CR 90-86

STATE OF WISCONSIN)
)
OFFICE OF THE COMMISSIONER OF INSURANCE)

I, Robert D. Haase, Commissioner of Insurance and custodian of the official records of this Office, certify that the attached rule-making order affecting ss. Ins 3.39, 3.41, 3.455, 3.46, and 3.55, Wis. Adm. Code, was issued by this Office on March 8, 1991.

I further certify that I have compared this copy with the original on file in this Office and that it is a true copy of the whole of the original.

Dated at Madison, Wisconsin, this 8 day of March 1991

Robert D. Haase
Commissioner of Insurance

19301T

6-1-91

ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

To amend Ins 3.41 (1) and 3.55 (4) (title), (1), (2) and (4) (a), repeal Ins 3.39 (9) (b) and 3.55 (3) (f), repeal and recreate Ins 3.46 and create Ins 3.455 and 3.55 (3) (cg) and (cm) relating to standards for policies, coverages, riders and certificates which are primarily designed to cover convalescent or custodial care or care for a chronic or terminal illness and for insurers and intermediaries who market those policies, coverages, riders or certificates.

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.

This rule establishes standards for conversion, loss ratios, reserves, policy forms, marketing, inflation protection, commissions, underwriting and claims administration for insurance which is primarily designed to cover convalescent or custodial care or care for a chronic or terminal illness. This includes long-term care, nursing home and home health care policies or certificates and life insurance policies providing these types of benefits.

Out-of-State Groups Not Exempt

Under the rule, group policies issued for delivery outside this state are subject to the rule and the Wisconsin insurance code even if it covers no more than one Wisconsin resident. The policy may be excepted from this provision only if it would otherwise be exempt from Wisconsin regulation, the policy is filed with OCI prior to being marketed and OCI determines that it is subject to substantially similar regulation under the law of another state and it is not contrary to the public interest.

Loss Ratio Requirements

The rule requires insurers which issue a long-term care, nursing home or home health policy or rider to establish and maintain a loss ratio under the policy or rider as follows:

1. 65% for individual policies, endorsements or riders or mass marketed group policy certificates;
2. 75% for other group policies.

The loss ratio requirement does not apply to life insurance-long-term care coverage.

Continuation and Conversion

The rule establishes standards regarding continuation and conversion of long-term care, nursing home and home health care policies or riders, including the requirement that an individual conversion policy be identical to the original policy. Insurers are allowed to offer an alternative conversion policy in addition to the prescribed conversion policy

Reserves

The rule establishes standards for computation of reserves for long-term care, nursing home and home health care policies, riders and endorsements and life insurance policies, riders and endorsements having this type of coverage.

Forms

The rule establishes standards for the forms for long-term care, nursing home and home health care, and life insurance policies, endorsements and riders containing these types of coverage. These standards include, but are not limited to, the following:

A. General Requirements.

All forms must include:

1. Limits on daily benefits of with the highest limit at not less than $30.
2. Limits which do not vary by more than 50% between benefits.
3. Elimination periods no longer than 365 days. A 180-day elimination period must be offered as an alternative to any policy with a longer elimination period.
4. Lifetime maximums of not less than 365 days.
5. Coverage of irreversible dementia.
6. Coverage of custodial care and without regard to medical necessity.
7. Coverage regardless of prior hospitalization or institutional care.
8. Coverage without distinction based on type of illness, treatment, medical condition or accident other than a lawful preexisting condition provision.
9. Attending physician certification is conclusive for plan of care, activities of daily living, and level of care
10. Substantial coverage of the facilities and programs which offer care in an institutional or community-based setting, or both, depending on the type of policy.

B. Form requirements applicable only to long-term care, nursing home and home health care policies or riders.

These forms must also include:

1. A 30-day right to return the policy or rider.
2. Captions
3. Extension of benefits on termination for any reason to cover an existing institutionalization.
4. A guaranty of renewability for life.

C. Only policies providing substantial coverage of care in both institutional and community-based setting are permitted to use the term "long-term care".

Marketing Practices

The rule requires delivery of an approved outline of coverage and the "Guide to Long-Term Care" at the time an insurer or intermediary contacts any person to solicit the sale of a long-term care, nursing home, or home health care policy, endorsement or rider or life insurance coverage containing that type of coverage. The format for the outline is prescribed.

The rule prohibits any insurer or intermediary from using the term "long-term care" or similar terminology in an advertisement or offer of a policy or rider unless the coverage includes coverage of care in both an institutional or community based setting and it is approved as a long-term care policy, endorsement or rider by the Office.

Insurers are prohibited from filing forms for approval by the office which do not comply with this rule.

Intermediaries and insurers are prohibited from attempting to dissuade a consumer from filing a complaint or to cooperate with an investigation by the Office.

Replacement

The rule prescribes standards for solicitaton and replacement of policies and certificates. Replacement policies and certificates cannot impose new preexisting condition, waiting, or elimination periods. Insurers and marketing firms are required to maintain procedures to prevent marketing abuses. Agents are required to obtain and submit information about other coverage the applicant has or previously had and to investigate the suitability of a product. Replacement group policies must cover all insureds under the former policy.

Inflation Protection

The rule requires insurers and agents to offer at the time of solicitation of the sale of a long-term care, nursing home or home health policy, or certificate an alternative policy or certificate which provides the same benefits with an inflation protection provision. The inflation protection provision must at a minimum provide for yearly increase of limits at a rate equal to not less than 5% except the policy may substitute the consumer price index (urban). The inflation protection provision may provide that it will terminate prospectively if the insured in any year declines the increase.

Underwriting

The rule includes provisions intended to limit "post claims underwriting." Insurers are required to take certain steps to investigate applications for those applicants who are 75 years of age or older. Insurers are also required to record and report rescissions or reformations of policies, riders or certificates based on misrepresentation in applications and to maintain written claims administration guidelines.

Commission Limits

Compensation paid to an agent for the sale of a long-term care, nursing home or home health care policy, rider or certificate is limited by the rule to:

1. 400% of the second and subsequent year commissions; or
2. No more than renewal commissions for policies, riders or certificates which replace another policy, rider, or certificate.

Applicability

The rule does not apply to individual policies issued prior to its effective date or the renewal of those policies. It also does not apply to group policies issued prior to the effective date if they either do not issue certificates after the effective date or are employer or labor union held policies.

The rule takes effect May 1, 1991, or on the first day of the second month commencing after it's publication, whichever is later.

Small businesses which are insurance intermediaries (agents) may be affected by this rule. Agents will be required to maintain procedures necessary to assure that the disclosures required by the rule are provided. No skills other than those generally necessary for a properly conducted agency business are required in order to comply with the rule.

SECTION 1. Ins 3.39 (9) (b) is repealed.

SECTION 2. Ins 3.41 (1) is amended to read:

Ins 3.41 (1) REASONABLY SIMILAR COVERAGE. An insurer provides reasonably similar coverage under s. 632.897 (4), Stats., to a terminated insured as defined in s. 632.897 (1) (f), Stats., if a person is offered individual coverage substantially identical to the terminated coverage under the group policy or individual policy, or is offered his or her choice of the

3 plans described in s. Ins 3.42, or is offered a high limit comprehensive plan of benefits approved for the purpose of conversion by the commissioner as meeting the standards described in s. Ins 3.43. Individual conversion policies must include benefits required for individual disability insurance policies by subch. VI, ch. 632, Stats. This subsection does not apply to a long-term care policy as defined under s. Ins 3.46 (3) (e).

SECTION 3. Ins 3.455 is created to read:

Ins 3.455 LONG-TERM CARE NURSING HOME AND HOME HEALTH CARE POLICIES; LOSS RATIOS; CONTINUATION AND CONVERSION, RESERVES. (1) FINDINGS. (a) The commissioner finds that long-term care policies and life insurance-long-term care coverage are offered and marketed to a population which is particularly susceptible to pressure sales tactics and misleading or fraudulent sales activities. These products are also complex and difficult for most purchasers to analyze and understand.

(b) The purchase of any of these products is an important and significant decision because of the cost and the significance of these insurance products in planning and providing for long-term care. This section and s. Ins 3.46 are adopted to provide adequate protection for Wisconsin insureds and the public.

(2) APPLICABILITY. (a) This section does not apply to an accelerated benefit coverage of a life insurance policy, endorsement or rider as described under s. Ins. 3.46 (2).

(b) This section, except for subs. (6) and (8), does not apply to individual long-term care policy or life insurance-long-term care coverage, to a group long-term care policy or life insurance-long-term care coverage or a certificate under the group policy, or to a renewal policy or coverage or certificate, if:

1. The individual long-term care policy or life insurance-long-term care coverage was issued prior to the effective date of this rule;

2. The group policy is issued prior to the effective date of this rule and all certificates under the policy are issued prior to the effective date of this rule; or

3. The group policy is issued prior to the effective date of this rule and the policy is exempt from s. Ins. 3.46 under s. Ins. 3.46 (2) (a).

(c) Section Ins. 3.46 in effect prior to the effective date of this rule and subs. (6) and (8) apply to those policies, coverages or certificates which qualify for exemption under par. (b).

(3) DEFINITIONS. In this section:

(a) "Life insurance-long-term care coverage" has the meaning provided under s. Ins 3.46 (3) (d).

(b) "Long-term care policy" has the meaning provided under s. Ins 3.46 (3) (e).

(4) APPLICATION OF THE INSURANCE CODE TO LONG-TERM CARE, NURSING HOME AND HOME HEALTH CARE GROUP POLICIES. A group or blanket long-term care policy or certificate may be exempt, under s. 600.01 (1) (b) 3, Stats., from chs. 600 to 646, Stats., and rules adopted under those statutes only if:

(a) The policy is issued for delivery and delivered in another state;

(b) The policy is subject to regulatory requirements substantially similar to those provided under chs. 600 to 646, Stats., and the rules;

(c) The policy is otherwise exempt under s. 600.01 (b) 3, Stats.;

(d) The policy and sufficient information to enable the office to determine compliance with pars. (a) to (c) is filed with the office; and

(e) The office makes a written determination that the policy complies with pars. (a) to (c) and that the policy is not contrary to the public

interest, before the policy or certificates under the policy are marketed or solicited in this state.

(5) MINIMUM LOSS RATIO REQUIREMENTS FOR LONG-TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES. (a) Insurers shall set and maintain rates and benefits for long-term care policies so that the loss ratio is at least:

1. 65%, for individual policies.

2. 65%, for group policies which issue coverage as the result of solicitation of individuals through the mail or the mass media, including, but not limited to, print or broadcast advertising.

3. 75%, for group policies other than those subject to subd. 2.

(b) For the purpose of this subsection a loss ratio shall be calculated on the basis of the ratio of the present value of the expected benefits to the present value of the expected premium over the entire period of coverage. An insurer shall consider and evaluate the following:

1. Statistical credibility of incurred claims experience and earned premium over the entire period of coverage;

2. The entire period for which rates have been computed to provide coverage;

3. Experienced and projected trends;

4. Concentration of experience within early policy duration;

5. Expected claim fluctuation;

6. Experience refunds, adjustments or dividends;

7. Renewability features;

8. Interest; and

9. Product features such as elimination periods, deductibles and maximum limits.

(c) An insurer shall submit its calculations of the loss ratio for a long-term care policy at the same time it submits a long-term care policy form

and at any time that it makes a filing for rates under a long-term care policy.

(6) ANNUAL LOSS RATIO REPORT. An insurer shall annually, not later than April 1, file a report with the office in the form prescribed by the commissioner regarding its loss ratios and loss experience under long-term care policies. The report shall be certified to by a qualified actuary.

(7) LONG-TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES, CONTINUATION AND CONVERSION REQUIREMENTS. (a) A group policy, as defined by s. 632.897 (1) (c), Stats., which is a long-term care policy shall provide terminated insureds the right to continue under the group policy as required under s. 632.897, Stats.

(b) An individual long-term care policy which provides coverage for a spouse shall permit the spouse to obtain individual coverage as required under s. 632.897 (9), Stats. upon divorce or annulment.

(c) For the purpose of s. 632.897, Stats., an insurer provides reasonably similar individual coverage to a person converting from a long-term care policy only if the insurer offers an individual policy which is identical to the terminated coverage.

(d) In addition to offering the individual conversion policy as required under par. (c) an insurer may also offer the person the alternative of an individual conversion policy which:

1. Is not underwritten;

2. Complies with this section and s. Ins 3.46;

3. Provides coverage of care in an institutional setting, if the original policy provided coverage in an institutional setting; and

4. Provides coverage of care in a community based setting, if the original policy provided coverage in a community based setting.

(8) RESERVE STANDARDS FOR LONG-TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES AND LIFE INSURANCE-LONG-TERM CARE COVERAGE.

(a) 1. Policy reserves for life insurance-long-term care coverage shall be determined in accordance with s. 623.06 (2) (g), Stats. Claim reserves must also be established if a life insurance-long-term care coverage is in claim status.

2. Reserves for coverage subject to this paragraph should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are 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 the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefits.

3. In the development and calculation of reserves for policies and riders subject to this subsection, 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, but not limited to, 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.

4. Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American academy of actuaries.

(b) Reserves for long-term care policies shall be determined in accordance with s. Ins 3.17 (8) (b) using tables established for reserve purposes by a qualified actuary meeting the requirements of s. Ins 6.12 and acceptable to the commissioner.

SECTION 4. Ins 3.46 is repealed and recreated to read:

Ins 3.46 STANDARDS FOR LONG-TERM CARE, NURSING HOME AND HOME HEALTH CARE INSURANCE AND LIFE INSURANCE-LONG-TERM CARE COVERAGE. (1) FINDINGS. The findings under s. Ins 3.455 (1) are incorporated by reference. The commissioner finds that the adoption of minimum standards, compensation restrictions and disclosure requirements for long-term care and life insurance-long-term care coverage will reduce marketing abuses and will assist consumers in their attempts to understand the benefits offered and to compare different products. The commissioner finds that failure to comply with this section is misleading and deceptive under s. 628.34 (12), Stats., and constitutes an unfair trade practice.

(2) APPLICABILITY. (a) This section does not apply to a group policy which is issued to one or more employers or labor organizations or to the trustees of a fund established by one or more employers, or labor organizations, or both, for employes or former employes, or both, or for members or former members, or both, of the labor organizations.

(b) This section, except for subs. (10) (b) to (e), does not apply to an individual long-term care policy or life insurance-long-term care coverage, to a group long-term care policy or life insurance-long-term care coverage or a certificate under the group policy, or to a renewal policy or coverage or certificate, if:

1. The individual long-term care policy or life insurance-long-term care coverage was issued prior to the effective date of this rule; or

2. The group policy is issued prior to the effective date of this rule and all certificates under the policy are issued prior to the effective date of this rule.

(c) Section Ins. 3.46 in effect prior to the effective date of this rule and subs. (10) (b) to (e) apply to those policies, coverages or certificates which qualify for exemption under par. (b).

(d) This section does not apply to an accelerated benefit coverage of a life insurance policy, rider, or endorsement which :

1. Provides payments on the occurrence of a severe illness or injury without regard to the incurral of expenses for services relating to the illness or injury; and

2. Is not sold primarily for the purpose of providing coverage of nursing home or home health care, or both..

(3) DEFINITIONS. In this section:

(a) "Compensation" means remuneration of any kind, including, but not limited to, pecuniary or nonpecuniary remuneration, commissions, bonuses, gifts, prizes, awards, finder's fees, and policy fees.

(b) "Guaranteed renewable for life" means a policy renewal provision which continues the insurance in force unless the premium is not paid on time, which prohibits the insurer from changing any provision of the policy, endorsement or rider while the insurance is in force without the express consent of the insured, and which requires the insurer to renew the policy, endorsement or rider for the life of the insured and to maintain the rates in effect for the policy, endorsement or rider at time of issuance, except the provision may permit the insurer to revise rates but on a class basis only.

(c) "Irreversible dementia" means deterioration or loss of intellectual faculties, reasoning power, memory, and will due to organic brain disease characterized by confusion, disorientation, apathy, and stupor of varying degrees which is not capable of being reversed and from which recovery is impossible. "Irreversible dementia" includes, but is not limited to, Alzheimer's.

(d) "Life insurance-long-term care coverage" means coverage which:

1. Provides coverage for convalescent or custodial care or care for a chronic condition or terminal illness; and

2. Is included in a life insurance policy or an endorsement or rider to a life insurance policy.

(e) "Long-term care policy" means a disability insurance policy, or an endorsement or rider to a disability insurance policy, designed or intended primarily to be marketed to provide coverage for care that is convalescent or custodial care or care for a chronic condition or terminal illness.

"Long-term care policy" includes, but is not limited to, a nursing home policy, endorsement or rider and a home health care policy, endorsement or rider. The term does not include:

1. A medicare supplement policy or medicare replacement policy or an endorsement or rider to such a policy;

2. A continuing care contract, as defined in s. 647.01 (2), Stats.

3. A rider designed specifically to meet the requirements for coverage of skilled nursing care under s. 632.895, Stats.

4. Life insurance-long-term care coverage.

(f) "Medicare" means the hospital and medical insurance program established by Title XVIII, 42 USC 1395 to 1395ss, as amended.

(g) "Medicare eligible persons" means persons who qualify for medicare.

(h) "Outline of coverage" means a document which gives a brief description of benefits in the format prescribed in Appendix 1 to this section and which complies with sub. (8).

(i) "Guide to long-term care" means the pamphlet prescribed by the commissioner which provides information on long-term care insurance and advice to consumers on the purchase of long-term care insurance.

(4) GENERAL FORM REQUIREMENTS FOR LONG-TERM CARE, NURSING HOME, AND HOME HEALTH CARE POLICIES AND LIFE INSURANCE-LONG-TERM CARE COVERAGE. Forms for a long term care policy, life insurance-long term care coverage and certificates shall:

(a) Provide coverage for each person insured for convalescent and custodial care and care for chronic conditions and terminal illness.

(b) Establish fixed daily benefit limits only if the highest limit is not less than $30 per day.

(c) Establish a fixed daily benefit limit based on the level of the covered care only if the lowest limit of daily benefits provided for under the policy or coverage is not less than 50% of the highest limit of daily benefits.

(d) Provide for an elimination period only if:

1. It is expressed in a number of days per lifetime or per period of confinement;

2. It is clearly disclosed;

3. Days for which medicare provides coverage are counted for the purpose of determining expiration of the elimination period; and

4. It does not exceed 365 days.

(e) Provide for a lifetime maximum limit only if the limit provides not less than 365 days of coverage. Only days of coverage under the policy, coverage or certificate may be applied against a lifetime maximum limit. Coverage by medicare may not be applied against a lifetime maximum limit.

(f) Clearly disclose that it does not cover duplicate payments by medicare for nursing home care or home health care if it has either exclusion.

(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.

(h) Not limit or condition coverage or benefits by requiring prior hospitalization or prior receipt of care, or benefits for care, in an institutional setting.

(i) Cover irreversible dementia. Coverage may not be excluded or limited on the basis of irreversible dementia.

(j) Define terms used to describe covered services, including, but not limited to, "skilled nursing care," "intermediate care," "personal care," or "home care" services, if those terms are used, in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

(k) Define terms used to describe providers whose services are covered, including, but not limited to, "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal care facility" and "home care agency", if those terms are used, in relation to the services and facilities required to be available and the licensing or degree status of those providing or supervising the services. A definition may require that a provider be appropriately licensed or certified. A form may not exclude coverage of any type of service normally provided by the defined provider, facility or agency.

(l) Clearly disclose any limitations of the coverage.

(m) Not exclude or limit coverage by type of illness, treatment, medical condition or accident, except it may include exclusions or limits for:

1. Preexisting conditions or diseases;

2. Illness, treatment or medical condition arising out of any one or more of the following:

a. Treatment provided in a government facility, unless coverage is otherwise required by law.

b. Services for which benefits are available under medicare or a governmental program other than medicaid, or under a state or federal worker's compensation, employer's liability, occupational disease, or motor vehicle no-fault law.

c. Services provided by a member of the insured's immediate family or for which no charge is normally made in the absence of insurance.

(n) Not exclude or limit any coverage of care provided in a community based setting, including, but not limited to, coverage of home health care, by:

1. Requiring that care be medically necessary;

2. Requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services before community based care is covered;

3. Limiting eligible services to services provided by registered nurses or licensed practical nurses;

4. Requiring that the insured have an acute condition before community based care is covered;

5. Limiting benefits to services provided by medicare certified agencies or providers.

(o) Provide substantial scope of coverage of facilities for any benefits it provides for care in an institutional setting.

(p) Provide substantial scope of coverage of facilities and programs for any benefits it provides for care in a community-based setting.

(q) Contain a description of the benefit appeal procedure and comply with s. 632.84, Stats.

(r) If coverage of care in a community-based setting is included, provide coverage of all types of care provided by state licensed or medicare certified home health care agencies.

(s) If coverage of care in an institutional setting is provided, not condition eligibility for coverage of custodial or intermediate care on the concurrent or prior receipt of intermediate or skilled care.

(5) FORM REQUIREMENTS FOR LONG-TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES ONLY. (a) This subsection and s. Ins 3.13 (2) (h) and 3.39 (9) (a) and s. 632.76 and 632.897, Stats., do not apply to life insurance-long-term care coverage.

(b) A form for long-term care policy or certificate shall:

1. Comply with the restrictions on preexisting condition provisions under s. 632.76, Stats.

2. Include the unrestricted right to return the policy or certificate within 30 days of the date it is received by the policyholder and comply with s. 632.73 (2m), Stats.

3. If it is a policy or certificate which covers care in both institutional and community based settings, contain a caption as follows:

THE WISCONSIN INSURANCE COMMISSIONER HAS ESTABLISHED MINIMUM STANDARDS FOR LONG-TERM CARE INSURANCE. THIS POLICY MEETS THOSE STANDARDS.

THIS POLICY COVERS CERTAIN TYPES OF NURSING HOME AND HOME HEALTH CARE SERVICES. THERE MAY BE LIMITATIONS ON THE SERVICES COVERED. READ YOUR POLICY CAREFULLY.

FOR MORE INFORMATION ON LONG-TERM CARE SEE THE "GUIDE TO LONG-TERM CARE" GIVEN TO YOU WHEN YOU APPLIED FOR THIS POLICY.

THIS POLICY'S BENEFITS ARE NOT RELATED TO MEDICARE.

4. If it is a policy or certificate which covers care only in an institutional setting, contain a caption as follows:

THE WISCONSIN INSURANCE COMMISSIONER HAS ESTABLISHED MINIMUM STANDARDS FOR NURSING HOME INSURANCE. THIS POLICY MEETS THOSE STANDARDS.

THIS POLICY COVERS CERTAIN TYPES OF NURSING HOME CARE. THIS POLICY DOES NOT COVER HOME HEALTH CARE. THERE MAY BE LIMITATIONS ON THE SERVICES COVERED. READ YOUR POLICY CAREFULLY.

FOR MORE INFORMATION ON LONG-TERM CARE SEE THE "GUIDE TO LONG-TERM CARE" GIVEN TO YOU WHEN YOU APPLIED FOR THIS POLICY.

THIS POLICY'S BENEFITS ARE NOT RELATED TO MEDICARE.

5. If it is a policy or certificate which covers care in a community setting only, contain a caption as follows:

THE WISCONSIN INSURANCE COMMISSIONER HAS ESTABLISHED MINIMUM STANDARDS FOR HOME HEALTH CARE INSURANCE. THIS POLICY MEETS THOSE STANDARDS.

THIS POLICY COVERS CERTAIN TYPES OF HOME HEALTH CARE. THIS POLICY DOES NOT COVER NURSING HOME CARE. THERE MAY BE LIMITATIONS ON THE SERVICES COVERED. THIS OUTLINE OF COVERAGE PROVIDES A BRIEF DESCRIPTION OF BENEFITS. READ YOUR POLICY CAREFULLY.

FOR MORE INFORMATION ON LONG-TERM CARE SEE THE "GUIDE TO LONG-TERM CARE" GIVEN TO YOU WHEN YOU APPLIED FOR THIS POLICY.

THIS POLICY'S BENEFITS ARE NOT RELATED TO MEDICARE.

6. Contain the caption required under subd. 3, 4 or 5 imprinted on the face of the policy or certificate in type not smaller than 18-point and either in contrasting color from the text or with a distinctly contrasting background which is at least as prominent as contrasting color.

7. Include an extension of benefits provision which provides that if the policy is terminated for any reason, including, but not limited to, failure to pay premium, any benefits provided for care in an institutional setting will continue to be payable for institutionalization if the institutionalization begins when the policy is in force and continues without interruption after termination. This extension of benefits 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 elimination period and all other applicable provisions of the policy.

8. If it is an individual policy, be plainly printed in black or blue ink in a uniform type of a style in general use with not less than 10-point with a lower case unspaced alphabet length not less than 120-point. If it is

a group policy, certificates issued under the policy shall be plainly printed in black or blue ink in a uniform type of a style in general use, not less than 10-point with a lower case unspaced alphabet length not less than 120-point.

9. If it is an individual policy, include a provision which provides that the policy is guaranteed renewable for life.

(6) NURSING HOME AND HOME HEALTH CARE COVERAGE FORMS MAY NOT USE THE TERM "LONG-TERM CARE". Only a form for a long term care policy, life insurance-long term care coverage or certificate which provides substantial coverage of care in both an institutional setting and in a community-based setting may use the term "long term care" or a substantially similar term.

(7) MISREPRESENTATIONS PROHIBITED. (a) No insurer or intermediary may use the term "long term care" or similar terminology in an advertisement or offer of a policy, coverage or certificate unless the policy, coverage or certificate advertised or offered:

1. Covers care in both institutional and community based settings;

2. Complies with this section; and

3. Is approved as a long-term care policy or certificate covering care in both institutional and community settings and as appropriately using the term "long-term care" by the office.

(b) No insurer may file a form under s. 631.20, Stats., for a long-term care policy, life insurance-long term care coverage or certificate, unless the form complies with this section.

(8) OUTLINE OF COVERAGE. (a) An outline of coverage for a long-term care policy, life insurance-long term care coverage or certificate shall:

1. Have captions printed in 18-point bold letters and conspicuously placed;

2. Be printed in an easy to read type and written in easily understood language; and

3. Comply with s. Ins 3.27 (5) (1) and (9) (zh).

(b) No insurer or intermediary may use an outline of coverage to comply with sub. (9) or advertise, market, or offer a long-term care policy, life insurance-long term care coverage or certificate, unless prior to the use, advertising, marketing or offer the outline of coverage is approved in writing by the office.

(9) DISCLOSURE WHEN SOLICITING. An insurer or intermediary at the time the insurer or intermediary contacts a person to solicit the sale of a long-term care policy, life insurance-long-term care coverage or certificate shall deliver to the person:

(a) A copy of the current edition of the guide to long-term care; and

(b) An outline of coverage.

(10) UNDERWRITING. (a) No insurer may issue a long term care policy, life insurance-long term-care coverage or a certificate to an applicant 75 years of age or older, unless prior to issuing coverage the insurer obtains one of the following:

1. A copy of a physical examination.

2. An assessment of functional capacity.

3. An attending physician's statement.

4. Copies of medical records.

(b) An insurer selling or issuing long-term care policies or life insurance-long-term care coverage shall maintain a record of all policies, coverage or certificate rescissions or reformations, including voluntary rescissions or reformations, categorized by policies, coverages and certificates within this state and nationwide.

(c) An insurer subject to par. (b) shall file a report with the office regarding rescissions and reformations not later than March 1 each year on the form prescribed by the commissioner.

(d) An insurer shall maintain a record of its claims administration guidelines for processing claims under long term care policies and life insurance-long-term care coverage and shall provide the record to the office on request.

(e) Sections Ins 3.28 and 3.31 apply to long-term care policies.

(11) SALE OF LONG-TERM CARE AND LIMITED BENEFIT POLICIES; REQUIRED OFFER OF COVERAGE WITH INFLATION PROTECTION. (a) No insurer may advertise, market or offer a long-term care policy or certificate unless the insurer has a form approved under s. 631.20, Stats., for the policy or certificate which adds inflation protection no less favorable than one of the following:

1. Benefit levels and maximum benefit amounts increase annually and are annually compounded at a rate of not less than 5%. The policy or certificate may provide that the individual insured or certificate holder will be permitted to decline a benefit increase and that if any benefit increase is declined future increases will not be available. Declination of an increase must be by express written election at the time the increase is to take effect.

2. Benefit levels and maximum benefit amounts increase annually and are annually compounded at a rate equal to the increase in the consumer price index (urban) for the previous year. The insurer may elect to provide in the form that the individual insured or certificate holder will be permitted to decline a benefit increase and that if the benefit increase is declined future increases will not be available. Such a provision shall provide that declination of an increase shall be by express written election at the time the increase is to take effect.

3. Coverage of a specified percentage, not less than 80%, of actual or reasonable charges for expenses incurred.

(b) No insurer may file a form for a long-term care policy or certificate under s. 631.20, Stats., unless the application form is filed with the policy or certificate form and the application form contains a clear and conspicuous disclosure of the offer required under par. (d).

(c) No insurer or intermediary may contact any person to solicit the sale of a long-term care policy or certificate unless, at the time of contact, the intermediary or insurer makes a clear and conspicuous offer to the person to provide the long-term care policy or certificate with the benefit levels selected by the person and inflation protection as provided under par. (a).

(d) No insurer or intermediary may accept an application for a long-term care policy or certificate unless it is signed by the applicant and the applicant has indicated acceptance or rejection of the inflation protection on the application.

(e) If a long-term care policy is a group policy the applicant for the purpose of par. (d) is the proposed certificate holder.

(f) No insurer or intermediary may advertise or represent that a long-term care policy includes inflation protection unless the policy includes inflation protection at least as favorable as provided under par. (a) 1, 2 or 3.

(g) This subsection does not require an insurer to accept an application for a long-term care policy or certificate with inflation protection as provided by this subsection if the applicant would be rejected under underwriting criteria for the policy or certificate without the inflation protection.

(12) SALE OF LONG-TERM CARE POLICY OR CERTIFICATE OR LIFE INSURANCE-LONG-TERM CARE COVERAGE WITH LENGTHY ELIMINATION PERIOD. (a) No insurer may advertise, market or offer a long-term care policy or certificate, or life insurance-long-term care coverage with an elimination period exceeding 180 days unless the insurer has a form approved under s. 631.20, Stats., providing the identical coverage, but with an elimination period of 180 days or less.

(b) No insurer may file a form for a long-term care policy or certificate or life insurance-long-term care coverage containing an elimination period in excess of 180 days, unless the application form contains a clear and conspicuous disclosure of the offer required under par. (d).

(c) No insurer or intermediary may contact any person to solicit the sale of a long-term care policy or certificate or life insurance-long-term care coverage with an elimination period in excess of 180 days unless, at the time of the contact, the intermediary or insurer makes a clear and conspicuous offer to the person to provide the policy, certificate or coverage with an elimination period of 180 days or less.

(d) No insurer or intermediary may accept an application for a long-term care policy or certificate, or life insurance-long-term care coverage, unless it is signed by the applicant and has indicated acceptance or rejection of the offer required under par. (c) on the application.

(e) If a policy or coverage is a group policy or coverage, the applicant for the purpose of par. (d) is the proposed certificate holder.

(f) This subsection does not require an insurer to accept an applicant for a policy, certificate or coverage with a 180-day or less elimination period if the applicant would be rejected for the same policy, certificate or coverage with the elimination period in excess of 180 days.

(13) COMMISSION LIMITS FOR LONG-TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES. (a) An insurer may provide compensation to an intermediary or other representative, and an intermediary or representative may accept compensation for the sale of a long-term care policy or certificate only if:

1. The first year compensation for the sale does not exceed 400% of the compensation paid in the second year or period for the sale or for servicing the policy or certificate; and

2. The compensation provided in subsequent years is the same as provided in the second year or period and is provided for at least five renewal years.

(b) No person may provide compensation to an intermediary, representative or producer, and no intermediary, representative or producer may accept compensation, relating to the replacement of a long-term care policy or certificate which is greater than the renewal compensation provided by the replacing insurer for the replacing policy or certificate. Long-term care policies this paragraph applies to include, but are not limited to, long-term care policies, nursing home policies and home health care policies issued prior to the effective date of this rule.

(14) REPLACEMENT; LONG-TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES. (a) If a long-term care policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods 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.

(b) If a group long-term care policy is replaced by another group long-term care policy purchased by the same policyholder, the succeeding

insurer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(c) Application forms for long-term care policies or certificates shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has anotherlong-term care policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing such questions may be used.

1. Do you have another long-term care, nursing home or home health care policy or certificate in force (including a health maintenance organization policy or certificate)?

2. Did you have another long-term care, nursing home or home health care policy or certificate in force during the last 12 months?

a. If so, with which company?

b. If the policy or certificate 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 or certificate?

(d) An intermediary taking an application for a long-term care policy or certificate shall:

1. List any other health insurance policies or certificates the intermediary has sold to the applicant;

2. List separately the policies or certificates that are still in force;

3. List policies or certificates sold in the past which are no longer in force; and

4. Submit the lists to the insurer with the application.

(e) Section Ins. 3.29 applies to the solicitation and sale of long-term care policies and certificates.

(f) Every insurer and person marketing long-term care insurance coverage in this state, directly or through its producers, shall:

1. Establish marketing procedures to assure that any comparison of policies by its intermediaries or other producers will be fair and accurate.

2. Establish marketing procedures to assure excessive insurance is not sold or issued.

3. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for a long-term care policy or certificate already has accident and sickness or a long-term care policy or certificate and the types and amounts of any such insurance.

4. Establish auditable procedure for verifying compliance with this paragraph.

(g) No person may:

1. Knowingly make any misleading representation or incomplete or fraudulent comparison of any insurance policies, certificate or insurers 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, certificate or to take out a policy of insurance or certificate with another insurer.

2. Employ any 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.

3. Make use directly or indirectly of any 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.

(h) In recommending the purchase or replacement of any long-term care policy or certificate an intermediary shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(i) In regards to any transaction involving a long-term care policy or certificate, no person subject to regulation under chs. 600 to 655, Stats., may knowingly prevent or dissuade or attempt to prevent or dissuade, any person from:

1. Filing a complaint with the office of the commissioner of insurance; or

2. Cooperating with the office of the commissioner of insurance in any investigation; or

3. Attending or giving testimony at any proceeding authorized by law.

(j) Replacement of long-term care, nursing home and home health care policies and certificates issued prior to the effective date of this rule is also subject to this subsection.

APPENDIX 1

(COMPANY NAME)

OUTLINE OF COVERAGE

(Insert the appropriate caption stated below.)

LONG-TERM CARE INSURANCE POLICY

THE WISCONSIN INSURANCE COMMISSIONER HAS ESTABLISHED MINIMUM STANDARDS FOR LONG-TERM CARE INSURANCE. THIS POLICY MEETS THOSE STANDARDS.

THIS POLICY COVERS CERTAIN TYPES OF NURSING HOME AND HOME HEALTH CARE SERVICES. THERE MAY BE LIMITATIONS ON THE SERVICES COVERED. THIS OUTLINE OF COVERAGE PROVIDES A BRIEF DESCRIPTION OF BENEFITS. READ YOUR POLICY CAREFULLY.

or

NURSING HOME INSURANCE POLICY

THE WISCONSIN INSURANCE COMMISSIONER HAS ESTABLISHED MINIMUM STANDARDS FOR NURSING HOME INSURANCE. THIS POLICY MEETS THOSE STANDARDS.

THIS POLICY COVERS CERTAIN TYPES OF NURSING HOME CARE. THIS POLICY DOES NOT COVER HOME HEALTH CARE. THERE MAY BE LIMITATIONS ON THE SERVICES COVERED. THIS OUTLINE OF COVERAGE PROVIDES A BRIEF DESCRIPTION OF BENEFITS. READ YOUR POLICY CAREFULLY.

or

HOME HEALTH CARE INSURANCE POLICY

THE WISCONSIN INSURANCE COMMISSIONER HAS ESTABLISHED MINIMUM STANDARDS FOR HOME HEALTH CARE INSURANCE. THIS POLICY MEETS THOSE STANDARDS.

THIS POLICY COVERS CERTAIN TYPES OF HOME HEALTH CARE. THIS POLICY DOES NOT COVER NURSING HOME CARE. THERE MAY BE LIMITATIONS ON THE SERVICES COVERED. THIS OUTLINE OF COVERAGE PROVIDES A BRIEF DESCRIPTION OF BENEFITS. READ YOUR POLICY CAREFULLY.

plus

FOR MORE INFORMATION ON LONG-TERM CARE SEE THE "GUIDE TO LONG-TERM CARE" GIVEN TO YOU WHEN YOU APPLIED FOR THIS POLICY.

THIS POLICY'S BENEFITS ARE <u>NOT</u> RELATED TO MEDICARE.

(1) The outline of coverage shall contain a description of the following items, if applicable:

(a) Pre-existing condition limitation

(b) Elimination periods

(c) Exclusions and limitations in the policy

(d) Prior authorization procedures

(e) Benefit periods and lifetime maximums in the policy

(f) Renewability provision of the policy

(g) "Free look" provisions of the policy

(h) Inflation protection provisions

(i) Definitions for skilled, intermediate and custodial care, activities of daily living, home health care, and respite care

(j) Benefit appeals internal procedures.

(2) The outline shall contain a statement that the policy will provide benefits for persons with irreversible dementia if the person requires the type of care covered by the policy and is otherwise eligible for benefits.

(3) A summary of the costs of the policy and any optional rider purchased. The summary may be completed at the time the outline is provided to an applicant.

(4) For life insurance products, a statement that the cash value and death benefits will be reduced if claims are paid under life insurance-long-term care coverage.

SECTION 5. Ins 3.55 (title), (1) and (2) are amended to read:

Ins 3.55 (title) Benefit appeals under long-term care policies, life insurance-long-term care coverage and medicare replacement or supplement policies. (1) PURPOSE. This section implements and interprets s. 632.84, Stats., for the purpose of establishing minimum requirements for the internal procedure for benefit appeals that insurers shall provide in ~~nursing-home insurance~~ long-term care policies, life insurance-long-term care coverage and medicare replacement or supplement policies. This section also facilitates the review by the commissioner of these policy forms.

(2) SCOPE. This section applies to individual and group nursing home insurance policies and medicare replacement or supplement policies issued or renewed on or after August 1, 1988, and to long-term care policies and life insurance-long-term care coverage issued or renewed after the effective date of this rule, except for policies or coverage exempt under s. Ins 3.455 (2) (b). This section does not apply to a health maintenance organization, limited service health organization, or preferred provider plan, as those are defined in s. 609.01, Stats.

SECTION 6. Ins 3.55 (4) (a) is amended to read:

Ins 3.55 (4) (a) Pursuant to s. 632.84 (2), Stats., an insurer shall include in any ~~nursing-home-insurance~~ long-term care policy, life insurance-long-term care coverage and any medicare replacement or supplement policy an internal procedure for benefit appeals.

SECTION 7. Ins 3.55 (3) (cg) and (cm) are created to read:

Ins 3.55 (3) (cg) "Life insurance-long-term care coverage" has the meaning provided under s. Ins. 3.46 (3) (d).

(cm) "Long-term care policy" has the meaning provided under s. Ins 3.46 (3) (e).

SECTION 8. Ins 3.55 (3) (f) is repealed.

SECTION 9. This rule takes effect on May 1, 1991, or on the first day of the second month commencing after its publication, whichever is later.

Dated at Madison, Wisconsin, this 8 day of March, 1991.

Robert D. Haase
Commissioner of Insurance