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

NOTICE OF FINAL 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 the adoption of the following amendments to Chapter 26 (Long-Term Care Insurance) of Title 26 (Insurance) of the D.C. Municipal Regulations. 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.

A notice of the proposed rulemaking was published in the *D.C. Register* on August 24, 2007 (54 DCR 8286). No substantive changes have been made to the rulemaking. These rules shall become effective on the date of publication in the *D.C. Register*.

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 first 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 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 policies 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]

- 2625.5 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.
- 2625.6 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 first 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 3608 (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 ("NAIC"), 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

Form with checkboxes for disclosure statement: 'The answers to the questions above describe my financial situation or I choose not to complete this information.' and '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] [\$ _____])
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

<u>Contingent Nonforfeiture</u>	
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) ____%

**CHAIRPERSON, DISTRICT OF COLUMBIA TAXICAB COMMISSION
NOTICE OF FINAL RULEMAKING**

The Chairperson of the District of Columbia Taxicab Commission (“Chairperson”), pursuant to the authority set forth under section 105 of the 2005 District of Columbia Omnibus Authorization Act, approved October 16, 2006 (120 Stat. 2023; D.C. Official Code § 50-381(a) (2007 Supp)), Mayor’s Order, 2007-231, dated October 17, 2007, and Section 14 of the District of Columbia Taxicab Commission Establishment Act of 1985, effective March 25, 1986 (D.C. Law 6-97; D.C. Official Code § 50-313) (2001)) hereby gives notice of the adoption of the following rules amending 31 DCMR, “Taxicabs and Public Vehicles for Hire”. The rules govern the implementation of a time and distance taximeter system for the District of Columbia.

The amendments were previously published at 55 DCR 2951 on March 21, 2008, as proposed rulemaking. Comments were received from individuals and entities. Where appropriate, some of these comments regarding clarification were accepted and the text of the proposed rules modified accordingly. The changes to the text of the proposed rules did not amount to a substantive modification of the rules, thus there is no need for an additional period of comment.

The Chairperson also gives notice that the final rules shall become effective upon publication in the D.C. Register.

Chapter 6, section 602 is deleted in its entirety and replaced with the following:

602 TAXIMETERS

602.1 Effective May 1, 2008, licensed taxicabs shall be equipped with a taximeter which allows for calculation of the following rates and charges:

- (a) Flag drop rate;
- (b) Distance rate;
- (c) Luggage charge;
- (d) Radio dispatch charge;
- (e) Fuel surcharge;
- (f) Snow emergency; and
- (g) Wait time charges.

602.2 Effective May 1, 2008, licensed taxicabs shall be equipped with a taximeter which allows for the following data and reports:

- (a) Customer receipts;
- (b) Shift statistics, including but not limited to paid miles, unpaid miles, and the number of trips; and
- (c) End-of-year statistics, including but not limited to paid miles, unpaid miles, and number of trips.

602.3 Effective May 1, 2008 licensed taxicabs shall be equipped with a taximeter which shall meet the following requirements:

- (a) Be fully electronic;
- (b) Have all access points sealed by a taximeter business licensed by the Commission;
- (c) Have casings made of hard impenetrable plastic or metal;
- (d) Be capable of operating within a temperature range of -20 F and +120 F;
- (e) Be capable of automatically producing a printed receipt for passengers as described in § 803.1;
- (f) Be capable of releasing a printed receipt within ten (10) seconds;
- (g) Be capable of producing a printed report for Commission personnel which shows total mileage, total paid mileage, total trips, total units, and total extras. All these readouts must show a minimum of six (6) digits exclusive of decimals, for example 999,999. This function shall be operated by a separate button or switch;
- (h) Have the name and license number of the licensed taximeter shop on the sealed surface of all seals. If an adjustment can be made to any component affecting the performance of the printer, then provision shall be made for applying a seal in a manner which requires the seal to be broken before an adjustment can be made;
- (i) Have an auxiliary power source contained in the unit which operates independently of the vehicle's electrical system contained in the unit and operates the memory at its full capacity for a minimum of two (2) years;
- (j) Have a memory which shall be non-erasable. Upon reaching the limits of any display, the unit shall be capable of turning over;

- (k) Have a fully programmable fare structure with low-cost rate change capability;
- (l) For two (2) piece units, have a printer capable of interfacing with and recording information from a fully approved electronic taximeter;
- (m) For two (2) piece units, have all connections between the display meter and the memory/printer unit permanently sealed and tamper-proof by use of approved tubing or electrical conduits. The display unit must be unable to function if disconnected from the memory/printer unit;
- (n) Be capable of automatically making meter displays inoperable if printer paper is not available in the memory/printer unit;
- (o) Have model and serial numbers appearing on the face of the unit. For two (2) piece units, model and serial numbers must appear on the display unit and the memory/printer unit;
- (p) Have all operating buttons and/or switches related to passenger functions appearing on the face of the unit properly labeled, and indicating each function;
- (q) Have all extra charges appear separately on the display as well as the receipt for passengers. Extra charge indicator shall be illuminated when in operation;
- (r) Have the fare displayed for a total of fifteen seconds (15) from the time the printer begins to print the customer receipt at the completion of the ride;
- (s) Have a clearly visible fare display;
- (t) Have a receipt dispenser unit which is visible to the passenger;
- (u) Have sufficient candlepower so that all illuminated indicators are visible to the passenger;
- (v) Be permanently affixed to the vehicle in a location approved by the Commission;
- (w) Have a cruiser light that is controlled by the engaging of the meter;
- (x) Be capable of calculating and displaying the regular metered rate of fare required by section 801 in Chapter 8 of these regulations;

- (y) Use switches, wiring and wire caps in all connections to the taximeter harness, cruiser light wires and pulse wires that meet the specifications of the Society of Automotive Engineers, where such specifications are applicable. All of the ports and peripheral connections shall be physically secure from tampering that could disrupt the functionality or compromise the integrity of the taximeter; and
 - (z) Meet the specifications and tolerances published in the National Bureau of Standards Handbook 44.
- 602.4 Taximeters shall only be installed by taximeter businesses licensed by the Commission which meet the requirements in Chapter 13 of these Regulations.
- 602.5 No taxicab shall be equipped with more than one taximeter.
- 602.6 Each taximeter shall be sealed to avoid tampering and only a licensed taximeter business shall perform the sealing:
- (a) Lead seals shall use a numbered seal press with an official inscription issued by the Commission;
 - (b) The taximeter business shall place a certification sticker, issued by the Commission on each taximeter that states the following:
 - (1) The taximeter's serial number;
 - (2) The date it was sealed;
 - (3) The name of the authorized sealer;
 - (4) The sealer's signature;
 - (5) The revolutions (constant "K") of the taximeter; and
 - (6) The wheel and tire size at the time of inspection and the recommended tire pressure.
- 602.7 Each taximeter shall be tested once per year by a taximeter business licensed by the Commission. The annual inspection shall not be conducted by a taximeter business on taxicabs owned or affiliated with the taximeter business conducting the inspection. The annual inspection shall be identical to the inspection process identified in section 1324.1.
- 602.8 Each new taximeter unit submitted for approval to the Commission by the manufacturer, its licensed representative, or the taximeter business shall be subject to a testing period.

- 602.9 Drivers shall comply with the following requirements as to the condition of the taximeter and cruiser lights:
- (a) A driver shall not drive a taxicab unless all taximeter seals and cable housing seals are in good condition and pressed by the Commission or its authorized designee. The serial number of the taximeter must be the same as that shown on the rate card assigned to the taxicab;
 - (b) A driver shall not pick up or transport a passenger unless the taximeter is properly equipped with paper for the printing of receipts; and
 - (c) A driver while on duty shall not operate a taxicab unless the cruiser light is lit when the taximeter is not in use, and unlit when the taximeter is in use.
- 602.10 Tampering with a taximeter, taximeter technology system or the cruiser light is prohibited:
- (a) A driver shall not operate a taxicab in which the taximeter or the seals affixed thereto by a licensed taximeter repair shop have been tampered with, broken or altered in any manner. The operation of a taxicab with a broken taximeter seal shall give rise to a rebuttable presumption that the driver knew of the tampering or alteration and operated the taxicab with such knowledge;
 - (b) A driver shall not tamper with, repair or attempt to repair, or connect any unauthorized device to the taximeter or any seal, cable connection or electrical wiring thereof, or make any change in the vehicle's mechanism or its tires which would affect the operation of the taximeter;
 - (c) A driver shall not tamper with the cruiser light or any of the interior lights or connections except to replace a defective bulb or fuse. The cruiser light of a taxicab shall be automatically controlled only by the movement of the taximeter button or ignition switch so that it is lighted only when the taximeter is in an off or "Vacant" position and unlighted when the taximeter is in a recording or "Hired" position. The operation of a taxicab with an unauthorized installation or device controlling interior or cruiser lighting shall give rise to a rebuttable presumption that the driver knew of the unauthorized installation or device and operated the taxicab with such knowledge; and
 - (d) A driver shall not place tires or wheels of a different size, or "off-size" tires, on the taxicab without reinspection and recalibration of the meter. The driver shall not operate a taxicab with tires inflated outside the manufacturer's recommended level, be it "under" or "over inflated".

Subsection 608.1 is amended as follows:

- 608.1 All taxicab vehicles shall be inspected semi-annually, or at other times as required by the Commission for the following:
- (a) Safe operating condition and compliance with District of Columbia motor vehicle regulations with respect to the condition of the body and fenders, cleanliness, repairs, and other mechanical parts relating to both the exterior and interior condition of the taxi vehicle; and
 - (b) Broken or damaged taximeter seals.

Chapter 8 is amended as follows, and shall be effective May 1, 2008:**The table of contents of Chapter 8 is amended as:****801 Passenger Rates and Charges****Section 801 is deleted in its entirety and replaced with the following:****801 Passenger Rates and Charges**

- 801.1 Passenger rates and charges for metered taxicab service provided within the District of Columbia shall be in accordance with the charges established in this chapter. No person shall knowingly or intentionally charge an amount in excess of the rates and charges established in this chapter.
- 801.2 The word "passenger" shall not include one child five (5) years of age or younger accompanied by an older person.
- 801.3 For trips within the District of Columbia, the regular metered rate of fare is as follows:
- (a) Three dollars (\$3.00) upon entry and first 1/6 of a mile;
 - (b) Twenty-five cents (\$0.25) for each one sixth of a mile after the first 1/6; and
 - (c) The wait rate is fifteen dollars (\$15.00) per hour.
- 801.4 Wait time begins five (5) minutes after time of arrival at the place the taxicab was called. No time shall be charged for premature response to a call. Waiting time shall be charged for time consumed while the taxicab is stopped or slowed to a speed of less than ten miles per hour for longer than sixty (60) seconds and for time consumed for delays or stopovers en route at the direction of the passenger. Wait time shall be

calculated in sixty (60) second increments. Wait time does not include time that is lost due to taxicab or driver inefficiency.

801.5 Except for declared snow emergency fares provided for in § 804, the regular metered fare listed in § 801.3, not including extra charges and surcharges listed in § 801.6, shall not exceed \$19.00 for trips originating and ending and with all stops en route in the District of Columbia.

801.6 Extra charges or surcharges shall be as follows:

- (a) Telephone dispatch service in response to a telephone call for taxicab service shall be two dollars (\$2.00);
- (b) Dismissal of a taxicab without use, after response to a telephone call, shall be one dollar and fifty cents (\$1.50) in addition to the one dollar and fifty cents (\$1.50) charge for responding;
- (c) Luggage including large bags of groceries or articles of similar size, there shall be no charge for one piece per passenger. For additional pieces, there is a charge of fifty cents (\$.50) for each piece handled by the driver. Briefcases and parcels of comparable size shall not be considered luggage;
- (d) Trunks or similar-sized large articles shall be charged at the rate of two dollars per piece (\$2.00). A trunk is a piece of baggage having a minimum dimension or cubic content in excess of 32 inches by 18 inches by 9 inches, or three (3) cubic feet, respectively;
- (e) Personal service shall be charged at the rate of two dollars (\$2.00). "Personal service" is any service requested by a passenger which requires the taxicab driver to leave the vicinity of the taxicab. No such charge shall be made for persons who are blind, handicapped or disabled;
- (f) Delivery service (messenger service and parcel pick-up and delivery) shall be at the same rate as for a single passenger unless the vehicle is hired by the hour;
- (g) Small dogs or other small animals, when securely enclosed in a box or basket designed for that purpose, may accompany a passenger without charge. Other animals not so enclosed may be carried at the discretion of the driver:
 - (1) If the driver agrees to carry a small dog or small animal which is not enclosed, there shall be a charge of one dollar (\$1.00);

- (2) A driver may refuse to transport any passenger traveling with a small dog or other small animal if the driver notifies the passenger that he/she suffers from a diagnosed medical condition such as allergies and cannot travel with the small dog or other small animal in the vehicle; and
- (3) No driver shall have a personal pet or animal of any kind in a vehicle for hire while holding the vehicle out for hire.
- (h) A service animal accompanying a passenger with a disability shall be carried without charge. The term “service animal” means a guide dog, a signal dog, or other animal trained to assist or perform tasks for the benefit of a passenger with a disability;
- (i) Devices for the aid of a disabled person, such as a folding wheelchair, when accompanying the passenger with a disability shall be carried without charge. No driver shall impose a personal service charge for loading or unloading such devices in or from a taxicab;
- (j) Where an airport surcharge is paid by the taxicab driver, that surcharge may be added to the fare of the trip; and
- (k) A taxicab employed on an hourly basis shall be \$25.00 for the first hour or fraction thereof and \$6.25 for each additional fifteen minutes or fraction thereof.
- (l) Additional passenger charge for groups of two or more passengers is one dollar and fifty cents (\$1.50) per passenger;
- 801.7 In cases where more than one passenger enters a taxicab at the same time on a pre-arranged basis (group riding) bound for different destinations, in addition to the applicable charges set out in this section, the fare shall be charged as follows: Whenever a passenger gets out, the fare shall be paid, the meter shall be reset, and the last passenger shall pay the remaining fee.
- 801.8 For trips beyond the limits of the District of Columbia, the provisions in Subsection 801.5 will not apply.
- 801.9 Any continuous trip where the point of origin and the destination are both within the limits of the District of Columbia shall not be considered a trip beyond the limits of the District though the shortest and most direct route requires traveling outside of the District’s boundaries into a contiguous jurisdiction. For such a trip the meter shall be kept in the recording position throughout.

- 801.10 As provided in § 808, shared riding is only allowed from Union Station at the discretion of a starter. Rates for shared riding shall be calculated in accordance with § 801.7.
- 801.11 Where the taxicab operator accepts a credit card for Payment:
- (a) There shall be no additional charge added to the fare for the use of a credit card;
 - (b) No minimum charge may be imposed for the use of a credit card to pay a fare;
 - (c) No service may be refused to any person desiring to use a credit card on the grounds that a trip will not exceed a minimum length or generate a minimum fare; and
 - (d) Any operator who accepts credit cards in payment of fares must have posted on a sign in a location that is conspicuous to all passengers the type of credit cards accepted for payment.
- 801.12 A sign approved by the Office of Taxicabs displaying passenger rates and charges shall be affixed to each taxicab on either the rear door window, rear vent window, or wrap around window and maintained in good conditions.

Section 802 is repealed

Section 803 is deleted in its entirety and replaced with the following:

803 CUSTOMER RECEIPTS FOR SERVICE

- 803.1 A taxicab operator, when requested by a passenger or a person requesting messenger or parcel delivery service, shall give a receipt showing the following:
- (a) Operator's name;
 - (b) Identification card number;
 - (c) Vehicle tag number;
 - (d) Time, date;
 - (e) The amount of the fare; and.
 - (f) Commission's complaint phone number.
- 803.2 In the case of messenger or parcel delivery service, the driver shall provide a written invoice describing the article(s) to be transported.

803.3 The operator shall retain a duplicate receipt for a period of one (1) year.

Subsection 804.1 is amended as follows:

804.1 During a snow emergency fare period, as declared by the Chairperson of the District of Columbia Taxicab Commission (Chairperson), the meter fare rate shall be 125% of the applicable regular fare.

Subsection 804.10 is amended as follows:

804.10 During snow emergency periods, there shall be prominently displayed on the back of the front seat of the taxicab, and pointed out to the passenger by the driver, a sign in size and form prescribed by the Office, which shall read as follows:

SNOW EMERGENCY FARE

DURING SNOW EMERGENCY PERIODS, AS DECLARED BY THE CHAIRPERSON OF THE DISTRICT OF COLUMBIA TAXICAB COMMISSION, PASSENGERS SHALL PAY 125 PERCENT OF THE APPLICABLE REGULAR FARE, NOT INCLUDING ANY APPLICABLE EXTRA CHARGES OR SURCHARGES.

BEGINNING AND END OF SNOW EMERGENCY PERIODS WILL BE PUBLICIZED ON RADIO, TELEVISION OR IN NEWSPAPERS.

IF DISPUTES ARISE, THE PASSENGER(S) SHALL PAY THE FARE STATED BY THE DRIVER AND THE DRIVER MUST FURNISH A RECEIPT. THE PASSENGER(S) MAY FILE A COMPLAINT IN WRITING WITHIN FIFTEEN (15) DAYS IN ACCORDANCE WITH THE STATEMENT OF PASSENGER RIGHTS POSTED IN THIS TAXICAB. THE COMPLAINT SHALL BE FILED WITH THE DISTRICT OF COLUMBIA TAXICAB COMMISSION, 2041 MARTIN LUTHER KING, JR., AVENUE, S.E., WASHINGTON, D.C. 20020, (202) 645-6003.

Subsection 805.2 is amended as follows:

805.2 The passenger(s) disputing a snow emergency fare shall file a written explanation of the nature of the dispute, along with a copy of the receipt required by § 804.11, with the District of Columbia Taxicab Commission.

Section 808 is deleted in its entirety and replaced with the following:

808 GROUP RIDING AND SHARED RIDING

- 808.1 Group riding for pre-formed groups, as defined in § 899, is permitted at all times. No driver shall refuse to engage in group riding at any time.
- 808.2 Shared riding, as defined in § 899, is only permitted at Union Station at such times as are determined to be necessary to achieve adequate service by a starter employed or authorized by Union Station.
 - (a) The starter shall have the sole authority to determine when a taxicab shall depart after taking on passengers, except that after an initial passenger has been taken on, the starter shall not unreasonably delay the departure of the taxicab for the purpose of securing additional passengers;
 - (b) The general direction of the destination of the first passenger shall determine the general direction of that particular trip. Other passengers whose destinations lie generally in that direction may be transported to the extent of the designed capacity of the taxicab; and
 - (c) Passengers shall be discharged in the order of the arrival at their respective destinations. In the event any questions arise as to the order of arrival at any destination, the question shall be resolved in favor of the passenger who entered the taxicab first.
 - (d) Passengers have the right to refuse shared riding.

Subsection 825.1 is amended as follows:

825.1 The civil infractions and their respective fine amounts set forth in this section do not include major moving violations.

<u>INFRACTION</u>	<u>FINE</u>
Accident	
Failure to report to insurance carrier within specified time	25.00
Air Conditioning	
Improperly operating system	100.00
Cruising Lights	
Broken	25.00
Failure to have	50.00
Failure to use	25.00
Curb	
Failure to pull to curb to pick up and discharge passenger(s)	25.00

DCTC License	
Failure to display	100.00
Failure to have	500.00
Destination	
Asking in violation of § 819.9	25.00
Dirty Taxicab	50.00
Dress of Operator	
Unkempt or improperly dressed	25.00
Failure to Notify	
The Office of a change in information	25.00
Fares	
Failure to charge proper fare	150.00
Failure to give receipt upon request	150.00
Refusing to pay	25.00
Soliciting	25.00
Heating	
Improperly operating system	100.00
Hubcaps and Wheel Covers	
Failure to have	25.00
Identification Cards	
Failure to display for passenger(s) view	25.00
Operating without an identification card	500.00
Permitting the operation without an identification card	500.00
Insignia	
Failure to have proper colors, number or insignia on vehicle	25.00
Loitering	25.00
Manifest	
Failure to have approved form in possession	25.00

Failure to properly complete and maintain	25.00
Failure to provide manifest to government agency	100.00
Failure to provide meter statistics to government agency	1,000.00
No Smoking	
Violation of law	25.00
Orders of Enforcement Personnel	
Failure to obey an order of a Civilian Hack Inspector or other law enforcement personnel engaged in enforcement of taxicab laws and regulations	50.00
Parked	
More than 5 feet from cab hack stand	5.00
Off stand	5.00
Passenger	
Loading or unloading in crosswalk	25.00
Overloading	25.00
Refuse to haul	250.00
Illegal Shared Ride	250.00
Property	
Failure to report property left in vehicle	25.00
Rate Sticker Sign	
Failure to display	150.00
Seat Belts	
Failure to have mandatory use of seat belts signage	100.00
Sign	
Improper use of "Off Duty"	100.00
Improper use of "On Call"	100.00
Speedometer or Odometer	
Defective	25.00
Taximeter	

Tampering with meter or seals	\$1,000.00 and suspension or revocation of hacker’s license
Operating without meter	1,000.00 and suspension or revocation of hacker’s license
Operating with non-functional meter	1,000.00
Operating a cab with “off-size” wheels or tires	1,000.00 and Suspension or revocation of hacker’s license
Operating a cab with “under” or “over” inflated tires	1,000.00
 Unlicensed Operator	
D.C. resident	500.00
Non-resident	500.00
 Unlicensed Vehicle	
D.C. resident	500.00
Non-resident	500.00

Subsections 825.2 is amended as follows:

- 825.2 In addition to the civil fine, failure to pay the fine or request a hearing within fifteen (15) calendar days of the issuance of a notice of infraction may result in the imposition of a penalty equal to the amount of the civil fine.
- 825.3 Failure to appear for a requested hearing may result in the imposition of a penalty equal to twice the amount of the civil fine.
- 825.4 The civil fines set forth in this section may be doubled for the second violation of the same infraction and may be doubled once more for any subsequent violation or violations of the same infraction.

Section 899 (Definitions) is amended as follows:

Group Riding – the transportation of two (2) or more passengers whose trip has a common point of origin and different destinations.

Shared Riding – trips arranged by a starter at Union Station that involve the transportation of two (2) or more passengers with common or different destinations.

Appendices 8-1 and 8-2 of Chapter 8 are deleted.

Appendix 8-3 is amended by substituting an amended Taxi Driver’s Daily Manifest Form (attached)

Chapter 10, subsection 1010.10 is amended as follows and shall be effective May 1, 2008:

1010.10 The Department of Motor Vehicles, acting as agent for the District of Columbia Taxicab Commission, shall inspect taxicabs to ensure compliance with the District of Columbia Taxicab Commission's regulations concerning paint color(s), trade name, insignias, rate and passenger rights signs, meter seals, cruising lights, upholstery condition, and sanitation.

Chapter 11, subsection 1102.3 is amended as follows, and shall be effective May 1, 2008:

1102.3 A Commission or panel investigation may include, but is not limited to, an investigation into any of the following subjects:

- (a) Rate studies;
- (b) Review of the taximeter;
- (c) Public education and awareness;
- (d) Education of taxicab operators and owners;
- (e) Enforcement activities; or
- (f) Discrimination in the taxicab industry.

Chapter 12, section 1299.1 is amended as follows, and shall be effective May 1, 2008:

1299.1 **Sedan** - a for-hire vehicle designed to carry fewer than six (6) passengers, excluding the driver, which charges for service on the basis of time and mileage.

A new Chapter 13 is added to 31 DCMR to read as follows:**CHAPTER 13 LICENSING AND OPERATIONS OF TAXI METER COMPANIES****Section**

1300	Application and Scope
1301	Unlicensed Business Activity Prohibited
1302	Taximeter Business License – General Requirements
1303	Taximeter Business License – Bond Required
1304	Taximeter Business – Financial Disclosure
1305	Taximeter Business – Fees
1306	Taximeter Business – Compliance with Licensing Requirements
1307	Taximeter Business – Change in Ownership
1308	Taximeter Business – Compliance with Applicable Laws
1309	Taximeter Business – Fees Charged by Licensees

- 1310 Taximeter Business – Premises and Equipment
- 1311 Taximeter Business – Equipment Maintenance
- 1312 Taximeter Business – Signage on Premises
- 1313 Taximeter Business – Personal Conduct
- 1314 Taximeter Business – Unlawful Activities Prohibited
- 1315 Taximeter Business – Notification of Criminal Conviction or Change in License Conditions
- 1316 Taximeter Business – Notification of any License Suspension or Revocation
- 1317 Taximeter Business – Bribery Prohibited
- 1318 Taximeter Business – Threatening, Harassing or Abusive Conduct Prohibited
- 1319 Taximeter Business – Cooperation with the Commission
- 1320 Taximeter Business – Liability for Conduct of Employees
- 1321 Taximeter Business – Liability for Tampering or Alteration
- 1322 Taximeter Business – Duty to Notify the Commission
- 1323 Taximeter Business – Seals
- 1324 Taximeter Business – Required Inspections
- 1325 Taximeter Business – Other Repair Limitations
- 1326 Taximeter Business – Record of Taximeter Tests
- 1327 Taximeter Business – Repair Work After Test Failure Prohibited
- 1328 Taximeter Business – Overcharges Prohibited
- 1329 Taximeter Business – Sale of Taximeters
- 1330 Taximeter Business – Record Keeping and Reporting
- 1331 Penalties for Violations
- 1399 Definitions

1300 APPLICATION AND SCOPE

- 1300.1 This chapter shall be applicable to and governs all taximeter businesses in the District of Columbia.
- 1300.2 The provisions of this chapter shall be interpreted to comply with the language and intent of section 105 of the 2005 District of Columbia Omnibus and Authorization Act, approved October 16, 2006, 120 Stat. 2023, D.C. Official Code § 50-381(a) (2007 Repl.) and the “District of Columbia Taxicab Commission Establishment Act of 1985,” as amended.

1301 UNLICENSED BUSINESS ACTIVITY PROHIBITED.

- 1301.1 No person shall sell, install, repair, adjust, or calibrate taximeters or install or replace seals, wiring harnesses or other equipment relating to the operation of a taximeter or cruiser light for use upon any licensed taxicab in the District of Columbia without a valid taximeter business license issued by the Commission.

1302 TAXIMETER BUSINESS LICENSE – GENERAL REQUIREMENTS

1302.1 The application for the initial and renewal of a taximeter business license shall be filed on a form provided by the Office of Taxicabs and shall contain a sworn and notarized statement that the information contained therein is true under penalty of perjury.

1302.2 License Application Requirements

- (a) An individual applicant for a taximeter business license shall meet the following requirements:
 - (1) Provide proof of identity in the form of a valid photo identification issued by the United States, any state or territory thereof, or any political subdivision of such state or territory; and a valid, original social security card;
 - (2) Be at least eighteen (18) years of age; and
 - (3) Be of good moral character as reflected by the outcome of the report required in section (d) and in accordance with the guidelines in § 1001.12.
- (b) An applicant that is a partnership shall provide the following:
 - (1) A certified copy of the partnership certificate from the jurisdiction where the principal place of business is located.
 - (2) Each partner must satisfy the requirements for individual applicants set forth in § 1302.2.
- (c) An applicant that is a corporation shall provide the following:
 - (1) A certified copy of its certificate of incorporation with a filing receipt issued by the Mayor, if incorporated less than one year from the date of the license application or a certificate of good standing; or if incorporated more than one year from the date of the license application, or if not a District of Columbia corporation, a copy of the certificate of incorporation, filing receipt, and authority to do business within the District of Columbia;
 - (2) A list of its officers and shareholders, including names, residence addresses, telephone numbers, and percentage of ownership interest of each shareholder; and
 - (3) A certified copy of the minutes of the organizational

meeting at which the current officers were elected.

- (d) Each of the following persons shall be fingerprinted, for purposes of securing criminal history records from the Federal Bureau of Investigation:
- (1) Each individual applicant;
 - (2) Each partner of a partnership applicant;
 - (3) Each officer or shareholder of a corporate applicant; and
 - (4) Each person who has provided funds either individually, or as a principal of a partnership or corporation, whether such funds were provided by gift, loan or otherwise, in connection with the operation of the taximeter business, unless such provider is a licensed bank or loan company. The applicant shall pay any processing fees required by the Office of Taxicabs or the Federal Bureau of Investigation.
- (e) The Commission shall have the right to reject the proposed name of any taximeter business that is substantially similar to any name in use by another taximeter business licensee.
- (f) Each license expires two (2) years from the date of issuance.

1303 TAXIMETER BUSINESS LICENSE – BOND REQUIRED

- 1303.1 Each applicant for an initial taximeter business license or renewal license shall deposit with the Commission and shall keep in full force and effect throughout the license period, a bond in the sum of fifty thousand (\$50,000) dollars, provided by one or more sureties approved by the Commission.
- 1303.2 Such bond shall be payable to the DC Treasurer and shall be conditioned on the licensee complying with all provisions of this title including, but not limited to, compliance with the Clean Hands Act and payment of any fines or judgments against said licensee by any court or administrative agency, including, but not limited to, the Office of Administrative Hearings for violations of this title.
- 1303.4 This bond shall remain in full force and effect for the term of the taximeter business license, and for one (1) year following the termination, non-renewal, or revocation of any license.

1304 TAXIMETER BUSINESS LICENSE – FINANCIAL DISCLOSURE

- 1304.1 Each individual, partner, corporate shareholder or corporate officer applicant for a new or renewal taximeter business license shall file with the Commission a financial disclosure statement, to be submitted on a form provided by the Office of Taxicabs, which shall include but not be limited to identifying such individual's assets, liabilities, income, net worth, source of bank accounts and any investments a business licensed or regulated by the Commission or with an individual or entity who is a participant in a business licensed or regulated by the Commission.
- 1304.2 Each individual, partner, shareholder or officer of a taximeter business shall disclose to the Commission his interest, whether as owner, partner, officer, shareholder, director, lender or other creditor, in any licensed taxicab.

1305 TAXIMETER BUSINESS LICENSE – FEES

- 1305.1 Every application for a license to operate a taximeter business shall be accompanied by a non-refundable application fee of five hundred dollars (\$500) to be deducted from the first bi-annual license fee of two thousand dollars (\$2,000).
- 1305.2 The license application fee and the license fee shall be payable by money order or by certified check and payable to the DC Treasurer.
- 1305.3 The bi-annual renewal license fee after the first license is one thousand and five hundred dollars (\$1,500) and is due on the anniversary of the issuance of the license.

1306 TAXIMETER BUSINESS – COMPLIANCE WITH LICENSING REQUIREMENTS

- 1306.1 If at any time during the term of the taximeter business license, the Chairman becomes aware that the licensee no longer meets the requirements for a taximeter business license, the Commission may suspend or revoke the license or deny any application for renewal.
- 1306.2 Nothing contained herein shall limit the authority of the Chairman to summarily suspend the license of any taximeter business where a threat to public health, safety or welfare exists.
- 1306.3 Appeals of actions taken by the Commission pursuant to sections 1306.1, 1306.2 and 1331 shall be heard by the Office of Administrative Hearings

1307 TAXIMETER BUSINESS – CHANGE IN OWNERSHIP

- 1307.1 A taximeter business owner shall not, without the prior consent of the Commission, transfer any interest in a taximeter business, including, but not limited to, the transfer of any ownership interest, or any agreement to transfer an ownership interest in the future.
- 1307.2 A taximeter business owner shall not, without prior notification and approval by the Commission, make any change in location, mailing address, corporate name, trade name, corporate officers, or any other material deviation from the description of the taximeter business as stated in the original or renewal application.

1308 TAXIMETER BUSINESS – COMPLIANCE WITH APPLICABLE LAWS

- 1308.1 A licensee shall obtain and keep in full force and effect all licenses and permits required by the District or federal laws.
- 1308.2 A licensee shall comply with all applicable Occupational Safety and Health Act (OSHA) standards and requirements at the licensee's place of business, as well as all other Federal and District laws governing the conduct of its business.
- 1308.3 A licensee shall pay any fines, fees, and/or taxes owed by it to the federal or District government.
- 1308.4 A licensee shall comply with all workers' compensation and disability benefits laws, and all federal laws regarding the withholding of taxes and payment of FICA and other withholding taxes.

1309 TAXIMETER BUSINESS – FEES CHARGED BY LICENSEES

- 1309.1 A licensee shall file with the Commission a schedule of current fees for all services related to the sale, repair, installation and calibration of taximeters, including, but not limited to, inspections, tests, adjustments, installations, corrections, or repairs.
- 1309.2 Any change in fees shall be filed with the Commission at least ten (10) days prior to the scheduled date of said change in fees.
- 1309.3 A taximeter business owner shall not engage in any business unless a current schedule of inspection and repair charges, including hourly rates, if applicable, is prominently displayed to the public on the business premises.
- 1309.4 A taximeter business owner shall not publicly display any fee schedule until after it has been filed with the Commission.

1310 TAXIMETER BUSINESS – PREMISES AND EQUIPMENT

1310.1 A taximeter business licensee shall meet the following requirements at all times:

- (a) Be located within an area zoned for this business activity;
- (b) Be of sufficient size to simultaneously accommodate at least three (3) vehicles of the type(s) and model(s) licensed by the Commission;
- (c) Have sufficient illumination and space in inspection, testing, and calibration areas to enable proper inspections and tests required by these regulations; and
- (d) Have all signs required by law and these rules.

1310.2 A taximeter business licensee may not use temporary structures that are not described in the certificate of occupancy for the premises.

1310.3 No installation, adjustment, correction, calibration, or repairs of any type may be performed on a public street or any facility other than the taximeter business premises.

1310.3 A taximeter business shall be equipped with, at a minimum, the equipment required by the Commission for the repair and installation of taximeters.

1311 TAXIMETER BUSINESS – EQUIPMENT MAINTENANCE

1311.1 A taximeter business owner shall properly maintain all equipment required by the Commission, or any other equipment required by law or regulation, in good working order, and in such a manner that an inspection, test, or calibration may be conducted in conformity with these rules.

1311.2 A taximeter business shall not conduct any test, calibration, or installation using equipment that is not in good working order.

1312 TAXIMETER BUSINESS – SIGNAGE ON PREMISES

1312.1 A “licensed taximeter business” sign, bearing the taximeter business license number and meeting the specifications of the Commission, shall, at all times, be hung or mounted on the outside of the premises in such a manner that it is easily visible to the public from outside the building.

1312.2 A taximeter business owner shall not display a “licensed taximeter business” sign if its taximeter business license, or any other necessary license, is expired, suspended or revoked or if it never was licensed.

1312.3 Each licensed taximeter business shall have affixed to the inside of the glass window thereon, to be clearly legible from the outside, a printed sign bearing its business name, license number, and the Commission’s complaint telephone number.

1313 TAXIMETER BUSINESS – PERSONAL CONDUCT

1313.1 A taximeter business owner or his representative, while performing duties and responsibilities as a licensed taximeter business, shall not commit or attempt to commit, alone or in concert with another, any act of fraud, misrepresentation, or larceny.

1313.2 Examples of fraud, larceny or misrepresentation include, but are not limited to:

- (a) Calibration of a fare other than that set by the Commission;
- (b) Adjustment of the tire size, driving axle, pinion gear, transducer, wiring, or other equipment, for the purpose of generating an inaccurate signal of time or distance into the taximeter; or
- (c) The manufacture, sale or installation of any device which is either designed to or does generate a false or inaccurate signal into the taximeter.

1313.3 A taximeter business owner or his representative shall not perform any willful act of omission or commission, which is against the best interest of the public, even if not specifically prohibited by these rules.

1314 TAXIMETER BUSINESS – UNLAWFUL ACTIVITIES PROHIBITED

1314.1 A taximeter business owner shall not use or permit any other person to use his business premises or office of record for any unlawful purpose.

1314.2 A taximeter business owner shall not conceal any evidence of a crime connected with his business premises or office of record.

1314.3 A taximeter business owner shall report immediately to the Commission and the police any attempt to use his business premises to commit a crime.

1314.4 A taximeter business owner shall not file with the Commission any statement, including but not limited to statements required to be filed pursuant to these rules,

which he or she knows or reasonably should know to be false, misleading, deceptive or materially incomplete.

1315 TAXIMETER BUSINESS – NOTIFICATION OF CRIMINAL CONVICTION OR OTHER CHANGE IN LICENSE CONDITIONS

1315.1 A taximeter business owner, including a member of a partnership or any officer or shareholder of a corporation, shall notify the Commission in writing of his/her conviction for a crime within fifteen (15) days of such conviction, and he or she shall deliver to the Commission a certified copy of the certificate of disposition issued by the clerk of the court within fifteen (15) days of conviction.

1315.2 In accordance with § 1307.2, a taximeter business owner shall notify the Commission of any material change in the information contained on such owner's latest taximeter business license application or renewal.

1316 TAXIMETER BUSINESS – NOTIFICATION OF ANY LICENSE SUSPENSION OR REVOCATION

1316.1 A taximeter business owner shall immediately notify the Commission in writing of any suspension or revocation of any license granted to the licensee, or any other person acting on his behalf, by any agency of the District of Columbia or federal government.

1317 TAXIMETER BUSINESS – BRIBERY PROHIBITED

1317.1 A taximeter business owner or any person acting on his behalf shall not offer or give any gift, gratuity, or thing of value to any employee, representative, or member of the Commission, or any public servant.

1317.2 A taximeter business owner or any person acting on his behalf or during the scope of his or her employment with said taximeter business owner, shall immediately report to the Commission and the Inspector General any request or demand for a gift, gratuity or thing of value by any employee, representative or member of the Commission or any public servant.

1317.3 A taximeter business owner or any person acting on his behalf shall not accept any gift, gratuity, or thing of value from an owner or driver of any vehicle licensed by the Commission, or any individual or any other person actually or purportedly acting on behalf of such owner or driver for the purpose of omitting an act required by these rules or committing any violation of these rules.

1317.4 A taximeter business owner shall notify the Commission immediately and in writing within twenty-four (24) hours thereafter of any offer of a gift or gratuity prohibited by § 1317.1.

1318 TAXIMETER BUSINESS – THREATENING, HARASSING OR ABUSIVE CONDUCT PROHIBITED

1318.1 A taximeter business owner, while performing his duties and responsibilities as a licensee, shall not:

- (a) Threaten, harass, or abuse any governmental or Commission representative, public servant, or other person; and
- (b) Use or attempt to use any physical force against a Commission representative, public servant or any other person.

1319 TAXIMETER BUSINESS – COOPERATION WITH THE COMMISSION

1319.1 A taximeter business owner shall, at all times, cooperate with all law enforcement officers and representatives of the Commission.

1319.2 A taximeter business owner shall answer and comply as directed with all questions, communications, notices, directives, and summonses from the Commission or its representatives.

1319.3 A licensee shall produce his/her Commission license and/or other documents whenever the Commission requires.

1320 TAXIMETER BUSINESS – LIABILITY FOR CONDUCT OF EMPLOYEES

1320.1 A taximeter business owner shall supervise and be responsible for the conduct of all its employees, contractors or agents, for the activities including, but not limited to, the sale, installation, inspection, testing, and calibration of taximeters.

1320.2 A taximeter business owner shall ensure that all employees are fully familiar with the rules and regulations contained herein, as well as any other pertinent regulatory agency rules and regulations.

1320.3 To this end, a taximeter business shall employ only such persons who have been certified as taximeter technicians by a taximeter manufacturer to perform any installation, testing, repair or calibration of the taximeter on which work is being performed:

- (a) Any work involving a taximeter, including, but not limited to, installation, inspection, calibration, and repair shall be performed by a technician certified by the taximeter manufacturer; and
- (b) The certified technician shall be responsible for maintaining all records required by the Commission and shall place his signature on all inspection, testing, repair or other reports prepared by him.

1320.4 A taximeter business owner shall ensure that all employees perform their duties in compliance with all relevant federal and District laws, rules, and regulations.

1320.5 A taximeter business shall furnish to the Commission, upon licensure or renewal, the names of all certified taximeter technicians employed by it and shall notify the Commission in writing of any changes in the employment of certified taximeter technicians.

1321 TAXIMETER BUSINESS – LIABILITY FOR TAMPERING OR ALTERATION

1321.1 By installing a seal on a taximeter, the taximeter business certifies that the taximeter has been tested and calibrated in accordance with these rules.

1321.2 A taximeter business owner shall be strictly liable for the tampering of a meter that is sealed with an unbroken seal issued by a taximeter business.

1321.3 By testing, installing or calibrating a taximeter, the taximeter business certifies that at the time of such installation, testing or calibration, it has:

- (a) Examined and found the wiring harness leading from the taximeter to the speed sensor is of one (1) piece construction with no intervening connectors, splices, “Y” connections, or direct or indirect interruptions of any kind whatsoever, and
- (b) Examined the pinion gear seal and has determined that it is properly sealed.

1322 TAXIMETER BUSINESS – DUTY TO NOTIFY THE COMMISSION

1322.1 A taximeter business shall notify the Commission by telephone immediately, and in writing within twenty-four (24) hours, of any of the following occurrences:

- (a) A taximeter which the taximeter business knows or has reason to know has been reported to the Commission as lost or stolen has been presented to the taximeter business for installation, repair, adjustment or calibration;
- (b) A taximeter has been presented for installation, repair, adjustment or calibration on which one or more seals are removed, damaged, broken or tampered with;
- (c) A person whom the taximeter business owner knows or should have known to be a licensee of the Commission, or to be acting on behalf of a licensee, has requested that the taximeter business engage in any activity prohibited by these rules;
- (d) A person whom the taximeter business owner knows or should have known to be a licensee of the Commission, or to be acting on behalf of a licensee, has attempted to repair, or connect any unauthorized device to, any taximeter, seal, cable connection or electrical wiring, which may have affected the operation of a taximeter; and
- (e) The taximeter business discovers the existence of any intervening connections, splices, "Y" connections or direct or indirect interruptions or connections of any kind whatsoever.

1322.2 Any notice required to be provided to the Commission hereunder shall contain, at a minimum, the following information:

- (a) The taxicab name and number and vehicle tag number;
- (b) The name(s) and license number(s), if any, of the driver(s) who presented the vehicle to the taximeter business;
- (c) The date of the inspection or repair; and
- (d) A detailed description of the taximeter as described in section 1322.1(a).

1323 TAXIMETER BUSINESS – SEALS

1323.1 Installation of a taximeter shall include the affixing of security seals to the taximeter as required by the Commission. Only seals which have been authorized and approved by the Commission shall be used by a taximeter business. The security seals shall be installed in a manner prescribed by the Commission, and in such manner that the security seals self-destruct when the taximeter or sealed part of the vehicle is disassembled.

1323.2 Each seal shall be numbered and the taximeter business shall keep a record of each seal used. Seals must be used in consecutive numerical order, and any seal not used must be accounted for. The record of seals shall be available for inspection by the Commission as set forth herein. The record shall contain, at a minimum, the following information:

- (a) The seal number;
- (b) The number of the taximeter in which the seal was installed;
- (c) The name and number of the taxicab in which the taximeter was installed;
- (d) The date the seal was installed;
- (e) The date and seal number of any seal removed;
- (f) The reason for installing any new seal; and
- (g) The wheel and tire size at the time of inspection and the recommended tire pressure.

1323.3 No taximeter business shall install a seal on a taximeter without removing all seals installed by another meter shop, whether or not broken.

1323.4 Each taximeter business shall maintain on its business premises either a fireproof safe secured to the floor of the establishment or a locked, secured room secured by an alarm connected to a centralized monitoring facility, for the storage of seals and taximeter repair records.

1323.5 Each taximeter business shall maintain and file with the Commission a description of the procedures used by it to prevent the loss, theft, destruction or misuse of taximeter seals.

1323.6 A taximeter business shall not install a meter or seal in a taxicab that it owns or with which it is affiliated.

1324 TAXIMETER BUSINESS – REQUIRED INSPECTIONS

1324.1 A taximeter shall be inspected by the taximeter business whenever it is installed, repaired, or calibrated. Inspection shall include examination of the taximeter installation and operation to verify compliance with:

- (a) The taximeter specifications, type approvals, tolerances, and all

other requirements of the commission, including, but not limited to a measured mile run test;

- (b) The rate of fare established by the Commission;
- (c) The standards set forth in the sections of the taxicab owners' rules regarding taximeters; and
- (d) All other applicable federal and District regulations and guidelines.

1324.2 This section shall not apply to repairs which are made exclusively to the printing mechanism or the resetting of the date and/or time on the printer receipt.

1325 TAXIMETER BUSINESS – OTHER REPAIR LIMITATIONS

1325.1 A taximeter business owner shall not perform any work on a taximeter, including, but not limited to, inspection, testing, calibration, or repair, if:

- (a) No valid vehicle license from the Commission is presented unless the taximeter is not for use in a taxicab licensed by the Commission;
- (b) The taximeter serial number is deleted, defaced, or otherwise altered;
- (c) The vehicle is licensed by the Commission and the taximeter make, model or serial number appears on the Commission vehicle license or rate card, and the commission has not otherwise authorized the use of that taximeter;
- (d) The taximeter business licensee knows or should know that the taximeter presented for testing was reported lost or stolen to the Commission or any other law enforcement agency; or
- (e) The taximeter business licensee has not obtained from the owner or driver of the vehicle, or his agent, a written consent to perform any work on the taximeter.

1326 TAXIMETER BUSINESS – RECORD OF TAXIMETER TESTS

1326.1 The taximeter business owner shall record the results of any inspections or tests, and the taximeter make, model, and serial number on a form, prescribed by the

Office of Taxicabs, which the taximeter business licensee shall submit to the Commission within seven (7) days of such inspection.

- 1326.2 Upon a determination that a taximeter has passed an inspection, the taximeter business owner, in addition to complying with § 1326.1, shall affix a certification sticker, prescribed and approved by the Office of Taxicabs, to the taximeter. Any certification sticker shall not be re-affixed to the taximeter if removed.
- 1326.3 A taximeter business owner shall provide for the safekeeping of certification stickers, shall control their sequence of issuance, and shall ensure that such stickers are placed only on taximeters in accordance with these regulations.
- 1326.4 When a taximeter is installed in preparation for “hack-up,” the taximeter business owner, in addition to complying with § 1326.1 and §1326.2 shall:
- (a) Prepare a vehicle “hack up” certification form approved by the Office of Taxicabs at the completion of the preparatory work for vehicle “hack-up”;
 - (b) Submit to the Commission, within 24 hours, all documents relating to the installation and inspection of such taximeter; and
 - (c) Provide the vehicle owner with an itemized list of all work performed in preparation for “hack-up.”

1327 TAXIMETER BUSINESS – REPAIR WORK AFTER TEST FAILURE PROHIBITED

- 1327.1 No taximeter business owner shall, as a condition of performing any test or other work, require a vehicle driver or owner to undertake any repair work at his business. He shall inform the owner or driver that he may select another licensed taximeter business to perform a repair.
- 1327.2 No taximeter business owner shall direct a vehicle owner to utilize any other taximeter business to perform said repair work.

1328 TAXIMETER BUSINESS – OVERCHARGES PROHIBITED

- 1328.1 A licensed taximeter business shall not charge fees for any work involving taximeters in excess of the fees set by its fee schedule, which shall be filed with the Commission and shall be publicly displayed pursuant to § 1309 of these rules.

1329 TAXIMETER BUSINESS – SALE OF TAXIMETERS

- 1329.1 A taximeter business owner shall only sell and install taximeters for use in a District of Columbia licensed taxicab that have been approved by the Commission.
- 1329.2 A taximeter business owner shall not sell a taximeter for use in a taxicab licensed by the Commission unless a valid vehicle license from the Commission is presented.
- 1329.3 A taximeter business owner shall not sell a taximeter for use in a Commission licensed vehicle unless the installation, testing and certification of the taximeter/vehicle assembly is performed by the taximeter business licensee or an employee thereof.
- 1329.4 A taximeter business owner shall report to the Commission, within seven (7) days, all sales, trades or exchanges of taximeters by the licensed taximeter business on a form prescribed by the Commission.
- 1329.5 A taximeter business owner shall inform all purchasers in writing, before the sale takes place, of any and all restrictions imposed by the taximeter manufacturer and/or taximeter business licensee regarding the testing, repairs, calibration and installation of the taximeter.
- 1329.6 A taximeter business owner shall remove, deface, or otherwise void the validity of the certification sticker upon receipt of a taximeter purchased, exchanged, or accepted in trade by the taximeter business licensee, and report such decertification to the Commission.
- 1329.7 The certification sticker must conform to all specifications established by the Commission and bear the name of the Chairperson of the Commission.
- 1329.8 All installations of taximeters in taxicabs license to operate in the District of Columbia must be in accordance with specifications which have been filed with and approved by the Commission.
- 1329.9 No change in the method of installation shall be made unless the installation method has been filed with and approved by the Commission.

1330 TAXIMETER BUSINESS – RECORD KEEPING AND REPORTING

- 1330.1 A taximeter business owner shall comply with all record keeping procedures established by the Office of Taxicabs. All records required to be kept by the Office of Taxicabs shall be in the form and manner prescribed by the Office of Taxicabs and must be maintained for a period of five (5) years.

- 1330.2 All record-keeping entries must be made by a technician certified in accordance with § 1320.3 of these rules.
- 1330.3 A taximeter business owner shall account for all certification stickers procured and issued by the taximeter business licensee.
- 1330.4 A taximeter business owner shall account for all new or used taximeters that the taximeter business licensee buys, loans, rents, exchanges, or accepts in trade.
- 1330.5 A taximeter business owner shall keep records of all sales, installations, inspections, re-inspections, calibrations, repairs and the results thereof.
- 1330.6 At any and all times, a taximeter business owner shall make available for examination, to any agent of the Commission, or any other properly authorized law enforcement officer, all the records the official taximeter business is required to keep.
- 1330.7 A taximeter business owner shall permit any agent of the Commission or any law enforcement official to inspect any portion of its business premises at any time.

1331 TAXIMETER BUSINESS – PENALTIES FOR VIOLATIONS

1331.1 The schedule below lists penalties for violations of requirements of specified sections of this Chapter.

<u>Section</u>	<u>Penalty</u>
1301 Unlicensed business activity	\$250
1305 Failure to pay bi-annual license fee	\$500 / Suspension after 30 days overdue
1307.1 Failure to notify Commission	\$5,000
1309 Change in fee schedule without notification	\$500
1310.3 Installation, adjustment, correction, calibration or repair of taximeter outside of premises of licensed taximeter business	\$500
1312 Failure to comply with signage requirements	\$250
1313 Fraud	\$25,000 and taximeter business license revocation

1314	Unlawful Activities	\$25,000 and taximeter business license revocation
1315	Failure to Notify	\$1,000
1316	Failure to notify	\$1,000
1317.1	Bribery of Commission	\$25,000 and taximeter business license revocation
1317.2	Failure to report	\$10,000
1317.3	Acceptance of bribe	\$25,000 and taximeter business license revocation
1317.4	Failure to notify Commission	\$10,000
1318	Threats, harassment, or abuse	\$10,000 and taximeter business license revocation
1319	Failure to cooperate with Commission	\$500
1320	Work by Non-Certified Technician	\$500
1322	Failure to notify Commission	\$1,000
1324	Installation without inspection	\$1,000
1325	Unauthorized work	\$5,000
1326	Defective certification/inspection	\$1,000
1327	Requiring repair work	\$1,000
1328	Overcharge	\$250
1329	Sale of unapproved meter for installation on a taxicab licensed by the DCTC	\$500
1330	Failure to keep appropriate records	\$100 per record
1331.2	The civil fines set forth in this section shall be doubled for the second violation of the same infraction, and shall be doubled once more for any subsequent violation or violations of the same infraction.	

- 1331.3 The Office of Administrative Hearings shall conduct hearings for violations of infractions delineated in Chapter 13.
- 1331.3 In addition to the civil fine, failure to pay the fine or request a hearing within fifteen (15) calendar days of the issuance of a notice of infraction may result in the imposition of a penalty equal to the amount of the civil fine.
- 1331.3.1 Failure to appear for a requested hearing may result in the imposition of a penalty equal to twice the amount of the civil fine.

1399 DEFINITIONS

- 1399.1 The words and phrases in this chapter shall have the meaning as set forth below:

Applicant – An individual, partnership or corporation seeking a taximeter business license from the Commission.

Commission – The DC Taxicab Commission.

Driver – A person licensed by the Commission to drive a licensed DC taxicab in the District of Columbia.

Hack-up – To outfit a vehicle as a taxicab and obtain approval from the Commission for that vehicle to serve as a taxicab for the first time.

Mailing address – The address designated by an applicant or licensee for the receipt of all notices and correspondence from the Commission. Unless otherwise approved in advance, the mailing address of a taximeter business licensee shall be the street address of the business.

Owner – An individual, partnership, limited liability company or corporation licensed by the Commission to own and operate a taxicab or taxicabs.

Rate of fare – The established fare which may be charged by a licensed taxicab, which fare has been promulgated by the Commission, and which fare may include, but is not limited to surcharges and waiting times.

Seal – A device, approved by the Commission, which may be installed on a taximeter, wire, wiring mechanism, gear or other device, so that no adjustment, repair, alteration or replacement can be made without removing or mutilating the seal or seals.

Taximeter – An instrument or device approved by the Commission by which the charge to a passenger for hire of a licensed taxicab is automatically calculated and on which such charge is plainly indicated.

Taximeter business – Any business which engages, in whole or in part, in the manufacture, sale (whether of new or used equipment), installation, repair, adjustment, testing, sealing or calibrating of taximeters, for use upon any licensed vehicle in the District of Columbia including any business which engages in whole or in part in the installation of taxicab cruiser lights.

Taximeter business owner – An individual, partnership or corporation licensed by the Commission to own and operate a taximeter business.

Taximeter test (sometimes alternatively referred to as “test”) – Shall mean a method to determine compliance with distance and time tolerances, utilizing either a road test over a precisely measured road course or a simulated road test determining the distance traveled by use of a roller device, or by computation from rolling circumference and wheel-turn data, said test having been conducted in accordance with the National Institute of Standards and Technology Handbook No. 44.

Wiring harness – Any wire or collection of wires, including all connections thereto, which is connected in any manner whatsoever to a taximeter or in any way affects the operation of a taximeter.

Repeal Subject Index reference as follows:

Zone charts §§ 801.1, 801.2