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(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

1995-96

(session year)

Assembly

(Assembly, Senate or Joint)

Committee on Insurance, Securities and Corporate Policy...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

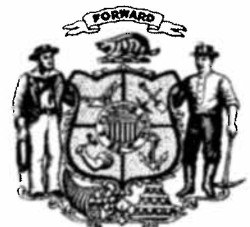
- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  - (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  - (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (October 2012)

Assembly	**Record of Committee Proceedings**
Clearinghouse Rule 95-204	Relating to the requirements for long-term care insurance sold in Wisconsin. Submitted by Office of the Commissioner of Insurance.
March 28, 1996	Referred to committee on Insurance, Securities & Corporate Policy.
April 11, 1996	Germane Amendment offered by Office of Commissioner of Insurance.
April 28, 1996	No action taken.

Darcy J. Demaske, Committee Clerk

WISCONSIN STATE LEGISLATURE



State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor

Josephine W. Musser
Commissioner

121 East Wilson Street
P.O. Box 7873
Madison, Wisconsin 53707-7873
(608) 266-3585

December 28, 1995

THE HONORABLE SHERYL K ALBERS
STATE REPRESENTATIVE
136 S STATE CAPITOL
MADISON WI 53702

Re: Clearinghouse Rule 95-204
Long-Term Care

Dear Representative Albers:

Thank you for your December 12, 1995, letter concerning Clearinghouse Rule 95-204 relating to long-term care insurance. I appreciate you sharing with me the concerns of representatives from the long-term care insurance industry concerning the rate stabilization provisions contained in the proposed rule.

Long-term care insurance has become an increasingly more important player in the funding of long-term care. As federal funds become scarcer for programs such as Medicare and Medicaid, private funding mechanisms are looked to take over the burden. One of the private funding mechanism being looked to for long-term care is private insurance. In fact, consideration is currently being given, at the federal level, for tax clarification for long-term care insurance premiums and benefits. These deliberations continue to legitimize this insurance product as an important player in the long-term care market place. This legitimacy sets this product apart from other products such as cancer insurance, hospital indemnity insurance, accident only insurance, and others which are considered secondary coverage products not designed to provide primary coverage for covered benefits.

With this increasing and more fundamental role of long-term care insurance in the funding for long-term care comes added responsibilities. These insurance products need some basic consumer protections to ensure that the coverage is available when the policyholder is most likely to need it. Our office has been working with other states on long-term care insurance regulatory standards for at least the last five years. The result of which has been model regulations to ensure the expected performance of these products. While it is true that this product is still in a somewhat evolutionary stage, sufficient experience has developed over the last 15 years and the market has sufficiently changed to warrant promulgation of these regulations.

Specifically, with regard to the proposed premium standards, the purpose of these standards is to:

1. Protect those who are most likely to need the coverage and least likely to afford large premium increases by restricting premium increases at older ages.

2. Require long-term care insurers to price their products properly at the earlier ages, thus curbing predatory pricing, inappropriate sales (to those who cannot afford the coverage) and lapses.

3. Recognize the evolving market because the proposal allows for changes to the standards if it is determined that the long-term care market has sufficiently changed to require adjustment.

According to the Health Insurance Association of America (HIAA), the average age to whom this product is sold is about 68. This means that a great majority of those who purchase this product are senior citizens, a market that has, in the past, been vulnerable to unscrupulous insurance sales tactics.

Even though we have had a relatively small number of long-term care insurance complaints regarding premium increases, studies, performed as part of the NAIC's Senior Issues Task Force work on long-term care insurance, show a predatory pricing (low-balling) problem with these products has existed. This is a textbook lapse driven product scenario.

In order to address this practice, the NAIC came up with two regulatory solutions. The first is to mandate that long-term care insurance policies contain a nonforfeiture benefit. This increases the price of the policy at all ages, prices the policy outside of the means of some consumers (thereby eliminating some unsuitable sales) and leaves the policyholder with some coverage even if they decide to lapse the policy. The problem with this fix is that it mandates a coverage and does not allow consumers to turn down the benefit. It adds substantial cost to the policy and may price it outside of the means of some consumers who might otherwise desire the coverage. Our proposed rule does not mandate a nonforfeiture benefit. Instead, it requires insurers to offer a nonforfeiture benefit, leaving the choice with the consumer.

The second fix is to set premium standards which require the companies to set adequate rates at the early ages by limiting the amount premiums may be increased after the policy is issued. This fix directly addresses the issue of predatory pricing and does not mandate a coverage that some consumers might not want. We chose the second fix.

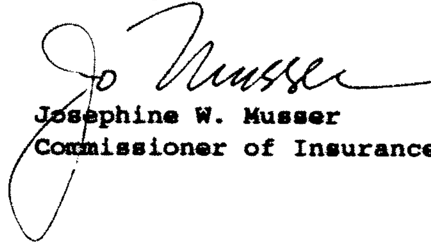
My staff has met with industry representatives on the rate stabilization standards proposed in this rule. We have indicated that we feel rate stabilization standards, which eliminate predatory pricing and stabilize premiums at the older ages when coverage is most likely needed, are necessary. We have indicated that we would seriously consider standards other than those contained in the proposed rule, so long as they result in the goals we have set for rate stabilization standards. At the December 15, 1995, hearing on the proposed amendments to the rule only one insurer testified that no rate

all testified against

stabilization standards should be promulgated. The HIAA and other insurers testified in opposition to the proposed standards, but offered alternatives.

I hope this responds to your inquiry. Should you require further information or desire to discuss this matter in more detail, please let me know.

Best regards,



Josephine W. Musser
Commissioner of Insurance

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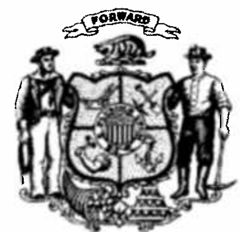
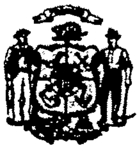
WISCONSIN STATE LEGISLATURE





State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
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Josephine W. Musser
Commissioner

121 East Wilson Street
P.O. Box 7873
Madison, Wisconsin 53707-7873
(608) 266-3585

April 11, 1996

The Honorable Sheryl Albers, State Representative
Chairperson, Assembly Committee on Insurance,
Securities and Corporate Policy
127 W State Capitol
Madison WI 53702

Re: Rule, Section Ins 3.455 and 3.46, Wis. Adm. Code, relating to the requirements for long term care insurance sold in Wisconsin

Clearinghouse Rule No. 95-204

Dear Representative Albers:

I am submitting a germane amendment to this proposed rule for your consideration under s. 227.19(4)(b)3, Wis. Stat. It is necessary to amend section 8 and 9 of the rule as follows:

SECTION 8. This rule ~~first~~ applies to any policy solicited, delivered or issued after September 1, 1996. After the effective date but before September 1, 1996, the insurer may market policies under either the current rule or this rule, if a policy form conforming to this rule has been approved.

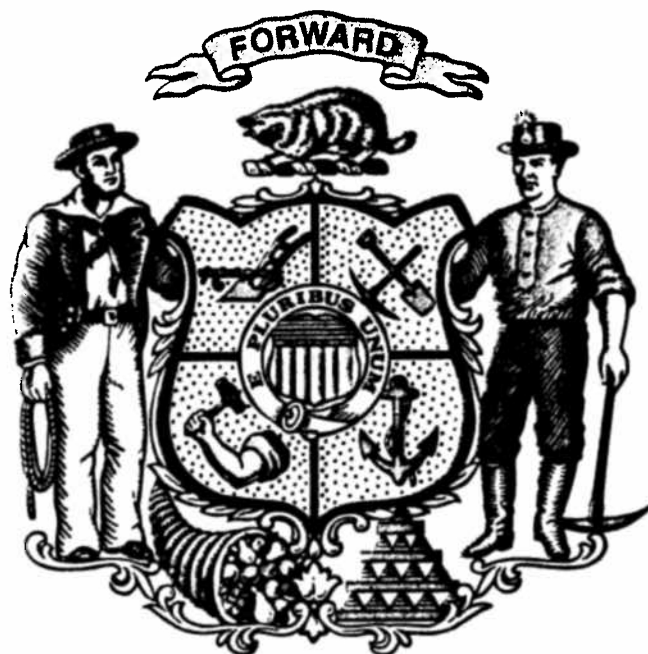
SECTION 9. This rule will take effect on the first day of the first month after publication, as provided in s. 227.22 (2) (intro.), ~~September 1, 1996, as provided in s. 227.22 (2) (b),~~ Stats.

These changes have been suggested to allow insurers to begin using the newly approved policy forms anytime after they have been approved but no later than September 1, 1996. If you have any questions regarding this, please contact Peter Farrow at 264-6239.

Sincerely,

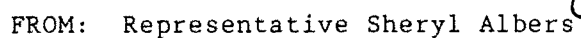
Randy Blumer
Deputy Commissioner of Insurance

RB:RRL


FORWARD
E PLURIBUS UNUM

TO: Assembly Insurance, Securities and Corporate Policy Committee Members

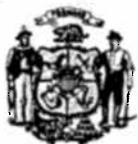
FROM: Representative Sheryl Albers



RE: Amendment to Clearinghouse rule 95-204

DATE: April 12, 1996

Attached please find a copy of a letter from Deputy Commissioner of Insurance, Randy Blumer, regarding an amendment to the above-referenced clearinghouse rule on requirements for long term care insurance sold in Wisconsin.



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Sincerely,

Randy Blumer
Deputy Commissioner of Insurance

RB:RRL

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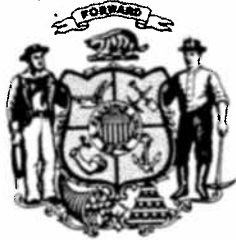
E PLURIBUS UNUM



STATE OF WISCONSIN

BOARD ON AGING AND LONG TERM CARE INSURANCE COUNSELING SERVICES

Medigap Helpline

214 North Hamilton Street
Madison, WI 53703-2118
(608) 266-8944 1-800-242-1060

George F. Potaracke
Executive Director

FAX 608-261-6570

26 Apr 96

Rep. Sheryl Albers
136 So., State Capitol
Madison, Wi.

Dear Rep. Albers:

The Wisconsin Board on Aging and Long Term Care supports and welcomes several of the amendments and additions to INS 3.455 and 3.46 as included in CR 95-204. However, we continue to have substantial concerns regarding the potential adverse effects of certain changes proposed as part of CR 95-204.

With already large public costs for long-term care and a growing aging population, the state has a significant interest in promoting the sale of long-term care insurance to certain segments of the population and assuring that these premium expenditures result in a product that truly helps to pay long-term care costs. The state also has an interest in having private long-term care policies recognize and reflect the system of long-term care services which exists in Wisconsin. We are concerned that some of the proposed changes either contradict or will hamper the state in meeting these goals. There are three aspects of this rule that we especially want you to consider: the applicant's financial suitability worksheet; the minimum standards for triggering benefit payments from a policy; and protection of consumer rights in cases where an insurer denies payment of a claim.

1. APPLICANT'S SUITABILITY WORKSHEET

INS. 3.46 (16) This new section establishes a requirement that an applicant complete a worksheet which includes a financial disclosure statement and submit this worksheet to the insurer with the application for insurance.

The Wisconsin Board on Aging and Long Term Care has a 7-member citizen board appointed by the governor. Our board members are primarily senior citizens and thus, representative of the audience to which insurers are marketing long-term care insurance products. We reviewed this suitability worksheet with our board members and sought their reaction as potential purchasers of long-term care insurance. This group voiced a **strong negative reaction** to any rule which would essentially force them to make a written disclosure of personal financial information in order to apply for or purchase long-term care insurance. While we understand and strongly empathize with the Commissioner's concern about preventing unsuitable long-term care insurance sales, we believe that there are other ways to accomplish this goal.

Instead of requiring applicants to complete and submit a personal worksheet, we suggest that insurers redraft the personal worksheet into a suitability advice paper. Some of the information in the personal worksheet, such as the company's premium history, and spending no more than 7% of income for premium, is very good information for consumers. Provide concrete advice about how to determine if such insurance may be suitable, rather than asking people to disclose details of their financial circumstances.

A worksheet such as is described by the rule should remain the sole property of the applicant and should not be submitted to the insurer or the agency. We are concerned that making the sale of a policy contingent upon disclosure and submission of financial information to an insurer will deter people from purchasing long-term care insurance. We are also concerned about a person's right to privacy and the possible dissemination of personal financial information. While (16)(c)(4) prohibits dissemination of the personal worksheet outside the agency or company, many agencies and companies offer wide arrays of insurance and financial products. We feel that it would be too easy for such information to be utilized within a multiple-line agency for purposes other than determining suitability of long-term care insurance.

Advocate for the long term care consumer.

2. STANDARDS FOR BENEFIT TRIGGERS

INS 3.46(a-c) Payment of a benefit is dependent on the condition of the insured, rather than the fact that a particular service is being utilized. This amendment affects the standards for determining when benefits are actually "triggered".

When someone who has a long-term care policy actually receives long-term care services, eligibility for benefits depends upon whether the care needed meets the policy's requirements. This rule proposes a minimum standard of needing assistance with 3 activities of daily living (ADLs), or the presence of a cognitive impairment. For example, if a policy required assistance with 3 ADLs to qualify for benefits and the insured receiving long-term care services only required assistance with 2 ADLs, the insurer will deny the claim.

Long-term care policies marketed today in Wisconsin typically contain a variety of types of benefits, such as nursing home care, home health care, assisted living facility benefits, adult-day care and respite care. Our concern is that the rule uses a uniform standard of "assistance with 3 ADLs" for all types of benefits. As proposed, the rule allows an insurer to use the same benefit trigger for adult day-care as for confinement in a skilled nursing facility. At the point where a policyholder would qualify for adult day-care, they could also qualify for full-time confinement in a nursing home. The rule needs to recognize that there is a continuum of long-term care services and that what may be an appropriate trigger for one type of care is not necessarily the appropriate trigger for other types of long-term care services. Under this proposed rule there is no incentive for someone whose needs could be met without being confined to a nursing facility to utilize less costly long-term care services. At a minimum, we would recommend that non-nursing home benefits be limited to a standard of assistance with no more than 2 activities of daily living or a cognitive impairment.

3 CONSUMER PROTECTION ISSUES IN CLAIM DENIALS

INS 3.46 (17)(f) This section refers to the requirement for certification of the insured's condition before benefits are payable.

INS 3.46 (17)(g) This section describes the requirement for the insurer to provide a method for the insured to appeal adverse benefit decisions.

The state surely has an interest in assuring that consumers who purchase long-term care insurance are treated fairly and equitably in the process of determining whether a claim will be paid or denied by the insurer. Our experience with claims payments under long-term care insurance is very limited at this point. Consumers need to be assured that if after years of paying premiums, they submit a claim to their insurer, the insurer will respond fairly and not engage in tactics that inappropriately delay or deny benefit payments.

Under the current rule a physician's certification as to a person's need for assistance with certain activities of daily living is considered conclusive, except in cases of fraud or collusion {Ins 3.46(4)(g)}. Thus, if a physician certifies that a patient requires help with 3 ADLs, the insurer must pay the claim. The insurer cannot substitute its own judgment about the need for assistance for the physician's.

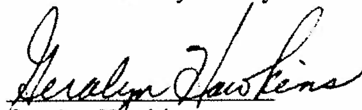
In the proposed changes, 17(f) allows additional professionals, such as nurses and social workers, to also perform assessments of care needs. We fully support this addition. However, the proposed rule also removes the language in 3.46 (4)(g) which requires the insurer to treat the professional's certification as conclusive. Under the proposed language, the insurer could, at its discretion, disregard a licensed medical professional's certification as to care needs and deny benefits to an applicant. This change puts the consumer at the mercy of the insurance company and its decisions about whether assistance is needed with ADLs or whether an individual has a cognitive impairment. The insurer is no longer bound by independent assessments of the policyholder's care needs. This change greatly upsets the balance of power between the individual insured and the insurance company.

If the state wants consumers to view long-term care insurance as a dependable source of funding long-term care services, it must rectify this imbalance. Unfortunately, in 17(g) all the proposed rule requires is that an insurer have "a clear description of the process for appealing and resolving benefit determination." As long as its described clearly, the process for resolving benefit determinations could simply amount to having a different employee of the insurance company review the claim. This lack of real protection for consumers in the claims process will not inspire consumers' confidence in the reliability of long-term care insurance as a means to help pay for long-term care expenses. In fact, this change is a major step backward and once the public begins to understand it, their interest in purchasing long-term care insurance may be significantly undermined.

We believe the rule should either re-establish the concept that the professional's certification will be considered conclusive, or it must require insurers to have an appeals process which includes resolving disputes about benefit determinations with an impartial arbiter. Ideally, boths points should be included in the final rule.

The Board on Aging and Long Term Care strongly recommends that the above issues be revisited and that changes be made to the rule which will preserve the rights of consumers to make fully informed choices and to have fair and understandable procedures for appeal of adverse decisions by insurers.

Thank you for your consideration in reviewing these comments.



Geralyn Hawkins
Lead Medigap Counselor

cc: Gordon Anderson
Legislative Council

FORWARD

Ms. Josephine Musser, Commissioner
Office of the Commissioner of Insurance
121 East Wilson Street
P.O. Box 7873
Madison, WI 53707-7873

Dear Commissioner Musser:

We are writing about proposed Clearinghouse Rule 95-204 relating to long-term care. We are specifically concerned about Section 1 relating to rate increases and urge the removal of this section.

A review of the statistics gathered by your department does not suggest that there is a problem of such magnitude to warrant rate restrictions. From 1988-1995 there have only been 13 long-term care rate complaints filed with your department.

Proposed Rule 3.455 would provide that long-term care policies would have limitations on the amounts of rate increases which an insurer could implement after issue.

- The long-term care product is still relatively new when compared to products such as medical reimbursement or hospital indemnity coverages. Wisconsin does not have any limits nor does it attempt to regulate the initial rates of these products or their renewal rates. Long-term care should not have a heavier burden imposed upon it during its developmental stage.
- The provision allowing the commissioner to amend the limits may not be sufficient to protect the long-term care product during this developmental stage. The time frame for such amending and the fairness to all companies is open to question given that Wisconsin does not have any experience in rate review other than MediGap insurance where the benefits are highly standardized.
- The limits would discourage the continued development of new approaches to long-term care coverage. The recent Society of Actuaries experience study has little data on the long range costs of the newest coverages (assisted living facility coverage) or benefit triggers (activities of daily living). By not assuring companies that the costs of these benefits can be fully recognized, the risk charge for providing them in Wisconsin would be to large to be included within the allowable expense margins.
- No other state has adopted the limits as proposed.

We would ask that this portion of the proposal be removed with the expectation that potential problems be analyzed and indicators of real problems be developed which would allow for appropriate alternatives to be developed to protect the insureds as well as encouraging safe development of new long-term care products.

After the public hearing on December 15 we look forward to reviewing the rule and again, urge the removal of Section 1. In advance, thank you for your consideration on this matter.

Sincerely,

Senator Dale Schultz

Representative Sheryl Albers

Revised Version

Ms. Josephine Musser, Commissioner
Office of the Commissioner of Insurance
121 East Wilson Street
P.O. Box 7873
Madison, WI 53707-7873

Dear Commissioner Musser:

We are writing about proposed Clearinghouse Rule 95-204 relating to long-term care. We are specifically concerned about Section 1 relating to rate increases and seek additional information about why your are proposing such a provision.

Recently, we met with representatives from the long-term care insurance industry and they made the following points. They stated:

- A review of the statistics gathered by your department does not suggest that there is a problem of such magnitude to warrant rate restrictions. From 1988-1995 there have only been 13 long-term care rate complaints filed with your department.
- The long-term care product is still relatively new when compared to products such as medical reimbursement or hospital indemnity coverages. Wisconsin does not have any limits nor does it attempt to regulate the initial rates of these products or their renewal rates. Long-term care should not have a heavier burden imposed upon it during its developmental stage.
- The provision allowing the commissioner to amend the limits may not be sufficient to protect the long-term care product during this developmental stage. The time frame for such amending and the fairness to all companies is open to question given that Wisconsin does not have any experience in rate review other than MediGap insurance where the benefits are highly standardized.
- The limits would discourage the continued development of new approaches to long-term care coverage. The recent Society of Actuaries experience study has little data on the long range costs of the newest coverages (assisted living facility coverage) or benefit triggers (activities of daily living). By not assuring companies that the costs of these benefits can be fully recognized, the risk charge for providing them in Wisconsin would be too large to be included within the allowable expense margins.
- No other state has adopted the limits as proposed.

We would appreciate your response to these items and also would be interested in knowing exactly why the rate increase limitations are being proposed. We look forward to hearing from you. In advance, thank you for your consideration on this matter.

Sincerely,

Senator Dale Schultz　　　　Representative Sheryl Albers

FORWARD
E PLURIBUS UNUM

NOTICE OF HEARING

STATE OF WISCONSIN--OFFICE OF THE COMMISSIONER OF INSURANCE

The Commissioner of Insurance, pursuant to the authority granted under s. 601.41 (3), Stats., and according to the procedures under s. 227.18, Stats., will hold a public hearing in Room 23, 121 East Wilson Street, Madison, Wisconsin, on December 15, 1995, at 10:00 a.m., or as soon thereafter as the matter may be reached, to amend Ins 3.46 (4) (b) and (g); and to create s. Ins 3.455 (9), 3.46 (3) (cm), (4) (t), (9) (c) (11m), (15), (16), (17), and Appendices 2, 3, and 4, Wis. Adm. Code, relating to the requirements for long-term care insurance sold in Wisconsin.

SUMMARY OF PROPOSED RULE

These revisions to the long-term care rule are mainly based on the new statnards set in the NAIC model rule for long-term care. The specific changes are as follows:

SECTION 1: Premium increases are limited based on the insured's age. For ages over 80, the premium increase limit is 10% in any 5-year period. For ages between 65 and 79, the premium increase limit is 15% in any 5-year period. For ages under 65, the premium increase limit is 25% in any 4-year period.

SECTION 2: The term cognitive impairment is defined for the rule.

SECTION 3: The daily minimum coverage is increased from $30 to $60.

SECTION 4: Policies are required to allow reinstatement in the event of lapse if reinstatement is requested within 5 months of the lapse and the lapse was due to the loss of functional capacity or cognitive impairment.

A notice regarding the coverage and how it may duplicate Medicare must be given to the insured with the application. This is a requirement of federal law.

Minimum requirements for nonforfeiture benefits are set out when a policy terminates or lapses. The nonforfeiture benefit is a paid-up benefit period and equal to at least 100% of all premiums paid.

The insurer must attempt to obtain the name of another person to whom lapse or termination notice must be given in addition to the insured before the policy can lapse.

Suitability standards for the sale of long-term care insurance are required to be set by insurers based on the completion of a worksheet defined in the rule. Factors such as income, savings and other source of revenues must be considered.

Minimum standards for benefit triggers are defined to be a deficiency in at least 3 activities of daily living out of a list of 6. Insurers can define additional triggers.

SUMMARY OF FISCAL ESTIMATE

There will be no state or local government fiscal effect.

INITIAL REGULATORY FLEXIBILITY ANALYSIS

This rule does not impose any additional requirements on small businesses.

CONTACT PERSON

A copy of the text of the proposed rule and fiscal estimate may be obtained from Meg Gunderson, Services Section, Office of the Commissioner of Insurance, 121 East Wilson Street, P. O. Box 7873, Madison, Wisconsin 53707-7873, (608) 266-0110.

PROPOSED ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

AMENDING AND CREATING A RULE

To amend Ins 3.46 (4) (b) and (g); and to create s. Ins 3.455 (9), 3.46 (3) (cm), (4) (t), 9 (c) (11m), (15), (16), (17), and Appendices 2, 3, and 4, Wis. Adm. Code, relating to the requirements for long-term care insurance sold in Wisconsin.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 600.01 (2), 601.41 (3), 601.42, 625.13 (1), 625.16, 625.21 (2), 628.34 (12), 631.20, 632.73 (2m), 632.76 (2), 632.81, 632.82, 632.84 and 631.897, Stats.

Statutes interpreted: ss. 600.01, 625.16, 628.34 (12), 631.20, 632.73 (2m), 632.81, 632.84 and 631.897, Stats.

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Minimum standards for benefit triggers are defined to be a deficiency in at least 3 activities of daily living out of a list of 6. Insurers can define additional triggers.

SECTION 1. Create s. Ins 3.455 (9) to read:

INS 3.455 (9) LONG-TERM CARE RATE INCREASE LIMITATIONS (a) The initial premium charged an insured covered by a long-term care policy shall not increase during the initial 4 years in which the policy is in force.

(b) Except as provided in par. (d), any premium rate increases after the initial 4-year period are subject to the following:

1. For insureds age 80 and over, the premium charged may not increase more than 10% in the aggregate for any 5-year period;

2. For insureds aged 65 through age 79, the premium charged may not increase more than 15% in the aggregate during any 5-year period;

3. For insureds under the age of 65, the premium charged may not increase more than 25% in the aggregate during any 4-year period.

4. The premium charged to an insured shall not increase due to either:

a. The increasing age of the insured at ages beyond 65; or

b. The duration the insured has been covered under the policy.

(c) Long-term care policies which provide for inflation protection shall be subject to the restrictions contained in pars. (a) and (b). However, the purchase of additional coverage shall not be considered a premium rate increase for purposes of determining compliance with par. (b) at the time additional coverage is purchased. The premium charged for the purchase of additional coverage shall be subject to par. (b) for any subsequent premium rate increases.

(d) The commissioner may amend the provisions in par. (b) in appropriate circumstances, including but not limited to:

1. Applicable state or federal law is enacted which materially affects the insured risk;

2. Unforeseen changes occur in long-term care delivery, insured morbidity or insured mortality; or

3. Judicial interpretations or rulings are rendered regarding policy benefits or benefit triggers resulting in unforeseen claim liabilities.

(e) Except as provided for in par. (f), the provisions of this subsection apply to all long-term care insurance policies or certificates issued or renewed on or after the effective date of this subsection.

(f) For certificates issued on or after the effective date of this subsection under a group long-term care insurance policy which is delivered or issued for delivery to one or more employers or labor

organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employes or former employes or a combination thereof or for members or former members or a combination thereof, of the labor organizations where such group policy was in force at the time of the effective date of this paragraph, the provisions of this subsection do not apply

SECTION 2. Create s. Ins 3.46 (3)(cm) to read:

Ins 3.46 (3)(cm) "Cognitive impairment" means a deficiency in a person's short- or long-term care memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

SECTION 3. Amend s. Ins 3.46 (4) (b) and (g) to read:

Ins 3.46 (4) (b) Establish fixed daily benefit limits only if the highest limit is not less than ~~$80~~ $60 per day.

(g) Provide coverage regardless of whether care is medically necessary. ~~If the form requires that care be provided according to a plan of care, that benefits are available only based on ability to perform activities of daily living, or that benefits are available or vary according to the level of care, the form shall also provide that, in the absence of fraud and collusion, the attending physician's certification of any of those matters is conclusive.~~ Coverage shall be triggered in conformance with the provisions contained in s. (17) of this rule.

SECTION 4. Create s. Ins 3.46 (4)(t), (9) (c), (11m), (15), (16) and (17) to read:

Ins 3.46 (4)(t) Include a provision which allows for reinstatement of coverage, in the event of lapse, if the insurer is provided proof of cognitive impairment or the loss of functional capacity if the reinstatement of coverage is requested within five (5) months after termination and provision is made for the collection of past due premiums, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more

stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity, if any, contained in the policy and certificate.

(9) (c) Disclosure Statements. The appropriate disclosure statement from Appendix 8 shall be used on the application or together with the application for each coverage in par. (c) to (e). The disclosure statement may not vary from the text or format including bold characters, line spacing, and the use of boxes around text contained in Appendix 8 and shall use a type size of at least 12 points.

(11m) SALE OF LONG-TERM CARE AND LIMITED BENEFIT POLICIES; REQUIRED OFFER OF NONFORFEITURE BENEFITS.

(a) No insurer may advertise, market or offer a long-term care, nursing home only or home health care only policy or certificate unless the insurer offers, at the time of sale, a shortened benefit period nonforfeiture benefit with the following standards.

1. Attained age rating is defined as a schedule of premiums starting from the issue date which increases with age at least 1% per year prior to age 50, and at least 3% per year beyond age 50.

2. The nonforfeiture benefit shall provide paid-up long-term care, nursing home only or home care only insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in subparagraph 3. of this paragraph.

3. The standard nonforfeiture credit shall be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the

calculation of the nonforfeiture credit is subject to the limitation of par. (b).

4. No policy or certificate shall begin a nonforfeiture benefit later than the end of the third year following the policy or certificate issue date except that for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

a. The end of the tenth year following the policy or certificate issue date; or

b. The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

5. 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.

(b) All benefits paid by the insurer while the policy or certificate is in premium-paying status and in the paid-up status will not exceed the maximum benefits which would have been payable if the policy or certificate had remained in premium-paying status.

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

(d) Premiums charged for a policy or certificate containing nonforfeiture benefits shall be subject to the loss ratio requirements contained in s. Ins 3.455 (5) treating the policy as a whole.

(15) UNINTENTIONAL LAPSE; LONG-TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES

(a) As part of the application process, an insurer shall obtain from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive a notice of lapse or termination of the policy or certificate for nonpayment of premium or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. Designation

shall not constitute acceptance of any liability on the third party for services provided to the insured. The written designation shall include the following:

1. Space for clearly listing at least one person.

2. The person's name and address.

3. In the case of an applicant who elects not to designate an additional person, the waiver shall state, "Protection against unintentional lapse. I understand that I have a right to designate at least one person, other than myself, to receive notice of lapse or termination of this policy for nonpayment of premium. I understand that final notice will not be given until 30 days after a premium is due and unpaid. I elect **NOT** to designate any person to receive such notice."

(b) For those insureds who designate another person(s) as provided in par. (a), the insurer, after the policy or certificate is issued shall send a letter to the designated person(s) indicating that the insured has designated the person(s) to receive notice of lapse or termination of the insured's long-term care, nursing home or home health care policy or certificate. The letter shall ask the person(s) to correct any information concerning the name or address of the person(s). It shall also explain the rights and duties of the designated person(s).

(c) Not less than once every two years an insurer shall notify its policyholders of their right to designate a person to receive the notices contained in par. (a). The notification shall allow policyholders to change, add to or, in the case of those policyholders who elected not to designate a person, designate a person to receive the notices provided in par. (a).

(d) When an insured pays premium through a payroll deduction plan, the requirements contained in par. (a), above need not be met until 60 days after the insured is no longer on a payroll deduction plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

(e) No long-term care, nursing home, or home health care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those designated by the insured pursuant to par. (a), above at the address provided by the insured for purposes of receiving notices of lapse or termination. Notice may not be given until 30 days after a premium is due and unpaid.

(16) SUITABILITY; LONG-TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES

(a) This subsection shall not apply to life insurance policies that accelerate benefits for long-term care.

(b) Every insurer marketing long-term care insurance policies shall:

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

2. Train its agents in the use of its suitability standards; and

3. Maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.

(c) 1. To determine whether the applicant meets the standards developed by the insurer, the agent and insurer 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.

2. The insurer, and where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in subd. 1. The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the insurer shall contain, at a minimum, the information in the format contained in Appendix 2, in not less than 12 point type. The insurer may request the applicant to provide additional information to comply with its suitability standards. A copy of the insurer's personal worksheet shall be filed with the commissioner.

3. A completed personal worksheet shall be returned to the insurer prior to the insurer'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 employes and their spouses.

4. The sale or dissemination outside the company or agency by the insurer or agent of information obtained through the personal worksheet in Appendix 2 is prohibited.

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

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

(f) 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 3, in not less than 12 point type.

(g) If the insurer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the insurer may reject the application. In the

alternative, the insurer shall send the applicant a letter similar to Appendix 4. However, if the applicant has declined to provide financial information, the insurer 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.

(h) The insurer shall maintain and have available for review by the commissioner the total number of applications received from residents of this state, the number of those 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.

(17) STANDARDS FOR BENEFIT TRIGGERS; LONG-TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES

(a) The following definitions apply to this subsection:

1. "Activities of daily living" means at least bathing, continence, dressing, eating, toileting, and transferring.

2. "Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

3. "Cognitive impairment" means a deficiency in a person's short- or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

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

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

6. "Eating" means 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.

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

8. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

9. "Transferring" means moving into or out of a bed, chair or wheelchair.

(b) A long-term care, nursing home only and home health care only policy or certificate 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 3 of the activities of daily living or the presence of cognitive impairment.

(c) 1. Activities of daily living shall include at least those contained in the definition in par. (a).

2. Insurers may use activities of daily living to trigger covered benefits in addition to those contained in par. (a) as long as they are defined in the policy.

(d) 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 are not in lieu of, the requirements contained in pars. (b) and (c).

(e) For purposes of this section, the determination of a deficiency shall not be more restrictive than:

1. Requiring hands-on assistance of another person to perform the prescribed activities of daily living; or

2. If the deficiency is due to the presence of cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured and others.

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

(g) Long-term care, nursing home only and home health care only policies shall include a clear description of the process for appealing and resolving benefit determinations.

SECTION 5. Create s. Ins 3.46 Appendices 2, 3, 4 to read:

Long-Term Care Insurance
Personal Worksheet

People buy long-term care insurance for a variety of reasons. These reasons include to avoid spending assets for long-term care, to make sure there are choices regarding the type of care received, to protect family members from having to pay for care, or to decrease the chances of going on Medicaid. However, long-term care insurance can be expensive, and is not appropriate for everyone. State law requires the insurance company to ask you to complete this worksheet to help you and the insurance company determine whether you should buy this policy.

Premium

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

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums in the future.] The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The last rate increase for this policy in this state was in [year], when premiums went up by an average of _______%]. [The company has not raised its rates for this policy.]

Drafting Note: The insurer shall use the bracketed sentence or sentence applicable to the product offered. If a company includes a statement regarding not having raised rates, it must disclose the company's rate increases under prior policies providing essentially similar coverage.

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

Drafting Note: The insurer shall use the bracketed sentence unless the policy is fully paid up or is a noncancelable policy.

Income

Where will you get the money to pay each year's premiums?

☐ Income ☐ Savings ☐ Family members

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 insurer 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.

Turn the Page

Savings and Investments

Not counting your home, what is the approximate value of all of your assets (savings and investments)? (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

☐ The information provided above accurately describes my financial situation.	☐ I choose not to complete this information.

Signed: ______________________ ______________________
(Applicant) (Date)

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

Signed: ______________________ ______________________
(Agent) (Date)

Agent's Printed Name: ______________________]

[Note: 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 appear to be suitable for me. However, I still want the company to consider my application.

Signed: ______________________ ______________________]
(Applicant) (Date)

Drafting Note: Choose the appropriate sentences depending on whether this is a direct mail or agent sale.

The company may contact you to verify your answers.

Drafting Note: When the Long-Term Care Insurance Personal Worksheet is furnished to employes and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.

Appendix 3

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 noncancelable 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 booklet called the "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 department on aging for more information about the senior health insurance counseling program in your state.

Appendix 4

Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for [long-term care insurance] [insurance for care in a nursing home] [insurance for care at home or other community setting] included a "personal worksheet," which asked questions about your finances and your reasons for buying this coverage. For your protection, state 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 insurance coverage you applied for may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state 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 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 nursing home only or home health care insurance only 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.

_______________________________ _______________

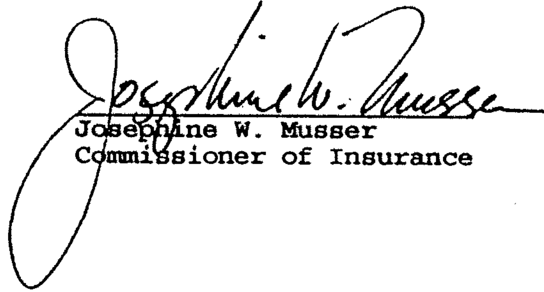
APPLICANT'S SIGNATURE DATE

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

SECTION 6. This rule first applies to any policy solicited or issued after July 1, 1996.

SECTION 7. This rule will take effect on July 1, 1996, as provided in s. 227.22 (2) (b), Stats.

Dated at Madison, Wisconsin, this 9th day of November, 1995.



Josephine W. Musser
Commissioner of Insurance

346rule.doc

1995 Session

FISCAL ESTIMATE
DOA-2048 N(R10/94)

☒ ORIGINAL ☐ UPDATED
☐ CORRECTED ☐ SUPPLEMENTAL

LRB or Bill No./Adm. Rule No.
3.455 & 3.46

Amendment No. If Applicable

Subject

Long term care requirements for insurance sold in Wisconsin

Fiscal Effect

State: ☒ No State Fiscal Effect

Check columns below only if bill makes a direct appropriation or affects a sum sufficient appropriation.

☐ Increase Existing Appropriation ☐ Increase Existing Revenues
☐ Decrease Existing Appropriation ☐ Decrease Existing Revenues
☐ Create New Appropriation

☐ Increase Costs - May be possible to Absorb Within Agency's Budget ☐ Yes ☐ No

☐ Decrease Costs

Local: ☒ No local government costs

1. ☐ Increase Costs
   ☐ Permissive ☐ Mandatory
2. ☐ Decrease Costs
   ☐ Permissive ☐ Mandatory
3. ☐ Increase Revenues
   ☐ Permissive ☐ Mandatory
4. ☐ Decrease Revenues
   ☐ Permissive ☐ Mandatory
5. Types of Local Governmental Units Affected:
   ☐ Towns ☐ Villages ☐ Cities
   ☐ Counties ☐ Others ____
   ☐ School Districts ☐ WTCS Districts

Fund Sources Affected

☐ GPR ☐ FED ☐ PRO ☐ PRS ☐ SEG ☐ SEG-S

Affected Ch. 20 Appropriations

Assumptions Used in Arriving at Fiscal Estimate

This rule will not result in any increased state or local costs because it merely sets standards for the benefits of these policies.

Long-Range Fiscal Implications

None

Agency/Prepared by: (Name & Phone No.)

Robert Luck 266-0082

Authorized Signature/Telephone No.

[signature]

Date

11/09/95

FORWARD
E PLURIBUS UNUM

CR 95-204

Rule - Long term care insurance rate stabilization

1988 - 1995 - 13 complaints