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☞ Details: Emergency Rule by Office of the Commissioner of Insurance.

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2007-08
(session year)

Joint
(Assembly, Senate or Joint)

Committee for Review of Administrative Rules...

COMMITTEE NOTICES ...

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

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

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

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

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Sean Dilweg, Commissioner

Wisconsin.gov

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Madison, Wisconsin 53707-7873
Phone: (608) 266-3585 • Fax: (608) 266-9935
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Web Address: oci.wi.gov

May 31, 2008

Members of the Legislature

Re: Emergency Rule affecting Section Ins 3.455, 3.46, 3.465, Wis. Adm. Code, relating to long-term care plans including plans qualifying for the Wisconsin long-term care insurance partnership program and affecting small business

Dear Senator or Representative to the Assembly:

I have promulgated the attached rule as an emergency rule. The rule will be published in the official State newspaper on June 2, 2008.

The attached copy of the rule includes the Finding of Emergency which required promulgation of the rule.

If you have any questions, please contact Julie E. Walsh at (608) 264-8101 or e-mail at julie.walsh@wisconsin.gov.

Sincerely,

Sean Dilweg
Commissioner of Insurance

SD:JEW
Attachment: 1 copy rule

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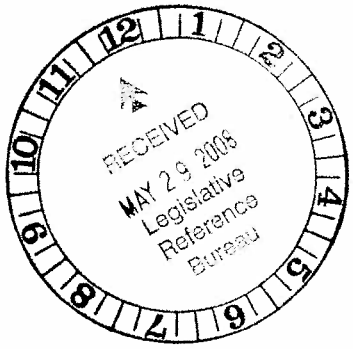

STATE OF WISCONSIN |
| SS
OFFICE OF THE COMMISSIONER OF INSURANCE |

I, Sean Dilweg, Commissioner of Insurance and custodian of the official records, certify that the annexed emergency rule affecting Section Ins 3.455, 3.46, 3.465, Wis. Adm. Code, relating to long-term care plans including plans qualifying for the Wisconsin long-term care insurance partnership program and affecting small business, is duly approved and adopted by this Office on May 29, 2008.

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

IN TESTIMONY WHEREOF, I have hereunto set my hand at 125 South Webster Street, Madison, Wisconsin, on May 29, 2008.

Sean Dilweg
Commissioner of Insurance

PROPOSED ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE
REPEALING, AMENDING, REPEALING AND RECREATING, AND CREATING A RULE

To repeal s. Ins 3.46 (2) (a);

To amend s. Ins 3.41 (1), 3.455 (7) (b) to (d), 3.46 (2) (d) (intro.); 3.46 (4) (c), (j) to (n) and (r); 3.46 (5) (a) and (b) 9.; 3.46 (16) (b).; and 3.55 (3) (cg) and (cm);

To repeal and recreate s. Ins 3.455 (3); 3.46 (3); 3.46 (14); 3.46 (19) (c) 4. and (d); and 3.46 Appendices.

To create s. Ins 3.455 (7) (e) to (j); 3.46 (8) (c); 3.46 (9) (k) to (m); 3.46 (10) (e) to (j); 3.46 (11) (a) 4.; 3.46 (19) (c) 4., (d) and (j); 3.46 (20) to (6); and Ins 3.465 and Ins 3.465 Appendices.

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

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.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

1. Statutes interpreted:

   ss. 49.45 (31), 600.01, 601.415 (8), and 628.34 (12), 628.348, 632.76, 632.81, 632.82, 632.825, 632.897, Stats.

2. Statutory authority:

   ss. 600.01 (2), 601.41 (3), 601.42, 628.34 (12), 628.348, 632.76, 632.81, 632.82, 632.897, Stats.

3. Explanation of OCI's authority to promulgate the proposed rule under these statutes:

   The OCI, in order to comply and implement the requirements of 2007 Wis. Act 20, creating the Wisconsin Long-Term Care Insurance Partnership Program (Partnership Program) including the requirements for intermediary training and the process by which insurers submit policies that are intended to qualify for the Partnership Program must adopt the 2000 and 2006 National Association of Insurance Commissioners (NAIC) Long-Term Care Insurance Model Act and Model Laws, pursuant to 42 U.S.C. 1396p (b) known as the Deficit Reduction Act of 2005 (DRA). These amendments are needed to expand consumer protection and comply with the requirements of the Center for Medicare and Medicaid Services (CMS) as delegated

to the NAIC the function of regulating the insurers offering long-term care insurance products.

4. Related statutes or rules:

   The Partnership Program is described at s. 49.45 (31), Stats., and requires coordination between the OCI and the Department of Health and Family Services.

5. The plain language analysis and summary of the proposed rule:

   The current administrative rule was last revised in 2001 and is not fully compliant with the NAIC Long-Term Care Model Act and NAIC Long-Term Care Model Law (NAIC Model Act and Model Law). When 2007 Wis. Act 20 created the Partnership Program, the OCI is required to implement the NAIC Model Act and Model Law in order for insurers to offer policies compliant with the DRA. Significant portions of the proposed rule update and expand definitions and require disclosure of these definitions to insureds so that they understand how the long-term care, home health care or nursing home insurance policy is able to be used and the limitations or exclusions that may be applied by insurers.

   In s. Ins 3.455, the modifications primarily address the conversion from a group long-term care insurance policy to an individual long-term care insurance policy. The expanded information is intended to both comply with the NAIC Model Act and Model Law and Wisconsin conversion and continuation law. The section also includes expanded definition related to conversion of long-term care insurance policies.

   Section Ins 3.46 modifications begin with updated and revised definitions that are intended to provide consumers with greater specificity regarding terms used within long-term care, home health care and nursing home care insurance policies. Of note the current NAIC Model Act and Model Law do not exempt group long-term care insurers and as such the exemption in s. Ins 3.46 (2) has been struck. Consumer protection elements are introduced or existing protections expanded throughout this section. One tool to both provide a check on the industry and its intermediaries and better assist consumers with the purchase of long-term care, home health care or nursing home care insurance is through the consolidation and expansion of the marketing requirements. Intermediaries and insurers are required to report on their prior dealings with consumers and state that the policy being sold is an appropriate product for that person. Although similar tools are currently required, the expansion requires additional data reporting to the OCI so that as the regulator we are provided a clearer picture of what sales are occurring and trends in the marketplace. The

information will also highlight for both OCI and the insurers contracting with intermediaries information that may reveal unacceptable practices including high pressure sales tactics or interactions with persons resulting in a higher rate of complaints than other intermediaries. Appropriateness of each sale is to be reviewed and must meet the insurer's guidelines.

Additionally, some of the modifications reflect changes in our society, for instance the recognition and use of the internet or on-line completion of applications. Also, nonforfeiture of benefits provisions reflect the increasing cost of long-term care and the effect those increases have on the insureds. Some seniors, at a time near to when the policy may be most useful are least able to afford premium increases. Nonforfeiture of benefits or contingent nonforfeiture provisions allow those who have paid premiums for many years benefits even after they are no longer able to keep their policy in force.

New paragraphs are also added regarding upgrade and downgrades of policies, and expanded disclosure requirements are included for various benefits including nonforfeiture benefits. These modifications reflect the marketplace and include oversight provisions. These types of benefits potentially give consumers greater control and options when faced with increasing premiums rather than just lapsing the policy due in part to financial constraints. Expanded notification to insureds of new benefits or changing access to providers is also contained in this proposed rule, a modification that allows insureds options that they may not previously have been informed of or had access to from within the same carrier. Requirements monitoring replacement of policies is also expanded to enhance oversight of actions by intermediaries and insurers.

Finally, s. Ins 3.46 includes a new section related to initial and ongoing intermediary training for all long-term care insurance products. OCI is required to assure the Department of Health and Family Services that the intermediaries dealing with Wisconsin consumers are aware of the unique programs available in Wisconsin. To achieve this requirement, the proposed rule contains a provision that delineates training requirements related to long-term care and the Wisconsin Partnership Program that is required for all intermediaries offering, selling or negotiating long-term care contracts. Insurers are required to verify compliance with this training to the OCI.

Section Ins 3.465 is newly created to implement the requirements of the Wisconsin Long-Term Care Insurance Partnership Program. This section contains minimum inflation protection percentage increases by age as outlined by the federal government in order for the policies offered by insurers to meet the requirements of the DRA and the Wisconsin Partnership Program. The section also delineates when and how insurers exchange existing long-term care insurance policies for policies that are intended to qualify for the Partnership Program in both the individual and group market. Appendices outline various notices that are to be provided to consumers at the time of solicitation and again at the point of sale. These are intended to educate the consumer so that the consumer may be better able to make informed decisions.

6. Summary of and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:

   It is understood that CMS is anticipating promulgating rules related to the reciprocity of the Partnership Program. Those rules are not anticipated to affect OCI.

7. Comparison of similar rules in adjacent states as found by OCI:

   Illinois: Illinois adopted NAIC Model Act and Law in January 2003 with no substantive deviations. Illinois noticed proposed regulations in compliance with the 2006 NAIC Model Act and Law on August 3, 2007, without substantive deviations. Illinois HB 517 authorizing the Medicaid Office to file the review State Partnership Application for participation in the Partnership Program was submitted on August 16, 2007.

   Iowa: Iowa adopted the 2000 version of the NAIC Model Act and Model Law in July 2003. With the exception of the intermediary training that Iowa promulgated effective January 1, 2009, the state has notice proposals to adopt the 2006 NAIC Model Act and Law. The requirement for intermediary training requires 4 hours of initial training and 3 hours of ongoing training every 3 years thereafter. Iowa has not implemented the Partnership Program in accordance with the DRA as yet.

   Michigan: Michigan adopted the 2006 version of the NAIC Model Act and Law in June 2007. Michigan regulates long-term care insurance by statute and as such did not adopt exact language as the NAIC Model but did incorporate each area covered by the Model. Michigan did enact authorizing legislation to implement the Partnership Program in 2007 and filed its State Partnership Application retroactive to October, 2007. Michigan has not implemented the intermediary training for all intermediaries and is currently formalizing the process.

Minnesota: Minnesota adopted the 2000 NAIC Model Act and Law in January 2002, without substantial deviation. The DRA, Partnership Program became effective July 1, 2006. However there have been delays and Minnesota's program was not operational until October 2007. Minnesota adopted the intermediary training and additionally requires non-resident intermediaries demonstrate knowledge of unique aspects of the Minnesota medical assistance program.

8. A summary of the factual data and analytical methodologies that OCI used in support of the proposed rule and how any related findings support the regulatory approach chosen for the proposed rule:

The OCI was required to implement portions of the Partnership Program in compliance with 2007 Wis. Act 20, and utilized a subcommittee of the Office's Life and Health Advisory Council comprised of consumer, industry, intermediary and regulatory members to achieve its duty. The group met, in open meetings, three times in the past three months to review and discuss the portions of this rule related to the partnership program being proposed by the OCI.

For the provisions updating and incorporating the NAIC models, the OCI reviewed each NAIC provision against existing Wisconsin law and rule to ensure consumer protections were not lost in the process and to expand consumer information.

9. Any analysis and supporting documentation that OCI used in support of OCI's determination of the rule's effect on small businesses under s. 227.114:

The key provision that may have an effect on small businesses is the requirement for long-term care intermediary initial and ongoing training. The OCI included a provision to permit the training to qualify as continuing education credits and to recognize courses non-resident intermediaries may take in states other than Wisconsin. With the exception of two-credit hours that must include the training information developed and maintained by the Department of Health and Family Services, the training requirements allow for the greatest flexibility to not unduly burden intermediaries or unnecessarily increase expenses related to receiving the required training. It is expected, in light of these considerations that if there is any effect, the effect on small businesses will not be significant.

10. See the attached Private Sector Fiscal Analysis.

11. A description of the Effect on Small Business:

This rule will have little or no effect on small businesses.

12. Agency contact person:

A copy of the full text of the proposed rule changes, analysis and fiscal estimate may be obtained from the Web site at: http://oci.wi.gov/ocirules.htm

or by contacting Inger Williams, OCI Services Section, at:

Phone: (608) 264-8110
Email: inger.williams@wisconsin.gov
Address: 125 South Webster St – 2nd Floor, Madison WI 53703-3474
Mail: PO Box 7873, Madison, WI 53707-7873

13. Place where comments are to be submitted and deadline for submission:

The deadline for submitting comments is 4:00 p.m. on the 7th day after the date for the hearing stated in the Notice of Hearing.

Mailing address:

Julie E. Walsh
Legal Unit - OCI Rule Comment for Rule Ins 3455ER
Office of the Commissioner of Insurance
PO Box 7873
Madison WI 53707-7873

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Web site: **http://oci.wi.gov/ocirules.htm**

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 delievered~~services 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 covered~~All 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 ~~licensing~~the 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 require~~requires that a provider be appropriately licensed, ~~or~~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 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 medicaid~~programs, 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.