

DEPARTMENT OF HEALTH

NOTICE OF PROPOSED RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth under § 302 (14) of the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1203.02(14)), and Mayor's Order 98-140, dated August 20, 1998, hereby gives notice of his intent to take final rulemaking action to adopt the following amendment to Chapter 67 of Title 17 of the District of Columbia Municipal Regulations (DCMR) in not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*. The purpose of this amendment is to clarify the amount of time given to submit proof of having completed the required continuing education credits for renewal of a license.

Chapter 67 (PHYSICAL THERAPY) of Title 17 DCMR (Business, Occupations & Professions) (May 1990) is amended as follows:

Section 6706.4 is amended to read as follows:

6706.4 An applicant for renewal of a license shall submit proof pursuant to § 6706.7 of having completed four (4) continuing education units or forty (40) hours of approved continuing education credit during the two-year period preceding the date the license expires. Such proof shall be submitted within ten (10) days after it is requested by the Board.

All persons desiring to comment on the subject of this proposed rulemaking should file comments in writing not later than thirty (30) days after the date of the publication of this notice in the *D.C. Register*. Comments should be sent to the Department of Health, Office of the General Counsel, 825 North Capitol Street, N.E., 4th Floor, Washington, D.C. 20002. Copies of the proposed rules may be obtained from the Department at the same address during the hours of 9:00 a.m. and 5:00 p.m., Monday through Friday, excluding holidays.

DISTRICT OF COLUMBIA HOUSING AUTHORITY

NOTICE OF PROPOSED RULEMAKING

The Board of Commissioners of the District of Columbia Housing Authority (DCHA) hereby gives notice, pursuant to D.C. Official Code Section 6-203 (2007 Ed.), of its intent to adopt the following proposed amendments and restatements of selected provisions of Chapters 60, 62, 64, and 65 of Title 14 of the District of Columbia Municipal Regulations in not less than thirty (30) days from the date of publication of this notice in the D.C. Register. The DCHA's rulemaking authority is found in the District of Columbia Housing Authority Act of 1999 at D.C. Official Code, § 6-202.

The proposed amendments contain the rules governing: definitions, repayment of security deposits, minimum rent, transfer policy, voluntary and involuntary termination of tenancy, Lessee responsibilities, charges to the Lessee for repairs, and DCHA's right to enter the dwelling unit. These proposed regulations were previously published in the D.C. Register on May 18, 2007 at 54 DCR 5006. Substantial changes were made to the proposed regulations, necessitating a second publication of the regulations as proposed.

Amendment: amend and restate Section 6099, Definitions, of Chapter 60, Low Rent Housing: General Provisions, to include the following definitions:

CHAPTER 60 LOW RENT HOUSING: GENERAL PROVISIONS**6099 DEFINITIONS**

Development - A DCHA property, including but not limited to buildings, the common areas of the buildings and grounds associated with all the buildings on either a mixed population, senior or general population public housing property owned by DCHA.

Handicapped Assistance Expenses - reasonable expenses that are anticipated, during the period for which annual income is computed, for attendant care and auxiliary apparatus for a handicapped or disabled family member and that are necessary to enable a family member (including the handicapped or disabled member) to be employed; Provided, that the expenses are neither paid to a member of the family nor reimbursed by an outside source.

Lessee -The "Lessee" is the individual(s) that sign(s) the Lease with the Authority. The Lessee is also deemed a Lessee. Each Lessee is individually, jointly and severally responsible for performance of all obligations under the lease including, but not limited to, the payment of rent and additional rent, as defined herein. No individual, other than the signatory to the lease, is deemed to be a Lessee or have any rights of a Lessee.

Leased Premises - Leased Premises includes the Lessee's dwelling unit as specified in the lease and any other buildings or areas that are provided for the exclusive use of the Lessee. The Leased Premises are located in a federally assisted public housing development owned or assisted by the Authority.

Amendment: add or amend, as appropriate, Chapter 62, Low Rent Housing: Rent and Lease, to read as follows:

CHAPTER 62 LOW RENT HOUSING: RENT AND LEASE

6204 REPAYMENT OF SECURITY DEPOSITS AND MOVE-OUT INSPECTIONS

6204.10 The Lessee shall return all keys and other entry devices whenever the unit is vacated, failure to return keys or other entry devices will result in a charge in accordance with a schedule of charges as posted in the property management office.

6205 DWELLING LEASE

6205.1 Each family admitted for occupancy in low rent housing, operated by DCHA, shall enter into a Dwelling Lease with DCHA, the Dwelling Lease shall have a twelve (12) month term which states the Lessee rent to be charged, and the conditions governing occupancy.

(a) The conditions governing occupancy shall be in accordance with HUD requirements, and;

(b) The Lease shall be automatically renewed for successive terms of one month with each term commencing to run on the 1st day of each month, unless terminated by either DCHA or the Lessee.

6205.2 The Lessee shall have the right to the exclusive use of the Leased Premises, including the dwelling unit identified in the lease and in the case of a townhouse, row house or single family home, all buildings or additional areas provided for the exclusive use of the Lessee, including the yard and any outbuildings, subject to the restrictions and obligations contained in the Dwelling Lease.

6205.3 Each Dwelling Lease shall be executed prior to occupancy. DCHA shall conduct a move-in inspection in accordance with Section 6505 of this Title prior to execution of the lease.

6205.4 Each Dwelling Lease shall be administered in accordance with the provisions stipulated, and kept current at all times.

6205.5 The DCHA shall add names to the Dwelling Lease, after initial occupancy only in

accordance with Section 6117 of this Title. Any person using or occupying the Leased Premises not in compliance with Section 6117 of this Title is an unauthorized occupant without tenancy or other rights under the Dwelling Lease, including any person using or occupying the Leased Premises without approval from DCHA.

6205.6

Changes to the Dwelling Lease shall be made only in writing and shall be signed by the Lessee, and an authorized representative of DCHA, except the following changes, which may be executed unilaterally by DCHA:

- (a) Any change in rent, either an increase or decrease, shall be stated in a special supplement which shall, upon issuance, become part of the lease;
- (b) Changes to implement excess utility charges;
- (c) Any revision to reflect change in family composition other than head of household, consistent with Subsection 6205.5;
- (d) Changes to implement Subsection 6205.9;
- (e) Late charges assessed pursuant to Subsection 6206.5;
- (f) Special supplements to a lease executed pursuant to Subsection 6205.10;
- (g) Changes in the amount of security deposit provided in Section 6203;
- (h) Changes in DCHA's policies, rules and regulations; and
- (i) Charges assessed pursuant to the Schedule of Charges posted in the Property Manager's Office.

6205.7

The DCHA shall provide the Lessee with a copy of any changes to the Dwelling Lease made in accordance with Subsection 6205.6.

6205.8

Unless a shorter time period is provided, a new Dwelling Lease shall be executed, within thirty (30) days whenever the following conditions occur:

- (a) The status of the head of household is altered pursuant to Chapter 64 of this Title; or
- (b) When a family is transferred from one dwelling unit to another.

6205.9

Any Lessee wishing to vacate his or her unit shall do so in accordance with Section 6404 of this Title. Lessees wishing to vacate prior to the end of the month shall be liable for the entire month's rent.

6205.10

The DCHA may unilaterally execute a special supplement to the new lease which

assesses the amount due under the prior lease.

6205.11 Lessees who execute a new Dwelling Lease as a result of a transfer from one unit to another, or as a result of any other requirement for a new Dwelling Lease, shall remain liable for any delinquent rent or other charges relating to the prior lease.

6210 MINIMUM RENT

6210.1 Based on information provided pursuant to Sections 6118, 6119, and 6200 the rent charged shall be the lesser of:

- (a) A fixed amount determined by DCHA for the Development ("market-based rent"); or
- (b) An amount based on a percentage of household income; or
- (c) An amount or percentage fixed from time to time; or
- (d) \$0, for families which DCHA has determined do not have any adjusted income, as defined in Subsection 6099.1, as determined by DCHA at certification or recertification.

Amendment: add or amend, as appropriate, Chapter 64, Public Housing Transfer Policy, to read as follows:

CHAPTER 64 PUBLIC HOUSING TRANSFER POLICY

6400 TRANSFER POLICY

6400.6 Upon acceptance of the new dwelling unit, the Lessee must execute a new Dwelling Lease. All causes of action of any nature whatsoever available to DCHA at the previous Leased Premises governed by the Dwelling Lease, shall be automatically transferred to, and actionable by, DCHA at the new unit after transfer, whether such transfer is mandatory or voluntary.

6403 VOLUNTARY TERMINATION OF TENANCY

6403.1 Termination of Tenancy by Lessee requires that the Lessee, all household members, guests as well as all others defined as any person under the Lessee's control or on the Leased Premises with Lessee's consent; including but not limited to, any individuals occupying or using the Leased Premises for any purpose with actual or implied consent of the Lessee (hereinafter referred to collectively as "others"), vacate the Leased Premises on or before the date specified in Lessee's written notice.

- 6403.2 Lessee may terminate tenancy by giving:
- (a) At least thirty (30) days notice; and
 - (b) The notice must be in writing; and
 - (c) On forms required by the DCHA; and
 - (d) Submitted to the property manager.
- 6403.3 The DCHA shall follow the requirements of Chapters 62 and 65 of this Title relating to termination of tenancy.
- 6403.4 Lessee shall leave the Leased Premises in as clean and good condition as Lessee received at the start of Lessee's occupancy; wear and tear excepted; and return all keys and all other entry devices to the DCHA.
- 6403.5 Given the limited availability of publicly assisted housing, absence of the Lessee for longer than ninety (90) consecutive days, without written notice to the Authority, shall be deemed an abandonment of the Leased Premises and a termination of the Lease by the Lessee, regardless of the reason for the absence, including death, incarceration, or disability.
- (a) If there are no remaining household members, any personal property remaining in the Leased Premises by the Lessee shall be treated as abandoned;
 - (b) DCHA shall have the right to reenter and secure the Leased Premises; and
 - (c) DCHA shall contact the person(s) who the Lessee has designated, if any, in writing, to take possession of Lessee's personal property. Access to the Leased Premises will be granted only to any such designated person, or to the Lessee's personal representative, administrator or guardian appointed by the Court.
- 6403.6 In the event that a Lessee gives written notice to DCHA that the Lessee will be absent for longer than ninety (90) but less than one hundred eighty (180) consecutive days, due to 24 (twenty four) hour medical treatment or nursing care:
- (a) The Lessee must vacate the unit in accordance with Subsection 6403.8; and
 - (b) Within thirty (30) days of discharge from medical treatment, the former Lessee must notify DCHA of their intent to return to public housing; and

- (c) The former Lessee must apply for public housing and complete all appropriate documentation pursuant to Section 6101; and
- (d) If the former Lessee has been determined as eligible for public housing in accordance with Chapter 61 of this Title, the DCHA shall allow the Lessee to return to the first available appropriate unit. The assignment of an appropriate dwelling unit will be based upon suitable type or size or unit, consistent with the objectives of Title VI of the Civil Rights Act of 1964 and applicable HUD regulations and requirements and Chapter 61 of this Title.

6403.7 If the Lessee gives notice that the absence is expected to be greater than 180 consecutive days it will be deemed to be notice of intent to terminate the Lease. Remaining household members may apply for a new lease in accordance Subsection 6403.6 of this Chapter.

6403.8 If the Lessee is no longer in occupancy of the unit or is deceased, a remaining adult household member already listed on the Dwelling Lease must submit a written application to become head of household to the property manager within thirty (30) days of the date the Lessee vacates the Leased Premises or dies, in order to sustain continued occupancy for the remaining household members at the Leased Premises. Details on the application process and exclusions from this rule are as follows:

- (a) This subsection does not apply if the head of household vacates the unit after the issuance of a notice to correct or vacate, notice of lease termination in the case of failure to pay rent or a notice to vacate. In such circumstances, the remaining family members must vacate the unit. If the remaining family members do not vacate the unit, they shall be deemed unauthorized occupants.
- (b) The remaining adult household member submitting an application to be made head of household must have been a household member listed on the Dwelling Lease for at least one year prior to the date the Lessee vacates the Leased Premises or dies, in order to sustain continued occupancy for the remaining household members at the Leased Premises.
- (c) The applicant to be made Lessee, and if applicable, the other remaining Household Members must be eligible for continued occupancy and not be in violation of the Dwelling Lease. The Authority will screen the application in accordance with federal law and regulations as well as DCHA's admissions and occupancy policies and regulations. Applicant(s) will be notified in writing of the disposition of the application:

- (1) If the application is approved, the new Lessee shall enter into a new lease agreement with the Authority within seven (7) working days of the date of approval of the application; and
 - (2) Any balance on the rental account existing prior to a remaining household member becoming the Lessee is the responsibility of the newly designated Lessee as head of household. Any obligations for rent, causes of action arising under the original Lease, stipulations of settlement, consent judgments, judgments, or repayment agreements of the prior Lessee shall be deemed part of the new Dwelling Lease and tenancy and shall be the responsibility of the new Lessee designated as head of household and actionable against such new Lessee; or
 - (3) If the applicant and other remaining Household Members are not approved to continue to occupy the Leased Premises, and the application is denied at the sole discretion of DCHA, and such remaining members do not vacate, they will be deemed unauthorized occupants and thus occupying premises without the consent of DCHA and shall be subject to eviction by the DCHA.
- (d) In circumstances where the remaining family members are minors:
- (1) If the remaining household consists of adult family and minor family members, only the eligible remaining adult household members may submit an application to be made head of household in accordance to this subchapter. The minors will not be made head of household; or
 - (2) If there are no adults remaining in the household, an application for head of household may be submitted from an adult that provides sufficient documentation to DCHA that a care giving relationship exists between the applicant and the minors listed on the family composition. Documentation supporting that a care giving relationship exists between the minors listed on the family composition must be provided to DCHA with the application to be made head of household.

6403.9

The Lessee shall be liable for rent until the earlier of the time the DCHA has taken possession of the Unit, or such time as all of the following are completed:

- (a) The proper written notice has been given;
- (b) The required vacate forms are completed;
- (c) The keys are turned in; and any other entry devices; and

- (d) Lessee and all household members, guests as well as all others defined as any person under the Lessee's control or on the Leased Premises with Lessee's consent; including but not limited to, any individuals occupying or using the Leased Premises for any purpose with actual or implied consent of the Lessee (hereinafter referred to collectively as "others"), have vacated the Leased Premises.

6404 TERMINATION OF TENANCY BY DCHA

- 6404.1 DCHA shall not terminate the lease other than for serious or repeated violation of material terms of the lease. Violations of an obligation of tenancy refer only to those obligations which are contained in a valid, written lease or in the federal or local regulations pertaining to public housing tenants or in the D.C. Housing Code. There is no time limitation on bringing an action based on a breach of the lease.
- 6404.2 If DCHA determines that a Lessee is in violation of the Dwelling Lease, except for lease violations predicated on the performance of an illegal act or non-payment of rent, the Lessee shall be issued a thirty (30) day notice to correct or vacate, stating in writing the violation(s) which provides the basis for the termination.
- (a) The notice shall inform the Lessee the applicability of his or her right to file an administrative complaint in accordance with chapter 63 of this title.
- (b) If a Lessee has filed a complaint requesting an administrative determination of his or her rights, in accordance with chapter 63 of this title, in response to service of a notice to correct or vacate or a notice of lease termination in the case of failure to pay rent and has not prevailed, the Lessee shall be issued a notice to vacate, as the time to cure has past and the Lessee shall be subject to legal action to gain possession of the unit (eviction).
- 6404.3 The DCHA shall issue a thirty day (30) written notice to cure or vacate in the case of failure to pay rent.
- 6404.4 DCHA shall issue a thirty (30) day notice to vacate to Lessees, for lease violations, predicated on the performance of an illegal act.
- 6404.5 Pursuant to 14 DCMR § 6403, DCHA will not issue a thirty (30) day notice to correct or vacate, or notice to vacate, where DCHA has determined that the head of household responsible for the dwelling unit under the Dwelling lease has abandoned the unit or is deceased.

- 6404.6 Lessees who refuse to vacate their unit after appropriate notice shall be subject to legal action to gain possession of the dwelling unit (eviction).
- 6404.7 The Lessee shall be solely responsible for the protection, care and disposition of the Lessee's possessions during, and after an eviction.
- 6404.8 Where DCHA has excluded from its procedure any grievance concerning an eviction or termination of tenancy based on a Lessee's creation or maintenance of a threat to the health or safety of other Lessees or DCHA employees, the Lessee against whom an eviction action has been filed in court shall be afforded the opportunity to examine all relevant documents, records, and regulations of DCHA prior to trial for the purpose of preparing a defense.
- 6404.9 Any document not made available after request by the Lessee shall not be relied on by DCHA at the trial.

Amendment: amend or add, as appropriate, Chapter 65, Low Rent Housing: Maintenance and Inspection, to read as follows:

CHAPTER 65 LOW RENT HOUSING: MAINTENANCE AND INSPECTION

6500 LESSEE RESPONSIBILITIES

- 6500.1 Lessees shall be responsible for their actions and the actions of household members, guests and others; "others" is defined as any person under the Lessee's control or on the Leased Premises with Lessee's consent; including but not limited to, any individuals occupying or using the Leased Premises for any purpose with actual or implied consent of the Lessee, including but not limited to, for the maintaining of their units in accordance with the provisions of the dwelling lease, including but not limited to, the following responsibilities:
- (a) To comply with all obligations imposed upon Lessees by applicable provisions of building, and other District of Columbia housing codes materially affecting health and safety;
 - (b) To keep the premises (and such other areas as may be assigned for his or her exclusive use) in a clean and safe condition;
 - (c) To dispose of all ashes, garbage, rubbish, and other waste from the premises in a sanitary and safe manner;
 - (d) To use only in a reasonable manner all electrical, plumbing, sanitary, heating, ventilating, air conditioning and other facilities and appurtenances, including elevators;

- (e) To refrain from, and to cause his or her household, guests and others, to refrain from, destroying, defacing, and/or damaging/removing any part of the premises or project; including but not limited to storing, hanging or leaving household or other personal property of any type, including clothes, outside the Leased Premises;
- (f) Not to assign the lease or to sublease the premises;
- (g) Lessee shall have no other residence;
- (h) Not to provide accommodations for boarders or lodgers;
 - (1) Guests shall not stay overnight for more than ten (10) consecutive days without the prior written permission of DCHA; and
 - (2) Guests shall not stay overnight for more than thirty (30) non-consecutive days within a twelve (12) month period without the prior written permission of DCHA;
- (i) To use the premises solely as a private dwelling for the Lessee and the Lessee's household as identified in the lease, and not to use or permit its use for any other purpose;
- (j) To abide by necessary and reasonable rules, regulations and policies, issued by DCHA for the benefit and well-being of the housing project and the Lessees and which shall be posted in the Development office and incorporated by reference in the lease;
- (k) To pay reasonable charges (other than normal wear and tear) for the repair of damages to the premises, project building, facilities or common areas caused by the Lessee, household members, guests and any others under the Lessee's control or on the Leased Premises with Lessee's consent; including but not limited to, any individuals occupying or using the Leased Premises for any purpose with actual or implied consent of the Lessee (hereinafter referred to collectively as "others");
- (l) To conduct himself or herself, and cause other persons who are on the premises with his or her consent to conduct themselves, in a manner which will not disturb his or her neighbors' peaceful enjoyment of their accommodations and will be conducive to maintaining the project in a decent, safe and sanitary condition; including but not limited to:
 - (1) Take precautions to prevent fires and not use any appliance that is a fire hazard. Not disable any fire alarm device or cause a false fire alarm, or generally permit or do anything, including storing

excess amounts of personal property; and

- (2) Not remove or tamper with any smoke detector, including removing any working batteries, so as to render the smoke detector inoperative.
- (m) To keep no dogs, cats or other animals in or on the premises, unless specifically permitted by DCHA in writing;
- (n) Not to place fixtures, signs or fences in or about the premises without the prior written permission of DCHA. No repairs or alterations to the Leased Premises may be made, including, but not limited to, painting, wallpapering, doors, gates, window bars, carpets, storage sheds, and antenna or satellite dishes, without the prior written approval of DCHA. Upon completion, any such repairs or alterations, made with or without prior written consent, become part of the Leased Premises. If the Lessee changes locks, installs an alarm or security system, or adds locks to the dwelling unit, he or she shall notify DCHA and shall make duplicate keys available to and or provide DCHA with access codes in order for DCHA to gain emergency access; and
- (o) Not to permit anyone who is currently barred from the Leased Premises or Development from occupying, staying overnight, visiting the Leased Premises, or inviting them to the Leased Premises or anywhere else on the Development at any time for any purpose, unless authorized in writing by DCHA in advance.

6500.2 At those properties where there is a defined front or rear yard assigned to the Lessee for his or her exclusive use, the Lessee shall be responsible for maintaining the individually defined lawn areas around his or her respective dwelling unit, cutting the grass, and keeping his or her lawn free of trash and garbage.

6500.3 Lessees who do not maintain these areas shall be given forty-eight (48) hours notice by DCHA to correct unsightly lawn areas. Lessees who fail to comply within forty-eight (48) hours of being notified by DCHA shall be in violation of the Dwelling Lease.

6500.4 Lessees shall report immediately to DCHA of any need for repairs to the Leased Premises or of any unsafe conditions in the common areas or the grounds surrounding the Leased Premises. Notification of repairs shall be in writing or by a telephone call to DCHA's Control Center and the Lessee shall obtain a control number for each repair. The number for the Control Center can be obtained from the Management office or the Central Office. Failure to obtain a control number shall result in the rebuttal presumption that no repair request was made to DCHA.

- 6500.5 Lessees shall conserve energy and water and preclude excess use of water, gas and/or electricity including but not limited to non-routine washing of Lessee's or household member's vehicles or any other excess use of utilities.
- 6500.6 Lessees shall not have waterbeds on the Leased Premises without prior written approval of DCHA, which approval may be withheld in DCHA's sole discretion.
- 6500.7 Lessee's shall not to permit anyone who is currently barred from the Leased Premises or Development from occupying, staying overnight, or visiting the Leased Premises or invite them to the Leased Premises or anywhere else on the Development at any time for any purpose, unless authorized in writing by DCHA in advance. Any person not identified in Subsection 9600.2 as an authorized person may be subject to the issuance of a Bar Notice for the period of time specified in the Bar Notice.
- 6500.8 Lessee is strictly liable for all actions or inactions of all guests, household members, and all others on the property with the consent of Lessee and/or the consent of household members; "others" defined as any person under the Lessee's control or on the Leased Premises with Lessee's consent; including but not limited to, any individuals occupying or using the Leased Premises for any purpose with actual or implied consent of the Lessee (hereinafter referred to collectively as "others"); the aforementioned parties, including the Lessee, are obligated to the following:
- (a) To not engage in the manufacture, sale, or distribution of any alcoholic beverages or engage in the open use of alcoholic beverages in any common areas in the Development or otherwise engage in use of alcoholic beverages in a manner that impairs the physical environment of the Development or may be a threat to the health, safety or right to peaceful enjoyment of the Development by other residents, service providers, or DCHA staff;
 - (b) To not engage in any criminal activity that threatens the health, safety or right to peaceful enjoyment of the Development;
 - (c) To not engage in:
 - (1) Any drug-related criminal activity on or off the Leased Premises or the Development; or
 - (2) Violent criminal activity or be in possession of any firearm or ammunition for a firearm;

- (d) To not assist Lessee, guests, household members, any others on the property with the consent of Lessee and or the consent of household members; and any others as identified in the Dwelling Lease from:
 - (1) Fleeing to avoid prosecution or custody or confinement after conviction for a crime, or attempt to commit a crime, that is a felony under the laws of the place from which such person is fleeing; or
 - (2) Violating a condition of probation or parole imposed under federal or state law; or
- (e) To assure that others under the Lessee's control, as identified in the Dwelling Lease, not engage in any:
 - (1) Criminal activity that threatens the health, safety or right to peaceful enjoyment of the Development by other lessees; or
 - (2) Any Drug-related Criminal Activity on the Leased Premises or the Development.

6503**CHARGE TO THE TENANT FOR REPAIRS AND SERVICES**

6503.6

In the event of a fire caused intentionally or by the neglect or negligence of the Lessee, household members, guests or others under the control of the Lessee or the control of household members, then Lessee is subject to the following:

- (a) Lessee is responsible for the payment of the lesser of the:
 - (1) Estimated costs for the repair of the fire damaged Leased Premises, or
 - (2) The insurance deductible, if any, afforded by any insurance policy held by DCHA and applicable to the damages caused by the fire at the Leased Premises.
- (b) DCHA may terminate the Lease for any fire on the Leased Premises caused intentionally or negligently by the Lessee or others.

6504**RIGHT TO ENTER DWELLING**

6504.1

The DCHA shall, upon written notice to the Lessee of at least two (2) days, be permitted to enter the dwelling unit during reasonable hours for the purpose of performing routine inspections or maintenance, make improvements or repairs, take photographs, record and document the condition of the unit or repairs, or to show the Leased Premises for releasing.

- 6504.2 The DCHA shall enter the Leased Premises at any time without advance notice when it has cause to believe that an emergency exists, or if DCHA determines the Leased Premises have been abandoned or when the Lessee has agreed to such entry.
- 6504.3 In the event that the Lessee and all adult household members are absent from the premises at the time of entry, DCHA shall leave on the premises a written statement specifying the date, time and purpose of entry prior to leaving the premises.
- 6504.4 If the Lessee changes or adds the following to the dwelling unit, he or she shall notify DCHA and shall make duplicate keys, entry codes, or any applicable access to the dwelling available to DCHA, within twenty four (24) hours of the change:
- (a) Any locks, and/or;
 - (b) Any entry devices, including but not limited to any and all security devices.
- 6504.5 The Authority may enter the Leased Premises and change the locks to secure the Leased Premises without advance notice if DCHA believes the Leased Premises to be abandoned. After DCHA has changed the locks and entered into the Leased Premises that it believed to be abandoned, DCHA shall post a notice on or under the Leased Premises door which will instruct the Lessee to report to the property management office.

All persons desiring to comment on the subject matter of this proposed rulemaking should file comments in writing not later than thirty (30) days after the date of publications of this notice in the D.C. Register. Comments should be filed with the Office of the General Counsel, DCHA, 1133 North Capitol Street, Suite 210, Washington, DC 20002-7599. Copies of these proposed rules may be obtained from the DCHA at the same address. Alternatively, copies of the rules can be requested from and comments may be sent to patricia.gracyalny@dchousing.org.

DISTRICT OF COLUMBIA HOUSING AUTHORITY**NOTICE OF PROPOSED RULEMAKING**

The Board of Commissioners of District of Columbia Housing Authority ("DCHA") hereby gives notice of its intent to take final rulemaking action to adopt a new chapter of Title 14 DCMR, "Chapter 94: Affordable Housing Rental Rehabilitation Financial Assistance." in not less than thirty (30) days from the date of publication of this notice in the D.C. Register. This Chapter governs the administration of financial assistance, which financial assistance, subject to availability of funding, may be made available by DCHA periodically in the form of loans or grants to assist in paying for costs of eligible rehabilitation, renovation or repair of affordable housing dwelling units occupied or to be occupied by persons with Housing Choice Vouchers. The DCHA's rulemaking authority is found in the District of Columbia Housing Authority Act of 1999 at D.C. Code, § 6-202.

Amendment: Chapter 94, affordable housing rental rehabilitation financial assistance, a new Chapter in Title 14 of the DCMR is to read as follows:

**CHAPTER 94 AFFORDABLE HOUSING RENTAL REHABILITATION
FINANCIAL ASSISTANCE**

- 9400 INTRODUCTION
- 9401 PROGRAM REQUIREMENTS
- 9402 ELIGIBILITY
- 9403 APPLICATIONS FOR FINANCIAL ASSISTANCE; ANNOUNCEMENT OF AVAILABILITY OF FINANCIAL ASSISTANCE
- 9404 APPROVAL AND FUNDING OF APPLICATIONS; CONTINUING RESPONSIBILITIES OF OWNERS
- 9405 CONDITIONS TO CLOSINGS
- 9499 DEFINITIONS

9400 INTRODUCTION

- 9400.1 DCHA recognizes that sufficient funding and financing sources may not be available to owners of eligible affordable housing dwelling units to finance or pay for costs of rehabilitation, renovation or repair necessary to modify such dwelling units to satisfy the Uniform Federal Accessibility Standards, or to make energy conservation improvements, or to satisfy the Housing Quality Standards. DCHA may periodically make financial assistance in the form of no or low interest loans and grants available to owners of existing dwelling units that are eligible to participate in DCHA's Partnership Program for Affordable Housing and enter into a Project-Based Housing Choice Voucher Housing Assistance Payments Contract with DCHA under the Partnership Program.
- 9400.2 This Chapter will set forth rules governing the administration of a DCHA program to provide financial assistance to owners of affordable housing dwelling units.

9400.3 The purpose of the program will be to provide financial assistance in the form of no or low interest loans or grants to owners of affordable housing dwelling units in need of rehabilitation, renovation or repair to comply with the Uniform Federal Accessibility Standards, or to make energy conservation improvements, or to satisfy the Housing Quality Standards. DCHA may, from to time and subject to availability of funding, announce the availability of financial assistance under this program.

9400.4 The program is established under the authority of D.C. Official Code § 6-203(10) (2001 Ed.).

9400.5 The Executive Director, for good cause shown in writing, may waive any provision of this Chapter consistent with applicable law. All waivers shall be justified by a determination that undue hardship will result from applying the requirements and where application of the requirement would adversely affect the purpose and objectives of the program.

9401 PROGRAM REQUIREMENTS

9401.1 Subject to availability of funding, DCHA may periodically make financial assistance available in accordance with this Chapter and an announcement in the form of no or low interest loans or grants to owners of eligible affordable housing dwelling units to pay for costs of rehabilitation work.

9401.2 Financial assistance may be used to pay directly or reimburse owner for:

- (a) Reasonable project costs approved by DCHA with respect to the property.
- (b) Professional services costs approved by DCHA for reasonable customary costs of architectural, engineering, construction management and related professional services required in preparation of project plans, drawings or specifications for rehabilitation work.
- (c) Reasonable costs approved by DCHA for providing temporary housing for tenants of the property holding Housing Choice Vouchers while rehabilitation work is being conducted in or affecting a tenant's dwelling unit.
- (d) Cost of building permits and related fees.
- (e) Contingency reserve fund approved by DCHA to be used for unanticipated project costs and unanticipated increases in other eligible costs.

9402 ELIGIBILITY

9402.1 In order to receive financial assistance under this Chapter, (a) the owner and dwelling units must satisfy the conditions for participation in the Partnership Program including, without limitation, location of property within the District of Columbia, site and neighborhood requirements, property eligibility and eligible tenants and tenant selection, provided that subject to availability of financial assistance and the conditions of the applicable announcement, a property which fails to satisfy HQS may receive financial assistance to fund all or a portion of the costs of repairs needed to satisfy HQS, (b) the dwelling units must be suitable, as determined by DCHA, for the proposed rehabilitation work, (c) the rehabilitation work may not have been commenced prior to approval of the application by DCHA unless DCHA approves earlier commencement of rehabilitation work, (d) the owner, the property and the project must satisfy the requirements for financial assistance contained in the applicable announcement and this Chapter, and (e) the owner must enter into and comply with an AHAP Contract for the property.

9403 APPLICATIONS FOR FINANCIAL ASSISTANCE; ANNOUNCEMENT OF AVAILABILITY OF FINANCIAL ASSISTANCE

9403.1 A person may be eligible to make application for financial assistance if the person:

- (a) consists of one or more individuals, corporations, partnerships, limited liability companies or other privately-controlled legal entities; and
- (b) can establish to the satisfaction of DCHA its reasonable capacity to meet the requirements applicable to receipt of financial assistance under this Chapter, applicable law and the applicable announcement; and
- (c) can establish to the satisfaction of DCHA that such person holds valid legal title to the property; and
- (d) is not on the U.S. General Services Administration List of Parties Excluded from Federal Procurement and Nonprocurement Programs; and
- (e) can demonstrate to the satisfaction of DCHA an effective plan to minimize the interruption of occupancy of the property by, and the duration of relocation of, tenants holding Housing Choice Vouchers.

9403.2 DCHA may periodically announce the availability of financial assistance and a summary of the requirements for application and approval for financial assistance.

9403.3 In an announcement, DCHA will provide general information, in a form prescribed by DCHA, which may include, but is not limited to, the following:

- (a) the deadline for submission of applications;
- (b) the method and location for requesting an application;
- (c) application fees, if any, payable by applicants;
- (d) a detailed description of the financial assistance available and the type of project and project costs eligible for financial assistance; and
- (e) criteria that will be used to evaluate applications and grant financial assistance.

9403.4 DCHA's announcement and summary of application requirements will be published in at least one (1) newspaper of general circulation in the District of Columbia, in at least one (1) newspaper serving minority communities in the District of Columbia, and in at least one (1) bi-lingual newspaper circulated in the District of Columbia.

9404 APPROVAL AND FUNDING OF APPLICATIONS; CONTINUING RESPONSIBILITIES OF OWNERS

9404.1 Upon receipt of an application for financial assistance, DCHA or its designee will perform an initial review to determine completeness and its compliance with the applicable announcement and the eligibility requirements as specified in this Chapter.

9404.2 DCHA or its designee shall reject applications which are initially determined to be incomplete or ineligible and may, in its sole discretion, grant additional time as it deems appropriate to enable applicants to correct deficiencies identified during the initial evaluation of the application.

9404.3 Applications determined to be complete and meeting intake requirements shall be reviewed by DCHA or its designee in accordance with the criteria established pursuant to this Chapter, applicable law and the applicable announcement. Applications determined to be complete and meeting intake requirements will be rated and ranked on the basis of the criteria set forth in the applicable announcement and to the extent of available funds, those applications with the highest ranking may be approved by DCHA to receive financial assistance.

9404.4 DCHA or its designee will notify all applicants in writing of its final decision regarding application approval or disapproval.

9404.5 The initial approval, if any, of an application by DCHA or its designee shall be in the form of a written conditional commitment letter to the applicant which shall establish conditions precedent to receipt of financial assistance for the property.

9404.6 Applications for financial assistance will be approved by DCHA or its designee upon a determination by DCHA or its designee that the project is economically feasible according to the criteria established by DCHA with respect to each announcement. The criteria may include one or more of HUD guidelines, Partnership Program guidelines and private market requirements and constraints and will be furnished to applicants. Criteria used to evaluate applications and grant financial assistance may include, but are not limited to, the following:

- (a) Loan to value ratio;
- (b) Debt coverage ratio;
- (c) Replacement and operating cost reserves;
- (d) Property condition, appraisal and market analysis; and
- (e) Owner capability and credit requirements.

9404.7 Financial assistance will be limited to amounts needed as determined by DCHA to finance or reimburse the eligible project costs.

9404.8 After a determination is made to grant financial assistance, current tenants of dwelling units receiving financial assistance must be eligible to receive a Housing Choice Voucher.

9404.9 Except as otherwise set forth in the applicable announcement, current tenants of the property holding Housing Choice Vouchers must not be permanently displaced as a result of the project.

9405 CONDITIONS TO CLOSINGS

9405.1 Prior to closing on financial assistance, the owner shall meet to the satisfaction of DCHA or its designee all conditions of the conditional commitment of DCHA and other requirements of this Chapter and the applicable announcement.

9405.2 Each owner shall agree in writing to permit all inspections of the property and property records as DCHA or its designee deems necessary to ensure the quality of rehabilitation work and compliance with applicable laws during the construction period.

9405.3 Owner shall demonstrate to the satisfaction of DCHA or its designee that the project was completed in accordance with applicable law and the plans and specifications for the rehabilitation work approved by DCHA or its designee and the dwelling units are re-occupied or occupied by tenants holding Housing Choice Vouchers.

9405.4 Owner shall execute and agree to be bound by an AHAP Contract, which, among other things, sets forth the terms and conditions of the HAP Contract.

9499 DEFINITIONS When used in this Chapter, the following words or phrases shall have the meanings ascribed:

AHAP Contract – Agreement to Enter into Project-Based Housing Choice Voucher Program Housing Assistance Payments Contract entered into by DCHA and owner with respect to the property in accordance with the Partnership Program.

Announcement – one or more announcements that may periodically be made by DCHA of the availability of financial assistance under this Chapter.

Applicable laws – federal and District of Columbia laws and regulations of the District of Columbia, DCHA or HUD in effect and applicable to DCHA, the owner or the property, as such laws and regulations, as the same may periodically be amended, modified, supplemented or replaced.

Dwelling unit – residential space in existing rental housing that qualifies under the laws of the District of Columbia as a place of habitation or abode for a family, including an apartment or house that contains a living room, kitchen area, sleeping area consisting of 2 or more bedrooms, and bathroom(s). Dwelling units shall not include any units occupied or to be occupied by the owner or any family member of the owner.

Energy conservation improvement – equipment or improvements which, as determined by DCHA, enhance the energy efficiency of the property, reduce energy consumption at the property or are otherwise consistent with the energy conservation policy of HUD or DCHA.

Financial assistance – loans or grants offered periodically by DCHA pursuant to this Chapter.

HAP Contract – Project-Based Housing Choice Voucher Program Housing Assistance Payments Contract entered into by DCHA and owner with respect to the property in accordance with the Partnership Program.

Housing Choice Voucher – a voucher for tenant-based assistance made available by or on behalf of HUD pursuant the Section 8 of the United States Housing Act of 1937, as amended.

Housing Quality Standards or HQS – the housing quality standards promulgated by HUD and set forth in Section 982.401 of Title 24 of the Code of Federal Regulations, as such standards may periodically be amended, modified, supplemented or replaced by HUD.

HUD – the United States Department of Housing and Urban Development.

Owner – one or more individuals, corporations, partnerships, limited liability companies or other privately-controlled legal entities that hold valid legal title to the property.

Partnership Program - Partnership Program for Affordable Housing of DCHA established pursuant to Chapter 93 of this Title 14 of the Code of District of Columbia Municipal Regulations, as the same may periodically be amended, modified, supplemented or replaced by DCHA

Project – (a) rehabilitation or renovation necessary, as determined by DCHA, to make dwelling units in the property comply with UFAS; (b) rehabilitation or renovation to construct or install energy conservation improvements in the property to enhance the energy conservation or efficiency of the dwelling units as determined by DCHA; or (c) repairs to the property necessary, as determined by DCHA, to correct or remove any violations of HQS including repair of specific conditions which could result in future violations of HQS occurring within five (5) years of the date of approval of the application for financial assistance.

Property – the improvements receiving financial assistance.

Rehabilitation work – renovation, rehabilitation, installation or repair of and to the property.

Uniform Federal Accessibility Standards or UFAS – the accessibility standards made applicable to public housing by HUD for purposes of complying with Section 504 of Rehabilitation Act of 1977, as amended, currently set forth in Sections 8.3, 8.32 and Appendix A to Section 40 of Title 24 of the Code of Federal Regulations, as the same may periodically be amended, modified, supplemented or replaced.

All persons desiring to comment on the subject matter of this rulemaking should file comments in writing no later than thirty (30) days after the publication of this Notice in the D.C. Register. Comments should be filed with the Office of the General Counsel, DCHA, 1133 North Capitol Street, NE, Suite 210, Washington, DC 20002-7599; copies of these rules may be obtained from DCHA at that same address. Alternatively, copies of the rules can be requested from and comments can be sent to Jean Everett, Senior Counsel, Office of the General Counsel, District of Columbia Housing Authority, at JEverett@dchousing.org.

**DISTRICT OF COLUMBIA
DEPARTMENT OF INSURANCE, SECURITIES, AND BANKING**

NOTICE OF PROPOSED RULEMAKING

The Commissioner of the Department of Insurance, Securities, and Banking, pursuant to the authority set forth in section 12 of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Official Code § 31-3611 (2001)), hereby gives notice of his intent to amend Chapter 26 (Long-Term Care Insurance) of Title 26 (Insurance) of the D.C. Municipal Regulations in not less than thirty days from the date of the publication of this notice in the *D.C. Register*. The purpose of this rulemaking is to correct and clarify various provisions in Chapter 26 and to add appendices that were inadvertently omitted from the original rulemaking.

Chapter 26 (Long-Term Care Insurance) of Title 26 DCMR (Insurance) of the D.C. Municipal Regulations is amended to read as follows:

CHAPTER 26 LONG-TERM CARE INSURANCE

2600 APPLICABILITY AND SCOPE

- 2600.1 Except as otherwise specifically provided, this chapter shall apply to all long-term care insurance policies and life insurance policies that accelerate benefits for long-term care that are delivered or issued for delivery in the District of Columbia on or after December 16, 2005, by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations, and all similar organizations.
- 2600.2 This chapter shall also apply to policies that have indemnity benefits that are triggered by activities of daily living and are sold as disability income insurance, if:
- (a) The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;
 - (b) The disability income policy is advertised, marketed, or offered as insurance for long-term care services; or
 - (c) Benefits under the policy may commence 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.

2601 POLICY TERMS AND DEFINITIONS

2601.1 A long-term care insurance policy delivered or issued for delivery in the District of Columbia shall not use any of the following terms unless the term is defined in the policy and is defined as set forth in section 2699:

- (a) "Activities of daily living";
- (b) "Acute condition";
- (c) "Adult day care";
- (d) "Bathing";
- (e) "Cognitive impairment";
- (f) "Continence";
- (g) "Dressing";
- (h) "Eating";
- (i) "Hands-on assistance";
- (j) "Home health care services";
- (k) "Medicare";
- (l) "Personal care";
- (m) "Toileting"; and
- (n) "Transferring".

2601.2 A long-term care insurance policy delivered or issued for delivery in the District of Columbia shall not define the phrase "mental or nervous disorder," or a phrase of similar import, to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

2601.3 When used in a long-term care insurance policy delivered or issued for delivery in the District of Columbia, the terms "skilled nursing care," "intermediate care," "personal care," "home 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.

2601.4 All terms referring to providers of services, including “skilled nursing facility,” “extended care facility,” “intermediate care facility,” “convalescent nursing home,” “personal care facility,” and “home care agency,” shall be defined in a long-term care insurance policy delivered or issued for delivery in the District of Columbia in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

2602 POLICY PRACTICES AND PROVISIONS: RENEWABILITY AND LEVEL PREMIUMS

2602.1 An individual long-term care insurance policy shall contain a renewal provision.

2602.2 A policy issued to an individual shall not contain a renewal provision other than a “guaranteed renewable” or “noncancellable” provision.

2602.3 Neither the term “guaranteed renewable” nor “noncancellable” shall be used in an individual long-term care insurance policy unless:

- (a) The use conforms with the requirements of this section; and
- (b) Further explanatory language, in conformity with the disclosure requirements of section 2618, is also included.

2602.4 The term “guaranteed renewable” may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

2602.5 The term “noncancellable” may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

2602.6 The term “level premium” may be used only when the insurer does not have the right to change the premium.

2602.7 In addition to the other requirements of this section, 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, approved August 21, 1996 (110 Stat. 2054; 26 U.S.C. § 7702B(b)(1)(C)).

2603 POLICY PRACTICES AND PROVISIONS: LIMITATIONS AND EXCLUSIONS

2603.1 A policy shall not be delivered or issued for delivery in the District of Columbia as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition, or accident, except for the following reasons:

- (a) Preexisting conditions or diseases;
- (b) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease;
- (c) Alcoholism and drug addiction;
- (d) Illness, treatment, or medical condition arising out of:
 - (1) War or act of war (whether declared or undeclared);
 - (2) Participation in a felony, riot, or insurrection;
 - (3) Service in the armed forces or auxiliary units of the armed forces;
 - (4) Suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or
 - (5) Aviation (if insured is non-fare-paying passenger).
- (e) Treatment provided in a government facility (unless otherwise required by law);
- (f) Services for which benefits are available under Medicare or another governmental program (except Medicaid), any state or federal workers' compensation, employer's liability, or occupational disease law, or any motor vehicle no-fault law;
- (g) Services provided by a member of the covered person's immediate family;
- (h) Services for which no charge is normally made in the absence of insurance;
- (i) Expenses for services or items available or paid under another long-term care insurance or health insurance policy; and

- (j) 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, approved July 30, 1965 (79 Stat. 290; 42 U.S.C. § 1395 *et seq.*), or would be so reimbursable but for the application of a deductible or coinsurance amount.

2603.2 This section is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

2604 POLICY PRACTICES AND PROVISIONS: EXTENSION OF BENEFITS

Termination of long-term care insurance shall be without prejudice to 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, if any, or to payment of the maximum benefits and may be subject to any policy waiting period and any other applicable provisions of the policy.

2605 POLICY PRACTICES AND PROVISIONS: CONTINUATION OR CONVERSION

2605.1 Group long-term care insurance issued in the District of Columbia on or after December 16, 2005, shall provide covered individuals with a basis for continuation or conversion of coverage.

2605.2 Written application for a converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (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.

2605.3 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. If 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 that was replaced.

2605.4 Continuation of coverage or issuance of a converted policy shall be mandatory, except if:

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

- (b) The terminating coverage is replaced, not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage if:
- (1) The replacement group coverage provides benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and
 - (2) The premium for the replacement group coverage is calculated in a manner consistent with the requirements of subsection 2605.3.

2605.5 Notwithstanding any other provision 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, together with the full benefits provided by the converted policy, would result in payment of more than one hundred percent (100%) of incurred expenses. The provision may be included in the converted policy only if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

2605.6 A converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

2605.7 Notwithstanding any other provision 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.

2605.8 For the purposes of this section, the phrase:

- (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 that is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services 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 Commissioner shall make a determination as to the substantial equivalency of benefits and, in doing so, shall take into consideration

the differences between managed care and non-managed care plans, including provider system arrangements, service availability, benefit levels, and administrative complexity;

- (b) "Basis for conversion of coverage" means a policy provision under which an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy that it replaced) for at least six (6) months immediately prior to 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) "Converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. If the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the Commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including provider system arrangements, service availability, benefit levels, and administrative complexity; and
- (d) "Managed-care plan" means 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.

2606 POLICY PRACTICES AND PROVISIONS: DISCONTINUANCE AND REPLACEMENT

2606.1 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 succeeding insurer and premiums charged to persons under the new group policy shall not:

- (a) Result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; or
- (b) Vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.

- 2606.2 The premium charged to an insured shall not increase due to either of the following:
- (a) The increasing age of the insured at ages beyond sixty-five (65); or
 - (b) The duration the insured has been covered under the policy.
- 2606.3 The purchase of additional coverage shall not be considered a premium rate increase, but for the purposes of the calculation required under section 2639, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.
- 2606.4 A reduction in benefits shall not be considered a premium change, but for the purposes of the calculation required under section 2639, the initial annual premium shall be based on the reduced benefits.

2607 POLICY PRACTICES AND PROVISIONS: ELECTRONIC ENROLLMENT FOR GROUP POLICIES

- 2607.1 In the case of the type of group long-term care insurance defined in section 2(4)(A) of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Official Code § 31-3601(4)(A) (2001)), a requirement that the signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:
- (a) Consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer;
 - (b) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention, and prompt retrieval of records; and
 - (c) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and privileged information is maintained.
- 2607.2 A verification of enrollment information shall be provided to an insured providing consent pursuant to subsection 2607.1.
- 2607.3 The insurer shall make available, upon the request of the Commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts of insureds providing consent pursuant to subsection 2607.1.

2608 UNINTENTIONAL LAPSE

An insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

- (a) No individual long-term care insurance policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one (1) 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 an additional person to receive notice. The applicant shall have the right to designate at least one (1) person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability by the third party for services provided to the insured. The form used for the written designation shall provide space clearly designated for listing at least one (1) 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 thirty (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, no less than once every two (2) years, of the right to change this written designation.
- (b) If the policyholder or certificateholder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in paragraph (a) of this subsection need not be met until sixty (60) days after the policyholder or certificateholder is no longer on the payroll or pension deduction plan. The application or enrollment form for such policies or certificates shall clearly indicate the payroll or pension deduction plan selected by the applicant.
- (c) No individual long-term care insurance policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to paragraph (a) of this subsection, at the address provided by the insured for the purpose 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 thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing.

2609 REINSTATEMENT

In addition to the requirements of section 2608, a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse, if the insurer is provided proof that the policyholder or certificateholder 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 (5) months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria for cognitive impairment or the loss of functional capacity contained in the policy or certificate.

2610 REQUIRED DISCLOSURE PROVISIONS: RENEWABILITY AND PREMIUM RATE CHANGES

2610.1 The renewal provision required by section 2602 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 subsection shall not apply to a policy that does not contain a renewal provision and under which the right to nonrenew is reserved solely to the policyholder.

2610.2 A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

2611 REQUIRED DISCLOSURE PROVISIONS: RIDERS AND ENDORSEMENTS

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 insurance policy after the 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 that increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. If a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider, or endorsement.

2612 REQUIRED DISCLOSURE PROVISIONS: PAYMENT OF BENEFITS

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 those terms and an explanation of the terms in the policy's accompanying outline of coverage.

2613 REQUIRED DISCLOSURE PROVISIONS: PREEXISTING CONDITIONS LIMITATIONS

If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate that shall be labeled "Preexisting Condition Limitations."

2614 REQUIRED DISCLOSURE PROVISIONS: LIMITATIONS AND CONDITIONS OTHER THAN PREEXISTING CONDITIONS

2614.1 A long-term care insurance policy or certificate that contains any limitations or conditions for eligibility, other than a limitation covered by section 2613, shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

2614.2 The disclosure of limitations with respect to preexisting conditions shall be governed by section 2613.

2615 REQUIRED DISCLOSURE PROVISIONS: TAX CONSEQUENCES

With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement shall be provided at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted; the disclosure statement shall state that receipt of the accelerated benefits may be taxable and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This section shall not apply to qualified long-term care insurance contracts.

2616 REQUIRED DISCLOSURE PROVISIONS: BENEFIT TRIGGERS

Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the policy or certificate in a separate section that shall be labeled "Eligibility for the

Payment of Benefits.” Additional benefit triggers, if any, shall also be explained in this section. If the triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person is required to certify a certain level of functional dependency in order to be eligible for benefits, this requirement shall be specified.

2617 REQUIRED DISCLOSURE PROVISIONS: QUALIFIED AND NON-QUALIFIED CONTRACTS

2617.1 A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage, which disclosure statement shall be in the form set forth in subsection 2642.6, stating 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, approved August 21, 1996 (110 Stat. 2054; 26 U.S.C. § 7702B(b)).

2617.2 A non-qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage, which disclosure statement shall be in the form set forth in subsection 2642.6, stating that the policy is not intended to be a qualified long-term care insurance contract.

2618 REQUIRED DISCLOSURE OF RATING PRACTICES TO CONSUMERS

2618.1 Except as provided in subsection 2618.2, this section shall apply to a long-term care insurance policy or certificate issued in the District of Columbia on or after June 16, 2006.

2618.2 For certificates issued on or after December 16, 2005, under a group long-term care insurance policy as defined in section 2(4)(A) of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Official Code § 31-3601(4)(A) (2001)), which policy was in force on December 16, 2005, the provisions of this section shall apply on the earliest policy anniversary that occurs on or after December 16, 2006.

2618.3 (a) Other than policies for which no applicable premium rate or rate schedule increase may be made, insurers shall provide the following information to an applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time, in which case an insurer shall provide the following information to the applicant no later than at the time of the delivery of the policy or certificate:

- (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 certificateholder's option in the event of a premium rate revision;
 - (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, next anniversary date or next billing date); and
 - (B) The right to a revised premium rate or rate schedule as provided in subparagraph (3) of this paragraph if the premium rate or rate schedule is changed; and
 - (5) Information regarding each premium rate increase on the policy form or a similar policy form over the past ten (10) years for the District of Columbia or any other jurisdiction that, at a minimum, identifies:
 - (A) The policy forms for which premium rates have been increased;
 - (B) The calendar years when the form was available for purchase; and
 - (C) The amount or percent of each increase, expressed as a percent of the premium rate prior to the increase, or expressed as minimum and maximum percents if the rate increase was variable by rating characteristics.
- (b) The insurer may provide additional explanatory information related to the rate increase if the additional explanatory information is provided in a fair manner.

2618.4 An insurer may exclude from the disclosure required by subsection 2618.3 premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or to long-term care insurance policies acquired from other nonaffiliated insurers if those increases occurred prior to the acquisition.

- 2618.5 If an acquiring insurer files for a rate increase on a long-term care insurance policy form acquired from a nonaffiliated insurer or a block of policy forms acquired from a nonaffiliated insurer on or before the later of December 16, 2005, or the end of a twenty-four (24) month period following the acquisition of the block of 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 subsection 2618.3(5).
- 2618.6 If the acquiring insurer described in subsection 2618.5 files for a rate increase, subsequent to a rate increase covered by subsection 2618.5, on the same policy form acquired from a nonaffiliated insurer or block of policy forms acquired from a nonaffiliated insurer described in subsection 2618.5, the acquiring insurer shall make all disclosures required by subsection 2618.3(5), including disclosure of the earlier rate increase covered by subsection 2618.5, even if the subsequent rate increase is filed within the twenty-four (24) month period described in subsection 2618.5.
- 2618.7 An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under subparagraphs (a)(1) and (a)(5) of subsection 2618.3. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign an acknowledgment no later than at the time of the delivery of the policy or certificate.
- 2618.8 An insurer shall use the forms in Appendices B and F to comply with the requirements of subsection 2618.3 through 2618.7.
- 2618.9 An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least forty-five (45) days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by subsections 2618.3 through 2618.6 when the rate increase is implemented.

2619 INITIAL FILING REQUIREMENTS

- 2619.1 The requirements of this section shall apply to a long-term care insurance policy issued in the District of Columbia on or after June 16, 2006.
- 2619.2 An insurer shall provide the following information to the Commissioner at least thirty (30) days prior to making a long-term care insurance form available for sale:
- (a) A copy of the disclosure documents required by section 2618; and
 - (b) An actuarial certification consisting of the following:

- (1) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;
- (2) A statement that the policy design and coverage provided have been reviewed and taken into consideration;
- (3) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;
- (4) A complete description of the basis for contract reserves that are anticipated to be held under the form, including the following:
 - (A) Sufficient detail or sample calculations so as to completely depict the reserve amounts to be held;
 - (B) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;
 - (C) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and
 - (D) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or, if such a statement cannot be made, a complete description of the situations where the difference is not sufficient. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the Commissioner may request a demonstration under subsection 2619.3 based on a standard age distribution; and
- (5) (A) 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

- (B) A comparison of the premium rate schedules for similar policy forms that are currently available from the insurer with an explanation of the differences between the premium rate schedule for the policy form and similar policy forms.

2619.3 The Commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

2619.4 If the Commissioner asks for additional information under this section, the period in subsection 2619.2 shall not include the period during which the insurer is preparing the requested information.

2620 APPLICATION QUESTIONS; PROHIBITION AGAINST POST-CLAIMS UNDERWRITING

2620.1 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.

2620.2 If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it shall also ask the applicant to list the medication that has been prescribed.

2620.3 If the medications listed in an application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

2620.4 Except for policies or certificates that are guaranteed issue, 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.

2620.5 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]

2620.6 Prior to the issuance of a long-term care insurance policy or certificate to an applicant who is age eighty (80) or older, the insurer shall obtain 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.

2621 COMPLETED APPLICATIONS

A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of the delivery of the policy or certificate unless a copy of the completed application was retained by the applicant at the time of application.

2622 RECORDS AND REPORTS OF RESCISSIONS

Every insurer or other entity selling or issuing long-term care insurance shall maintain a record of all policy or certificate rescissions, both in the District and nationally, except those that the insured or other entity voluntarily effectuated, and shall annually furnish this information to the Commissioner in the format prescribed in Appendix A.

2623 MINIMUM STANDARDS FOR HOME HEALTH AND COMMUNITY CARE BENEFITS

2623.1 A long-term care insurance policy or certificate that provides benefits for home health care or community care services shall not limit or exclude those benefits by any of the following means:

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

- (b) 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;
- (c) Limiting eligible services to services provided by registered nurses or licensed practical nurses;
- (d) Requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide or other licensed or certified home care worker acting within the scope of his or her licensure or certification;
- (e) Excluding coverage for personal care services provided by a home health aide;
- (f) 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;
- (g) Requiring that the insured or claimant have an acute condition before home health care services are covered;
- (h) Limiting benefits to services provided by Medicare-certified agencies or providers; or
- (i) Excluding coverage for adult day care services.

2623.2 A long-term care insurance policy or certificate that provides for home health care or community care services shall provide total home health care or community care coverage that is a dollar amount equivalent to at least one-half (1/2) of one (1) year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health care or community care services are being received. This requirement shall not apply to a policy or certificate issued to a resident of a continuing care retirement community.

2623.3 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.

2624 REQUIREMENT TO OFFER INFLATION PROTECTION

2624.1 No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection 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 shall offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

- (a) Increases benefit levels annually in such a manner that the increases are compounded annually at a rate of not less than five percent (5%);
- (b) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or
- (c) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

2624.2 If the policy is issued to a group, the offer required by subsection 2624.1 shall be made to the group policyholder; except, if the policy is issued to a group defined in section 2(4)(D) of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Official Code § 31-3601(4)(D) (2001)), other than to a continuing care retirement community, the offer shall be made to each proposed certificateholder.

2624.3 The offer otherwise required by subsection 2624.1 shall not be required of a life insurance policy or rider containing accelerated long-term care benefits.

2624.4 An insurer shall include the following information in or with the outline of coverage:

- (a) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period; and
- (b) Expected premium increases or additional premiums to pay for automatic or optional benefit increases.

2624.5 An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of making the disclosures required under subsection 2624.4.

2624.6 Inflation protection benefit increases under a policy that contains these benefits shall continue without regard to an insured's age, claim status, claim history, or the length of time the person has been insured under the policy.

- 2624.7 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.
- 2624.8 Inflation protection as provided in this section shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this 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 reject inflation protection."

2625 REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE

- 2625.1 (a) Application forms shall include the following questions 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 insurance policy or certificate is intended to replace another accident and sickness or long-term care insurance policy or certificate presently in force:
- (1) "Do you have another long-term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)?"
 - (2) "Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months?"
 - (A) "If so, with which company?"
 - (B) "If that policy lapsed, when did it lapse?"
 - (3) "Are you covered by Medicaid?"
 - (4) "Do you intend to replace any of your medical or health insurance coverage with this [policy] [certificate]?"
- (b) 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 set forth in paragraph (a) of this subsection may be used.

- (c) With regard to a replacement policy issued to a group as defined in section 2(4)(A) of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Official Code § 31-3601(4)(A) (2001)), the questions set forth in paragraph (a) of this subsection may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement.

2625.2 An agent shall list any other health insurance policy that he or she has sold to the applicant, including the following:

- (a) A policy sold that is still in force; and
- (b) A policy sold in the past five (5) years that is no longer in force.

2625.3 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, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of 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 following form:

**NOTICE TO APPLICANT REGARDING REPLACEMENT
OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE
INSURANCE**

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

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

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

STATEMENT TO APPLICANT BY [AGENT, BROKER, OR OTHER REPRESENTATIVE]:

(Use additional sheets, as necessary.)

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

1. Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. District of Columbia law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature of Agent or Broker or Other Representative)

[Typed Name and Address of Agent or Broker or Other Representative]

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

(Applicant's Signature)

(Date)

2625.4 Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following form:

**NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE**

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

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

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

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. District of Columbia law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) or similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

[Company Name]

- 2610.6 Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured, and policy number or address including zip code. Notice shall be made within five (5) working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.
- 2610.7 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 any life insurance replacement requirements. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

2626 REPORTING REQUIREMENTS

- 2626.1 An insurer shall maintain records for each agent of the agent's amount of replacement sales as a percent of the agent's total annual 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.
- 2626.2 An insurer shall report annually by June 30 the ten percent (10%) of its agents with the greatest percents of lapses and replacements as measured under subsection 2626.1. The report shall be provided on a form conforming with Appendix G.
- 2626.3 Reported replacement and lapse rates shall not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports shall be for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

- 2626.4 An 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. The report shall be provided on a form conforming with Appendix G.
- 2626.5 An 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. The report shall be provided on a form conforming with Appendix G.
- 2626.6 An 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. The report shall be provided on a form conforming with Appendix E.
- 2626.7 The information in the reports required under this section shall be provided on a District of Columbia-wide basis.
- 2626.8 Reports required by this section shall be filed with the Commissioner.
- 2626.9 For the purposes of this section, the word:
- (a) "Policy" means only long-term care insurance;
 - (b) "Claim" means, subject to paragraph (c) of this subsection, a request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met; and
 - (c) "Denied" means the insurer refuses to pay a claim for a reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

2627 LICENSING

- 2627.1 A producer shall not sell, solicit, or negotiate long-term care insurance except as authorized by the Producer Licensing Act of 2002, effective March 27, 2003 (D.C. Law 14-264; D.C. Official Code § 31-1131.01 *et seq.* (2001)).

2628 DISCRETIONARY POWERS OF COMMISSIONER

- 2628.1 The Commissioner may upon written request and after an administrative hearing issue an order to modify or suspend a specific provision or provisions of this chapter with respect to a specific long-term care insurance policy or certificate upon a written finding that:

- (a) The modification or suspension would be in the best interest of the insureds;
- (b) The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and
- (c)
 - (1) The modification or suspension is necessary for the development of an innovative and reasonable approach for insuring long-term care;
 - (2) 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 and the modification or suspension is reasonably related to the special needs or nature of such a community; or
 - (3) The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

2629 RESERVE STANDARDS

2629.1 If long-term care benefits are provided through the acceleration of benefits under group or individual life insurance policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with section 1 of chapter V of the Life Insurance Act, approved June 19, 1934 (48 Stat. 1156; D.C. Official Code § 31-4701 (2001)). Claim reserves shall also be established when the policy or rider is in claim status.

2629.2 Reserves for policies and riders subject to subsection 2629.1 shall be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations shall be 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 life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

2629.3 In the development and calculation of reserves for policies and riders subject to subsection 2629.1, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures, and all other considerations which have an impact on projected claim costs, including the following:

- (a) Definition of insured events;

- (b) Covered long-term care facilities;
- (c) Existence of home convalescence care coverage;
- (d) Definition of facilities;
- (e) Existence or absence of barriers to eligibility;
- (f) Premium waiver provision;
- (g) Renewability;
- (h) Ability to raise premiums;
- (i) Marketing method;
- (j) Underwriting procedures;
- (k) Claims adjustment procedures;
- (l) Waiting period;
- (m) Maximum benefit;
- (n) Availability of eligible facilities;
- (o) Margins in claim costs;
- (p) Optional nature of benefit;
- (q) Delay in eligibility for benefit;
- (r) Inflation protection provisions; and
- (s) Guaranteed insurability option.

2629.4 Any applicable valuation morbidity table used in the calculation of reserves for policies or riders subject to subsection 2629.1 shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

2629.5 If long-term care benefits are provided other than as in subsection 2629.1, reserves shall be determined in accordance with the requirements and standards for determining health insurance reserves.

2630 LOSS RATIO

2630.1 This section shall apply to all long-term care insurance policies or certificates except those covered under sections 2619 and 2631.

2630.2 Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums if the expected loss ratio is at least sixty percent (60%), calculated in a manner that provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

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

2630.3 Subsection 2630.2 shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit shall be considered to provide reasonable benefits in relation to premiums paid if the policy complies with all of the following provisions:

- (a) The interest credited internally to determine cash value accumulations, including long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
- (b) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of section 5 of chapter V of the Life Insurance Act, approved June 19, 1934 (48 Stat. 1161; D.C. Official Code § 31-4705.02 (2001));
- (c) The policy meets the disclosure requirements of sections 7(e), 7(f), and 9 of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Official Code §§ 31-3606(e), 3606(f), and 3608 (2001));
- (d) Any policy illustration meets the applicable requirements of the National Association of Insurance Commissioners Life Insurance Illustrations Model Regulation; and
- (e) An actuarial memorandum is filed with the Department of Insurance, Securities, and Banking that includes the following:
 - (1) A description of the basis on which the long-term care rates were determined;
 - (2) A description of the basis for the reserves;
 - (3) A summary of the type of policy, benefits, renewability, general marketing methods, and limits on ages of issuance;
 - (4) A description and a table of each actuarial assumption used. For expenses, an insurer shall include a percent of premium dollars per policy and dollars per unit of benefits, if any;
 - (5) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
 - (6) The estimated average annual premium per policy and the average issue age;
 - (7) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting.

Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

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

2631 **PREMIUM RATE SCHEDULE INCREASES**

2631.1 This section shall apply as follows:

- (a) Except as provided in paragraph (b) of this subsection, this section shall apply to a long term care insurance policy or certificate issued in the District of Columbia on or after June 16, 2006.
- (b) For certificates issued on or after December 16, 2005, under a group long-term care insurance policy as defined in section 2(4)(A) of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Official Code § 31-3601(4)(A) (2001)), which policy was in force on December 16, 2005, the provisions of this section shall apply on the earliest policy anniversary date that occurs on or after December 16, 2006.

2631.2 An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the Commissioner at least thirty (30) days prior to the notice to the policyholders and shall include the following:

- (a) The information required by section 2618;
- (b) Certification by a qualified actuary that:
 - (1) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increase are anticipated; and
 - (2) The premium rate filing is in compliance with the provisions of this section;
- (c) An actuarial memorandum justifying the rate schedule change request that includes the following:
 - (1) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase and the

method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale, in accordance with the following conditions:

- (A) Annual values for the five (5) years preceding and the three (3) years following the valuation date shall be provided separately;
- (B) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;
- (C) The projections shall demonstrate compliance with subsection 2631.3; and
- (D) For exceptional increases:
 - (i) The projected experience shall be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and
 - (ii) In the event the Commissioner determines as provided in subsection 2632.3 that offsets may exist, the insurer shall use appropriate net projected experience;
- (2) Disclosure of how reserves have been incorporated in the rate increase whenever the rate increase will trigger contingent benefit upon lapse;
- (3) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;
- (4) A statement that policy design, underwriting, and claims adjudication practices have been taken into consideration;
- (d) If it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, a document setting forth composite rates reflecting projections of new certificates;
- (e) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences

attributable to benefits, unless sufficient justification is provided to the Commissioner; and

- (f) Sufficient information for review (and approval) of the premium rate schedule increase by the Commissioner.

2631.3 All premium rate schedule increases shall be determined in accordance with the following requirements:

- (a) Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;
- (b) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:
 - (1) Fifty-eight percent (58%) of the accumulated value of the initial earned premium;
 - (2) Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;
 - (3) Fifty-eight percent (58%) of the present value of future projected initial earned premiums; and
 - (4) Eighty-five percent (85%) of the present value of future projected premiums not in subparagraph (3) of this paragraph on an earned basis;
- (c) If a policy form has both exceptional and other increases, the values in subparagraphs (2) and (4) of paragraph (b) of this subsection shall also include seventy percent (70%) for exceptional rate increase amounts; and
- (d) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in the National Association of Insurance Commissioners Health Reserves Model Regulation Appendix A, Section IIA. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

2631.4 For each rate increase that is implemented, the insurer shall file for review and approval by the Commissioner updated projections, as defined in subsection

2631.2(c)(1), annually for the next three (3) years and shall include a comparison of actual results to projected values. The Commissioner may extend the period to longer than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection 2631.11, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the Commissioner.

2631.5 If a premium rate in the revised premium rate schedule is greater than two hundred percent (200%) of the comparable rate in the initial premium schedule, lifetime projections, as defined in subsection 2631.2(c)(1), shall be filed for review and approval by the Commissioner every five (5) years following the end of the required period in subsection 2631.4. For group insurance policies that meet the conditions in subsection 2631.11, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the Commissioner.

2631.6 (a) If the Commissioner determines that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection 2631.3, the Commissioner may require the insurer to implement:

- (1) Premium rate schedule adjustments; or
- (2) Other measures to reduce the difference between the projected and actual experience.

(b) In determining whether the actual experience adequately matches the projected experience, consideration should be given to subsection 2631.2(d), if applicable.

2631.7 If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(a) A plan, subject to Commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the Commissioner may impose the condition in subsection 2631.8; and

(b) The original anticipated lifetime loss ratio and the premium rate schedule increase that would have been calculated according to

subsection 2631.3 had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculations described in subsections 2631.3(b)(1) and 2631.3(b)(3).

- 2631.8 (a) For a rate increase filing that meets the following criteria, the Commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapsation has occurred or is anticipated:
- (1) The rate increase is not the first rate increase requested for the specific policy form or forms;
 - (2) The rate increase is not an exceptional increase; and
 - (3) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.
- (b) If significant adverse lapsation has occurred, is anticipated in the filing, or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the Commissioner may determine that a rate spiral exists. Following a determination that a rate spiral exists, the Commissioner may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase the option to replace existing coverage with one (1) or more reasonably comparable products being offered by the insurer or its affiliates.
- (c) An offer required by paragraph (b) of this subsection shall:
- (1) Be subject to the approval of the Commissioner;
 - (2) Be based on actuarially sound principles, but shall not be based on attained age; and
 - (3) Provide that maximum benefits under a new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.
- (d) The insurer shall maintain the experience of all of the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of the following:

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

2631.9 If the Commissioner determines that an insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the Commissioner may, in addition to the provisions of subsection 2631.8, prohibit the insurer from:

- (a) Filing and marketing comparable coverage for a period of up to five (5) years; or
- (b) Offering similar coverage and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

2631.10 Subsections 2631.1 through 2631.9 shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in subsection 2699, if the policy complies with all of the following provisions:

- (a) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
- (b) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements, as applicable, of:
 - (1) Section 5b of chapter V of the Life Insurance Act, approved June 19, 1934 (62 Stat. 30; D.C. Official Code § 31-4705.02 (2001));
 - (2) Section 5c of chapter V of the Life Insurance Act, approved October 13, 1978 (D.C. Law 2-120; D.C. Official Code § 31-4705.03 (2001)); and
 - (3) Any other District of Columbia law or regulation setting forth nonforfeiture requirements;
- (c) The policy meets the disclosure requirements of sections 7(e), 7(f), and 8 of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Official Code §§ 31-3606(e), 3606(f), and 3607 (2001));

- (d) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements of any applicable:
- (1) District of Columbia life insurance policy illustrations law or regulation; and
 - (2) District of Columbia annuity and variable annuity disclosure law or regulation;
- (e) An actuarial memorandum is filed with the Department of Insurance, Securities, and Banking that includes the following:
- (1) A description of the basis on which the long-term care rates were determined;
 - (2) A description of the basis for the reserves;
 - (3) A summary of the type of policy, benefits, renewability, general marketing methods, and limits on ages of issuance;
 - (4) A description and a table of each actuarial assumption used. For expenses, an insurer shall include the percent of premium dollars per policy and dollars per unit of benefits, if any;
 - (5) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
 - (6) The estimated average annual premium per policy and the average issue age;
 - (7) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. For a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
 - (8) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

- 2631.11 Subsections 2631.6 and 2631.8 shall not apply to a group long-term care insurance policy as defined in section 2(4)(A) of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Official Code § 31-3601(4)(A) (2001)), if:
- (a) The policy insures two hundred and fifty (250) or more persons and the policyholder has five thousand (5,000) or more eligible employees of a single employer; or
 - (b) The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed.

2632 EXCEPTIONAL INCREASES

- 2632.1 Except as provided in section 2631, exceptional increases shall be subject to the same requirements as other premium rate schedule increases.
- 2632.2 The Commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.
- 2632.3 The Commissioner, in determining whether a justification for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.
- 2632.4 For the purposes of this section, the term "exceptional increase" means an increase filed by an insurer as exceptional and for which the Commissioner determines the need for the premium rate increase is justified due to:
- (a) Changes in laws or regulations applicable to long-term care coverage in the District of Columbia; or
 - (b) Increased and unexpected utilization that affects the majority of insurers of similar products.

2633 FILING AND APPROVAL REQUIREMENT FOR GROUP POLICIES

- 2633.1 Prior to an insurer or similar organization offering group long-term care insurance to a resident of the District of Columbia pursuant to section 5 of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Official Code § 31-3604 (2001)), it shall file with the Commissioner evidence that the group policy or certificate has been approved by a state having statutory or regulatory long-term care insurance

requirements substantially similar to those adopted in the District of Columbia.

2634 FILING REQUIREMENTS FOR ADVERTISING

- 2634.1 An insurer, health care service plan, or other entity providing long-term care insurance or benefits in the District of Columbia shall provide a copy of any long-term care insurance advertisement intended for use in the District of Columbia whether through written, electronic, radio, or television medium to the Commissioner.
- 2634.2 Each advertisement described in subsection 2634.1 shall be subject to review or approval by the Commissioner to the extent required under District of Columbia law.
- 2634.3 Each advertisement described in subsection 2634.1 shall be retained by the insurer, health care service plan, or other entity for at least three (3) years from the date the advertisement was first used.
- 2634.4 The Commissioner may exempt an advertisement from a requirement of this section if, in the Commissioner's opinion, the requirement may not be reasonably applied.

2635 STANDARDS FOR MARKETING — GENERAL

- 2635.1 An insurer, health care service plan, or other entity marketing long-term care insurance or benefits in the District of Columbia, directly or through its producers, shall:
- (a) Establish marketing procedures and agent training requirements to assure the following:
 - (1) Marketing activities, including comparison of policies, by its agents or other producers will be fair and accurate; and
 - (2) Excessive insurance is not sold or issued;
 - (b) 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.” ;

- (c) Provide copies of the disclosure forms required by subsections 2618.3 through 2618.8 (Appendices B and F) to the applicant;
- (d) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance, 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 shall not be required;
- (e) Establish auditable procedures for verifying compliance with this subsection;
- (f) If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the state's insurance commissioner, provide, at solicitation, written notice to the prospective policyholder and certificateholder that the program is available and the name, address, and telephone number of the program;
- (g) For long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to subsections 2602.5 and 2602.6; and
- (h) Provide an explanation of contingent benefit upon lapse provided for in subsection 2639.6.

2635.2 The following acts and practices are prohibited:

- (a) **Twisting.** Knowingly making a misleading representation or incomplete or fraudulent comparison of an insurance policy or insurer for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer;
- (b) **High pressure tactics.** Employing 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;
- (c) **Cold lead advertising.** 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;
and

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

2636 STANDARDS FOR MARKETING — ASSOCIATIONS

2636.1 With respect to the obligations set forth in this section, the primary responsibility of an association, as defined in section 2(4)(B) of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Official Code § 31-3601(4)(B) (2001)), 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. An association shall provide objective information regarding a long-term care insurance policy or certificate endorsed or sold by the association to ensure that members of the association receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold. In meeting the obligations of this section, the following actions shall be taken:

- (a) The insurer shall file with the Department of Insurance, Securities, and Banking the following material:
 - (1) The policy and certificate;
 - (2) A corresponding outline of coverage; and
 - (3) All advertisements requested by the Department of Insurance, Securities, and Banking.
- (b) The association shall disclose the following in a long-term care insurance solicitation:
 - (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 an association selling or endorsing a long-term care insurance policy or certificate shall review and approve the insurance policy as well as the compensation arrangements made with the insurer.
- (e) (1) The association shall:
 - (A) 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 examination of the policy, including its benefits, features, and rates, and update the examination thereafter in the event of material change;
 - (B) Actively monitor the marketing efforts of the insurer and its agents; and
 - (C) Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policy or certificate.
- (2) Sub-subparagraph (e)(1)(A) of this subsection shall not apply to a qualified long-term care insurance contract.

2636.2 No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the Department of Insurance, Securities, and Banking the information required by this section.

2636.3 An insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this section.

2636.4 Failure to comply with the filing and certification requirements of this section shall constitute an unfair trade practice.

2637 SUITABILITY

2637.1 This section shall not apply to life insurance policies that accelerate benefits for long-term care.

2637.2 Every insurer, health care service plan, or other entity marketing long-term care insurance (the "issuer") shall:

- (a) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;
- (b) Train its agents in the use of its suitability standards; and
- (c) Maintain a copy of its suitability standards and make them available for inspection upon request by the Commissioner.

2637.3 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:

- (a) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
- (b) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and
- (c) The values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

2637.4 The issuer and, where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in subsection 2637.3. The efforts shall include presentation to the applicant, at or prior to application, of a "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix B, in not less than twelve (12) point type. The issuer may request that the applicant provide additional information to comply with its suitability standards. A copy of the personal worksheet used by the issuer shall be filed with the Commissioner.

2637.5 A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

2637.6 The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet is prohibited.

2637.7 The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance to an applicant is appropriate.

- 2637.8 Agents shall use the suitability standards developed by the issuer in marketing long-term care insurance.
- 2637.9 At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix C and shall be in not less than twelve (12) point type.
- 2637.10 If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant declines to provide information on the personal worksheet, the issuer shall either reject the application or send the applicant a letter similar to Appendix D; provided, if the applicant declines 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.
- 2637.11 The issuer shall report annually to the Commissioner the total number of applications received from residents of the District of Columbia, the number of applicants who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

2638 RESTRICTION ON PREEXISTING CONDITIONS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES

- 2638.1 If a long-term care insurance policy or certificate replaces another long-term care insurance policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

2639 NONFORFEITURE BENEFIT REQUIREMENT

- 2639.1 This section shall not apply to life insurance policies or riders that accelerate benefits for long-term care.
- 2639.2 To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of section 11 of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Official Code § 31-3610 (2001)), all of the following conditions shall be met:
- (a) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers, and benefit length that are the same as coverage to be issued without nonforfeiture benefits.

- (b) The nonforfeiture benefit included in the offer shall be the benefit described in subsection 2639.9 and shall comply with subsection 2639.10.
- (c) 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.

- 2639.3 If an offer required to be made under section 11 of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Official Code § 31-3610 (2001)), is rejected, the insurer shall provide the contingent benefit upon lapse described in this section.
- 2639.4 If an offer required to be made under section 11 of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Official Code § 31-3610 (2001)), is rejected for individual and group policies without nonforfeiture benefits issued after December 16, 2005, the insurer shall provide a contingent benefit upon lapse.
- 2639.5 If a group policyholder makes a nonforfeiture benefit an option to a certificate holder, the certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.
- 2639.6 The contingent benefit upon lapse shall be 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 set forth in the chart below based on the insured's issue age (i.e., every time a "substantial premium increase" is triggered), and the policy or certificate lapses within one hundred and twenty (120) days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase. The triggers for a substantial premium increase shall be as follows:

Triggers for a Substantial Premium Increase	
Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%

50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

2639.7 To determine whether contingent benefit upon lapse provisions are triggered under subsection 2639.6, 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.

2639.8 On or before the effective date of a substantial premium increase as defined in section 2639.6 above, the insurer shall:

- (a) Offer to reduce policy benefits provided by the current coverage, without requiring additional underwriting, so that required premium payments are not increased;
- (b) Offer to convert to a paid-up status with a shortened benefit period in accordance with the terms of subsection 2639.9. This option may be elected at any time during the one hundred and twenty (120) day period referenced in subsection 2639.6; and
- (c) Notify the policyholder or certificate holder that a default or lapse at any time during the one hundred and twenty (120) day period referenced in subsection 2639.6 shall be deemed to be the election of the offer to convert described in paragraph (b) of this subsection.

2639.9 The following benefits shall be required as nonforfeiture benefits and shall be provided in accordance with the following standards:

- (a) 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) shall be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in paragraph (b) of this subsection.
- (b) The standard nonforfeiture credit shall be equal to one hundred percent (100%) of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit shall be subject to the limitation of subsection 2639.11.
- (c) 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.

- 2639.10
- (a) The nonforfeiture benefit shall begin not later than the end of the third year after the issue date of the policy or certificate. The contingent benefit upon lapse shall be effective during the first three (3) years as well as thereafter.
 - (b) Notwithstanding paragraph (a) of this subsection, for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

- (1) The end of the tenth year following the policy or certificate issue date; or
 - (2) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.
- (c) For the purposes of this subsection, attained age rating shall be defined as a schedule of premiums starting from the issue date that increases age at least one percent (1%) per year prior to age fifty (50) and at least three percent (3%) per year beyond age fifty (50).
- 2639.11 All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status shall not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.
- 2639.12 There shall be no difference in the minimum nonforfeiture benefits required under this section for group and individual policies.
- 2639.13 The requirements set forth in this section shall become effective on December 16, 2006, and shall apply as follows:
- (a) Except as provided in paragraph (b) of this subsection, the provisions of this section shall apply to a long-term care policy issued in the District of Columbia on or after December 16, 2005.
 - (b) For certificates issued on or after December 16, 2005, under a group long-term care insurance policy as defined in section 2(4)(A) of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Code § 31-3601(4)(A)), which policy was in force on December 16, 2005, the provisions of this section shall not apply.
- 2639.14 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 section 2630 treating the policy as a whole.
- 2639.15 A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets all of the following requirements:
- (a) The nonforfeiture provision shall be appropriately captioned.
 - (b) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially

granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the Commissioner for the same contract form.

- (c) The nonforfeiture provision shall provide at least one of the following:
- (1) Reduced paid-up insurance;
 - (2) Extended term insurance;
 - (3) Shortened benefit period; or
 - (4) Other similar offerings approved by the Commissioner.

2640 STANDARDS FOR BENEFIT TRIGGERS

2640.1 A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment.

2640.2 Activities of daily living shall include at least the following:

- (a) Bathing;
- (b) Continence;
- (c) Dressing;
- (d) Eating;
- (e) Toileting; and
- (f) Transferring.

2640.3 Each activity of daily living shall be defined in the policy. The definition in the policy of an activity of daily living listed in subsection 2640.2 shall be the same as the definition of the activity set forth in section 2699.

2640.4 Insurers may use activities of daily living in addition to those contained in subsection 2640.2 to trigger covered benefits, if the activities are defined in the policy.

- 2640.5 An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however, the provisions shall not restrict, and shall not be in lieu of, the requirements in subsections 2640.1 and 2640.2.
- 2640.6 For the purposes of this section, the determination of a deficiency shall not be more restrictive than the following:
- (a) Requiring the hands-on assistance of another person to perform the prescribed activity of daily living; or
 - (b) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.
- 2640.7 Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses, or social workers.
- 2640.8 A long-term care insurance policy shall include a clear description of the process for appealing and resolving benefit determinations.
- 2640.9 The requirements set forth in this section shall be effective on December 16, 2006, and shall apply as follows:
- (a) Except as provided in paragraph (b) of this subsection, the provisions of this section shall apply to a long-term care insurance policy issued in the District of Columbia on or after December 16, 2005; and
 - (b) For certificates issued on or after December 16, 2005, under a group long-term care insurance policy as defined in section 2(4)(A) of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Official Code § 31-3601(4)(A) (2001)), that were in force on December 16, 2005, the provisions of this section shall not apply.
- 2641 ADDITIONAL STANDARDS FOR BENEFIT TRIGGERS FOR QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS**
- 2641.1 A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.
- 2641.2 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 ninety (90) days due to a loss of functional capacity or to severe cognitive impairment.

- 2641.3 Certifications regarding activities of daily living and cognitive impairment required pursuant to subsection 2641.2 shall be performed by the following licensed or certified practitioners: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the United States Department of the Treasury.
- 2641.4 Certifications required pursuant to subsection 2641.2 may be performed by a licensed health care practitioner 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 ninety (90) days due to a loss of functional capacity and the insured is in claim status, the certification shall not be rescinded and additional certifications shall not be performed until after the expiration of the ninety (90) day period.
- 2641.5 Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.
- 2641.6 For the purposes of this section the following definitions shall apply:
- (a) "Qualified long-term care services" has the meaning prescribed in section 7702B(c)(1) of the Internal Revenue Code of 1986, approved August 21, 1996 (110 Stat. 2055; 26 U.S.C. § 7702B(c)(1)). Under that provision, the term "qualified long-term care services" means necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services that are required by a chronically ill individual and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.
 - (b) (1) "Chronically ill individual" has the meaning prescribed in section 7702B(c)(2) of the Internal Revenue Code of 1986, approved August 21, 1996 (110 Stat. 2055; 26 U.S.C. § 7702B(c)(2)). 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 (2) activities of daily living for a period of at least ninety (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.
- (2) The term “chronically ill individual” shall not include an individual otherwise meeting the requirements of subparagraph (1) of this paragraph unless within the preceding twelve (12) month period a licensed health care practitioner has certified that the individual meets those requirements.
- (c) “Licensed health care practitioner” means a physician, as defined in section 1861(r)(1) of the Social Security Act, approved July 30, 1965 (79 Stat. 321; 42 U.S.C. § 1395x(r)), a registered professional nurse, licensed social worker, or other individual who meets requirements prescribed by the Secretary of the United States Department of the Treasury under section 7702B(c)(4) of the Internal Revenue Code of 1986, approved August 21, 1996 (110 Stat. 2056; 26 U.S.C. § 7702B(c)(4)).
- (d) “Maintenance or personal care services” means care the primary purpose of which is the provision of needed assistance with a disability 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).

2642 STANDARD FORMAT OUTLINE OF COVERAGE

- 2642.1 This section implements, interprets, and makes specific the provisions of section 7 of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Official Code § 31-3606 (2001)) in prescribing a standard format and the content of an outline of coverage.
- 2642.2 The outline of coverage shall be a free-standing document, using type that is no smaller than ten (10) points.
- 2642.3 The outline of coverage shall contain no material of an advertising nature.
- 2642.4 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.
- 2642.5 Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.
- 2642.6 The format for the outline of coverage shall be as follows:

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates that are guaranteed issue, the following caution statement, or language substantially similar, shall appear as follows in the outline of coverage.]

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

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

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

OR

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

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

- (a) [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:]
- (1) [Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS [POLICY] [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your [policy] [certificate], to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.
 - (2) [Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS [POLICY] [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.
- (b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy.]
- (c) [Describe waiver of premium provisions or state that there are no such provisions.]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS

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

6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return—"free look" provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) [For agents] Neither [Company Name] nor its agents represent Medicare, the federal government, or any state government.

(b) [For direct response] [Company Name] is not representing Medicare, the federal government, or any state government.

8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. BENEFITS PROVIDED BY THIS POLICY.

[Describe:

- (a) Covered services, related deductibles, waiting periods, elimination periods, and benefit maximums.
- (b) Institutional benefits, by skill level.
- (c) Non-institutional benefits, by skill level.
- (d) Eligibility for Payment of Benefits

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

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

10. LIMITATIONS AND EXCLUSIONS

[Describe:

- (a) Preexisting conditions;
- (b) Non-eligible facilities and providers;
- (c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);
- (d) Exclusions and exceptions;
- (e) Limitations.]

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

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

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted.

[As applicable, indicate the following:

- (a) That the benefit level will not increase over time;
- (b) Any automatic benefit adjustment provisions;
- (c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;
- (d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;
- (e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision that provides preconditions to the availability of policy benefits for such an insured.]

13. PREMIUM.

- [(a) State the total annual premium for the policy;
- (b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium that corresponds to each benefit option.]

14. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

2643 REQUIREMENT TO DELIVER SHOPPER'S GUIDE

2643.1 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 Commissioner, shall be provided to all prospective applicants for a long-term care insurance policy or certificate.

2643.2 In the case of agent solicitations, an agent shall deliver the shopper's guide prior to the presentation of an application or enrollment form.

2643.3 In the case of direct response solicitations, the shopper's guide shall be presented in conjunction with an application or enrollment form.

2643.4 Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the shopper's guide but shall furnish the policy summary required under section 7 of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Official Code § 31-3606 (2001)).

2644 PENALTIES

2644.1 In addition to any other penalties provided by the laws of the District of Columbia, an insurer or agent found to have violated a requirement of District of Columbia law 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 (3) times the amount of any commissions paid for each policy involved in the violation or up to ten thousand dollars (\$10,000), whichever is greater.

2699 DEFINITIONS

For the purposes of this chapter, the following words and phrases shall have the meanings ascribed:

Activities of daily living - at least bathing, continence, dressing, eating, toileting, and transferring.

Acute condition - condition where the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

Adult day care - a program for six (6) 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.

Applicant - has the same meaning as set forth in section 2(1) of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Official Code § 31-3601(1) (2001)).

Bathing - 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.

Certificate - has the same meaning as set forth in section 2(2) of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Official Code § 31-3601(2) (2001)).

Cognitive impairment - 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.

Commissioner - the Commissioner of the Department of Insurance, Securities, and Banking.

Continence - the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

Dressing - putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

Eating - feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

Group long-term care insurance - has the same meaning as set forth in section 2(4) of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Official Code § 31-3601(4) (2001)).

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

Home health care services - medical and nonmedical services provided to ill, disabled, or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living, and respite care services.

Incidental - as used in section 2631, that the value of the long-term care benefits provided is less than ten percent (10%) 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.

Long-term care insurance - has the same meaning as set forth in section 2(5) of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Official Code § 31-3601(5) (2001)).

Medicare - "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.

Personal care - the provision of hands-on services to assist an individual with activities of daily living.

Policy - has the same meaning as set forth in section 2(7) of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Official Code § 31-3601(7) (2001)).

Qualified actuary - a member in good standing of the American Academy of Actuaries.

Qualified long-term care insurance contract - has the same meaning as set forth in section 2(8) of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Official Code § 31-3601(8) (2001)).

Similar policy forms - 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 section 2(4)(A) of the Long-Term Care Insurance Act of 2000, effective May 23, 2000 (D.C. Law 13-121; D.C. Official Code § 31-3601(4)(A) (2001)) are not considered similar to certificates or policies otherwise issued as long-term care insurance, but shall be considered similar

to other comparable certificates with the same long-term care benefit classifications. For the 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.

Toileting - getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring - moving into or out of a bed, chair, or wheelchair.

APPENDIX A

Rescission Reporting Form For Long-Term Care Insurance Policies

For the District Of Columbia For the Reporting Year of _____

Due: March 1 annually

Company Name: _____

Address: _____

Phone Number: _____

Instructions:

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission: _____

Signature

Name and Title (please type)

Date

APPENDIX B

LONG-TERM CARE INSURANCE
PERSONAL WORKSHEET

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long term care insurance may be expensive and may not be right for everyone.

Under District of Columbia law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _____

The premium for the coverage you are considering will be [\$_____ per month, or \$_____ per year,] [a one-time single premium of \$_____].

Type of Policy (noncancellable/guaranteed renewable): _____

The Company's Right to Increase Premiums: [The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in the District of Columbia.] [Insurers shall use the appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

Rate Increase History

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

Drafting Note: A company may use the first bracketed sentence above only if it has never increased rates under any prior policy forms in the District of Columbia or any other state. The issuer shall list each premium increase it has instituted on this or similar policy forms in the District of Columbia or any other state during the last 10 years. The list shall provide the policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if

the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.

Questions Related to Your Income

How will you pay each year's premium?

From my income From my savings/investments My family will pay

[Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?]

Drafting Note: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.

What is your annual income? (check one) Under \$10,000 \$[10-20,000]
 \$[20-30,000] \$[30-50,000] Over \$50,000

Drafting Note: The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)

No change Increase Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) Yes No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

From my income From my savings/investments My family will pay

The national average annual cost of care in [insert year] was [insert \$ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert \$ amount] if costs increase 5% annually.

Drafting Note: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.

What elimination period are you considering?

Number of days _____ Approximate cost \$ _____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

From my income From my savings/investments My family will pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

- Under \$20,000
- \$20,000-\$30,000
- \$30,000-\$50,000
- Over \$50,000

How do you expect your assets to change over the next ten years? (check one)

- Stay about the same
- Increase
- Decrease

If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

<input type="checkbox"/> The answers to the questions above describe my financial situation or <input type="checkbox"/> I choose not to complete this information. (Check one.)
<input type="checkbox"/> I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history, and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history, and potential for premium increases in the future.] I understand the above disclosures. I understand that the rates for this policy may increase in the future. (This box must be checked).

Signed: _____ (Applicant) _____ (Date)

I explained to the applicant the importance of completing this information.

Signed: _____ (Agent) _____ (Date)

Agent's Printed Name: _____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.]

APPENDIX C

**Things You Should Know Before You Buy
Long-Term Care Insurance**

- Long-Term Care Insurance**
- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
 - [You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]
- Drafting Note:* For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
- Medicare**
- Medicare does **not** pay for most long-term care.
- Medicaid**
- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
 - Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
 - When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
 - Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.
- Shopper's Guide**
- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.
- Counseling**
- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

APPENDIX D

Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for long-term care insurance included a personal worksheet, which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, District of Columbia law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." The District of Columbia insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

Drafting Note: Choose the paragraph above that applies.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy.

You should understand that you will not have any coverage until we hear back from you, approve your application, and issue you a policy.

Please check one box and return in the enclosed envelope.

- Yes**, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

Drafting Note: Delete the phrase in brackets if the applicant did not answer the questions about income.

- No**. I have decided not to buy a policy at this time.

APPLICANT'S SIGNATURE

DATE

Please return to [issuer] at [address] by [date].

APPENDIX E

**Claims Denial Reporting Form
Long-Term Care Insurance**

For the District of Columbia
For the Reporting Year of _____

Due: June 30 annually

Company Name: _____

Company Address: _____

Company NAIC Number: _____

Contact Person: _____ Phone Number: _____

Line of Business: Individual Group

Instructions

The purpose of this form is to report all long-term care claim denials under in-force long-term care insurance policies. "Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

		D.C. Data	Nationwide Data ¹
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid Due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid Due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided by Line 1)		
7	Number of Long-Term Care Claims Denied Due to:		
8	• Long-Term Care Services Not Covered Under the Policy ²		
9	• Provider/Facility Not Qualified Under the Policy ³		
10	• Benefit Eligibility Criteria Not Met ⁴		
11	• Other		

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for the District of Columbia are small in number.
2. Example — home health care claim filed under a nursing home only policy.
3. Example — a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
4. Examples — a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

APPENDIX F

**Long-Term Care Insurance
Potential Rate Increase Disclosure Form**

Instructions: This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

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

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

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

2. **The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.**
3. **Rate Schedule Adjustments:** The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): _____.
4. **Potential Rate Revisions: This policy is Guaranteed Renewable.** This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

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

Turn the Page

*** Contingent Nonforfeiture**

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

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

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

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

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the \$1,000 annual premium for 10 years, so you have paid a total of \$10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or \$500 for a new annual premium of \$1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are \$10,000 (provided you have at least \$10,000 of benefits remaining under your policy).

Turn the Page

Contingent Nonforfeiture	
Cumulative Premium Increase Over Initial Premium	
That Qualifies for Contingent Nonforfeiture	
(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)	
Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

APPENDIX G

**Long-Term Care Insurance
Replacement and Lapse Reporting Form**

For the District of Columbia
For the Reporting Year of _____

Due: June 30 annually

Company Name: _____

Company Address: _____

Company NAIC Number: _____

Contact Person: _____ Phone Number: (____) _____

Instructions

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

Listing of the 10% of Agents with the Greatest Percent of Replacements

Agent's Name	Number of Policies Sold by this Agent	Number of Policies Replaced by this Agent	Number of Replacements as Percent of Number Sold by this Agent

Listing of the 10% of Agents with the Greatest Percent of Lapses

Agent's Name	Number of Policies Sold by this Agent	Number of Policies Lapsed by this Agent	Number of Lapses as Percent of Number Sold by this Agent

Company Totals

Percent of Replacement Policies Sold to Total Annual Sales _____%

Percent of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year) _____%

Percent of Lapsed Policies to Total Annual Sales _____%

Percent of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) _____%

Persons desiring to comment on these proposed rules should submit comments in writing to Mrs. Leslie E. Johnson, Hearing Officer, Department of Insurance, Securities and Banking, 810 First Street, N.E., Suite 701, Washington, D.C. 20002. Comments must be received not later than thirty (30) days after the date of publication of this notice in the *D.C. Register*.

Copies of the proposed rules may be obtained from the Department at the address stated above.