deny a claim because services are provided in a state other than the state of policy issued under the following conditions:

(A) when the state other than the state of policy issue does not have the provider licensing, certification, or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers instead of licensure, certification, or registration; or

(B) when the state other than the state of policy issue licenses, certifies or registers the provider under another name.

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

(9) This subsection is not intended to prohibit territorial limitations.

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

(d) Continuation or conversion of coverage is subject to the following provisions:

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

(A) For the purposes of this section, “a basis for continuation of coverage” means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The director shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including provider system arrangements, service availability, benefit levels, and administrative complexity;

(B) For the purposes of this section, “a basis for conversion of coverage” means a policy provision that an individual whose coverage under the group policy

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would otherwise terminate or has been terminated for a 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 a group policy which it replaced, for at least six months immediately before termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability;

(C) For the purposes of this section, “converted policy” means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the director to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the director, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including provider system arrangements, service availability, benefit levels, and administrative complexity;

(D) For the purposes of this section 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.

(2) Written application for the converted policy shall be made and the first premium due, 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;

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(3) 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;

(4) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

(A) termination of group coverage was the result of an individual's failure to make a required payment of premium when due; or

(B) the terminating coverage is replaced not later than 31 days after termination, by group coverage effective on the day following the termination of coverage:

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

(ii) the premium for the coverage is calculated in a manner consistent with the requirements of (6) of this subsection;

(5) Notwithstanding other provisions of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage,

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together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. The 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;

(6) 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, may not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect; and

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

(e) 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:

(1) may not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

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

(f) The purchase of additional coverage may not be considered a premium rate increase, but for purposes of the calculation required under 3 AAC 28.579, the portion of the premium

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attributable to the additional coverage shall be added to and considered part of the initial annual premium. A reduction in benefits may not be considered a premium change, but for purpose of the calculation required under 3 AAC 28.579, the initial annual premium shall be based on the reduced benefits. The premium charged to an insured may 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.

(g) In the case of a group defined under AS 21.53.200(3)(A), a requirement that a signature of an insured be acquired by an agent or insurer shall be considered satisfied if:

(1) the consent is acquired by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

(2) the telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records;

(3) the telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of personally identifiable information and other confidential information or records is maintained; and

(4) the insurer shall make available not later than 10 business days, upon request of the director, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.53.020 AS 21.53.030
AS 21.53.050 AS 21.53.090

3 AAC 28.554. Unintentional lapse. (a) Each insurer offering long-term care insurance shall comply with the following:

(1) 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 may not constitute acceptance of 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 a person to receive this notice." The insurer shall notify the insured of the right to change this written designation, no less often than once every two years;

(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 (1) of this subsection need not be met until 60 days after the policyholder or certificate holder is no longer on a payment plan. The application or enrollment form for the

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policies or certificates shall clearly indicate the payment plan selected by the applicant;

(3) no individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least 45 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated under (1) of this subsection, 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 45 days after a premium is due and unpaid. Notice shall be considered to have been given as of five days after the date of mailing.

(b) In addition to the requirements in (a) of this section, a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage if a lapse occurs and the insurer is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. 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 may not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.53.020 AS 21.53.030
 AS 21.53.050 AS 21.53.090

3 AAC 28.555. Required disclosure provisions. (a) Individual long-term care insurance policies shall contain a renewability provision that:

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(1) shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or noncancellable. This provision may not apply to policies that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder, and;

(2) shall include a statement that premium rates may change for a long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium.

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

(c) A long-term care insurance policy that 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 these terms and an explanation of the terms in its accompanying outline of coverage.

(d) If a long-term care insurance policy or certificate contains limitations with respect to

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preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as “Preexisting Condition Limitations. ”

(e) A long-term care insurance policy or certificate containing limitations or conditions for eligibility other than those prohibited in AS 21.53.040(a)(3) shall set out a description of the limitations or conditions, including required number of days of confinement, in a separate paragraph of the policy or certificate and shall label the paragraph “Limitations or Conditions on Eligibility for Benefits. ”

(f) With regard to life insurance policies that 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 other related documents. This subsection may not apply to qualified long-term care insurance contracts.

(g) 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.” Additional benefit triggers shall also be explained in this section. If these additional benefit 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 functional dependency to be eligible for benefits, this requirement shall be specified.

(h) A qualified long-term care insurance contract shall include a disclosure statement in

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the policy and in the outline of coverage as contained in 3 AAC 28.588(5) 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, as amended.

(i) A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in 3 AAC 28.588(5) that the policy is not intended to be a qualified long-term care insurance contract. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.53.020 AS 21.53.030
AS 21.53.040 AS 21.53.050 AS 21.53.090

3 AAC 28.556. Required disclosure of rating practices to consumers. (a) This section shall apply as follows:

(1) except as provided in (2) of this subsection, this section applies to a long-term care policy or certificate issued in this state on or after January 1, 2023;

(2) for certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in AS 21.53.200(3)(A), which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following January 1, 2023.

(b) Except for policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subsection to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In that case, an insurer shall provide to the applicant, no later than at the

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time of delivery of the policy or certificate, all of the following information:

(1) a statement that the policy may be subject to rate increases in the future;

(2) an explanation of potential future premium rate revisions, and the policyholder's or certificate holder's options if a premium rate revision occurs;

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

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

(A) a description of when premium rate or rate schedule adjustments will be effective, for example the next anniversary date or next billing date; and

(B) the right to a revised premium rate or rate schedule as provided in (3) of this subsection if the premium rate or rate schedule is changed;

(5) information regarding each premium rate increase on this policy form, or similar policy forms, over the past 10 years for this state or another state that:

(A) at a minimum, identifies:

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

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

and

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

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(B) may provide additional explanatory information related to the rate increases.

(c) An insurer shall have the right to exclude from the disclosure, any 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 before the acquisition.

(d) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this section 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 nonaffiliated selling company shall include the disclosure of that rate increase in accordance with (b)(5)(A) of this section.

(e) If the acquiring insurer in (d) of this section 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 (d) of this section, the acquiring insurer shall make all disclosures required by (b)(5) of this section, including disclosure of the earlier rate increase referenced in (d) of this section.

(f) An applicant shall sign an acknowledgement at the time of application that the insurer made the disclosure required under (b)(1) and (5) of this section, unless the method of application does not allow for signature at that time. If due to the method of application, the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign not later than at the time of delivery of the policy or certificate.

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(g) An insurer shall use the forms prescribed by the director to comply with the requirements of (b) and (f) of this section.

(h) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders at least 45 days before the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by (b) of this section when the rate increase is implemented. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.53.020 AS 21.53.030
AS 21.53.050 AS 21.53.090 AS 21.53.200

3 AAC 28.557. Initial filing requirements. (a) This section applies to a long-term care policy issued in this state on or after January 1, 2023.

(b) An insurer shall provide to the director 45 days before making a long-term care insurance form available for sale the following information:

- (1) a copy of the disclosure documents required in 3 AAC 28.556; and
- (2) an actuarial certification consisting of at least the following:

(A) 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;

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

(C) a statement that the underwriting and claims adjudication processes

have been reviewed and taken into consideration;

(D) a statement that the premiums contain at least the minimum margin for moderately adverse experience defined in (i) of this subparagraph or the specification of and justification for a lower margin as required by (ii) of this subparagraph:

(i) a composite margin may not be less than 10 percent of lifetime claims;

(ii) a composite margin that is less than 10 percent may be justified in uncommon circumstances. The proposed amount, full justification of the proposed amount and methods to monitor developing experience that would be the basis for withdrawal of approval for the lower margins must be submitted;

(iii) a composite margin lower than otherwise considered appropriate for the standalone long-term care policy may be justified for long-term care benefits provided through a life policy or an annuity contract. The lower composite margin, if utilized, shall be justified by appropriate actuarial demonstration addressing margins and volatility when considering the entirety of the product; and

(iv) a greater margin may be appropriate in circumstances where the company has less credible experience to support its assumptions used to determine the premium rates.

(E) 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

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schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

(F) a statement that reserve requirements have been reviewed and considered. Support for this statement shall include:

(i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; and

(ii) 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 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.

(3) an actuarial memorandum prepared, dated and signed by a member of the Academy of Actuaries shall be included and shall address and support each specific item required as part of the actuarial certification and provide at least the following information:

(A) an explanation of the review performed by the actuary before making the statements in (b)(2)(B) and (C) of this section;

(B) a complete description of pricing assumptions; and

(C) sources and levels of margins incorporated into the gross premiums that are the basis for the statement in (b)(2)(A) of this section of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. Deviations in margins between ages, sexes, plans, or states shall be clearly

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described. Deviations in margins required to be described are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating gross premium scales;

(D) a demonstration that the gross premiums include the minimum composite margin specified in (b)(2)(D) of this section.

(c) In a review of the actuarial certification and actuarial memorandum, the director may request review by an actuary with experience in long-term care pricing who is independent of the company. If the director asks for additional information as a result of a review, the period in (b) of this section does not include the period during which the insurer is preparing the requested information. (Eff. ____ / ____ / ____, Register ____)

Authority: AS 21.06.090 AS 21.53.020 AS 21.53.030
AS 21.53.050 AS 21.53.090

3 AAC 28.558. Prohibition against post-claims underwriting. (a) All applications for long-term care insurance policies or certificates, except those that are guaranteed issue, shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(b) If an application for long-term care insurance contains a question that 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 the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate

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may not be rescinded for that condition.

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

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

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

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

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

(3) before issuance of a long-term care policy or certificate to an applicant age 80 or older, the insurer shall get one of the following:

- (A) a report of a physical examination;
- (B) an assessment of functional capacity;
- (C) an attending physician's statement; or
- (D) copies of medical records.

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(d) The completed application or enrollment form, whichever is applicable, is part of the policy and shall be delivered to the insured with the policy or certificate unless it was retained by the applicant at the time of application.

(e) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and shall annually furnish this information to the insurance director in the format prescribed by the director. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.53.020 AS 21.53.030
 AS 21.53.050 AS 21.53.090

3 AAC 28.559. Minimum standards for home health and community care benefits in long-term care insurance policies. (a) If it provides benefits for home health care or community care services, a long-term care insurance policy or certificate may not limit or exclude benefits:

(1) by requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;

(2) by requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before home health care services are covered;

(3) by limiting eligible services to services provided by registered nurses or licensed practical nurses;

(4) by requiring that a nurse or therapist provide services covered by the policy

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that can be provided by a home health aide or other home care worker;

(5) by excluding coverage for personal care services provided by a home health aide;

(6) 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;

(7) by requiring that the insured or claimant have an acute condition before home health care services are covered;

(8) by limiting benefits to services provided by Medicare-certified agencies or providers; or

(9) by excluding coverage for adult day care services.

(b) If it provides for home health or community care services, a long-term care insurance policy or certificate shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement may not apply to policies or certificates issued to residents of continuing care retirement communities.

(c) Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.53.020 AS 21.53.030
AS 21.53.050 AS 21.53.090

3 AAC 28.560. Requirement to offer inflation protection. (a) No insurer may offer a long-term care insurance policy unless the insurer also offers the policyholder, in addition to other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

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

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

(3) covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(b) Where the policy is issued to a group, the required offer in (a) of this section shall be made to the group policyholder; except, if the policy is issued to a group defined in AS 21.53.200(3)(D) other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder.

(c) The offer in (a) of this section may not be required of life insurance policies or riders

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containing accelerated long-term care benefits.

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

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

(2) an expected premium increases or additional premiums to pay for automatic or optional benefit increases;

(3) an insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

(e) An inflation protection benefit that 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.

(f) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium that 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.

(g) Inflation protection as provided in (a)(1) of this section shall be included in a long-term care insurance policy unless an insurer gets a rejection of inflation protection signed by the policyholder as required in this subsection. 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

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reject inflation protection. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.53.020 AS 21.53.030
AS 21.53.050 AS 21.53.090 AS 21.53.200

3 AAC 28.562. Requirements for application forms and replacement coverage. (a)

Application forms shall include the questions prescribed by the director designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace another 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 agent, except where the coverage is sold without an agent, containing the questions may be used. With regard to a replacement policy issued to a group defined by AS 21.53.200(3)(A), the 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, if the certificate holder has been notified of the replacement.

(b) Agents shall list other health insurance policies they have sold to the applicant including:

- (1) listing policies sold that are still in force; and
- (2) listing policies sold in the past five years that are no longer in force.

(c) Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its agent, shall furnish the applicant, before issuance or delivery of the individual long-term care insurance policy, a notice regarding

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replacement of accident and sickness or long-term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the manner prescribed by the director.

(d) 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 manner prescribed by the director.

(e) Where replacement is intended, the replacing insurer may 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. Notice shall be made not later than five working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

(f) Life insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of 3 AAC 26.790 – 3 AAC 26.819 . If a life insurance policy that accelerates benefits for long-term care is replaced by another policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.53.020 AS 21.53.030
AS 21.53.050 AS 21.53.090 AS 21.53.200

3 AAC 28.563. Reporting requirements. (a) Every insurer shall maintain records for each agent of that agent’s amount of replacement sales as a percent of the agent’s total annual

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sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

(b) Every insurer shall report annually by June 30, the 10 percent of its agents with the greatest percentages of lapses and replacements as measured by (a) of this section.

(c) 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.

(d) 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.

(e) 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.

(f) Reports required under this section shall be filed with the director.

(g) For purposes of this section:

(1) "policy" means only long-term care insurance;

(2) subject to (3) of this subsection, "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 the terms or conditions of the policy have been met;

(3) "denied" means the insurer refuses to pay a claim for a reason other than for

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claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

(4) “report” means on a statewide basis. (Eff. ____/____/____,

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Authority: AS 21.06.090 AS 21.53.020 AS 21.53.030
AS 21.53.050 AS 21.53.090

3 AAC 28.564. Annual rate certification requirements. (a) This section applies to a long-term care policy issued in this state on or after January 1, 2023. The following annual submission requirements apply after the initial rate filings for individual long-term care insurance policies.

(b) An actuarial certification prepared, dated, and signed by a member of the American Academy of Actuaries who provides the information shall be included and shall provide at least the following information:

(1) a statement of the sufficiency of the current premium rate schedule including:

(A) for the rate schedules currently marketed:

(i) the premium rate schedule continues to be 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; or

(ii) if the above statement cannot be made, a statement that margins for moderately adverse experience may no longer be sufficient. In this

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situation, the insurer shall provide to the director, not later than 60 days of the date the actuarial certification is submitted to the director, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience so that the ultimate premium rate schedule would be reasonably expected to be sustainable over the future life of the form with no future premium increases anticipated. Failure to submit a plan of action to the director not later than 60 days or to comply with the time frame stated in the plan of action constitutes grounds for the director to withdraw or modify its approval of the form for future sales under AS 21.42.120 and AS 21.42.130; or

(B) for the rate schedules that are no longer marketed:

(i) that the premium rate schedule continues to be sufficient to cover anticipated costs under best estimate assumptions; or

(ii) that the premium rate schedule may no longer be sufficient. In this situation, the insurer shall provide to the director, not later than 60 days of the date the actuarial certification is submitted to the director, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience; and

(2) a description of the review performed that led to the statement.

(c) An actuarial memorandum dated and signed by a member of the American Academy of Actuaries who prepares the information shall be prepared to support the actuarial certification and provide at least the following information:

(1) a detailed explanation of the data sources and review performed by the actuary

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before making the statement in (b)(2)(A) of this section;

(2) a complete description of experience assumptions and their relationship to the initial pricing assumptions;

(3) a description of the credibility of the experience data; and

(4) an explanation of the analysis and testing performed in determining the current presence of margins.

(d) The actuarial certification required under (b)(2)(A) of this section must be based on calendar year data and submitted to the director annually not later than May 1st of each year starting in the second year following the year in which the initial rate schedules are first used. The actuarial memorandum required under (c) of this section must be submitted at least once every three years with the certification. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.42.120 AS 21.42.130
AS 21.53.020 AS 21.53.030 AS 21.53.050
AS 21.53.090

3 AAC 28.565. Licensing. A producer is not authorized to sell, solicit, or negotiate with respect to long-term care insurance except as authorized by AS 21.27. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.27.010 AS 21.53.020
AS 21.53.030 AS 21.53.050 AS 21.53.090

3 AAC 28.566. Discretionary powers of the Director. The director may, upon written

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request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this article with respect to a specific long-term care insurance policy or certificate upon a written finding that:

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

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

(3) the modification or suspension

(A) is necessary to the development of an innovative and reasonable approach for insuring long-term care; or

(B) is reasonably related to the special needs or nature of the community when the policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly; or

(C) is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.53.090

3 AAC 28.568. Reserve standards. (a) When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to the policies, policy reserves for the benefits shall be determined in accordance with AS 21.45.300. Claim reserves shall also be established in the case when the policy or rider is in claim status. Reserves for policies and riders subject to this subsection should be based on the multiple

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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. An applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries. In the development and calculation of reserves for policies and riders subject to this subsection, consideration shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an effect on projected claim costs, including the following:

- (1) definition of insured events;
- (2) covered long-term care facilities;
- (3) existence of home convalescence care coverage;
- (4) definition of facilities;
- (5) existence or absence of barriers to eligibility;
- (6) premium waiver provision;
- (7) renewability;
- (8) ability to raise premiums;
- (9) marketing method;
- (10) underwriting procedures;

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- (11) claims adjustment procedures;
- (12) waiting period;
- (13) maximum benefit;
- (14) availability of eligible facilities;
- (15) margins in claim costs;
- (16) optional nature of benefit;
- (17) delay in eligibility for benefit;
- (18) inflation protection provisions; and
- (19) guaranteed insurability option.

(b) When long-term care benefits are provided other than as in (a) of this section, reserves shall be determined in accordance with AS 21.18.080 – AS 21.18.086. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.18.080 AS 21.18.082
AS 21.18.084 AS 21.18.086 AS 21.53.090

3 AAC 28.569. Loss ratio. (a) This section shall apply to all long-term care insurance policies or certificates except those covered under 3 AAC 28.557 and 3 AAC 28.570.

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

- (1) statistical credibility of incurred claims experience and earned premiums;

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- (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 including long elimination periods, high deductibles, and

high maximum limits.

(c) Subsection (b) may 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:

(1) the interest credited internally to determine cash value accumulations, including long-term care, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set out in the policy;

(2) the portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of AS 21.45.300;

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(3) the policy meets the disclosure requirements of AS 21.53.060;

(4) a policy illustration that meets the applicable requirements of the 3 AAC 28.800 – 3 AAC 28.849; and

(5) an actuarial memorandum is filed with the insurance division that includes:

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

(B) a description of the basis for the reserves;

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

(D) a description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars for each policy and dollars for each unit of benefits;

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

(F) the estimated average annual premium for each policy and the average issue age;

(G) 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, like medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or a dependent will be underwritten and when underwriting occurs; and

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(H) 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. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.45.300 AS 21.53.060
AS 21.53.090

3 AAC 28.570. Premium rate schedule increases for policies subject to loss ratio

limits related to original filings. (a) This section shall apply as follows:

(1) except as provided in (2) of this subsection, this section applies to a long-term care policy or certificate issued in this state on or after January 1, 2023; and

(2) for certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in AS 21.53.200(3)(A), which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following January 1, 2023.

(b) An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the director at least 45 days before the notice to the policyholders and shall include:

(1) information required by 3 AAC 28.556;

(2) certification by a qualified actuary that:

(A) if the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no

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further premium rate schedule increases are anticipated;

(B) the premium rate filing is in compliance with the provisions of this section; and

(C) the insurer may request a premium rate schedule increase less than what is required under this section and the director may approve a premium rate schedule increase, without submission of the certification in (A) of this paragraph, if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required under (A) of this paragraph, the premium rate schedule increase filing satisfies all other requirements of this section, and is, in the opinion of the director, in the best interest of policyholders;

(3) an actuarial memorandum justifying the rate schedule change request that includes:

(A) 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 assumptions that deviate from those used for pricing other forms currently available for sale. Additionally,

(i) annual values for the five years preceding and the three years following the valuation date shall be provided separately;

(ii) the projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(iii) the projections shall demonstrate compliance with (c) of this section; and

(iv) 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 if the director determines, as provided in 3 AAC 28.599(2)(E), that offsets may exist, the insurer shall use appropriate net projected experience;

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

(C) 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;

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

(E) if 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; and

(F) a demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin specified in 3 AAC 28.557(b)(2)(D) is projected to be exhausted;

(4) 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 director; and

(5) sufficient information for review and approval of the premium rate schedule

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increase by the director.

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

(1) 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;

(2) premium rate schedule increases shall be calculated so that the sum of the lesser of either the accumulated value of actual incurred claims, without the inclusion of active life reserves, or the accumulated value of historic expected claims, without the inclusion of active life reserves, plus the present value of the future expected incurred claims, projected without the inclusion of active life reserves, will not be less than the sum of the following:

(A) the accumulated value of the initial earned premium times the greater of:

(i) 58 percent; and

(ii) the lifetime loss ratio consistent with the original filing

including margins for moderately adverse experience;

(B) 85 percent of the accumulated value of prior premium rate schedule increases on an earned basis;

(C) the present value of future projected initial earned premiums times the greater of:

(i) 58 percent; and

(ii) the lifetime loss ratio consistent with the original filing

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including margins for moderately adverse experience; and

(D) 85 percent of the present value of future projected premiums not in

(C) of this paragraph on an earned basis;

(3) expected claims shall be calculated based on the original filing assumptions assumed until new assumptions are filed as part of a rate increase. New assumptions shall be used for all periods beyond each requested effective date of a rate increase. Expected claims are calculated for each calendar year based on the in-force at the beginning of the calendar year. Expected claims shall include margins for moderately adverse experience; either amounts included in the claims that were used to determine the lifetime loss ratio consistent with the original filing or as modified in a rate increase filing;

(4) if a policy form has both exceptional and other increases, the values in (2)(D) of this subsection and (d) of this section will also include 70 percent for exceptional rate increase amounts; and

(5) all present and accumulated values used to determine rate increases, including the lifetime loss ratio consistent with the original filing reflecting margins for moderately adverse experience, shall use the maximum valuation interest rate for contract reserves as specified in the AS 21.18.110. The actuary shall disclose as part of the actuarial memorandum the use of appropriate averages.

(d) For each rate increase that is implemented, the insurer shall file for review by the director, updated projections as defined in (b)(3)(A) of this section, annually for the next three years and include a comparison of actual results to projected values. The director may extend the period to greater than three years if actual results are not consistent with projected values from

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prior projections. For group insurance policies that meet the conditions in (l) of this section, the projections required by this subsection shall be provided to the policyholder instead of filing with the director.

(e) If a 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 (b)(3)(A) of this section, shall be filed for review and approval by the director every five years following the end of the required period in (d) of this section. For group insurance policies that meet the conditions in (l) of this section, the projections required by this subsection shall be provided to the policyholder instead of filing with the director.

(f) If the director has determined that the actual experience following a rate increase does not adequately match the projected experience, with consideration given to (b)(3)(E) of this section if applicable, and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in (c) of this section, the director may require the insurer to implement the following:

(1) premium rate schedule adjustments; or

(2) other measures to reduce the difference between the projected and actual experience.

(g) 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 plan, subject to director 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

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implemented or are in effect; otherwise the director may impose the condition in (h) or (i) of this section.

(h) For a rate increase filing that meets the following criteria, the director 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 a significant adverse lapse 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.

(i) If a significant adverse lapse 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 director may determine that a rate spiral exists. Following the determination that a rate spiral exists, the director 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. If required by the director:

(1) the offer shall:

(A) be subject to the approval of the director;

(B) be based on actuarially sound principles, but not be based on attained

age; and

(C) provide that maximum benefits under a 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. If a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

(A) the maximum rate increase determined based on the combined experience; and

(B) the maximum rate increase determined based only on the experience of the insureds originally issued the form plus 10 percent.

(j) If the director determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the director may, in addition to the provisions of (h) and (i) of this section, prohibit the insurer from either of the following:

(1) filing and marketing comparable coverage for a period of up to five years; or

(2) offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

(k) Subsections (a) – (j) may not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in 3 AAC 28.599(3), if the policy complies with all of the following provisions:

(1) the interest credited internally to determine cash value accumulations, including long-term care, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set out in the policy;

(2) the portion of the policy that provides insurance benefits other than long-term

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care coverage meets the nonforfeiture requirements as applicable in the following:

- (A) AS 21.45.300;
- (B) AS 21.45.305, and
- (C) 3 AAC 28.140;

(3) the policy meets the disclosure requirements of AS 21.53.060;

(4) The portion of the policy that provides insurance benefits other than long-term

care coverage meets the requirements as applicable in the following:

- (A) policy illustrations as required by 3 AAC 28.800 – 3 AAC 28.849;
- (B) disclosure requirements in 3 AAC 26.755; and
- (C) disclosure requirements in 3 AAC 28.010 – 3 AAC 28.190.

(5) An actuarial memorandum is filed with the insurance division that includes:

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

(B) a description of the basis for the reserves;

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

(D) a description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars for each policy and dollars for each unit of benefits;

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

(F) the estimated average annual premium for each policy and the average

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issue age;

(G) 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, like as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or a dependent will be underwritten and when underwriting occurs; and

(H) 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.

(I) Subsections (f), (h), and (i) of this section may not apply to group insurance policies as defined in AS 21.53.200(3)(A) where:

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

(2) the policyholder, and not the certificate holders, pays a material portion of the premium, which may not be less than 20 percent of the total premium for the group in the calendar year before the year a rate increase is filed. (Eff. ____/____/____, Register ____)

Authority:	AS 21.06.090	AS 21.18.100	AS 21.18.110
	AS 21.45.300	AS 21.45.305	AS 21.53.060
	AS 21.53.090	AS 21.53.200	

3 AAC 28.573. Filing requirement. Before an insurer or similar organization offers

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group long-term care insurance to a resident of this state under AS 21.53.070, it shall file with the director 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. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.53.070 AS 21.53.090

3 AAC 28.574. Filing requirements for advertising. (a) Every insurer, health care service plan, or other entity providing long-term care insurance or benefits in this state shall provide a copy of a long-term care insurance advertisement intended for use in this state whether through written, radio, television, or other electronic advertising medium to the director of insurance of this state for review or approval by the director to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer, health care service plan, or other entity for at least three years from the date the advertisement was first used.

(b) The director may exempt from these requirements an advertising form or material when, in the director's opinion, this requirement may not be reasonably applied. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.36.030 AS 21.53.090

3 AAC 28.575. Standards for marketing. (a) Every insurer, health care service plan, or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

(1) establish marketing procedures and agent training requirements to assure that:

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(A) marketing activities, including a comparison of policies, by its agents or other producers will be fair and accurate; and

(B) excessive insurance is not sold or issued;

(2) 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.”;

(3) provide copies of the disclosure forms required in 3 AAC 28.556(c) to the applicant;

(4) 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 insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required;

(5) every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this subsection;

(6) 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 director, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificate holder that the program is available and the name, address and telephone number of the program;

(7) for long-term care health insurance policies and certificates, use the terms “noncancellable” or “level premium” only when the policy or certificate conforms to 3 AAC

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28.552(a)(3); and

(8) provide an explanation of contingent benefit upon lapse provided for in 3 AAC 28.582(d) and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in 3 AAC 28.582(d)(2).

(b) In addition to the practices prohibited in AS 21.36, the following acts and practices are prohibited:

(1) “high pressure tactics,” which is defined as employing a 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; and

(2) “cold lead advertising,” which is defined as making use directly or indirectly of a method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.36.030 AS 21.53.080
AS 21.53.090 AS 21.53.200

3 AAC 28.576. Association standards for marketing. (a) With respect to the obligations set out in subsections (a) – (h), the primary responsibility of an association, as defined in AS 21.53.200(3)(B), when endorsing or selling long-term care insurance shall be 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

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insurance policies or certificates endorsed or sold by the associations to ensure that members of the associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold. 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.

(b) The association shall disclose in any long-term care insurance solicitation the following:

(1) 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

(2) a brief description of the process under which the policies and the insurer issuing the policies were selected.

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

(d) 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.

(e) The association shall:

(1) at the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an

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examination of the policies, including its benefits, features, and rates and update the examination thereafter if there is a material change;

(2) actively monitor the marketing efforts of the insurer and its agents;

(3) review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates; and

(4) paragraphs (1) through (3) of this subsection may not apply to qualified long-term care insurance contracts.

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

(g) The insurer may not issue a long-term care policy or certificate to an association or continue to market a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set out in this section.

(h) Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of AS 21.36 and AS 21.53.080. (Eff.

____/____/____, Register _____)

Authority: AS 21.06.090 AS 21.36.030 AS 21.53.080
AS 21.53.090 AS 21.53.200

3 AAC 28.577. Suitability. (a) This section may not apply to life insurance policies that accelerate benefits for long-term care.

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(b) Every insurer, health care service plan, or other entity marketing long-term care insurance shall:

(1) develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

(2) train its agents in the use of its suitability standards; and

(3) maintain a copy of its suitability standards and make them available for inspection upon request by the director.

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

(1) the ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(2) the applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

(3) the values, benefits, and costs of the applicant's existing insurance, when compared to the values, benefits, and costs of the recommended purchase or replacement.

(d) The issuer, and where an agent is involved, the agent, shall make reasonable efforts to get the information set out in (c) of this section. The efforts shall include presentation to the applicant, at or before application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format as prescribed by the director, 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 director.

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(e) A completed personal worksheet shall be returned to the issuer before 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.

(f) The sale or dissemination outside the company or agency by the issuer or agent of information gotten through the personal worksheet is prohibited.

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

(h) Agents shall use the suitability standards developed by the issuer in marketing long-term care insurance.

(i) 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 as prescribed by the director, in not less than 12-point type.

(j) 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 the format prescribed by the director. 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.

(k) The issuer shall report annually to the director the total number of applications received from residents of this state, the number of those who declined to provide information on

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the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter. (Eff.

____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.53.066 AS 21.53.090

3 AAC 28.578. 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 the 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. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.53.030 AS 21.53.090

3 AAC 28.579. Availability of new services or providers. (a) An insurer shall notify policyholders of the availability of a new long-term policy series that provides coverage for new long-term care services or providers material in nature and not previously available through the insurer to the general public. The notice shall be provided within 12 months of the date of the new policy series is made available for sale in this state.

(b) Notwithstanding (a) of this section, notification is not required for a policy issued before the effective date of this section or to a policyholder or certificate holder who is currently eligible for benefits, within an elimination period or on a claim, or who previously had been in claim status, or who would not be eligible to apply for coverage due to issue age limitations

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under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add new services or providers.

(c) The insurer shall make the new coverage available in one of the following ways:

(1) by adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age;

(2) by exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits shall be based on premiums paid or reserves held for the prior policy or certificate;

(3) by exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or

(4) by an alternative program developed by the insurer that meets the intent of this section if the program is filed with and approved by the director.

(d) An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of this subsection, "limited distribution channel" means through a discrete entity, similar to a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders that purchased a new proprietary policy shall be notified when a

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new long-term care policy series that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel.

(e) Policies issued under this section shall be considered exchanges and not replacements. These exchanges may not be subject to 3 AAC 28.562 and 3 AAC 28.578, and the reporting requirements of 3 AAC 28.563(a) – (d).

(f) Where the policy is offered through an employer, labor organization, professional, trade or occupational association, the required notification in (a) of this section shall be made to the offering entity. However, if the policy is issued to a group defined in AS 21.53.200(3)(D), the notification shall be made to each certificate holder.

(g) Nothing in this section shall prohibit an insurer from offering a policy, rider, certificate, or coverage change to a policyholder or certificate holder. However, upon request a policyholder may apply for currently available coverage that includes the new services or providers. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add new services or providers.

(h) This section does not apply to life insurance policies or riders containing accelerated long-term care benefits. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.53.050 AS 21.53.090

3 AAC 28.580. Right to reduce coverage and lower premiums. (a) Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificate holder to reduce coverage and lower the policy or certificate premium. The insurer may also offer other coverage reduction options that are consistent with the policy or certificate

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design or the carrier's administrative processes. If the reduction in coverage involves the reduction or elimination of the inflation protection provision, the insurer shall allow the policyholder to continue the benefit amount in effect at the time of the reduction. The policy or certificate premium may be reduced or lowered in at least one of the following ways:

- (1) reducing the maximum benefit; or
- (2) reducing the daily, weekly, or monthly benefit amount.

(b) The provision shall include a description of the process for requesting and implementing a reduction in coverage.

(c) The premium for the reduced coverage shall:

- (1) be based on the same age and underwriting class used to determine the premium for the coverage currently in force; and
- (2) be consistent with the approved rate table.

(d) The insurer may limit a 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.

(e) If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificate holder of his or her right to reduce coverage and premiums in the notice required by 3 AAC 28.554(a)(3).

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

(g) The requirements of subsections (a) – (f) shall apply to a long-term care policy issued in this state on or after January 1, 2023.

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(h) A premium increase notice required by 3 AAC 28.556(h) shall include:

(1) an offer to reduce policy benefits provided by the current coverage consistent with the requirements of this section;

(2) a disclosure stating that all options available to the policyholder may not be of equal value; and

(3) in the case of a partnership policy, a disclosure that some benefit reduction options may result in a loss in partnership status that may reduce policyholder protections.

(i) The requirements of (h) of this section shall apply to a rate increase implemented in this state on or after January 1, 2023. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.53.090

3 AAC 28.582. Nonforfeiture benefit requirement. (a) This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(b) To comply with the requirement to offer a nonforfeiture benefit under the provisions of AS 21.53.064:

(1) 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 (h) of this section; and

(2) 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.

(c) If the offer required to be made under AS 21.53.064 is rejected, the insurer shall provide the contingent benefit upon lapse described in this section. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in (d)(2) of this section shall still apply.

(d) After rejection of the offer required under AS 21.53.064, for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the insurer shall provide a contingent benefit upon lapse. If 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. A contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set out 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 before the due date of the premium reflecting the rate increase. The triggers for a substantial premium increase shall comply with the following:

(1):

Triggers for a Substantial Premium Increase

<u>Issue Age</u>	<u>Percent Increase Over Initial Premium</u>
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

(2) a contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set out below based on the insured's issue

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age, the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio in (f)(2) of this section is 40 percent or more. Unless otherwise required, policyholders shall be notified at least 30 days before the due date of the premium reflecting the rate increase. This provision shall be in addition to the contingent benefit provided by (d) of this section and where both are triggered, the benefit provided shall be at the option of the insured.

The triggers for a substantial premium increase shall comply with the following:

Triggers for a Substantial Premium Increase

<u>Issue Age</u>	<u>Percent Increase Over Initial Premium</u>
Under 65	50%
65-80	30%
Over 80	10%

(e) on or before the effective date of a substantial premium increase as defined in (d)(1) of this section, the insurer shall:

(1) offer to reduce policy benefits provided by the current coverage consistent with the requirements of 3 AAC 28.580 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 (h) of this section. This option may be elected during the 120 day period referenced in (d) of this section; and

(3) notify the policyholder or certificate holder that a default or lapse during the 120 day period referenced in (d) of this section shall be considered to be the election of the offer

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to convert in (2) of this subsection unless the automatic option in paragraph (f)(3) of this section applies.

(f) on or before the effective date of a substantial premium increase as defined in (d)(2) of this section, the insurer shall:

(1) offer to reduce policy benefits provided by the current coverage consistent with the requirements of 3 AAC 28.580 so that required premium payments are not increased;

(2) offer to convert the coverage to a paid-up status where the amount payable for each benefit is 90 percent of the amount payable in effect immediately before lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at during the 120-day period referenced in (d)(2) of this section; and

(3) notify the policyholder or certificate holder that a default or lapse during the 120-day period referenced in (d)(2) of this section shall be considered to be the election of the offer to convert in (2) of this subsection if the ratio is 40 percent or more.

(g) for a long-term care policy issued in this state on or after January 1, 2023:

(1) if the policy or certificate was issued at least 20 years before the effective date of the increase, a value of zero percent shall be used in place of all values in the above table; and

(2) values above 100 percent in the table in (d)(1) of this section shall be reduced to 100 percent.

(h) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with (d)(1) but not (d)(2) of this section, are described in this subsection.

(1) For purposes of this subsection, attained age rating is defined as a schedule of

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premiums starting from the issue date which increases age at least one percent a year before age 50, and at least three percent a year beyond age 50.

(2) For purposes of this subsection, 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 (d) of this section.

(3) The standard nonforfeiture credit will be equal to 100 percent of the sum of all premiums paid, including the premiums paid before 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 may 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 (j) of this section.

(i) Nonforfeiture benefits are subject to the following:

(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 (1) of this subsection, for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

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

or

(B) the end of the second year following the date the policy or certificate

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is no longer subject to attained age rating; and

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

(j) 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.

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

(l) The requirements set out in this section shall become effective 12 months after adoption of this provision and shall apply as follows:

(1) Except as provided in (2) and (3) of this subsection, the provisions of this section apply to a long-term care policy issued in this state on or after the effective date of this amended regulation.

(2) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in AS 21.53.200(3)(A), which policy was in force when this amended regulation became effective, the provisions of this section may not apply.

(3) The notification requirements in (c) and (d)(2) and (f)(3) of this section shall apply to a long-term care insurance policy or certificate issued in this state after six months after their adoption, except new certificates on a group policy as defined in AS 21.53.200(3)(A) one year after adoption.

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(m) 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 3 AAC 28.569 or 3 AAC 28.570, whichever is applicable, treating the policy as a whole.

(n) To determine whether contingent nonforfeiture upon lapse provisions are triggered under (d)(1) or (d)(2) of this section, 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.

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

(1) the nonforfeiture provision shall be appropriately captioned;

(2) the nonforfeiture provision shall provide a benefit available if a default in the payment of premiums and shall state that the amount of the benefit may be adjusted after 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 director for the same contract form; and

(3) the nonforfeiture provision shall provide at least one of the following:

(A) reduced paid-up insurance;

(B) extended term insurance;

(C) shortened benefit period; or

(D) other similar offerings approved by the director. (Eff.

____/____/____, Register _____)

Authority: AS 21.06.090 AS 21.53.064 AS 21.53.090

3 AAC 28.583. Standards for benefit triggers. (a) 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 may 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.

(b) Insurers may use activities of daily living to trigger covered benefits as long as they are defined in the policy. Activities of daily living shall include at least the following as defined in 3 AAC 28.551 and in the policy:

- (1) bathing;
- (2) continence;
- (3) dressing;
- (4) eating;
- (5) toileting; and
- (6) transferring;

(c) An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions may not restrict, and are not instead of, the requirements contained in (a) and (b) of this section.

(d) For purposes of this section the determination of a deficiency may not be more restrictive than:

- (1) requiring the hands-on assistance of another person to perform the prescribed

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activities of daily living; or

(2) if the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed to protect the insured or others.

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

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

(g) The requirements set out in this section shall be effective January 1, 2023 and shall apply as follows:

(1) except as provided in (2) of this subsection, the provisions of this section apply to a long-term care policy issued in this state on or after the effective date of the amended regulation;

(2) for certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in AS 21.53.200(3)(A) that was in force when this amended regulation became effective, the provisions of this section may not apply. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.53.064 AS 21.53.090

3 AAC 28.584. Additional standards for benefit triggers for qualified long-term care insurance contracts. (a) A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided under a plan of care prescribed by a licensed health care practitioner.

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(b) 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.

(c) Certifications regarding activities of daily living and cognitive impairment required under (b) of this section 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.

(d) Certifications required under (b) of this section 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.

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

(f) For purposes of this section,

(1) "qualified long-term care services" means services that meet the requirements of Section 7702(c)(1) of the Internal Revenue Code of 1986, as amended, 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 under a plan of care prescribed by a licensed health care practitioner;

(2) "chronically ill individual" has the meaning prescribed for this term by section

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7702B(c)(2) of the Internal Revenue Code of 1986, as amended. The term “chronically ill individual” may 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 Under this provision, a chronically ill individual means an individual who has been certified by a licensed health care practitioner as:

(A) 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

(B) requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment;

(3) “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; and

(4) “maintenance or personal care services” means care the primary purpose of which is the provision of needed assistance with 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. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.53.064 AS 21.53.090

3 AAC 28.585. Appealing an insurer’s determination that the benefit trigger is not met. (a) For purposes of this section, “authorized representative” is authorized to act as the covered person’s personal representative within the meaning of 45 CFR 164.502(g) adopted by

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the Secretary under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act and means the following:

(1) a person to whom a covered person has given express written consent to represent the covered person in an external review;

(2) a person authorized by law to provide substituted consent for a covered person; or

(3) a family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent.

(b) If an insurer determines that the benefit trigger of a long-term care insurance policy has not been met, it shall provide a clear, written notice to the insured and the insured's authorized representative, if applicable, of all of the following:

(1) the reason that the insurer determined that the insured's benefit trigger has not been met;

(2) the insured's right to internal appeal in accordance with (c) of this section, and the right to submit new or additional information relating to the benefit trigger denial with the appeal request; and

(3) the insured's right, after exhaustion of the insurer's internal appeal process, to have the benefit trigger determination reviewed under the independent review process in accordance with (d) of this section.

(c) The insured or the insured's authorized representative may appeal the insurer's adverse benefit trigger determination by sending a written request to the insurer, along with additional supporting information, within 120 calendar days after the insured and the insured's

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authorized representative, if applicable, receives the insurer's benefit determination notice. The internal appeal shall be considered by an individual or group of individuals designated by the insurer, if the individual or individuals making the internal appeal decision may not be the same individual or individuals who made the initial benefit determination. The internal appeal shall be completed and written notice of the internal appeal decision shall be sent to the insured and the insured's authorized representative, if applicable, not later than 30 calendar days of the insurer's receipt of all necessary information upon which a final determination can be made. The internal appeal is subject to the following:

(1) if the insurer's original determination is upheld upon internal appeal, the notice of the internal appeal decision shall describe additional internal appeal rights offered by the insurer. Nothing herein shall require the insurer to offer internal appeal rights other than those described in this subsection;

(2) if the insurer's original determination is upheld after the internal appeal process has been exhausted, and new or additional information has not been provided to the insurer, the insurer shall provide a written description of the insured's right to request an independent review of the benefit determination as described in (d) of this section to the insured and the insured's authorized representative, if applicable;

(3) as part of the written description of the insured's right to request an independent review, an insurer shall include the following, or substantially equivalent, language: "We have determined that the benefit eligibility criteria ("benefit trigger") of your [policy] [certificate] has not been met. You may have the right to an independent review of our decision conducted by long-term care professionals who are not associated with us. Please send a written

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request for independent review to us at [address]. You must inform us, in writing, of your election to have this decision reviewed within 180 days of receipt of this letter. Listed below are the names and contact information of the independent review organizations available to conduct long-term care insurance benefit eligibility reviews. If you wish to request an independent review, please choose one of the listed organizations and include its name with your request for independent review. If you elect independent review, but do not choose an independent review organization with your request, we will choose one of the independent review organizations for you and refer the request for independent review to it;”

(4) if the insurer does not believe the benefit trigger decision is eligible for independent review, the insurer shall inform the insured and the insured’s authorized representative, if applicable, in writing and include in the notice the reasons for its determination of independent review ineligibility; and

(5) the appeal process described in (c) of this section is not considered to be a ‘new service or provider’ as referenced in 3 AAC 28.579, and therefore does not trigger the notice requirements of that section.

(d) The insured or the insured’s authorized representative may request an independent review of the insurer’s benefit trigger determination after the internal appeal process outlined in (c) of this section has been exhausted. A written request for independent review may be made by the insured or the insured’s authorized representative to the insurer not later than 180 calendar days after the insurer’s written notice of the final internal appeal decision is received by the insured and the insured’s authorized representative, if applicable. The cost of the independent review shall be borne by the insurer. The independent review process is subject to the following:

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(1) not later than five business days of receiving a written request for independent review, the insurer shall refer the request to the independent review organization that the insured or the insured's authorized representative has chosen from the list of certified or approved organizations the insurer has provided to the insured. If the insured or the insured's authorized representative does not choose an approved independent review organization to perform the review, the insurer shall choose an independent review organization approved or certified by the state. The insurer shall vary its selection of authorized independent review organizations on a rotating basis;

(2) the insurer shall refer the request for independent review of a benefit trigger determination to an independent review organization, subject to the following:

(A) the independent review organization shall be on a list of certified or approved independent review organizations that satisfy the requirements of a qualified long-term care insurance independent review organization contained in this section;

(B) the independent review organization may not have conflicts of interest with the insured, the insured's authorized representative, if applicable, or the insurer; and

(C) a review shall be limited to the information or documentation provided to and considered by the insurer in making its determination, including information or documentation considered as part of the internal appeal process.

(3) if the insured or the insured's authorized representative has new or additional information not previously provided to the insurer, whether submitted to the insurer or the independent review organization, the information shall first be considered in the internal review process, as set out in (c) of this section in accordance with the following:

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(A) while this information is being reviewed by the insurer, the independent review organization shall suspend its review and the time period for review is suspended until the insurer completes its review;

(B) the insurer shall complete its review of the information and provide written notice of the results of the review to the insured and the insured's authorized representative, if applicable, and the independent review organization not later than five business days of the insurer's receipt of new or additional information;

(C) if the insurer maintains its denial after a review, the independent review organization shall continue its review, and render its decision within the time period specified in (9) of this subsection. If the insurer overturns its decision following its review, the independent review request shall be considered withdrawn.

(4) the insurer shall acknowledge in writing to the insured and the insured's authorized representative, if applicable, that the request for independent review has been received, accepted and forwarded to an independent review organization for review. The notice will include the name and address of the independent review organization.

(5) not later than five business days of receipt of the request for independent review, the independent review organization assigned under this paragraph shall notify the insured and the insured's authorized representative, if applicable, the insurer that it has accepted the independent review request and identify the type of licensed health care professional assigned to the review. The assigned independent review organization shall include in the notice a statement that the insured or the insured's authorized representative may submit in writing to the independent review organization not later than seven days following the date of receipt of the

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notice additional information and supporting documentation that the independent review organization should consider when conducting its review;

(6) the independent review organization shall review all of the information and documents received under (5) of this subsection that has been provided to the independent review organization. The independent review organization shall provide copies of the documentation or information provided by the insured or the insured's authorized representative to the insurer for its review, if it is not part of the information or documentation submitted by the insurer to the independent review organization. The insurer shall review the information and provide its analysis of the new information in accordance with (8) of this subsection;

(7) the insured or the insured's authorized representative may submit new or additional information not previously provided to the insurer but pertinent to the benefit trigger denial. The insurer shall consider the information and affirm or overturn its benefit trigger determination. If the insurer affirms its benefit trigger determination, the insurer shall promptly provide the new or additional information to the independent review organization for its review, along with the insurer's analysis of the information;

(8) if the insurer overturns its benefit trigger determination:

(A) the insurer shall provide notice to the independent review organization and the insured and the insured's authorized representative, if applicable, of its decision;
and

(B) the independent review process shall immediately stop.

(9) the independent review organization shall provide the insured and the insured's authorized representative, if applicable, the insurer and the director written notice of its

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decision, not later than 30 calendar days from receipt of the referral referenced in (d)(2) of this section. If the independent review organization overturns the insurer's decision, it shall:

(A) establish the precise date within the specific period of time under review that the benefit trigger was considered to have been met;

(B) specify the specific period of time under review for which the insurer declined eligibility, but during which the independent review organization considered the benefit trigger to have been met; and

(C) for tax-qualified long-term care insurance contracts, provide a certification, made only by a licensed health care practitioner as defined in Section 7702B(c)(4) of the Internal Revenue Code, that the insured is a chronically ill individual.

(10) the decision of the independent review organization with respect to whether the insured met the benefit trigger will be final and binding on the insurer;

(11) the independent review organization's determination shall be used solely to establish liability for benefit trigger decisions, and is intended to be admissible in a proceeding only to the extent it establishes the eligibility of benefits payable;

(12) nothing in this section shall restrict the insured's right to submit a new request for benefit trigger determination after the independent review decision, should the independent review organization uphold the insurer's decision;

(g) Nothing contained in this section shall limit the ability of an insurer to assert rights an insurer may have under the policy related to:

(1) an insured's misrepresentation;

(2) changes in the insured's benefit eligibility; and

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(3) terms, conditions, and exclusions of the policy, other than failure to meet the benefit trigger.

(h) The requirements of this section apply to a benefit trigger request made on or after January 1, 2023 under a long-term care insurance policy.

(i) The provisions of this section supersede other external review requirements found in 3 AAC 28.950 – 3 AAC 28.982. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.07.005 AS 21.53.064
AS 21.53.090

3 AAC 28.586. Prompt payment of clean claims. (a) Not later than 30 days after receipt of a claim for benefits under a long-term care insurance policy or certificate, an insurer shall pay the claim if it is a clean claim, or send a written notice acknowledging the date of receipt of the claim and one of the following:

(1) the insurer is declining to pay all or part of the claim and the specific reason or reasons for denial; or

(2) that additional information is necessary to determine if all or a part of the claim is payable and the specific additional information that is necessary.

(b) Not later than 30 days after receipt of all the requested additional information, an insurer shall pay a claim for benefits under a long-term care insurance policy or certificate if it is a clean claim, or send a written notice that the insurer is declining to pay all or part of the claim, and the specific reason or reasons for denial.

(c) If an insurer fails to comply with (a) or (b) of this section, the insurer shall pay

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interest at the rate of 15 percent annually on the amount of the claim that should have been paid but that remains unpaid 30 days after the receipt of the claim with respect to (a) of this section or 15 days after receipt of all requested additional information with respect to (b) of this section. The interest payable under this subsection shall be included in a late reimbursement without requiring the person who filed the original claim to make an additional claim for the interest.

(d) This section may not apply where the insurer has a reasonable basis supported by specific information that the claim was fraudulently submitted.

(e) A violation of this section by an insurer if committed flagrantly and in conscious disregard of the provisions of this section or with a frequency that constitutes a general business practice shall be considered a violation of AS 21.36.

(f) To the extent there is a conflict, this section supersedes another claim payment requirement found in AS 21.36.495.

(g) For purposes of this section:

(1) “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 the terms or conditions of the policy have been met; and

(2) “clean claim” means a claim that has no defect or impropriety, including the lack of required substantiating documentation, like satisfactory evidence of expenses incurred, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim. (Eff. ____ / ____ / ____, Register ____)

Authority: AS 21.06.090 AS 21.53.060 AS 21.53.090

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3 AAC 28.588. Standard format outline of coverage. An outline of coverage to a prospective applicant for long-term care insurance shall follow a standard format and content for an outline of coverage, subject to the following standards:

(1) the outline of coverage shall be a free-standing document, using no smaller than ten-point type;

(2) the outline of coverage shall contain no advertising material;

(3) text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring;

(4) use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated; and

(5) the outline of coverage will follow the format as prescribed by the director.

(Eff. ____ / ____ / ____, Register ____)

Authority: AS 21.06.090 AS 21.53.050 AS 21.53.090

3 AAC 28.590. Requirement to deliver shopper's guide. (a) A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the director, shall be provided to all prospective applicants of a long-term care insurance policy or certificate. The shopper's guide is subject to the following:

(1) in the case of agent solicitations, an agent must deliver the shopper's guide before the presentation of an application or enrollment form; or

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(2) in the case of direct response solicitations, the shopper’s guide must be presented in conjunction with an application or enrollment form.

(b) Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under AS 21.53.020 – AS 21.53.060. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.53.020 AS 21.53.030
AS 21.53.040 AS 21.53.050 AS 21.53.060
AS 21.53.090

3 AAC 28.592. Permitted compensation arrangements. (a) An insurer, hospital or medical service corporation, or fraternal benefit society may provide commission or other compensation to an agent for the sale of a long-term care insurance policy or certificate only if the first year commission or other first year compensation is not more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

(b) The commission or other compensation provided in renewal years must be the same as that provided in the second year or period and must be provided for a reasonable number of renewal years.

(c) No entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing insurer on renewal policies.

(d) For purposes of this section, “compensation” includes pecuniary or non-pecuniary

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remuneration relating to the sale or renewal of the policy or certificate including bonuses, gifts, prizes, awards, and finders fees. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.53.090

3 AAC 28.595. Penalties. In addition to other penalties provided by the laws of this state, an insurer and an agent found to have violated a requirement of this state relating to the regulation of long-term care insurance or the marketing of long-term care insurance shall be subject to a fine of up to three times the amount of the commissions paid for each policy involved in the violation or up to \$10,000, whichever is greater. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.36.020 AS 21.36.025
AS 21.53.090

3 AAC 28.599. Definitions. In this chapter, the following definitions apply:

(1) “benefit trigger”, for the purposes of independent review, means a contractual provision in the insured’s policy of long-term care insurance conditioning the payment of benefits on a determination of the insured’s ability to perform activities of daily living and on cognitive impairment. For purposes of a tax-qualified long-term care insurance contract, as defined in Section 7702B of the Internal Revenue Code of 1986, as amended, “benefit trigger” shall include a determination by a licensed health care practitioner that an insured is a chronically ill individual;

(2) “exceptional increase” means only those increases filed by an insurer as

exceptional for which the director determines the need for the premium rate increase is justified:

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

(B) due to increased and unexpected utilization that affects the majority of insurers of similar products;

(C) except as provided in 3 AAC 28.570, exceptional increases are subject to the same requirements as other premium rate schedule increases;

(D) the director 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;

(E) the director, in determining that the necessary basis for an exceptional increase exists, shall also determine potential offsets to higher claims costs.

(3) “incidental,” as used in 3 AAC 28.570(k), 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;

(4) “independent review organization” means an organization that conducts independent reviews of long-term care benefit trigger decisions;

(5) “licensed health care professional” means an individual qualified by education and experience in an appropriate field, to determine, by record review, an insured’s actual functional or cognitive impairment;

(6) “qualified actuary” means a member in good standing of the American Academy of Actuaries;

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(7) “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 in AS 21.53.200(3)(A) 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, non-institutional long-term care benefits only, or comprehensive long-term care benefits. (Eff. ____ / ____ / ____, Register ____)

Authority: AS 21.06.090 AS 21.53.090 AS 21.53.200