

CHAPTER 26.1-45
LONG-TERM CARE INSURANCE

26.1-45-01. Definitions.

In this chapter, unless the context requires otherwise:

1. "Applicant" means:
 - a. In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits.
 - b. In the case of a group long-term care insurance policy, the proposed certificate holder.
2. "Certificate" means any certificate issued under a group long-term care insurance policy that has been delivered or issued for delivery in this state.
3. "Group long-term care insurance" means a long-term care insurance policy that is delivered or issued for delivery in this state to:
 - a. One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof, or for members or former members or a combination thereof, of the labor organizations.
 - b. Any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if the association:
 - (1) Is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation; and
 - (2) Has been maintained in good faith for purposes other than obtaining insurance.
 - c. An association, a trust, or the trustee of a fund established, created, or maintained for the benefit of members of one or more associations meeting the requirements of section 26.1-45-02.
 - d. A group other than a group described in subdivision a, b, or c if the commissioner finds that:
 - (1) The issuance of the group policy is not contrary to the best interest of the public;
 - (2) The issuance of the group policy would result in economies of acquisition or administration; and
 - (3) The benefits are reasonable in relation to the premiums charged.
4. "Long-term care insurance" means any insurance policy or rider primarily advertised, marketed, offered, or designed to provide coverage for not less than twelve consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital. The term includes group and individual annuities and life insurance policies or riders, whether issued by insurers, fraternal benefit societies, nonprofit health service corporations, prepaid health plans, health maintenance organizations, or any similar entity, which provide directly or which supplement long-term care insurance. The term also includes home health care type insurance policies or riders which provide directly or which supplement long-term care insurance; and includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term includes qualified long-term care insurance contracts. The term includes long-term care insurance products issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations; or a similar organization to the extent that the organization is otherwise authorized to issue life or health insurance. The term does not include any insurance policy that is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expenses coverage, hospital confinement indemnity coverage, major medical expense

coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision contained herein, any product advertised, marketed, or offered as a long-term care insurance is subject to the provisions of this chapter.

5. "Policy" means any policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in this state by an insurer, fraternal benefit society, nonprofit health, hospital, or medical service corporation, prepaid health plan, health maintenance organization, or any similar entity.
6. a. "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means an individual or group insurance contract that meets the requirements of section 7702B(b) of the Internal Revenue Code of 1986, as amended, as follows:
 - (1) The only insurance protection provided under the contract is coverage of qualified long-term care services. A contract satisfies the requirements of this paragraph even if payments are made on a per diem or other periodic basis without regard to the period in which the expenses are incurred;
 - (2) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under title XVIII of the Social Security Act, as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this paragraph do not apply to expenses that are reimbursable under title XVIII of the Social Security Act only as a secondary payer. A contract satisfies the requirements of this paragraph even if payments are made on a per diem or other periodic basis without regard to the period in which the expenses are incurred;
 - (3) The contract is guaranteed renewable, within the meaning of section 7702B(b)(1)(c) of the Internal Revenue Code of 1986, as amended;
 - (4) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in paragraph 5;
 - (5) All refunds of premiums and all policyholder dividends or similar amounts under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract; and
 - (6) The contract meets the consumer protection provisions set forth in section 7702B(g) of the Internal Revenue Code of 1986, as amended.
- b. "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" also means the portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of sections 7702B(b) and (e) of the Internal Revenue Code of 1986, as amended.

26.1-45-02. Group long-term care insurance - Association requirements - Approval.

Group long-term care insurance may be issued or delivered for the benefit of members of an association, as defined in subdivision c of subsection 3 of section 26.1-45-01, if prior to advertising, marketing, or offering a policy within this state, the association, or the insurer of the association, files evidence with the insurance commissioner that the association has at the outset a minimum of one hundred persons, has been organized and maintained in good faith for

purposes other than that of obtaining insurance, has been in active existence for at least one year, and has a constitution and bylaws that provide that:

1. The association hold regular meetings not less than annually to further the purposes of the members.
2. Except for credit unions, the association collect dues or solicit contributions from members.
3. The members have voting privileges and representation on the governing board and committees.

Thirty days after the filing, the association is deemed to satisfy the organizational requirements, unless the commissioner makes a finding that the association does not satisfy the organizational requirements.

26.1-45-03. Limits of group long-term care insurance.

No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in subdivision d of subsection 3 of section 26.1-45-01 unless the insurance commissioner or an insurance department in another state having statutory and regulatory long-term care insurance requirements substantially similar to those in this state has made a determination that the long-term care insurance requirements have been met.

26.1-45-04. Disclosure and standards for long-term care insurance.

The insurance commissioner may adopt rules that include standards for full and fair disclosure setting forth the manner, content, and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definitions of terms.

26.1-45-04.1. Adoption of long-term care benefits comparison guides by commissioner.

The insurance commissioner shall adopt rules to create a long-term care benefits comparison guide to be presented at the point of sale between the client and insurance producer. The guide must include information regarding nursing home coverage and alternatives to nursing home coverage.

26.1-45-05. Cancellation - Nonrenewal - Termination.

No long-term care insurance policy may:

1. Be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder.
2. Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder.
3. Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

26.1-45-05.1. Incontestability and rescission of long-term care insurance policy or certificate.

1. If a policy or certificate has been in force for less than six months, an insurer may not rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim except upon a showing of misrepresentation that is material to the acceptance for coverage.

2. If a policy or certificate has been in force for at least six months but less than two years, an insurer may not rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim except upon a showing of misrepresentation that is both material to the acceptance for coverage and that pertains to the condition for which benefits are sought.
3. If a policy or certificate has been in force for two years, the policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health. The policy or certificate may not be contested based upon misrepresentation alone.
4. A long-term care insurance policy or certificate may not be field-issued based on medical or health status. For purposes of this section, "field-issued" means a policy or certificate issued by an agent or a third-party administrator pursuant to the underwriting authority granted to the agent or third-party administrator by an insurer.
5. If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.
6. In the event of the death of the insured, this section does not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies are governed by section 26.1-33-05. In all other situations, this section applies to life insurance policies that accelerate benefits for long-term care.

26.1-45-05.2. Nursing home policy - Guaranteed renewable for life - Limitation on preexisting conditions.

Any long-term care insurance policy or certificate providing benefits for confinement to a nursing home must be guaranteed renewable for life. For purposes of this section, "guaranteed renewable for life" means the insured has the right to continue the policy in force for life subject to the policy's terms by the timely payment of premiums during which the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force. The insurer may, however, in accordance with the provisions of the policy, make changes in premium rates as to all insureds who are placed in the same class for purposes of rate determination in the process of issuance of the policy or making it guaranteed renewable.

A policy or certificate of insurance providing benefits for confinement to a nursing home which is sold to a consumer in addition to another nursing home policy or which is sold to a consumer to replace such a policy may not contain any provision limiting payment of benefits due to preexisting conditions of the insured except if there is any time period remaining relating to the exclusion of coverage for preexisting conditions as specified in the underlying policy that the remaining waiting period for coverage of preexisting conditions shall apply to the new policy unless the policy otherwise provides.

26.1-45-06. Preexisting conditions.

1. No long-term care insurance policy or certificate other than a policy or certificate issued to a group as defined in subdivision a of subsection 3 of section 26.1-45-01 may define "preexisting condition" as more restrictive than meaning 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.
2. No long-term care insurance policy or certificate issued on a group long-term care insurance policy other than a policy or certificate issued to a group as defined in subdivision a of subsection 3 of section 26.1-45-01 may exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within six months following the effective date of coverage of an insured person.
3. The commissioner may extend the limitation periods set forth in this section as to the specific age group categories or specific policy forms upon findings that the extension is in the best interest of the public.

4. The limitation on defining a preexisting condition does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subsection 2 expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in subsection 2.

26.1-45-07. Prior institutionalization requirement prohibited.

1. No long-term care insurance policy or certificate may be delivered or issued for delivery in this state if such policy:
 - a. Conditions eligibility for any benefits on a prior hospitalization requirement.
 - b. Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of such institutional care.
 - c. Conditions eligibility for any benefits other than waiver of premium, postconfinement, postacute care, or recuperative benefits on a prior institutionalization requirement.
2.
 - a. A long-term care insurance policy containing postconfinement, postacute care, or recuperative benefits must clearly label in a separate paragraph of the policy or certificate entitled "limitations or conditions on eligibility for benefits" such limitations or conditions, including any required number of days of confinement.
 - b. A long-term care insurance policy or rider which conditions eligibility of noninstitutional benefits on the prior receipt of institutional care may not require a prior institutional stay of more than thirty days.
3. No long-term care insurance policy or rider which provides benefits only following institutionalization may condition such benefits upon admission to a facility for the same or related conditions within a period of less than thirty days after discharge from the institution.

26.1-45-08. Loss ratio standards.

The commissioner may adopt or amend rules establishing loss ratio standards for long-term care insurance policies; provided, that a specific reference to long-term care insurance policies is contained in the rules.

26.1-45-09. Right to return policy - Outline of coverage required - Contents of certificate - Summary of policy provisions - Report of benefits status.

1. Long-term care insurance applicants have the right to return the policy or certificate within thirty days of the date of its delivery or within thirty days of its effective date, whichever occurs later, and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates must have a notice prominently printed on the first page or attached thereto stating in substance that the applicant has the right to return the policy or certificate within thirty days of the date of its delivery or within thirty days of its effective date, whichever occurs later, and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in subdivision a of subsection 3 of section 26.1-45-01, the applicant is not satisfied for any reason.
2.
 - a. An outline of coverage must 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.
 - (1) The commissioner shall prescribe a standard format, including style, arrangement, overall appearance, and the content of an outline of coverage.

- (2) In the case of insurance producer solicitations, an insurance producer must deliver the outline of coverage prior to the presentation of an application or enrollment form.
 - (3) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.
 - (4) In the case of a policy issued to a group defined in subdivision a of subsection 3 of section 26.1-45-01, an outline of coverage is not required to be delivered, provided that the information described in paragraphs 1 through 7 of subdivision b is contained in other materials relating to enrollment. Upon request, these other materials must be made available to the commissioner.
- b. The outline of coverage must include:
- (1) A description of the principal benefits and coverage provided in the policy.
 - (2) A statement of the principal exclusions, reductions, and limitations contained in the policy.
 - (3) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage must be specifically described.
 - (4) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains the governing contractual provisions.
 - (5) A description of the terms under which the policy or certificate may be returned and premium refunded.
 - (6) A brief description of the relationship of cost of care and benefits.
 - (7) A statement that discloses to the policyholder or certificate holder whether the policy is intended to be a federally tax-qualified long-term care insurance contract under 7702B(b) of the Internal Revenue Code of 1986, as amended.
3. A certificate issued pursuant to a group long-term care insurance policy which policy is delivered or issued for delivery in this state must include:
- a. A description of the principal benefits and coverage provided in the policy.
 - b. A statement of the principal exclusions, reductions, and limitations contained in the policy.
 - c. A statement that the group master policy determines governing contractual provisions.
4. If an application for a long-term care insurance contract or certificate is approved and issued, the issuer, directly or through an authorized representative, shall deliver the contract or certificate of insurance to the applicant no later than thirty days after the date of approval.
5. At the time of policy delivery, a policy summary must be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary must also include:
- a. An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;
 - b. An illustration on the amount of benefits, the length of benefit, and the guaranteed lifetime benefits, if any, for each covered person;
 - c. Any exclusions, reductions, and limitations on benefits of long-term care;
 - d. A statement as to whether a long-term care inflation protection option is available under this policy;
 - e. If applicable to the policy type, the summary shall also include:
 - (1) A disclosure of the effects of exercising other rights under the policy;

- (2) A disclosure of guarantees relating to long-term care costs of insurance charges; and
 - (3) Current and projected maximum lifetime benefits; and
 - f. The provisions of the policy summary listed above may be incorporated into a basic illustration or into a life insurance policy summary delivered to the consumer.
6. Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status a monthly report must be provided to the policyholder. Such report must include:
 - a. Any long-term care benefits paid out during the month;
 - b. An explanation of any changes in the policy, e.g., death benefits or cash values, due to long-term care benefits being paid out; and
 - c. The amount of long-term care benefits existing or remaining.
 7. If a claim under a long-term care insurance contract is denied, the issuer shall, within sixty days of the date of a written request by the policyholder or certificate holder, or a representative thereof:
 - a. Provide a written explanation of the reasons for the denial; and
 - b. Make available all information directly related to the denial.

26.1-45-10. Application.

Any policy or rider advertised, marketed, or offered as long-term care or nursing home insurance must comply with the provisions of this chapter and all other applicable insurance laws insofar as they do not conflict with this chapter.

26.1-45-11. Rulemaking authority.

The commissioner may adopt reasonable rules to promote premium adequacy, protect the policyholder in the event of substantial rate increases, and to establish minimum standards for correcting abusive marketing practices, replacement forms, insurance producer testing, penalties, and reporting practices for long-term care insurance.

26.1-45-12. Penalties.

In addition to any other penalties provided by the laws of this state, any insurer and any insurance producer found to have violated any requirement of this title relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three times the amount of any commissions paid for each policy involved in the violation or up to ten thousand dollars, whichever is greater.

26.1-45-13. Qualified service providers.

Any insurance company providing long-term care coverage for home and community-based services shall pay a provider meeting qualified service provider standards a daily payment allowance as defined in the policy or certificate. "Qualified service provider" means a county agency or independent contractor that agrees to meet standards for personal attendant care service as established by the department of human services.

26.1-45-14. Nonforfeiture benefits.

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

as group long-term care insurance as defined in subdivision d of subsection 3 of section 26.1-45-01, other than to a continuing care retirement community or other similar entity, the offering must be made to each proposed certificate holder.

3. The commissioner shall adopt rules specifying the type of nonforfeiture benefits to be offered as part of long-term care insurance policies and certificates, the standards for nonforfeiture benefits, and the rules regarding contingent benefit upon lapse, including a determining of the specific period of time during which a contingent benefit upon lapse will be available and the substantial premium rate increase that triggers a contingent benefit upon lapse as described in subsection 1.