Department of Consumer & Business Services
Oregon Division of Financial Regulation – 5
P.O. Box 14480 Salem, Oregon 97309-0405
Phone (503) 947-7983

STANDARD PROVISIONS FOR LONG TERM CARE - INDIVIDUAL AND GROUP

This product standard checklist is for Long Term Care which means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than 24 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary services, including but not limited to nursing, diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. “Long term care insurance” includes group and individual annuities and life insurance policies or riders that provide directly or supplement long term care insurance. “Long term care insurance” also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity, and qualified long term care insurance contracts.

This list includes the national standards, relevant statutes, rules, bulletins and other documented positions to enforce ORS 731.016. The standards are summaries and review of the entire statute or rule is recommended. Complete each item to confirm that diligent consideration has been given to each and is certified by the signature on the certificate of compliance form. “Not applicable” can be used only if the item does not apply to the coverage being filed.

Please check the box below indicating the type of product you are filing:

TOI (type of insurance):
- ☐ LTC03G - Group LTC
- ☐ LTC03I - Individual LTC
- ☐ Annual certification
- ☐ Annual rate filing

Sub-TOI:

☐ LTC03G.001	☐ LTC03I.001 Tax Qualified
☐ LTC03G.002	☐ LTC03I.002 Non Qualified
☐ LTC03G.003	☐ LTC03I.003 Other
☐ LTC03G.004	☐ LTC03I.004 Partnership – see item 11 under Submission package requirements below.

Note: Stand alone nursing home, assisted living, and home health care insurance may be qualified federal long term care products; however, they do not qualify in Oregon as “Long Term Care” products (see ORS 743.656(2)).

For a group policy that is to be issued to a trust or an association, the filing must include a complete transmittal and product standards Form, 440-2441A, found on our website at: http://dfr.oregon.gov/rates-forms/associations-trusts/Pages/index.aspx.

If filing for the annual certification on individual plans under OAR 836-052-0637, please complete page 1 & 10 only.

Review Requirements	Reference	Description of review standards requirements	Check answer
GENERAL REQUIREMENTS (FOR ALL FILINGS)			
Submission package requirements	OAR 836-010-0011 As required on SERFF or our Web site	Required forms are located on SERFF or on our website: http://dfr.oregon.gov/rates-forms/associations-trusts/Pages/index.aspx. In order for your filing to be accepted it must include the following documents: 1. NAIC transmittal form (for paper filings only, not required in SERFF). 2. Filing description on general information tab in SERFF or cover letter. 3. Third party filer's letter of authorization. 4. Certificate of compliance form signed by authorized person. 5. Readability certification. 6. Product standards for forms (this document). Every line item must be completed on the product standards, unless otherwise noted. 7. Actuarial memorandum with an overview of the contents of the filing and the reasons and procedures used to derive the rates. 8. For mailed filings, submit two sets of the complete filing and one self addressed stamped envelope large enough to return the approved forms. 9. All relevant components listed on our Web site for this product must be completed and submitted with this filing. The filing will be disapproved if all the required components are not attached in accordance to the directions on our Web site. 10. If you are submitting your filing electronically, each line item must be book marked. 11. If you are submitting a previously-approved form to now be marketed as a partnership policy, please include a completed partnership checklist Form 440-4838 with this filing instead of completing the Forms, Policy Provisions, and Rates sections starting on page 4 of this document. 12. The product standards are required and must be submitted with your filing, in compliance with OAR 836-010-0011(2) 13. Any line left blank will cause this filing to be considered incomplete. Not including required information or policy provisions might result in disapproval of the filing.	Yes ☐ N/A ☐

Review Requirements	Reference	Description of review standards requirements	Check answer
Review requested	ORS 742.005(1), OAR 836-010-0011	The following are submitted in this filing for review: 1. New policy. 2. Amendment to an approved form. 3. Addition of supplement options to previously approved plans. 4. Rider, addendum, or endorsement. 5. Filing previously approved policy for approval as a partnership policy. Form #: _____ Prior Approval Date: _____ Include copy of perforated approved form with this submission or SERFF tracking number from filing previously approved.	Yes N/A ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Filing description on transmittal form	OAR 836-010-0011(4), OAR 836-052-0531(7)	The filing description (cover letter) includes the following: 1. Changes made to prior approved forms or variations from other approved forms. 2. Summary of the differences between prior approved like forms and the new form. 3. The differences between in-network and out-of-network, if applicable. 4. Is this form intended to be a “qualified partnership policy”?	Yes N/A ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Advertising	OAR 836-052-0696	Filing of advertisements is required with new products only. If this is a new product, is the advertisement included?	Yes N/A ☐ ☐
Redline version	OAR 836-010-0011(4)	Forms filed for approval. If filing revised forms, include a highlighted or redlined copy of the revised form to identify the modification, revision, or replacement language. The cover letter must identify any exceptions the insurer is using to modify the required design.	Yes N/A ☐ ☐

FORMS			
Review Requirements	**Reference**	**Description of review standards requirements**	**Check answer**
Variable data	ORS 742.005(2), ORS 742.023	Variable data must be bracketed. Identify all applicable options or ranges of variables. The variable data may be included within the policy and certificate or submitted as a separate form, identified by a form number. A separate document must also refer to the form it applies to, the form page number and the paragraph and line if necessary for clarity. (Example of bracketed variable: Maximum benefits [$5,000 - $200,000]). The minimum and maximum variables must be included in an actively marketed plan.	Yes N/A ☐ ☐
Applications	OAR 836-052-0626	Product standard, Form 440-2442H, must be included in the filing if an application form is submitted.	Yes N/A ☐ ☐
Personal Worksheet	OAR 836-052-0726(3)(b)	Filing includes the “Long-Term Care Insurance Personal Worksheet” according to OAR 836-052-0556(4) Exhibit 1.	Yes N/A ☐ ☐

Review Requirements	Reference	Description of review standards requirements	Check answer
Outline of coverage	OAR 836-052-0776(2)	If an outline of coverage is filed it follows the standard format provided by the Department of Consumer Business Services and displayed on the department's website.	Yes ☐ N/A ☐
Cover page	ORS 743.655(6)	The applicant has the right to inspect the policy or certificate and return for a full premium refund within 30 days of delivery. Prominent notice of this right appears on the first page of the policy or is attached to it.	Yes ☐ N/A ☐
	OAR 836-052-0546(6)	Applies to life insurance accelerated benefits only. A notice of the tax disclosure is prominently displayed on the first page of the policy or rider.	Yes ☐ N/A ☐
	ORS 743.685(7), OAR 836-052-0160(5)	The long-term care policy or certificate includes a disclosure stating, "This is Not a Medicare Supplement policy". (Not applicable to riders/endorsements/addendums)	Yes ☐ N/A ☐
	OAR 836-052-0526, OAR 836-052-0546(1)	Applies to individual policies. (Not applicable to riders/endorsements/addendums.) On the first page of the policy, include a renewability provision if the policy is "guaranteed renewable" or is "non-cancellable".	Yes ☐ N/A ☐

POLICY PROVISIONS

Review Requirements	Reference	Description of review standards requirements	Check answer or enter page & paragraph
Renewability	OAR 836-052-0526(1)	Individual policies do not contain a renewable provision other than "guaranteed renewable" or "non-cancellable," which is defined.	Yes ☐ N/A ☐
	OAR 836-052-0546(8), ORS 743.655(7)	If filing a qualified long-term care insurance contract, the contract and the outline of coverage each contain a statement that the policy is intended to be a qualified long-term care contract, within the meaning of Section 7702B(b) of the Internal Revenue Code of 1986, amended as defined in ORS 743.652(6)	Yes ☐ N/A ☐
	OAR 836-052-0546(9)	If filing a non-qualified long-term care contract, the policy and outline of coverage each contain a statement that the policy is not intended to be a qualified long-term care insurance contract.	Yes ☐ N/A ☐
	OAR 836-052-0740 Applies to policies issued on or after December 1, 2008	Policy language includes options for the policyholder to reduce benefits and premiums, allowing at a minimum: a. Reducing the maximum benefit; or b. Reducing the daily, weekly, or monthly benefit amount	Yes ☐ ☐ No ☐ ☐
Continuation	OAR 836-052-0526(5)	Group policies provide for continuation or conversion of benefits.	Yes ☐ N/A ☐

Review Requirements	Reference	Description of review standards requirements	Enter page & paragraph
Benefit reimbursement	ORS 743.656, OAR 836-052-0596 Minimum standards	Minimum standards for benefit eligibility. Benefits must include services provided by: 1. Nursing homes per ORS 836-052-0596(1) 2. Assisted living per ORS 836-052-0596(2) 3. Home care per ORS 836-052-0596(3) 4. Adult foster care per ORS 836-052-0596(4) 5. Residential care per ORS 836-052-0596(5)	
	OAR 836-052-0546(7) Eligibility for the payment of benefits	Activities of daily living and cognitive impairment shall both be considered when determining benefit eligibility and policy form complies with related disclosure requirements. It shall be described in the policy in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits."	
	ORS 443.886, ORS 743.656(1)(c), OAR 411-057-0000	Oregon licenses care facilities with Alzheimer's endorsements. Indicate where the policy provides benefits for services of this type.	
	OAR 836-052-0586(2)	Policy does not limit or exclude home health and community care benefits outlined in OAR 836-052-0586. Home care or community care services shall provide total home care 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, certificate, or rider at the time covered home care or community care services are being received per OAR 836-052-0586(2).	
	OAR 836-052-0756 LTC benefit triggers	Policies shall condition payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment.	
	OAR 836-052-0766(2) Benefit triggers for Qualified LTC contracts only	A qualified long term care insurance contract shall only pay benefits received by a chronically-ill individual which has a definition in OAR 836-052-0766(1)(b)(A) that is being unable to perform at least two (2) activities of daily living for a period of at least 90 days due to loss of functional capacity.	
	OAR 836-052-0756(2)(c)	Cognitive impairment must be a result of clinically diagnosed organic dementia, including but not limited to Alzheimer's Disease or a related progressive degenerative dementia of an organic origin.	
Non-forfeiture	OAR 836-052-0746(2)	A long-term care policy, certificate, or rider offered with non-forfeiture benefits must have coverage elements, eligibility, benefit triggers, and length of benefits that are the same as coverage to be issued without non-forfeiture benefits.	

Review Requirements	Reference	Description of review standards requirements	Enter page & paragraph
Non-forfeiture, continued	OAR 836-052-0746(12)(c)	The non-forfeiture provision shall provide at least one of the following: • reduced paid-up insurance; • extended term insurance; • shortened benefit period; • or other similar offerings approved by the Director.	
	OAR 836-052-0746(6)(c)	The standard non-forfeiture credit must be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard non-forfeiture credit for that duration. However, the minimum non-forfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse.	
	OAR 836-052-0746(3)(4) Contingent benefit	Does the policy or rider provide the insured with a contingent benefit if the offer for a non-forfeiture benefit is rejected? Is the contingent benefit triggered 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? And the policy or certificate lapses within 120 days of the due date of the premium so increased?	
Internal Appeal and External Review	OAR 836-052-0508, OAR 836-052-0768	The contract provides for an external review process in accordance with regulations. The process must include all components required by the cited rules, including but not limited to: - Definition of terms not substantially different from those in OAR 836-052-0508. - Clear written notice when an insurer determines a benefit trigger has not been met, including the reason the trigger has not been met, and the insured's right to internal appeal, and to external review at the exhaustion of internal appeals; - Allows the insured to request appeal in writing within 120 days of receiving notice of determination that benefit trigger has not been met; - An internal appeal procedure taking no longer than 30 days; - At the exhaustion of the appeals process, a notice containing substantially the following text:	

Review Requirements	Reference	Description of review standards requirements	Enter page & paragraph
Internal Appeal and External Review, continued	OAR 836-052-0508, OAR 836-052-0768	○ "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 request for independent review to us at [address]. You must inform us, in writing, of your election to have this decision reviewed within 120 days after you receive this letter. Listed below are the names and contact information of the independent review organizations approved or certified by the Department of Consumer and Business Services 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;" - The right to request an external review within 120 days after the insured receives notification of the final determination that the benefit trigger has not been met; - The cost of the process must be born by the insurer; - The insurer is bound by the decision of the independent review organization conducting the external review.	
Prompt Payment	OAR 836-052-0770	The contract complies with the provisions of Oregon rule requiring prompt payment of clean claims, including but not limited to: - The definition of "clean claim;" - A requirement the insurer to either begin paying a claim or provide notice that the claim is being denied (and the reason) or that more information is required for the insurer to decide to pay the claim (including a list of the information needed) within 30 days of receipt of the claim. - That if the insurer fails to do the above, the insurer will be required to pay interest on the claim at a rate of 1% per month.	
Minimum amount payable	OAR 836-052-0586(2)	Home care or community care coverage is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits	

Review Requirements	Reference	Description of review standards requirements	Enter page & paragraph
Definitions	OAR 836-052-0766 (1)(b)(A) Chronically ill	Contract contains definition of "chronically ill" in accordance with section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. (Applies to tax-qualified contracts). A chronically ill individual must be certified by a licensed health care practitioner as: Being unable to perform at least two ADLs for a period of at least 90 days due to a loss of functional capacity or requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.	
	OAR 836-052-0516 General definitions	Definitions in the policy are no more restrictive than those found in OAR 836-052-0516.	
	ORS 743.652(4) Long term care	Contractual definition of "long term care" includes requirement that benefit period may not be less than 24 months for each covered person.	
	OAR 836-052-0606	Use and definition of "home" or similar wording complies.	
	ORS 743.655(3) Pre-existing conditions	If policy contains a pre-existing condition limitation, it is no more restrictive than ORS 743.655(3). "Pre-existing condition" means a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within six months preceding the effective date of coverage of an insured person	
	OAR 836-052-0516(7) Cognitive impairment	The policy contains a definition for cognitive impairment that is defined according to the definitions in OAR 836-052-0516(7).	
	OAR 836-052-0756 ADLs	Activities of daily living (ADLs) includes at least bathing, continence, dressing, eating, toileting, and transferring.	
Creditable coverage	OAR 836-052-0736	Policy provides creditable coverage for pre-existing conditions, waiting periods, and probationary periods in replacement polices and certificates.	
Exclusions and limitations	OAR 836-052-0546(4)(5)	Exclusions and limitations are consistent with and listed under a label "Limitation or Conditions on Eligibility for Benefits."	
	OAR 836-052-0526(2), ORS 743A.164	Permitted exclusions. Refer to the Administrative Rule for the complete list and description. The following information pertains specifically to item "b" on the list of permitted exclusions: Alcoholism and drug addiction: ORS 743A.164 prohibits individual policies from excluding coverage for treatment of accident or sickness resulting from the use of alcohol or drugs as any other condition.	
Conversion	ORS 743.655(7)(b)(C), OAR 836-052-0526(5)	Group contracts issued after September 1, 2005 provide continuation or conversion coverage.	
Grace period	ORS 743.655(2)(e)	The policy cannot be non-renewed or terminated for nonpayment of premium, until 31 days overdue, and then only after notice of nonpayment has been given to the policyholder prior to the expiration of the 31 days.	

Review Requirements	Reference	Description of review standards requirements	Enter page & paragraph or check answer
Inflation protection	OAR 836-052-0616	Policy must include inflation protection offers as stipulated in the rule provided, that is that this benefit is no less favorable than 3% compounded annual interest or 3% increase in benefit levels or percentage of actual charges.	
Unintentional lapse	OAR 836-052-0536 (1)(a)(b)	Policy contains an unintentional lapse provision requiring a non-payment notice be sent not earlier than 30 days (60 days for policies paid by payroll or pension) after the premium due date, to be effective not earlier than 30 days from the date of the notice.	
Reinstatement	OAR 836-052-0536(2)	Allows the insured to request reinstatement within five months, with collection of past due premium.	
Premiums	OAR 836-052-0546(1)(b)	A long-term care insurance policy or certificate, other than one in which the insurer does not have the right to change the premium, shall include a statement that premium rates may change.	
	OAR 836-052-0556(5) Notice of premium change	An insurer shall provide notice of upcoming premium rate increase to all policyholders at least 45 days prior to implementation.	
Rescission and fraud	ORS 743.662(1)(2)	A carrier may rescind a policy that has been in force for less than six (6) months by showing material misrepresentation in acceptance of the policy. For a policy that has been in force for over six (6) months but less than two (2) years the insurer may rescind by showing misrepresentation that is material to the acceptance of coverage and also pertains to the condition for which benefits were sought.	
Incontestability period	ORS 743.662 (3)	After the two years, a LTC policy can only be contested by the insurer by showing that the insured knowingly and intentionally misrepresented relevant facts relating to their health.	
Reasonable & customary or Usual & Customary	OAR 836-052-0546(3), ORS 742.005	Include definition of terms, used in the policy, such as “usual and customary”, “reasonable and customary.” Definitions should be included in the policy and explained in the outline of coverage.	
Applicability	ORS 743.655, OAR 836-052-0716 Disclosure statement	A “disclosure statement” is mandated by the rule provided. Are all the applicable matters in the same rule part of this disclosure statement and is this statement attached to the policy?	Yes ☐ N/A ☐
	OAR 836-052-0626, OAR 836-052-0726, OAR 836-052-0526(5)	Requirements to identify if duplicate or replacement coverage. Requirements to determine suitability. (Does not apply to life insurance that accelerates benefits for long term care.) Requires guaranteed issue to members covered under a group policy when that group is replaced.	Yes ☐ N/A ☐

Review Requirements	Reference	Description of review standards requirements	Enter page & paragraph or check answer
Outline of coverage	ORS 743.655(7)(a)(A)	An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose. It must include all the provisions listed in ORS 743.655(7)(b).	Yes ☐ N/A ☐
Summary	ORS 743.655(10)	For an individual life insurance policy that provides long term care benefits within the policy or by rider a policy summary must be delivered. The summary must also include the provisions required in this statute.	Yes ☐ N/A ☐

RATES			
Review Requirements	**Reference**	**Description of review standards requirements**	**Enter page & paragraph or check answer**
Annual rate Certification (Individual only)	OAR 836-052-0637	Filing includes an actuarial certification prepared, dated and signed by the member of the American Academy of Actuaries who provides the information.	Yes ☐ N/A ☐
		Annual certification being filed	Yes ☐ N/A ☐
		Annual individual rate submission being filed (required at least every 3 years)	Yes ☐ N/A ☐
Rate disclosures	OAR 836-052-0556(2)	Rate disclosures must be filed with the rates submitted after March 1, 2006. At the time of the delivery the insurer shall provide: (a) A statement that the policy may be subject to rate increases in the future, unless the policy is non-cancellable. (b) An explanation of potential future premium rate revisions and the policyholder or certificate holder's option in the event of a premium rate revision. (c) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase. (d) A general explanation for applying premium rate or rate schedule adjustments.	
	OAR 836-052-0656, OAR 836-052-0666, OAR 836-052-0526(9)	Rate filings, both new and revised, comply with regulation. Three-year cumulative rate increase may be limited to 40%.	Yes ☐ N/A ☐