ins003_EmR0817.pdf **Insurance – Revises Ch. Ins 3 – EmR0817**

PROPOSED ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

Relating to long-term care plans including the long-term care partnership program qualifying policies and affecting small business.

FINDING OF EMERGENCY

The Commissioner of Insurance finds that an emergency exists and that the attached rule is necessary for the immediate preservation of the public peace, health, safety, or welfare. Facts constituting the emergency are as follows:

The State of Wisconsin will be implementing the Wisconsin Partnership Program effective January 1, 2009, the date approved by the federal government in accordance with the Department of Health and Family Services' application for participation. As part of the enabling statute as amended, the state requires that all insurance intermediaries receive specific training prior soliciting any long-term care products on or after January 1, 2009. In order to minimize the impact of the additional training, the proposed rule permits the training, if approved, to qualify for continuing education therefore, intermediaries can meet two training requirements simultaneously. For training to be approved and courses offered prior to January 1, 2009, the office needs to promulgate this rule to provide the guidelines necessary for creation and submission of training programs. Therefore the office must promulgate this rule as an emergency rule.

In addition, in order for insurers to offer products intended to qualify for the Wisconsin partnership program, such products shall be submitted to the office prior to use. The insurers must submit those products sufficiently in advance of January 1, 2009, so that there is time for review by the office and implementation time for the insurers. These changes include modifications to s. Ins 3.455 including repealing and recreating the applicable definitions and modifying the conversion requirements; modifications to s. Ins 3.46 including deletion of the blanket exemption for group long-term care products replaced with narrow exceptions, modification to the marketing and advertising requirements with notable new requirements for insurers and intermediaries to submit to OCI marketing and advertisement material prior to use, new group insurance requirements, modifications to the permissive limitations and exclusions, disclosures, replacement requirements, reporting requirements for insurers added regarding suitability; conversion modifications, incontestability and standards for marketing. The appendices to s. Ins 3.46 have also been repealed and recreated and now include several reporting forms for tracking suitability, rescissions, claims denial, replacement and lapses by state to be filed by insurers. As noted above, the major addition to s. Ins 3.46 is the intermediary training requirement as required by s. 628.348 (1), Stats. Finally, the changes also include a new section, s. Ins 3.465 and appendices, related to the Wisconsin Partnership Program that is to be available beginning January 1, 2009.

A combined rule hearing will be held for both the emergency and permanent rule on June 16th as noticed.

The proposed rule changes are:

SECTION 1. 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 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 of ch. 632, Stats. This subsection does not apply to a long-term care policy as defined under s. Ins 3.46 (3) ~~(e)~~ (m).

SECTION 2. Ins 3.455 (3) is repealed and recreated to read:

Ins 3.455 (3) DEFINITIONS. In this section:

(a) "Basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and that is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plan, including but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(b) "Basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy, and any group policy that it replaced, for at least 3 months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

(c) "Converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy form which conversion is made restricts provision of benefits and services to or contains incentives to use certain providers or facilities, the commissioner, in making a determination as to the substantial equivalency of the benefits, shall

take into consideration the differences between managed-care and non-managed-care plans, including but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity. The converted policy offered shall be on a form generally available in the state.

(d) "Exceptional increase" means an increase in premium by an insurer that the commissioner determines is justified under any of the following circumstances:

1. Changes in laws or rules applicable to long-term care coverage in this state.

2. Increased and unexpected utilization that affects the majority of insurers of similar products.

(e) "Guaranteed renewable" has the meaning given in s. Ins 3.46 (3) (f).

(f) "Incidental" means that the value of the long-term care benefits provided is less than 10% of the total value of the benefits provided over the life of the policy measured as of the date of issue.

(g) "Life insurance-long-term care coverage" has the meaning given in s. Ins 3.46 (3) (j).

(h) "Long-term care policy" has the meaning given in s. Ins 3.46 (3) (k).

(i) "Managed-care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

(j) "Qualified actuary" means a member in good standing of the American academy of actuaries.

(k) "Similar policy forms" means all of the long-term care, nursing home and home health care insurance policies and certificates offered by an insurer that fall within one of the following categories:

1. Institutional long-term care, nursing home benefits only.

2. Non-institutional long-term care, home health care benefits only.

3. Comprehensive long-term care, nursing home and home health care benefits.

SECTION 3. Ins 3.455 (7) (b) to (d) are amended to read:

Ins 3.455 (7) (b) An individual long-term care policy ~~which~~that 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~~that is identical to or in excess of the benefits provided under 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~~that complies with all of the following:

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.

SECTION 4. Ins 3.455 (7) (e) to (j) are created to read:

Ins 3.455 (7) (e) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed to the insurer within 30 days after notice of termination of group coverage. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be guaranteed renewable annually.

(f) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced except when the premium was a flat composite premium. If the premium for the policy from which conversion is made was a flat composite premium then at conversion the premium shall be based upon attained age at the time of conversion.

(g) The offer of continuation of coverage or issuance of a converted policy shall comply with s. 632.897, Stats., except when either of the following occurs:

1. Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due.

2. The terminating coverage is replaced not later than 31 days after termination by group coverage effective on the day following the termination of coverage providing benefits identical to or in excess of those provided by the terminating coverage and the premium for which is calculated in a manner consistent with the requirements of par. (f).

(h) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100% of incurred expenses. The provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund that reflects the reduction in benefits payable.

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

(j) Notwithstanding any other provision of this section, an insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

SECTION 5. Ins 3.46 (2) (a) is repealed.
SECTION 6. Ins 3.46 (2) (d) (intro.) is amended to read:

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

SECTION 7. Ins 3.46 (3) is repealed and recreated to read:

(3) DEFINITIONS. In this section:

(a) "Assisted living facility" or "assisted living care facility" means a living arrangement in which people with special needs reside in a facility that provides supportive services to persons unable to live independently and requires supportive services, including, but not limited to, personal care and assistance taking medications, and that is in compliance with ch. HFS 89.

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

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

(d) "Department" means the Wisconsin department of health services.

(e) "Group long-term care insurance" means a long-term care insurance policy that is delivered or issued for delivery in this state and issued 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 both, for employees or former employees, or both, or for members or former members, or both, of the labor organizations; or a professional, trade or occupational association for its members or former or retired members, or both, if the association is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation and has been maintained in good faith for purposes other than obtaining insurance or an association or a trust or the trustees of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering the policy within this state the association or the insurer of the association shall demonstrate that at least 25% of its members are residents of this state.

(f) "Guaranteed renewable for life" means an individual policy renewal provision that continues the insurance in force unless the premium is not paid on time, that 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 that 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.

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

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

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

(j) "Life insurance-long-term care coverage" means coverage that includes all of the following:

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

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

(k) “Long-term care insurance” means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. The term includes group and individual annuities and life insurance policies or riders that provide directly or supplement long-term care insurance. The term also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term includes qualifying partnership policies. Long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance does not include an insurance policy that is offered primarily to provide basic Medicare supplement coverage. With regard to life insurance, this term does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision of this section, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this section.

(L) “Long-term care insurance policy qualifying for the Wisconsin Long-Term Care Insurance Partnership Program” or “qualifying partnership policy” means a long-term care insurance policy that is intended to qualify an insured under the Wisconsin Long-Term Care Insurance Partnership Program, as defined at s. 49.45 (31) (a), Stats.

(m) "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 any of the following:

1. A Medicare supplement policy, 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 (3), Stats.

4. Life insurance-long-term care coverage.

(n) “Medicaid” means the federal and state entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources established by Title XIX, 42 U.S.C. 1396 to 1396r-3. The federal government provides matching funds to the state Medicaid programs.

(o) "Medicare" means the hospital and medical insurance program established by Title XVIII, 42 U.S.C. 1395 to 1395ss, as amended.

(p) "Medicare eligible persons" means persons who qualify for Medicare.

(q) “Mental or nervous disorder” may not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

(r) "Noncancellable" means an individual policy in which the insured has the right to continue the insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

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

(t) “Personal care” means the provision of hands-on services to assist an individual with activities of daily living.

(u) “Qualified long-term care services” means services that meet the requirements of s. 7702(c)(1) of the Internal Revenue Code of 1986, as amended, including the following:

1. Necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services.

2. Maintenance or personal care services that are required by a chronically ill individual.

3. Services that are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(v) “Skilled nursing care,” “personal care,” “home care,” “specialized care,” “assisted living care,” and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care shall be delivered.

(x) “Wisconsin Long-Term Care Insurance Partnership Program” or “state partnership program” means the program developed by the department to meet the requirements of s. 49.45 (31), Stats.

SECTION 8. Ins 3.46 (4) (c), (j) to (n), and (r) are amended to read:

Ins 3.46 (4) (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. and the following when applicable:

1. If the policy provides for home health or community care services, it shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement may not apply to policies or certificate issued to residents of continuing care retirement communities.

2. Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

(j) Define terms used to describe covered services, including, but not limited to, "skilled nursing care," "intermediate extended care facility," "convalescent nursing home," "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 deliveredservices and facilities required to be available and the licensure, certification, registration or degree status of those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified or registered, it shall also state what requirements a provider shall meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or when the state licenses, certifies or registers the providers of services under another name.

(k) Define terms used to describe providers whose services are coveredAll providers of services, including, but not limited to, "skilled nursing facility," "extended care facility," "intermediate care facility,""convalescent nursing home," "personal care facility," "specialized care providers," "assisted living," and "home care agency," if those terms are used,shall be defined in relation to the services and facilities required to be available and licensingthe licensure, certification, registration or degree status of those providing or supervising the services in the state where the policy was issued. A When the definition may requirerequires that a provider be appropriately licensed, orcertified or registered, it shall also state what requirements a provider shall meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of such services to be licensed, certified or registered, or if the state licenses, certifies or registers the provider of services under another name. A form may not exclude coverage of any type of service normally provided by the defined provider, facility or agency.

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

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

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

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

b. Services for which benefits are available under Medicare or a other governmental program other than medicaidprograms, except Medicaid, or under a state or federal worker's compensation, employer's liability, occupational disease law, or any 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.

d. War or act of war, whether declared or undeclared.

e. Participation in a felony, riot or insurrection.

f. Service in the armed forces or its auxiliary units.

g. Suicide, sane or insane, attempted suicide or intentionally self-inflicted injury.

h. Aviation, however, this exclusion applies only to non-fare-paying passengers.

3. Mental or nervous disorders; however, this may not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease.

4. Alcoholism or drug addiction.

5. Expenses for services or items available or paid under another long-term care insurance or health insurance policy.

6. This paragraph is not intended to prohibit exclusions or limitation by type of provider. In this subdivision, "state of policy issue" means the state in which the individual policy or certificate was originally issued. However, no long-term care insurer may deny a claim because services are provided in a state other than the state of policy issue when either of the following conditions occurs:

a. When a state other than the state of policy issue does not have the provider licensing, certification, or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration.

b. When a state other than the state of policy issue licenses, certifies or registers the provider under another name.

7. This paragraph is not intended to prohibit territorial limitations.

8. If payment of benefits is based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of these terms and include an explanation of the terms in its accompanying outline of coverage and comply with s. Ins 3.60 (5).

9. In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Medicare or would be so reimbursable but for the application of a deductible or coinsurance amount.

10. Subject to the policy provisions, any plan of care required under the policy shall be provided by a licensed health care practitioner and does not require insurer approval. The insurer may provide a predetermination of benefits payable pursuant to the plan of care. This does not prevent the insurer from having discussions with the licensed health care practitioner to amend the plan of care. The insurer may also retain the right to verify that the plan of care is appropriate and consistent with generally accepted standards.

11. A long-term care policy containing post-confinement, post-acute care, or recuperative benefits shall include in a separate policy provision entitled "Limitation or Conditions on Eligibility for Benefits," the limitations or conditions applicable to these benefits, including any required number of days of confinement.

(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 any of the following:

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.

(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. A long-term care insurance policy may not, if it provides benefits for home health care or community care services limit or exclude benefits by any of the following acts:

1. Requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided.

2. Requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before home health care services is covered.

3. Requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide or other licensed or certified home care worker acting within the scope of his or her licensure or certification.

4. Excluding coverage for personal care services provided by a home health aide.

5. Requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service.

6. Requiring that the insured or claimant have an acute condition before home health care services are covered.

7. Limiting benefits to services provided by Medicare-certified agencies or providers.

8. Excluding coverage for adult day care services.

SECTION 9. Ins 3.46 (5) (a) and (b) 9. are amended to read:

Ins 3.46 (5) (a) This subsection and ss. Ins 3.13 (2) ~~(h)~~(j) and 3.39 (9) (a) and ss. 632.76 and 632.897, Stats., do not apply to life insurance-long-term care coverage.

9. If it is an individual policy, include a provision which provides that the policy is guaranteed renewable for life or noncancellable, then such provision shall be appropriately captioned and shall appear on the first page of the policy and shall include any reservation by the insurer of the right to change premiums and any automatic renewal premium increase based on the policyholder's age.

SECTION 10. Ins 3.46 (8) (c) is created to read:

Ins 3.46 (8) (c) Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy all of the following:

1. "Notice to Buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

2. A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation by the insurer of the right to change premium. Continuation or conversion provisions of group coverage shall be specifically described.

(d) This par. does not apply to a group that is offered coverage as a result of collective bargaining and has guaranteed issue.

SECTION 11. Ins 3.46 (9) (k) to (m) are created to read:

(k) An insurer shall provide copies of the disclosure forms required in Appendices 2 and 5 to the applicant.

(L) 1. In the case of a group insurance policy defined in s. 600.03 (23), Stats., any requirement that a signature of an insured be obtained by an intermediary or insurer shall be deemed satisfied if all of the following are met:

a. The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. Verification of enrollment and enrollment information shall be provided to the enrollee in writing.

b. The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records.

c. The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and personal medical information is maintained.

2. The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

3. This par. does not apply to a group that is offered coverage as a result of collective bargaining and has guaranteed issue.

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

SECTION 12. Ins 3.46 (10) (f) –(j) are created to read:

Ins 3.46 (10) (f) All applications for long-term care insurance policies or certificates, except those that are guaranteed issue, shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant and shall comply with all of the following when applicable:

1. If the application contains a question that asks whether the applicant has had medication prescribed by a physician, it shall also ask the applicant to list the medication that has been prescribed.

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

(g) The following language shall be set out in bold font and in a conspicuous location that is in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

"Caution: If your answers on this application are incorrect or untrue, [insurer's name] has the right to deny benefits or rescind your policy."

(h) The following language, or language substantially similar to the following, shall be set out in bold font and in a conspicuous location on the long-term care insurance policy or certificate at the time of delivery:

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

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

(j) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and shall annually furnish this information to the commissioner in the format contained in Appendix 8.

SECTION 13. Ins 3.46 (11) (a) 4. is created to read:

Ins 3.46 (11) (a) 4. Activities of daily living and cognitive impairment triggers shall be described in the policy in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." If an attending physician or other specified person is required to certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

SECTION 14. Ins 3.46 (14) is repealed and recreated to read:

Ins 3.46 (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 may not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(c) 1. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care 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 the following questions may be used:

a. Do you have another long-term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)?

b. Did you have another long-term care insurance policy or certificate in force during the last 12 months?

c. If so, with which [company or insurer]?

d. If that policy lapsed, when did it lapse?

e. Are you covered by Medicaid?

f. Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

2. Agents shall list any other health insurance policies they have sold to the applicant, including all of the following.

a. List policies sold that are still in force.

b. List policies sold in the past 5 years that are no longer in force.

3. Upon determining that a sale will involve replacement, an insurer; other than an insurer using direct response solicitation methods, or its intermediaries; shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in compliance with Appendix 6.

4. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in compliance with Appendix 7.

5. Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Notice shall be made within 5 working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

6. Life insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of s. Ins 2.07. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

(d) An intermediary taking an application for a long-term care policy or certificate shall do all of the following:

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.

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

(e) Every insurer and person marketing long-term care insurance coverage in this state, directly or through its intermediaries, shall do all of the following:

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 an accident and sickness or a long-term care policy or certificate and the types and amounts of any such insurance, except that in the case of qualified long-term care insurance contract, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required.

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

(f) 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.

(g) Replacement of long-term care, nursing home and home health care policies and certificates issued prior to June 1, 1991 is also subject to this subsection.

SECTION 15. Ins 3.46 (16) (b) is amended to read:

Ins 3.46 (16) (b) Every insurer marketing long-term care insurance policies shall do all of the following:

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.

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

4. Report annually to the commissioner all of the following:

a. The total number of applications received from residents of this state.

b. The number of those who declined to provide information on the personal worksheet.

c. The number of applicants who did not meet the suitability standards.

d. The number of applicants who chose to confirm after receiving a suitability letter.

SECTION 16. Ins 3.46 (19) (c) 4., (d) are repealed and recreated to read:

Ins 3.46 (19) (c) 4. On or before the effective date of a substantial premium increase as described in subd. 3. the insurer shall do all of the following:

a. Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased.

b. Offer to convert the coverage to a paid-up status where the amount payable for each benefit is 90% of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in subd. 3.; and

c. Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in subd. 3. shall be deemed to be the election of the offer to convert in subd. 4. b., if the ratio is 40% or more.

(d) The required benefits continued as nonforfeiture benefits under par. (a), including contingent benefits upon lapse under par. (b), are computed as follows:

1. "Attained age rating" as applied in this paragraph 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 for age 50 and beyond.

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

3. The standard nonforfeiture credit shall be at least 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 may 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. (e).

4. The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first 3 years and subsequent years. For a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of end of the tenth year following the policy or certificate issue date or of 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.

SECTION 17. Ins 3.46 (19) (j) is created to read:

3.46 (19) (j) A contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in par. (c) 3. based on the insured's issue age, the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio is 40% or more. Unless otherwise required, policyholders shall be notified at least 30 days prior to the due date of the premium reflecting the rate increase.

SECTION 18. Ins 3.46 (20) to (26) are created to read:

Ins 3.46 (20) INCONTESTABILITY PERIOD. (a) For a policy or certificate that has been in force for less than 6 months, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage in accordance with s 632.76, Stats.

(b) After an individual policy or certificate has been in force for 2 years, it is not contestable upon the grounds of misrepresentation alone; such policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health in accordance with s. 632.76, Stats.

(c) 1. No long-term care insurance policy or certificate may be field issued based on medical or health status unless the compensation to the field issuer is not based on the number of policies or certificates issued.

2. For purposes of this paragraph, a policy or certificate that is "field issued" means the producer or third-party administrator using the insurer's underwriting guidelines underwrites the policy not the insurer, pursuant to the authority granted to the producer or third-party administrator by an insurer.

(d) If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

(e) In the event of the death of the insured, this subdivision may not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies shall be governed by s 632.46, Stats. In all other situations, this subdivision shall apply to life insurance policies that accelerate benefits for long-term care.

(21) REPORTING REQUIREMENTS. (a) Every insurer shall maintain records for each intermediary of that intermediary's amount of replacement sales as a percent of the intermediary's total annual sales and the amount of lapses of long-term care insurance policies sold by the intermediary as a percent of the intermediary's total annual sales.

(b) Every insurer shall report annually by June 30 the 10% of its intermediaries with the greatest percentages of lapses and replacements as measured by par. (a) using Appendix 10.

(c) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely intermediary activities regarding the sale of long-term care insurance.

(d) Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year using Appendix 10.

(e) Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year using Appendix 10.

(f) Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied using Appendix 9.

(22) FILING REQUIREMENTS FOR ADVERTISING. Every insurer, health care service plan or other entity providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement whether through written, radio or television medium to the commissioner as required by s. Ins 3.27. In addition, all advertisements shall be retained by the insurer, health care service plan or other entity for at least 3 years from the date the advertisement was first used.

(23) STANDARDS FOR MARKETING. (a) Every insurer or other entity marketing long-term care insurance coverage in this state, directly or through its intermediaries, shall do all of the following:

1. Establish marketing procedures and intermediary training requirements to assure that both of the following are met:

a. Any marketing activities, including any comparison of policies, by its intermediaries or other producers will be fair and accurate.

b. Excessive insurance is not sold or issued.

2. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following notice:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

3. Provide copies of the disclosure forms required in Appendices 2 and 3 to the applicant.

4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance, except that in the case of qualified long-term care insurance contracts as defined in s. Ins 3.465 (2) (d), an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required.

5. Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this paragraph.

6. If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificateholder that the program is available and the name, address and telephone number of the program.

7. For long-term care insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms with sub. (3) (f).

8. Provide an explanation of contingent benefit upon lapse provided for in sub. (19) (c), and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in sub. (15)(e).

(b) In addition to the practices prohibited in s. 628.34 (12), Stats., the following acts and practices are prohibited by insurers or other entities marketing long-term care insurance coverage in this state, directly or through its intermediaries:

1. "Twisting." Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies 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 or to take out a policy of insurance with another insurer.

2. "High pressure tactics." Employing 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. "Cold lead advertising." Making 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.

4. "Misrepresentation." Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

(c) In regards to any transaction involving a long-term care insurance product, 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 any of the following:

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

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

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

(d) If an insured exercises the right to return a policy during the free-look period, the issuer shall mail the entire premium refund directly to the person who paid the premium.

(e) 1. With respect to the obligations set forth in this subsection, the primary responsibility of an association, as described at s. 600.01 (1) (b) 3., Stats., when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

2. The insurer shall file with the office of the commissioner of insurance all of the following material:

a. The policy and certificate.

b. A corresponding outline of coverage.

c. All advertisements requested by the insurance department.

3. The association shall disclose in any long-term care insurance solicitation the following:

a. The specific nature and amount of the compensation arrangements, including all fees, commissions, administrative fees and other forms of financial support, that the association receives from endorsement or sale of the policy or certificate to its members.

b. A brief description of the process under which the policies and the insurer issuing the policies were selected.

4. If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

5. The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

6. The association shall also do all of the following:

a. At the time of the association's decision to endorse or engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of its policies, including benefits, features, and rates and subsequently update the examination in the event of material change.

b. Actively monitor the marketing efforts of the insurer and its intermediaries.

c. Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

d. This subd. 6. a. to c. may not apply to qualified long-term care insurance contracts.

7. No group long-term care insurance policy may be issued to an association unless the insurer files with the office of the commissioner of insurance the information required in this subsection.

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

9. Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of s. 628.34 (11), Stats.

(24) AVAILABILITY OF NEW SERVICES OR PROVIDERS. (a) An insurer shall notify policyholders of the availability of a new long-term care policy series that provides coverage for new long-term care services or providers material in nature and not previously available through the insurer to the general public. The notice shall be provided within 12 months of the date the new policy series is made available for sale in this state.

(b) Notwithstanding par. (a), notification is not required for any policy issued prior to the effective date of this section or to any policyholder or certificateholder who is eligible for benefits, is within an elimination period or is receiving benefits, or who previously received benefits under the terms of the policy, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

(c) The insurer shall make the new coverage available in one of the following ways:

1. By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age.

2. By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits shall be based on premiums paid or reserves held for the prior policy or certificate.

3. By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate.

(d) An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of this paragraph, "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders that purchased such a proprietary policy shall be notified when a new long-term care policy series that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel.

(e) Policies issued pursuant to this subsection may not be considered replacements.

(f) Where the policy is offered through an employer, labor organization, or professional, trade or occupational association, the required notification in par. (a) shall be made to the offering entity.

(g) Nothing in this subsection shall prohibit an insurer from offering any policy, rider, certificate or coverage change to any policyholder or certificateholder. However, upon request any policyholder may apply for available coverage that includes the new services or providers. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

(h) This subsection does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(25) RIGHT TO REDUCE COVERAGE AND LOWER PREMIUMS. (a) 1. Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:

a. Reducing the maximum benefit.

b. Reducing the daily, weekly or monthly benefit amount.

2. The insurer may also offer other reduction options that are consistent with the policy or certificate design or the insurer's administrative processes.

(b) The provision shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

(c) The age to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the existing coverage.

(d) The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.

(e) If a policy or certificate is due to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by sub. (15) (e).

(f) This subsection does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(26) INSURANCE INTERMEDIARY TRAINING REQUIREMENTS. This section applies to all insurance intermediaries that sell, solicit or negotiate long-term care insurance products in this state. For purposes of this paragraph, an hour of training means a period of study consisting of no less than 50 minutes. The requirements of this paragraph do not supersede any other intermediary education requirements contained in chs. Ins 26 and 28.

(a) No insurance intermediary may sell, solicit or negotiate long-term care insurance in this state unless the intermediary is duly licensed and appointed by an insurer and has completed the initial training and ongoing training every 24 months as specified in s. 628.348 (1), Stats. The insurer shall be able to verify compliance with the training requirements as specified in this paragraph and s. 628.348 (2), Stats. The training shall meet the requirements set forth in this paragraph to par. (d).

1. a. Initial Training. The initial training required shall be no less than 8 hours, of which 2 hours shall contain Wisconsin specific Medicaid and long-term care information.

b. Ongoing Training. After completion of the initial 8 hours of training, all insurance intermediaries shall complete 4 hours of training specific to long-term care insurance and shall incorporate updates to the state partnership program as is available from the department's website. Training shall be completed as specified in par. (b) 2.

2. The training specified in this subsection may not include training that is insurer or company product specific or that includes any sales or marketing information, materials, or training, other than those required by state or federal law.

3. The training required by this subsection shall be submitted and approved and may be approved as continuing education courses under ch. Ins 28.

4. The training required by this subsection may be completed in 2-hour increments.

5. The training required by this subsection shall consist of topics related to long-term care insurance, long-term care services and the state partnership program. The training shall include, but not be limited to, all of the following:

a. State and federal regulations and requirements and the relationship between qualified state long-term care partnership plan policies and other public and private coverage of long-term care services, including Medicaid programs in this state.

b. Available long-term care services and providers.

c. Changes or innovations in long-term care services or providers.

d. Alternatives to the purchase of private long-term care insurance.

e. The effect of inflation on benefits and the importance of inflation protection.

f. Insurance suitability standards and guidelines.

6. Wisconsin specific Medicaid and long-term care training shall consist of the training developed and made available by the department.

7. Satisfaction of the training requirements in any state shall be deemed to satisfy the training requirements in this state subject to verification and compliance with the training requirements in par. (a) 1. except for the initial 2 hours of Wisconsin specific Medicaid and long-term care information training.

(b) 1. Insurance intermediaries licensed prior to January 1, 2009, shall complete the initial training prior to January 1, 2009, in order to sell long-term care products on or after January 1, 2009. Completion of initial training courses on or after October 27, 2007, that meet the requirements of subd. (a) 5., may be counted towards completion of the initial 8 hour training requirement.

2. For purposes of complying with s. 628.348 (1), Stats., compliance with this subsection will comply with s. 628.348 (1), Stats., Insurance intermediaries who complete initial training by January 1, 2009, are required to complete the required 4 hours of ongoing training by the first complete license renewal date as specified in s. Ins 6.63. Insurance intermediaries completing initial training after

January 1, 2009 shall complete the required 4 hours of ongoing training by the date of their next license renewal date as specified in s. Ins 6.63.

(c) Insurers subject to this section shall obtain and maintain verification that the intermediaries appointed with the insurer received the training required by sub. (1) and shall make such information available to the commissioner upon request.

(d) Insurers offering long-term care insurance intended as a qualifying partnership policy shall maintain records that its authorized insurance intermediaries have demonstrated an understanding of the state partnership program and the relationship of the state partnership program to public and private coverage of long-term care including Wisconsin Medicaid long-term care programs. Information maintained shall be in a form that allows the commissioner to provide assurance to the department that the insurer's intermediaries have received the long-term care insurance training.

SECTION 19. Ins 3.46 Appendices (1) – (5) are repealed and recreated to read:

Ins 3.46 APPENDIX 1

(COMPANY NAME)

OUTLINE OF COVERAGE

(Insert the appropriate caption stated below.)

1. This policy is [an individual policy of insurance]([a group policy] that was issued in the [indicate jurisdiction in which group policy was issued]).

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

3. FEDERAL TAX CONSEQUENCES.

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

OR

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

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

(a) [For long-term care insurance policies or certificates describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

(c) [Describe waiver of premium provisions or state that there are not such provisions.]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

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

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

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

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

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

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

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

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

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

9. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductibles, waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Non-institutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

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

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

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities and providers;

(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions and exceptions;

(e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 9 above.]

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

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

(a) That the benefit level will not increase over time;

(b) Any automatic benefit adjustment provisions;

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

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

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

13. PREMIUM.

[(a) State the total annual premium for the policy;

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium that corresponds to each benefit option.]

14. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

15. CONTACT THE WISCONSIN SENIOR HEALTH INSURANCE INFORMATION PROGRAM OR YOUR COUNTY BENEFIT SPECIALIST IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

Ins 3.46 APPENDIX 2
Long-Term Care Insurance
Personal Worksheet

People buy long-term care insurance for a variety of reasons. These reasons include avoiding 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

Policy Form Number(s) _____
The premium for the coverage you are considering will be [$_____ per month, or $_____ per year,] [a one-time single premium of $_____.]
Type of Policy (noncancellable/guaranteed renewable): _____
[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees may not be shown on this form.]

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 shall disclose the company's rate increases under prior policies providing essentially similar coverage.

RATE INCREASE HISTORY

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

QUESTIONS RELATED TO YOUR INCOME

_ Income _ Savings _ Family members
[Have you considered whether you could afford to keep this policy if the premiums were raised, for example, by 20%?]
Note: The insurer shall use the bracketed sentence unless the policy is fully paid up or is a noncancellable policy.
What is your annual income? (check one)
_ Under $10,000 _ $10,000-20,000 _ $20,000-30,000 _ $30,000-50,000 _ Over $50,000
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.
Will you buy inflation protection? (check one) □Yes □No
If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?
□From my Income □From my Savings \ Investments □My Family will Pay
The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.
What elimination period are you considering? Number of days _____Approximate cost $_____ for that period of care.
How are you planning to pay for your care during the elimination period? (check one)
□From my Income □From my Savings \ Investments □My Family will Pay

QUESTIONS RELATED TO YOUR SAVINGS AND INVESTMENTS

Not counting your home, 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 answers to the questions above describe my financial situation.

or

___I choose not to complete this information.

(Check one.)

___I acknowledge that the carrier or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. I understand that the rates for this policy may increase in the future. (This box shall be checked).

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)

Ins 3.46 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.]

[Note: For single premium policies, delete the above bullet; for noncancellable policies, delete the second sentence only.]

	▪	The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
Medicare	▪	Medicare does not pay for most long-term care.
Medicaid	▪	Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.
	▪	Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
	▪	When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
	▪	Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.
Shopper's Guide	▪	Make sure the insurance company or agent gives you a copy of a booklet called the "Guide to Long-Term Care." 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.
Facilities	▪	Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

Ins 3.46 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" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." The Wisconsin Office of the Commissioner of Insurance also has information about long-term care insurance and may be able to refer you to a county Benefit specialist or a Senior Health Insurance Information specialist 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.]

Note: Choose the paragraph and bracketed sentences in that paragraph that apply.

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.

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].

Ins 3.46 APPENDIX 5

Long-Term Care Insurance
Potential Rate Increase Disclosure Form

Instructions:

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

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

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

2. The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.

3. Rate Schedule Adjustments:

The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): _____.

4. Potential Rate Revisions:

This policy is Guaranteed Renewable. This means that the rates for this policy may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

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

• Pay the increased premium and continue your policy in force as is.

• Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)

• Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)

• Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

*Contingent Nonforfeiture

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

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

Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table and

You lapse (not pay more premiums) within 120 days of the increase.

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

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

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

Example:

You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.

In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).

Your paid-up policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your policy.)

Contingent Nonforfeiture
Cumulative Premium Increase over Initial Premium
That qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%

77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

[The following contingent nonforfeiture disclosure need only be included for those limited pay policies to which sub. (19) (j) is applicable.]

In addition to the contingent nonforfeiture benefits described above, the following reduced "paid-up" contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced "paid up" benefit AND the contingent benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced "paid up" contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below;

Triggers for a Substantial Premium Increase

Issue Age	**Percent Increase Over Initial Premium**
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect; AND
3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option, your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

a. The total lifetime amount of benefits your reduced paid up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

b. The daily benefit amounts you purchased will also be adjusted by the same ratio.
If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy.

SECTION 1. **Ins 3.46 Appendices (6) to (10) are created to read:**

Ins 3.46 APPENDIX 6
NOTICE TO APPLICANT REGARDING REPLACEMENT
OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE
[Insurance company's name and address]

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

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

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

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

(Use additional sheets, as necessary.)

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

1. Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before your sign it, reread it carefully to be certain that all information has been properly recorded.

_____

(Signature of Agent, Broker or Other Representative)

[Typed Name and Address of Agent or Broker]

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

_____ _____

(Applicant's Signature) (Date)

Ins 3.46 APPENDIX 7
NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

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

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

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

1. Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

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

[Company Name]

Ins 3.46 APPENDIX 8
RESCISSION REPORTING FORM FOR
LONG-TERM CARE POLICIES

FOR THE STATE OF _____
FOR THE REPORTING YEAR [ ]
Company Name: _____
Address: _____
_____
Phone Number: _____

Due: March 1 annually

Instructions:

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

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

Detailed reason for rescission:
_____
_____
_____
_____
_____

_____
Signature

_____
Name and Title (please type)

_____
Date

INS 3.46 Appendix 9
Claims Denial Reporting Form
Long-Term Care Insurance

For the State of _____
For the Reporting Year of _____
Company Name: _____
Due: June 30 annually
Company Address:
_____
_____
Company NAIC Number: _____
Contact Person: _____Phone Number: _____
Line of Business: Individual Group

Instructions

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

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

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

INS 3.46 Appendix 10

Long-Term Care Insurance
Replacement and Lapse Reporting Form

For the State of _____
For the Reporting Year of _____
Company Name: _____
Due: June 30 annually
Company Address: _____
Company NAIC Number: _____
Contact Person: _____
Phone Number: (____)_____

Instructions:

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

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

Agent's Name	Number of Policies Sold By This Agent	Number of Policies Replaced By This Agent	Number of Replacements As % of Number Sold By This Agent

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

Agent's Name	Number of Policies Sold By This Agent	Number of Policies Lapsed By This Agent	Number of Lapses As % of Number Sold By This Agent

Company Totals

Percentage of Replacement Policies Sold to Total Annual Sales ____%
Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year) ____%
Percentage of Lapsed Policies to Total Annual Sales _____%
Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) ____%

SECTION 2. **Ins 3.465 is created to read:**

INS 3.465 WISCONSIN LONG-TERM CARE PARTNERSHIP PROGRAM. **(1)** GENERAL APPLICABILITY. The provisions within s. Ins 3.46 regarding insurance transactions for long-term care and life insurance policies with long-term care provisions apply to insurance transactions described within this section.

(2) DEFINITIONS. The definitions contained in ss. Ins 3.455 and 3.46 also apply in this section. In addition, the following definitions apply in this section:

(a) "Automatic exchange" means the issuance of a notice from an insurer informing an existing insured that the policy the insured purchased prior to January 1, 2009, from the insurer has been approved by the commissioner as a policy that meets the requirements of the state's partnership program and, as such, the policy will be treated from the date of the notice as a qualifying partnership policy.

(b) "Consumer price index" means the consumer price index for all urban consumers, U.S. city average, all items, as determined by the Bureau of Labor Statistics of the United States Department of Labor.

(c) "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means an individual or group insurance long-term care, nursing home or home health care contract that meets the requirements of s. 7702B(b) of the Internal Revenue Code of 1986, as amended, or the portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of sections 7702B(b) and (c) of the Internal Revenue Code of 1986, as amended.

(d) "Qualifying partnership policy exchange" means the exchange of an existing long-term care insurance plan with an identical policy that on or after January 1, 2009 is certified by the insurer to meet the federal requirements established for the state's partnership program or the exchange of an existing long-term care insurance policy with an identical policy except for the addition of a benefit or rider that, on or after January 1, 2009, is certified by the insurer to meet the federal requirements established for the state's partnership program.

(e) "Secretary" means the U. S. Secretary of the Department of Health and Human Services.

(3) QUALIFYING PARTNERSHIP POLICIES. (a) This section applies to an insurer offering a long-term care policy that is intended to qualify an insured under the state's partnership program and that is in compliance with the requirements of 42 U.S.C 1396p (b).

(b) In order for a long-term care policy to qualify as a qualifying partnership policy, the policy shall comply with the requirements set forth in s. 49.45 (31), Stats., and the all of the following:

1. Be filed with and approved by the commissioner prior to use and contain the certification referenced in sub. (5) (a), and comply with s. 631.28, Stats.

2. Meet the requirements of a tax-qualified long-term care insurance contract as defined in Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

3. Meet all applicable requirements of this section and ss. Ins 3.455 and 3.46.

4. Be accompanied by a clear disclosure that the policy is intended to be a qualifying partnership policy. The disclosure shall be in the format contained in Appendix 1.

5. Provide inflation protection provisions in compliance with sub. (5).

6. Not base underwriting criteria upon whether or not the policy is a qualifying partnership policy.

(4) FORM REQUIREMENTS FOR QUALIFYING PARTNERSHIP POLICIES. An insurer that offers a long-term care insurance policy that is intended to qualify an insured under the state's partnership program shall comply with all of the following:

(a) File the policy, outline of coverage, premium rates, and actuarial memorandum to the commissioner in accordance with s. 631.20, Stats., and s. Ins 3.455, and include the qualifying partnership policy certification form.

Note: The qualifying partnership policy certification form (OCI No. 26-113) can be obtained from the Office of the Commissioner of Insurance at no cost from the OCI website www.oci.wi.gov or by writing to the State of Wisconsin Office of the Commissioner of Insurance 125 S. Webster, Madison, WI 53703.

(b) Submit the qualifying partnership policy certification form to the commissioner, prior to use, for approval if an insurer intends to use a previously approved policy to qualify as a qualifying partnership policy.

(c) File the endorsement or rider and submit the qualifying partnership policy certification form to the commissioner, prior to use, for approval if the insurer intends to amend a previously approved policy with an endorsement or rider, as needed, to qualify the policy as a qualifying partnership policy.

(d) Certification shall be in the format specified by the commissioner and identified as OCI No. 26-113, and comply with the following:

1. The certification shall be made and signed by an officer of the insurer having the authority to bind the insurer and shall include full contact information for the certifying officer.

2. The certification for pars. (b) and (c) shall identify the policy by the original form number and approval date.

(5) INFLATION PROTECTION REQUIREMENTS. An insurer offering a long-term care insurance policy that is intended to qualify an insured under the state partnership program shall comply with the following inflation protection provisions.

(a) For a person who is less than 61 years of age as of the date of purchase of the policy, the policy shall provide compound annual inflation protection that complies with one of the following:

1. Provide and maintain a level premium that contains automatic annual compounded inflation increases at a rate that is at least 3%.

2. Provide and maintain a level premium that contains automatic annual compounded inflation increases at a rate based on changes in the consumer price index.

3. Provide for annual compounded inflation increases at a rate that is at least 3% and meet all of the following requirements:

a. Each benefit increase occurs automatically, unless the insured specifically rejects an increase.

b. The increases shall be provided until the insured has at least attained age 76 and each increase up to and including the increase that takes effect at age 76 may not be rejected by the insured in order to retain qualifying partnership policy status.

c. Increases may end when the insured has attained age 76, rejected an offer of inflation increase, or becomes eligible for benefits on or after age 76.

d. The additional premium for each increase under this feature may be based on the premium rates that apply to the insured's attained age at the time of the increase.

e. Rejection of an increase may not limit the coverage under the policy, except for the asset disregard feature of a qualified partnership policy, and from the insured receiving future premium increases as contemplated in s. Ins 3.455.

(b) For a person who is at least 61 years of age but less than 76 years of age as of the date of purchase of the policy, the policy shall provide inflation protection that meets the requirements of par. (5) (a) or an inflation protection feature that provides at least 3% annual simple inflation protection.

(c) For a person who is at least 76 years of age as of the date of purchase of the policy, the policy may provide inflation protection with terms no less restrictive than those identified in pars. (a) and (b), but inflation protection is not required.

(6) DISCLOSURE WHEN SOLICITING. In addition to the requirements of s. Ins 3.46, an insurer issuing or marketing a policy that is intended to qualify an insured for the state's partnership program~~,~~ shall explain at the time of solicitation the benefits associated with a qualifying partnership policy and comply with all of the following:

(a) 1. An insurer or its intermediary shall provide to each prospective applicant all of the following:

a. Qualifying partnership policy notices in the format contained in Appendix 1 and 2.

b. The Guide to Long-term Care booklet.

c. The Wisconsin Long-term Care Programs guide.

2. No insurer or intermediary shall be responsible for providing applicants the revised guides until 90 days after the insurer or intermediary has been given notice that the revised guides are available.

(b) For a qualifying partnership policy issued to a group when an outline of coverage is not delivered, the insurer or intermediary shall deliver copies of the qualifying partnership policy disclosure notice, The Guide to Long-term Care booklet, and The Wisconsin Long-term Care Programs guide.

(c) For a life insurance policy that offers long-term care insurance as a provision in the policy or in a rider that is intended to qualify an insured under the state's partnership program, the insurer or intermediary at the time of solicitation shall deliver the disclosure notice (Appendix 1), the Guide to Long-term Care booklet, and the Wisconsin Long-term Care Programs guide.

(7) OTHER DISCLOSURES. (a) When an insurer is made aware that the insured or certificateholder initiated a policy change request or declined a benefit increase that will result in the loss of the status as a qualifying partnership policy, the insurer shall provide, in writing, an explanation of how such action impacts the insured. The insurer shall also advise the insured or certificateholder of how to retain the policy as a qualified partnership policy, if requested.

(b) If a qualifying partnership policy no longer meets the requirements of the state's partnership program, the insurer shall explain, in writing, to the policyholder or certificateholder the reason for the loss of status.

(c) The insurer shall provide a completed qualifying partnership policy summary document in the format of OCI No: 26-114, when requested by the insured or the insured's authorized representative.

(8) EXCHANGE OF LONG-TERM CARE INSURANCE POLICY TO A QUALIFYING PARTNERSHIP POLICY. (a) RESTRICTIONS ON EXCHANGE. 1. Insurers offering long-term care policies that are intended to qualify an insured under the state's partnership program are subject to s. Ins 3.455 (9m).

2. Insurers issuing an automatic exchange shall comply with all of the following:

a. Only a policy that requires no modifications or additions is eligible for an automatic exchange.

b. The new policy may not be underwritten.

c. The rate used in determining the premium charged for the new policy shall be determined using the original issue age and risk class of the insured that was used to determine the rate of the existing policy and may not contemplate that the new policy is a qualified partnership policy.

d. Insurers issuing automatic exchanges shall provide insureds, at the time of notice of the automatic exchange, a copy of Appendix 1, the Guide to Long-Term Care booklet and the Wisconsin Long-Term Care Programs guide. After issuance of the notice for automatic exchange, if the insured does not decline the offer, the insurer shall provide the insured a copy of Appendix 2.

e. Insurers issuing an automatic exchange shall offer to the insured, at the time of notice of the automatic exchange, the option to decline the automatic exchange and retain the existing policy if the insured responds within a period of time not less than 120 days.

3. An insurer offering an exchange as to a qualifying partnership policy with an actuarial value of benefits exceeding the actuarial value of benefits of the existing policy shall be subject to all of the following:

a. The insurer shall treat the exchange as a replacement and comply with s. Ins 3.46, including suitability.

b. The insurer shall apply its new business long-term care underwriting guidelines to the increased benefits only.

c. The premium charged for the new policy shall be determined using the method in par. (a) (3) for existing benefits and the rate for the additional benefits using the then current age and risk class of the insured for the additional benefits only.

4. An insurer shall maintain documentation of the actuarial value analysis determination and shall provide the analysis to the commissioner upon request.

(b) OFFER OF EXCHANGE. An insurer that submits and receives approval to offer a long-term care insurance policy that is intended to be a qualifying partnership policy in this state may, subject to the following requirements, offer an exchange:

1. Within one year from the date the insurer begins to advertise, market, offer, sell, or issue policies that are intended to be qualifying partnership policies, on a one-time basis in writing, offer to all existing policyholders or certificateholders that were issued long-term care coverage by the insurer with an issue date before February 9, 2006, the option to exchange their existing long-term care policy for a qualifying partnership policy.

2. The offer shall be made on a nondiscriminatory basis without regard to the age or health status of the insured.

3. The offer shall remain open for a minimum of 120 days from the date of the mailing by the insurer.

4. The effective date of the partnership plan policy shall be the date of the exchanged policy.

5. In the event of an exchange, the insured may not lose any rights that have accrued under the original policy including, but not limited to, rights established because of the lapse of time related to pre-existing condition exclusions, elimination periods, or incontestability clauses.

6. The written offer to exchange shall include the disclosure form contained in Appendix 2 and also shall include the Guide to Long-Term Care booklet and the Wisconsin Long-Term Care Programs guide. The insurer shall file with the commissioner, prior to use and for informational purposes, the exchange letter to be used in the exchange offer.

(c) EXCHANGED POLICY REQUIREMENTS. 1. The new policy offered in an exchange or automatic exchange shall be of a form that is offered for sale by the insurer in the general market at the time of exchange.

2. A policy received in an exchange on or after January 1, 2009, is treated as newly issued and thus is eligible for partnership program status. For purposes of applying the Medicaid rules relating to the state partnership program, the addition of a rider, endorsement, or change in schedule page for a policy may be treated as giving rise to an exchange.

(d) EXCEPTIONS AND EXEMPTIONS. 1. Insurers offering group long-term care policies are exempt from pars. (4) – (6) and (7) (a)-(c), if they comply with all of the following:

a. The policy is issued to a local, municipal, county, or state public employee group;

b. The group coverage was negotiated as part of a collective bargaining agreement;

c. The group coverage is provided to all eligible employees on a guaranteed issue basis;

d. The policy provides insureds with at least 5% compound annualized inflation protection;

e. The policy meets the requirements of par. (2) and (3);

f. No later than one year from the date the insurer begins to advertise, market, offer, sell, or issue policies that are intended to be qualifying partnership policies, the insurer shall provide notice that the policy meets the requirements of a qualifying partnership plan and shall provide the insureds with Appendix 1, the Guide to Long-Term Care booklet and the Wisconsin Long-Term Care Programs

guide. The insurer shall file with the commissioner, prior to use and for informational purposes, the exchange letter to be used in the exchange offer.

g. To accomplish an automatic exchange the insurer shall apply the exchange to all group members.

h. The effective date of the qualifying partnership policy shall be the date of the exchanged policy.

i. In the event of an exchange, the insured and its certificateholders may not lose any rights that have accrued under the original policy including, but not limited to, rights established because of the lapse of time related to pre-existing condition exclusions, elimination periods, or incontestability clauses.

2. Notwithstanding par. (b), an insurer is not required to offer an exchange to an individual who is eligible for benefits or within an elimination period or who is, or who has been in, claim status on or after January 1, 2009, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders or certificateholders meet all eligibility requirements, including plan design, underwriting, if applicable, and payment of the required premium.

INS 3.465 Appendix 1

Partnership Policy Status Disclosure Notice

Important Notice Regarding Your Policy's
Long-Term Care Insurance Partnership Plan Status

(Please keep this Notice with Your Policy or Certificate)

The Wisconsin Long-Term Care Insurance Partnership Program (Wisconsin Partnership Program) is a partnership between the State of Wisconsin and private insurers of long-term care insurance policies [certificates]. The Wisconsin Partnership Program became effective on January 1, 2009. This Notice explains the Medicaid asset protection that you may receive being insured under a Partnership Policy [Certificate].

Notice of Partnership Plan Policy Status. Your long-term care insurance policy [certificate] is intended to qualify as a Qualifying Partnership Policy [Certificate] under the Wisconsin Long-Term Care Insurance Partnership Program as of your policy's [certificate's] effective date.

You should also be aware that insurers are required to provide personally identifying information, including your name, to the federal government to be entered into a federal data base to which state Medicaid departments will have access.

Medicaid Asset Protection Provided by the State Medicaid Program. Long-term care insurance is one tool that helps individuals prepare for future long-term care needs. **The purchase of a Qualifying Partnership Policy [certificate] does not automatically qualify you for Medicaid.**

In particular, such policies [certificates] may permit individuals to protect assets from spend-down requirements under Wisconsin's Medicaid program if assistance under this program is ever needed and you otherwise qualify for Medicaid.

Specifically, the asset eligibility and recovery provisions of the Wisconsin Medicaid program are applied by disregarding the amount of assets equal to the amount of insurance benefits you have received from your Qualifying Partnership Policy [Certificate]. The disregarded assets are also exempt from estate recovery. For example, if you receive $200,000 of insurance benefits from your Qualifying Partnership Policy [Certificate], you generally would be able to retain $200,000 of assets above and beyond the amount of assets normally permitted for Medicaid eligibility.

Other Medicaid eligibility requirements apart from permissible assets shall be met, including special rules that may apply if the equity in your home exceeds [$750,000]. In addition, you shall meet the Medicaid program's income requirements and may be required to contribute some of your income to the costs of your care once you become eligible for Medicaid. Medicaid eligibility requirements may vary by county and may change over time. Medicaid eligibility requirements may also be different from state to state.

Additional Consumer Protections. In addition to providing Medicaid asset protection, your Partnership Policy [Certificate] has other important features. Under the rules governing Wisconsin's Long-Term Care Insurance Partnership Program, your Qualifying Partnership Policy [Certificate] shall be a tax-qualified long-term care insurance contract under Federal tax law, and as such the insurance benefits you receive from the policy generally will not be subject to income tax. (Please note that a policy or certificate can be a qualified long-term care insurance contract under Federal and State income tax law, with the same income tax treatment, even if it is not a Qualifying Partnership Policy [Certificate].) In addition, if you were under age 76 when you purchased your Qualifying Partnership Policy [Certificate], it shall provide inflation protection to help protect against potential future increases in the cost of long-term care. (For older purchasers, only an offer of inflation protection is required.)

What Could Disqualify Your Policy as a Partnership Policy [Certificate]. If you make any changes to your policy or certificate, such changes could affect whether your policy [certificate] continues to be a Qualifying Partnership Policy [Certificate]. Before you make any changes, you should consult with the [carrier's name] to determine the effect of a proposed change. In addition, if you move to a state that does not maintain a Partnership Program or does not recognize your policy as a Qualifying Partnership Policy [Certificate], you would not receive Medicaid asset protection in that state. However, the coverage contained in your policy would **not** be affected. Also, changes in Federal or State law could modify, reduce or eliminate the Medicaid asset protection available with respect to your Qualifying Partnership Policy [Certificate] after you have purchased the policy.

Additional information. If you would like further information about the Medicaid asset protection provided by your Qualifying Partnership Policy [Certificate] or the Wisconsin's Long-Term Care Insurance Partnership Program, please contact State of Wisconsin Member Services at 1-800-362-3002.

INS 3.465 Appendix 2

Partnership Program Notice
Important Consumer Information Regarding the Wisconsin Long-Term Care Insurance Partnership Program

Some long-term care insurance policies [certificates] sold in Wisconsin may qualify for the Wisconsin Long-Term Care Insurance Partnership Program (the Partnership Program). The Partnership Program is a partnership between state government and private insurance companies to assist individuals in planning their long-term care needs. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance policies [certificates] that qualify as Qualifying Partnership Policies [Certificates] may protect the policyholder's [certificateholder's] assets through a feature known as "Asset Disregard" under Wisconsin's Medicaid program.

Asset Disregard means that amount of the policyholder's [certificateholder's] assets equal to the amount of long-term care insurance benefits received under a Qualifying Partnership Policy [Certificate] will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a Qualifying Partnership Policy [Certificate] without affecting the person's eligibility for Medicaid. The disregarded assets are also exempt from estate recovery. All other Medicaid eligibility criteria will apply and special rules may apply to persons whose home equity exceeds $750,000. Asset Disregard is available under a Qualifying Partnership Policy [Certificate]. Therefore, you should consider if Asset Disregard is important to you, and whether a Qualifying Partnership Policy meets your needs. The purchase of a Qualifying Partnership Policy does not automatically qualify you for Medicaid.

What are the Requirements for a Partnership Policy [Certificate]? In order for a policy [certificate] to qualify as a Qualifying Partnership Policy [Certificate], it shall, among other requirements:

- Have an effective date on or after January 1, 2009;
- Be issued to an individual who was a Wisconsin resident when coverage first becomes effective under the policy;
- Be a tax-qualified policy under s. 7702(B)(b) of the Internal Revenue Code of 1986, as amended;
- Meet certain consumer protection standards; and,
- Meet the following inflation requirements:
  - For persons age 60 or younger – provide compound annual inflation protection of at least 3%.
  - For persons age 61-75 – provide annual inflation protection of at least 3% not compounded.
  - For persons age 76 and older – there are no requirements for purchasing inflation protection.

If you apply and are approved for long-term care insurance coverage, [carrier name] will provide you with written documentation as to whether or not your policy [certificate] is a Qualifying Partnership Policy.

You should also be aware that insurers are required to provide personally identifying information, including your name, to the federal government to be entered into a federal data base to which state Medicaid departments will have access.

What Could Disqualify a Policy [Certificate] from Continuing to be a Qualifying Partnership Policy? Certain types of changes to a Qualifying Partnership Policy [Certificate] could affect whether or not such policy [certificate]continues to be a Qualifying Partnership Policy [Certificate]. If you purchase a Qualifying Partnership Policy [Certificate] and later decide to make a change, you should first consult with [carrier name] to determine the effect of the proposed changes. In addition, if you move to a state that does not maintain a Partnership Program or does not recognize your policy [certificate] as a Qualifying Partnership Policy [Certificate], you would not receive treatment of you policy [certificate] under the Medicaid program of that state. However, the coverage under your policy will **not** be affected. The information contained in this disclosure is based upon current Wisconsin and Federal laws. These laws may be subject to change. Any change in law could modify, reduce or eliminate the treatment of your policy [certificate] under Wisconsin's Medicaid program.

Additional Information: If you have questions regarding long-term care insurance policies [certificates] please contact [carrier name]. If you have questions regarding current laws governing Wisconsin Medicaid eligibility, you should contact State of Wisconsin Member Services at 1-800-362-3002.

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

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

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

SECTION 4. These sections may be enforced under ss. 601.41, 601.64, 601.65, Stats., or ch. 645, Stats., or any other enforcement provision of chs. 600 to 646, Stats.

SECTION 5. These sections first apply to policies or certificates issued on or after January 1, 2009 or on the first renewal date on or after January 1, 2009, but no later than January 1, 2010 for collectively bargained policies or certificates.

SECTION 6. These emergency rule changes will take effect on the date after publication, June 3, 2008, as provided in s. 227.24 (1) (c), Stats.

Dated at Madison, Wisconsin, this _____ day of _____, 2008.

This rule change will have no significant effect on the private sector regulated by OCI.