THE LONG-TERM CARE PARTNERSHIP & MEDICAID STATE REFERENCE GUIDE

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MEDICAID ELIGIBILITY OVERVIEW

The Georgia Medicaid program is administered by the Department of Community Health, Medical Assistance Plan Division (MAP). The Medicaid program is funded by the federal and state governments. States administer the Medicaid program using federal regulations and guidelines. Medicaid is available only to certain low-income individuals and families who fit into an eligibility group that is recognized by federal and state law.

https://medicaid.georgia.gov/

BASIC ELIGIBILTY

Every individual must meet all the following basic eligibility criteria:

- Must be a resident in Georgia.
- Must be a U.S. Citizen or a qualified alien.
- Must have income and resources below the prescribed limits.
- Must agree to assign to the State all rights to medical support and third-party support payments (hospital and medical benefits).
- Must pursue other benefits you may be entitled to (e.g., Medicare / Social Security / applicable VA benefits), as required by program rules.
- Must apply for a Social Security Number.

ASSET TRANSFERS AND LOOK-BACK PERIOD

Medicaid eligibility for long-term care is also affected by **asset transfers** made prior to application. Federal law requires states to review certain financial transactions during a **five-year (60-month) lookback period** preceding the Medicaid application date.

Transfers of assets for less than fair market value during this period may result in a **penalty period of ineligibility**, during which Medicaid will not pay for long-term care services. The length of the penalty is determined by the value of the transferred assets and the state's applicable penalty divisor.

Not all transfers result in a penalty, and certain exceptions may apply depending on the circumstances and the relationship of the recipient. Because transfer rules are complex, individuals are encouraged to seek guidance before making gifts or reallocating assets.

GEORGIA MEDICAID LONG-TERM CARE SERVICES AND SUPPORTS*

**Waiver availability, enrollment caps, and services may change; applicants should always consult the Georgia Department of Community Health for current program details.*

Elderly and Disabled Waiver Program (EDWP) (formerly CSSP) The EDWP provides home- and community-based services to elderly and/or functionally impaired or disabled members. The program includes case management, adult day health

care, alternative living services, personal care, home-delivered meals and services, extended home health, respite care and emergency response services.

Independent Care Medicaid Waiver Program (ICWP) ICWP offers services to a limited number of adult members with physical disabilities, including persons with traumatic brain injuries (TBI). This program is available for eligible Medicaid members who are severely physically disabled and between the ages of 21 and 64 when they apply. ICWP services include personal support, home health, emergency response services, specialized medical equipment and supplies, counseling and home modifications.

New Options Waiver Program/Comprehensive Supports Waiver Program (NOW/COMP) NOW and COMP offer home- or community-based services for people with developmental disabilities or intellectual disabilities. Six regional offices under the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) coordinate service delivery for these programs. The programs cover supported employment, residential services, personal care and respite services, specialized medical equipment and supplies, vehicle adaptations, home modifications, and behavioral support services.

Nursing Facility Nursing Facility services include skilled nursing care, rehabilitation services and health-related care in an institutional setting. People in nursing facilities need around-the-clock nursing oversight. These services also include Intermediate Care Facilities-Intellectual Disability/Developmental Disability (ICF-ID/DD) and swing-bed services.

Service Options Using Resources in a Community Environment (SOURCE) SOURCE serves frail, elderly and disabled Georgians who are eligible for Supplemental Security Income/ Medicaid. The SOURCE program uses primary care physicians on the case management team. In addition to core services of monitoring and assistance with functional tasks, SOURCE recipients can have Assisted Living Services (ALS), extended home health, personal care, home-delivered meals, adult day health care, emergency response services and 24-hour medical access to a case manager and primary care physician.

Home Health Services Home Health Services include skilled nursing, home health aide, and physical, speech and occupational therapy services. Services are provided in the member's home and require physician orders. Because they are meant to be short term in nature, there is an annual limit on the number of home health visits that can be reimbursed.

Hospice Hospice includes palliative medical care and services for terminally ill persons and their families. Hospice offers nursing care, medical social services, counseling, medications, medical appliances and supplies, and hospice-aide. Care may be provided in the member's home or in an inpatient facility, including nursing facilities.

Community Mental Health Services Community Mental Health Services are provided to persons who have mental illness or issues with substance use or addiction. Services are provided in the community, in outpatient facilities, clinics or inpatient facilities. Services include: Diagnostic assessments; Crisis intervention; Psychiatric treatment; Nursing assessment and care; Individual, group and family outpatient therapies; Medication administration; Behavioral health rehabilitation services; Substance abuse and detoxification services; Short-term, in-patient care for severely emotionally disturbed youth.

Home and community-based waiver programs are subject to **enrollment caps, waiting lists, and program-specific eligibility criteria**, and the services offered may change over time. Availability is not guaranteed, even if all financial and functional eligibility requirements are met. Applicants should consult the Georgia Department of Community Health or the administering agency for current program information.

INCOME AND ASSETS LIMITATIONS

Financial need must exist in order for an individual to be eligible under all Medicaid programs including the long-term care coverage programs listed above. Financial criteria are divided into two groups, income and assets.

INCOME

Income is any item an individual receives in cash or in-kind that can be used to meet his or her need for food or shelter. The income retirement for Medicaid states that gross monthly income of the applicant cannot exceed a certain figure. The State of Georgia determines the income requirement, which changes each January. However, if an individual's income exceeds

the income limit listed above the individual may establish an Irrevocable Qualified Income Trust (QIT), also known as a Miller Trust. (Contact your local county Department of Family and Children Services for additional information).

ASSETS

Assets include all income and resources of the individual and of the individual's spouse, including income and resources which the individual or such individuals spouse is entitled to but does not receive. To meet the asset criteria, an individual must have countable resources of $2,000 or less ($3000 for a couple). If only one spouse applies and the other is a community spouse, spousal impoverishment rules apply and the community spouse may retain resources up to the applicable CSRA (subject to federal/state standards). Resources are those assets, both real and personal property, which an individual or couple owns and can apply, either directly or by sale or conversion, by meeting basic needs of food, clothing and shelter (like bank accounts, real property, or other items that can be sold for cash).

If the long-term care individual has a spouse who is not institutionalized or receives home and community-based services, the resources of the spouse MUST be considered in the eligibility determination.

MEDICAID INCOME AND RESOURCE LIMITS

When **only one spouse applies for Medicaid long-term care benefits** and the other spouse remains in the community, federal and state **spousal impoverishment rules** apply. These rules are intended to prevent the community spouse from being left without adequate income or resources.

Under these provisions, the community spouse may retain a portion of the couple's combined countable resources, known as the **Community Spouse Resource Allowance (CSRA)**, as well as a minimum level of monthly income, subject to applicable limits and adjustments.

The specific allowances are established by federal and state standards and may change annually. The treatment of income and resources in spousal cases is highly fact specific.

2025 Financial Limits

2025 Medicaid Income and Resource Limits

ASSET PROTECTION UNDER THE LTCP PROGRAM

The cost of long-term care in Georgia can be significant. Recent estimates indicate that nursing home care may exceed **$100,000 per year** for a semi-private room, with costs varying by facility and geographic location. Home and community-based services may be less costly but are subject to program availability and enrollment limits. (See the Genworth Cost of Care Study for most recent median costs.)

These expenses underscore the importance of advance planning for individuals who may require long-term care services.

The Georgia Long-Term Care Partnership (Partnership) is designed to reward Georgians who plan ahead for future long- term care needs. The most unique aspect of a Georgia Partnership policy is the Medicaid **asset protection** feature. This feature provides **dollar-for-dollar asset protection:** for every dollar that a Partnership policy pays out in benefits, a dollar of assets can be protected from the long-term care Medicaid asset limit. When determining long-term care Medicaid eligibility, any assets you have up to the amount the Partnership insurance policy paid in benefits will be disregarded.

EXAMPLE

If your Partnership policy paid $200,000 in benefits, Georgia's Medicaid program would allow you to keep $200,000 in assets and still qualify for Medicaid benefits. The amount of assets you are able to protect under the Partnership is in addition to the $2,000 everyone is allowed to keep, including any assets your spouse may be allowed to retain. The protected assets will also be exempted from estate recovery in an amount equal to the benefits paid by the long-term care insurance policy.

REMEMBER:

- The Partnerships Medicaid asset protection feature is not available under other long-term care insurance policies.
- The purchase of a Partnership Policy does not automatically qualify you for Medicaid.

MEDICAID ESTATE RECOVERY

Georgia participates in the **Medicaid Estate Recovery Program**, which allows the state to seek reimbursement from the estate of a Medicaid recipient for certain benefits paid on the recipient's behalf after age 55, including long-term care services.

Estate recovery generally occurs after the recipient's death and may be deferred or limited in certain circumstances, such as when a surviving spouse or other qualifying individual remains. Assets protected through a qualifying Long-Term Care Partnership insurance policy may be exempt from recovery up to the amount of benefits paid under the policy.

KENTUCKY

KENTUCKY

STATE SPECIFIC INFORMATION

Basic Long-Term Care Eligibility Criteria Relating To:

- ✓ Resources
- ✓ Resource Assessment
- ✓ Look-Back Period
- ✓ Estate Recovery
- ✓ Long Term Care Partnership Insurance

DISCLAIMER: The Purpose of this document is to provide a general overview of eligibility for Medicaid Long Term Care (LTC) in Kentucky. It is intended to serve as a prerequisite to training required for insurance producers who sell, solicit or negotiate LTC Partnership insurance policies as part of the LTC partnership in Kentucky.

The document is not to be used to determine eligibility for Medicaid LTC services. Determining eligibility for Medicaid is the responsibility of the Kentucky Department of Community Based Services (DCBS), Division of Family Support. **All Medicaid eligibility determinations shall be made only by local DCBD offices. Producers should refer consumers to their local DCBS office for assistance with Medicaid eligibility determinations.**

All dollar figures and examples are provided for illustrative purposes only and do not reflect current eligibility thresholds.

RESOURCES

OVERVIEW OF RESOURCES

Resources are generally defined as those assets an individual or couple own and/or can convert to cash. Resources may be available money, real property, personal property or other assets and may have a lien or loan attached. They may include homestead, and the cash surrender value of life insurance policies the individual has at the time of application for Medicaid. Savings, checking, stock accounts, retirement accounts, and vehicles are also exampling of resources that are reviewed. Some resources may be countable, and some may be excluded depending on the ownership or usage. Those issues are clarified during the application process. Although a resource may not be considered as available to the individual at application or may meet one of the exclusion criteria, it may still be subject to the Estate Recovery efforts.

RESOURCE LIMITS

An institutionalized individual's current resource limit is generally $2,000, subject to applicable state and federal standards.

The community spouse's allowable resources are established at the resource assessment. The protected amount for the community spouse is referred to as the *Community Spouse Resource Allowance (CSRA).*

RESOURCE ASSESSMENT

A resource assessment determines the amount of a couple's assets which can be protected for the use and benefit of the community spouse. The couples' total assets are added together and compared to the resource allowance minimum and maximum limits in place at the time of assessment. The amount that can be protected for the community spouse is adjusted each January.

A couple or their representative can request a resource assessment when the individual is institutionalized. Once an assessment is completed it is valid unless it is discovered that all resources were not disclosed, or the institutionalized spouse leaves long term care. The assessment requires the disclosure of all resources of the institutionalized spouse and community spouse. Once the resources are identified and the determination regarding countable versus excluded resources is made, the countable resources are totaled, and each spouse is assigned ½. If that ½ is not greater than the community spouses' resource maximum for that year, that figure becomes the amount the community spouse can keep. Any amount over the maximum is added to the institutionalized spouse's portion and must be spent down before Medicaid eligibility can be established. If the ½ is less than the minimum, additional resources from the institutionalized spouse can be transferred to the community spouse to bring her protected portion up to the resource minimum.

The portion that is determined to be protected for the benefit of the community spouse must be placed in the name of the community spouse **only** within six months of Medicaid approval.

RESOURCE ASSESSMENT EXAMPLES

The following examples use historical dollar amounts for demonstration purposes only. Current CSRA minimums and maximums are updated annually and differ from those shown below.

EXAMPLE 1:

Sam and Sally have the following countable resources:

Checking:	$10,000
Savings:	$50,000
Boat:	$10,000
Annuity:	$50,000
Total:	$120,000

Sam is in the nursing facility, Sally is the community spouse. $120,000 divided by 2 equals $60,000 each which is below the maximum community spouse resource allowance. Sally can protect $60,000 and Sam must spend down to $2,000. When a future application is made for Medicaid assistance the total countable resources must be equal to or less than $62,000. Sally has six months from the date of application to remove Sam's name from the protected resources. Therefore, if Sally chooses to protect the boat and annuity, she must have Sam's name removed from those assets.

EXAMPLE 2:

John and Mary requested a resource assessment. They have the following countable resources:

Vacation home:	$50,000
C.D:	$110,000
Life insurance policy with cash value:	$90,000
Building lot:	$25,000
Checking:	$30,000
Savings:	$60,000
Total:	$365,000

$365,000 divided by 2 equals $182,500 each. The maximum allowable in 2019 for the community spouse to protect was $126,420. $182,500 minus $126,420 equals $56,080. $56,080 must be added to the institutionalized spouse's share of $182,500 which results in his countable resource of $238,580. The institutionalized spouse must spend this down to $2,000 prior to Medicaid eligibility.

Therefore, when a reapplication is made the joint countable resources must not exceed $128,420, the amount protected for the community spouse $126,420 and the $2,000 allowable for the institutionalized spouse.

EXAMPLE 3:

Tara and Cliff have the following countable resources during the resource assessment January 3, 2018:

CD:	$20,000
Checking:	$10,000
Total:	$30,000

$30,000 divided by 2 equals $15,000 each. However, the community spouse minimum for 2018 is $25,284. Therefore, the community spouse can protect $25,284. The joint resources at the time of reapplication must be equal to or less than $27,284. (The community spouses protected amount and the institutionalized spouses $2,000). In this example only $2,716 ($30,000-$27,284) must be spent down to obtain eligibility.

NOTE: All dollars spent after the resource assessment must be accounted for at the new application.

LOOK BACK PERIOD AND PENALTIES

Federal law requires that Medicaid eligibility workers determine that assets were not disposed of for less than fair market value in order to gain Medicaid eligibility. The Deficit Reduction Act (DRA) of 2006 strengthened the language requiring that all transfers of resources shall be presumed to be for the purpose of establishing Medicaid eligibility unless the applicant could prove otherwise. The DRA also required that this investigation cover the previous 60 months from application. To accomplish this, the application date becomes the base line date (starting point) and all transfers in the previous 60 months are investigated. Goods and/or services for fair market value must be received for any transfer that occurs during this time period. For example, $10,000 given to a daughter in the 32nd month from the baseline date would be investigated. If the applicant could not demonstrate goods and/or services received for this amount, then this would be considered a prohibited transfer of resource and would be subject to a penalty period.

All resources disposed of during the "look back period" for less than fair market value is added, and the total amount is used to determine an ineligibility period. The ineligibility period is based on the average daily cost of care and that factor is revised annually. The ineligibility period begins on either the date of transfer or the date the client would be otherwise eligible (had the transfer not occurred) – whichever date occurs last.

The following is an example of calculating a transfer of resources ineligibility period for Long Term Care Medicaid benefits:
A Long-Term Care application was taken on August 1, 2018. There were multiple transfers that occurred prior to the application.

$4,000 was given away on 3/1/2017
$2,000 was given away on 5/15/2017
$2,000 was given away on 7/19/2017

The eligibility worker would add all transfers together, in this situation, the total is $8,000.

The worker would then determine the ineligibility period by dividing the total amount of the transfer by the current transfer of resource factor.

$8,000 divided by $199.46 (2018 factor) = 40.11 days, rounded down is 40 days of ineligibility.

The ineligibility period would begin once the individual is otherwise eligible for Medicaid long-term care services and has applied for coverage. The ineligibility period is 40 days. On the 41st day, the applicant can reapply and if all other eligibility criteria are met, the applicant would be eligible.

WAIVER PROGRAM AVAILABILITY

Kentucky Medicaid long-term care services may be provided through **institutional care** or through **home and community-based waiver programs**, depending on medical need and program availability.

Eligibility for Medicaid financial and medical assistance **does not guarantee immediate access to waiver services**. Home and community-based waiver programs are subject to **program capacity limits, enrollment caps, and waiting lists**, which may result in delayed services even when an individual meets all eligibility requirements.

Waiver program availability, covered services, and enrollment procedures may change based on federal approval, state policy, and funding.

ESTATE RECOVERY

Medicaid has the authority to seek recovery from the estate of a deceased Medicaid recipient in order to be reimbursed up to an amount equal to the total medical assistance paid for long term care benefits.

An estate is subject to estate recovery if the individual is at least 55 years of age AND if at any time the individual received medical assistance for any of the following:

A. Nursing Facility (NF), not including institutionalized Hospice;
B. Intermediate Care Facility (ICF);
C. Intermediate Care Facility services for individuals with intellectual or developmental disabilities (ICF/IID);
D. Long Term Care (LTC) services provided by a waiver.

The estates of individuals under 55 years of age are also subject to estate recovery if the individual has been receiving Medicaid for NF, ICF/MR/DD or LTC waiver services for a total of six consecutive months or more at the time of death.

NOTE: Resources that were excluded during the application process may still be subject to estate recovery.

EXEMPTION AND LIMITATIONS

Estate Recovery shall not be made from the estate if the estate representative can verify that:

A. There is a surviving spouse
B. There is a surviving minor child (under 21) or disabled child
C. The estate is valued at less than $10,000
D. Recovery would create a hardship for a surviving family member. This type of exception would require a request in writing with supporting documentation.

Estate recovery is generally deferred until after the death of a surviving spouse.

CHANGES IN MEDICAID RULES AND FINANCIAL STANDARDS

Medicaid eligibility rules, financial standards, and program interpretations are subject to change due to **federal law, state regulation, administrative policy, and cost-of-living adjustments**.

Income limits, resource limits, penalty divisors, spousal allowances, and home equity thresholds may be revised annually or more frequently. Eligibility determinations are based on the rules and standards in effect **at the time of application**.

Nothing in this document should be relied upon to determine actual Medicaid eligibility.

LONG TERM CARE PARTNERSHIP INSURANCE

A qualified Long-Term Care (LTC) Partnership Insurance policy will allow for an asset disregard at the time of the Medicaid application. The disregard is a one dollar ($1) increase in protected assets for each dollar ($1) paid by the insurance policy at the time of application. Any assets protected at the Medicaid application, shall also be protected from estate recovery.

At the time of application an individual with a qualified LTC partnership policy must produce documentation of the dollar amount paid by the insurance as a direct reimbursement of LTC expenses, as well as benefits paid on a per diem or other periodic basis, for periods

during which the individual received LTC services. It is not required that the partnership policy funds be fully exhausted. However, the resource protection is based on the amount actually paid at the time of application.

The applicant must identify the assets they wish to protect as a result of the LTC Partnership payments. The applicant **cannot** change the selection after Medicaid approval. The eligibility worker will then disregard the assets chosen when determining Medicaid eligibility and those assets will also be protected from estate recovery.

The applicant may wish to apply their LTC Partnership insurance protection to an asset that was excluded in the eligibility determination process. They may choose to apply their protection to that asset in order to insure protection from estate recovery.

NOTE: Applicants without a community spouse or a minor dependent child in the home equity greater than the applicable home equity limit in effect for the year of the application are technically ineligible for Medicaid. Due to this technical ineligibility, LTC Partnership insurance cannot apply in this situation.

EXAMPLES OF THE BENEFIT OF LTC PARTNERSHIP INSURANCE

If an applicant has purchased a qualified LTC partnership insurance policy and that policy paid out $100,000 as of the month of application for Medicaid, that applicant could protect an additional $100,000 of assets.

EXAMPLE 1:

Bob, a single individual, has been in the nursing facility for three years. He has homestead property valued at $85,000 and a CD valued at $20,000. On the date of his application, his LTC Partnership policy has paid out $103,000. He can protect $103,000 of resources. He can have $2,000 in resources; therefore, he can gain eligibility and protect his homestead property and CD from estate recovery.

In order to understand how LTC Partnership insurance can affect applicants with a community spouse, below are the original examples we listed in the resource assessment section. In each example, we will consider that the LTC partnership insurance has paid $50,000 benefits as of the month of application for Medicaid.

EXAMPLE 2:

Sam and Sally have the following countable resources:

Checking:	$10,000
Savings:	$50,000
Boat:	$10,000
Annuity:	$50,000
Total:	$120,000

Sam is in the nursing facility, Sally is the community spouse. $120,000 divided by 2 equals $60,000 each which is below the maximum community spouse resource allowance. Sally can protect $60,000 and Sam can apply his LTC partnership policy payout of $50,000 at the time of application. The couple could protect up to $112,000 ($60,000 + 50,000 + 2,000).

Sam will need to determine when to make his second application based on the dollar amount, he was over resource limit at the original application. He will need to take into consideration the monthly benefits from his LTC Partnership insurance policy and the amount he is paying for his cost of care, reducing his resources. For example, if Sam's LTC Partnership policy is paying $4,000 per month to the facility and Sam is also paying

$4,000 privately he can apply the following month.

EXAMPLE 3:

John and Mary requested a resource assessment in November 2018. They have the following countable resources:

Vacation home:	$50,000
C.D:	$110,000
Life insurance policy with cash value:	$90,000
Building lot:	$25,000
Checking:	$30,000
Savings:	$60,000
Total:	$365,000

$365,000 divided by 2 equals $182,500 each. The maximum allowable in 2018 for the community spouse to protect was $126,420. $182,500 minus $126,420 equals $56,080. $56,080 must be added to the institutionalized spouse's share of $182,500 which results in his countable resource of $238,580. The LTC Partnership policy has paid out $50,000, he is only over the resource limit by $188,580.

The community spouse's protected assets remain the same if the institutionalization remains unchanged. John needs to determine the appropriate time to reapply based on the monthly benefit of his LTC Partnership policy and the rate at which his cost of care is reducing his resources.

EXAMPLE 4:

Tara and Cliff have the following countable resources during the resource assessment January 3, 2018:

CD:	$20,000
Checking:	$10,000
Total:	$30,000

$30,000 divided by 2 equals $15,000 each. However, the community spouse minimum for 2018 is $25,284. Therefore, the community spouse can protect $25,284. The joint resources at the time of reapplication must be equal to or less than $27,284 (the community spouses protected amount and the institutionalized spouses $2,000). In this example, since Cliff's LTC Partnership policy has spent more than the couple's countable resources, all resources can be protected, and Cliff is financially eligible.

NOTE: All dollars spent after the resource assessment must be accounted for at the new application.

MASSACHUSETTS

MASSACHUSETTS

STATE SPECIFIC INFORMATION

MASSHEALTH GENERAL ELIGIBILITY RULES

PURPOSE AND USE OF THIS APPENDIX

This appendix summarizes selected MassHealth eligibility rules related to long-term-care services and reflects guidance issued by the Commonwealth of Massachusetts. It is provided for informational and educational purposes only and is not intended to determine eligibility for benefits.

Eligibility determinations are made by MassHealth based on the rules, policies, and procedures in effect at the time of application.

MASSHEALTH GENERAL ELIGIBILITY RULES

There are special eligibility rules for persons who need long-term-care services at home, or who are waiting to go into a long-term-care facility.

A long-term-care facility is a type of medical institution that includes:

- licensed nursing facilities;
- chronic-disease and rehabilitation hospitals;
- state hospitals and state schools specifically designated as long-term-care facilities; and
- **intermediate-care facilities for individuals with intellectual or developmental disabilities (ICF/IID).** *(updated terminology)*

Long-term-care services are the types of services needed if you are frequently ill and/or permanently disabled and need help or cannot take care of yourself. These include medical and personal services. Generally, people get long-term-care services while they are in a long-term-care facility.

To be eligible for payment of long-term-care services in a long-term-care facility, you must be eligible for MassHealth Standard as a person who is:

- aged 65 or older;
- aged 19 through 65 and disabled according to the Social Security Administration's disability rules; or
- under age 19;

and must:

- meet the requirements of citizenship and identity;
- be determined by MassHealth as medically needing long-term-care services; and
- prove that you (and your spouse) meet certain income and asset rules.

CITIZENSHIP DOCUMENTATION REQUIREMENTS

(Please see Annex A for actual copy of announcement in .pdf file)

MassHealth verifies citizenship and identity through electronic data sources whenever possible. Applicants are required to provide documentation only when electronic verification is unavailable or incomplete.
(NEW – framing for alignment and modernization)

NEW CITIZENSHIP DOCUMENTATION REQUIREMENTS

Due to a change in federal law, effective July 1, 2006, MassHealth requires individuals who state they are U.S. citizens or nationals to provide acceptable documentation of their citizenship and identity when first applying for MassHealth or upon MassHealth redetermination.

Verification of citizenship and identity is a one-time activity. Members who have verified citizenship and identity satisfactorily will not be asked to do so again.

The new federal law does not include changes for documented immigrants, who must continue to provide proof of their status when they apply for MassHealth.

MassHealth will use electronic data matching to the greatest extent possible and allowable to assist members with fulfilling this requirement.

TIMEFRAMES

Applicants: MassHealth coverage will not begin until all necessary documentation, including proof of citizenship and identity, is submitted within the required timeframes. MassHealth will inform applicants when documents are due — either 60 or 30 days, depending on coverage type.

Time-limited presumptive coverage for pregnant women and children will not be delayed pending documentation of citizenship and identity, but documentation must be submitted within 60 days of application in order for benefits to continue.

Current members: MassHealth requires a redetermination of eligibility at least once each year. When a member's redetermination is due, the member will be notified that they have either 60 or 30 days, depending on coverage type, to provide documentation of citizenship and identity. These timeframes may be extended if the member indicates to MassHealth that he or she is making a good-faith effort to submit documentation.

Applicable submission timeframes and documentation procedures may vary based on coverage type and individual circumstances.

PHONE NUMBERS FOR ASSISTANCE IN OBTAINING NECESSARY DOCUMENTATION

- ➔ **To receive or renew a Passport:** National Passport Information Center, U.S. Department of State: 1-877-487-2778
- ➔ **For Certificate of Naturalization or Certificate of U.S. Citizenship:** U.S. Department of Homeland Security: 1-800-375-5283/TTY 1-800-767-1833
- ➔ **For Massachusetts Birth Certificates:** Registry of Vital Records and Statistics, Massachusetts Department of Public Health: 150 Mount Vernon Street, 1st Floor, Dorchester, MA 02125-3105, 617-740-2600
- ➔ **For a Massachusetts Driver's License or Massachusetts ID card:** Massachusetts Registry of Motor Vehicles: 617-351-4500/TTY 617-536-7534 or 1-877-768-8833
- ➔ **General questions**: MassHealth Customer Service: 1-800-841-2900/TTY 1-800-497-4648

Contact information and assistance methods may change over time; applicants should consult MassHealth customer service or the official MassHealth website for the most current guidance.

U.S. CITIZENSHIP/NATIONAL STATUS AND IDENTITY REQUIREMENTS

- **US Citizenship/National Status and Identity Requirements for MassHealth [C+I (03/10)]**

  A form that provides complete information about acceptable proofs of U.S. citizenship/national status and identity.

  (***(Please see Annex B for actual copy of the form in .pdf file)***

U.S. Citizenship/National Status and Identity Requirements for MassHealth/Commonwealth Care

Effective 7/1/06 from the Federal Deficit Reduction Act of 2005

<u>Proof of both U.S. Citizenship/National Status and Identity*</u>

- **Exception:** Seniors and disabled persons who get or can get Medicare or Supplemental Security Income (SSI), or disabled persons who get Social Security Disability (SSDI) do NOT have to give proof of their U.S. citizenship/national status and identity. A child born to a mother who was getting MassHealth on the date of the child's birth does not have to give proof of U.S. citizenship/national status and identity.

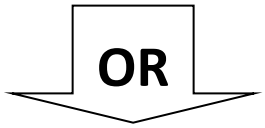
The following **FIRST-LEVEL DOCUMENTS** may be accepted as proof of BOTH U.S. citizenship/national status AND identity. (No other documentation is required.) Individuals born outside the U.S. who were not U.S. citizens/nationals at birth must submit first-level documents or appropriate second-level documents (where applicable for a birth abroad) or, if such documents are not available, affidavits of citizenship. Adopted children born outside the U.S. may establish citizenship under the Child Citizenship Act.

1. a U.S. passport; or

2. a Certificate of Naturalization (DHS Form N-550 or N-570); or

3. a Certificate of U.S. Citizenship (DHS Form N-560 or N-561); or

4. a document issued by a federally recognized American Indian tribe showing membership or enrollment in, or affiliation with, such tribe



Proof of U.S. Citizenship/National Status Only plus Proof of Identity Only

Proof of U.S. Citizenship/National Status Only	Proof of Identity Only
(Submit documentation from the highest level possible!) The following **SECOND-LEVEL DOCUMENTS** may be accepted as proof of U.S. citizenship/national status only. • A U.S. public record of birth (including the 50 states, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam (on or after April 10, 1899), the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986). The individual may also be collectively naturalized under federal regulations. The birth record must have been recorded within 5 years of birth. • A Report of Birth Abroad of a U.S. Citizen (Form FS-545, Form FS-240, or Form DS-1350) • A U.S. Citizen ID card (INS Form I-197 or I-179) • An American Indian Card (I-872 with the classification code KIC) issued by the Department of Homeland Security (DHS) to identify U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border • Final adoption decree showing the child's name and U.S. place of birth (if adoption is not finalized, a statement from a state-approved adoption agency) • Evidence of U.S. civil service employment before June 1, 1976 • An official military record showing a U.S. place of birth	The following documents may be accepted as proof of identity only. 1. A state driver's license containing the individual's photo or other identifying information 2. A government-issued identity card containing the individual's photo or other identifying information 3. Certificate of Indian Blood or other U.S. tribal document with photo or other identifying information 4. U.S. military card or draft record 5. Three or more of the following documents, such as, marriage licenses, divorce decrees, high school diplomas, employer ID cards, and property deeds/titles (This documentation cannot be used if fourth-level documents were submitted as proof of U.S. citizenship/national status.) 6. School identity card with photo, except for children under age 16 7. Military dependent's identity card 8. U.S. Coast Guard Merchant Mariner card 9. For children under age 16: a clinic, doctor, or hospital record, or a school record, or a daycare or nursery school record that is verified with the school, or a parental, guardian, or caretaker relative affidavit attesting to the child's date and place of birth that is signed under penalty of perjury (cannot be used if an affidavit for citizenship/national status was provided). For children between the ages of 16 and

- A Northern Mariana Identification Card (I-873) issued by the INS to a collectively naturalized citizen of the United States who was born in the Northern Mariana Islands before November 4, 1986
- Documentary evidence under the Child Citizenship Act for adopted children born outside the U.S

The following **THIRD-LEVEL DOCUMENTS** may be accepted as proof of U.S. citizenship/national status only.

- Extract of U.S. hospital record of birth on hospital letterhead established at the time of the person's birth that was created 5 years before the initial application date and that indicates a U.S. place of birth.

For children under age 16, the hospital record must have been created near the time of birth or 5 years before the application date. A souvenir birth certificate is not acceptable.

- Life, health, or other insurance record showing a U.S. place of birth that was created at least 5 years before the initial application date that indicates a U.S. place of birth.

For children under age 16, the document must have been created near the time of birth or 5 years before the application date.

- An official religious record recorded with the religious organization in the U.S. within 3 months of birth showing the birth occurred in the U.S. and showing either the date of birth or the individual's age at the time the record was made. Entries in a family bible are not considered religious records.
- An early school record showing the child's name, U.S. place of birth, date of admission, and date of birth

The following **FOURTH-LEVEL DOCUMENTS** may be accepted as proof of U.S. citizenship/national status only.

- Birth records recorded after the person turned age 5
- Federal or state census record showing U.S. citizenship or a U.S. place of birth and person's age
- Admission papers from a nursing home, skilled-care facility, or other institution that were created at least 5 years before the initial application date and that indicate a U.S. place of birth

18, the affidavit can be used where a school photo ID or driver's license with photo is not available in that area until that age.

10. For disabled individuals in residential care facilities: an affidavit signed under penalty of perjury by the facility director or administrator when the disabled individual does not have or cannot get any identity document listed in 1 through 9 above.

• Medical (clinic, doctor, or hospital) record indicating a U.S. place of birth that was created at least 5 years before the initial application date. For children under age 16, the medical record must have been created near the time of birth or 5 years before the application date. • Other documents that show a U.S. place of birth that were created at least 5 years before the application for MassHealth (For children under age 16, the document must have been created near the time of birth or 5 years before the application date.): Seneca or Navajo Indian tribal census records, U.S. State Vital Statistics official notification of birth registration, an amended U.S. public birth record that was amended more than 5 years after the person's birth, a statement from a physician/midwife who was in attendance at the birth, or the Bureau of Indian Affairs Roll of Alaska Natives • Written affidavit**	

****Affidavits (written statements) of U.S. citizenship/national status should be used only in rare circumstances when the applicant or member is unable to provide evidence of U.S. citizenship/national status from any other source listed.** Two affidavits must be submitted. One of the two affidavits must be from an individual who is not related to the applicant or member. Each individual providing an affidavit must have personal knowledge of the event(s) establishing the applicant's or member's claim of U.S. citizenship/national status; for example, the date and place of the applicant's birth in the United States, if applicable. The individuals providing the affidavits must also provide proof of both their own U.S. citizenship/national status and identity for the affidavit to be accepted. If these individuals also know why documentary evidence of the applicant's or member's claim of U.S. citizenship/national status cannot be provided, this should be included in the affidavit. The applicant or member (or other knowledgeable individual) must also provide a separate affidavit explaining why this evidence cannot be provided. Different requirements apply to affidavits of identity for children and institutionalized individuals.

- be determined by Mass Healthy as medically needing long-term-care services; and
- prove that you (and your spouse) meet certain income and asset rules

To decide if you can get Mass Health, we look at your income and assets and, in some cases, your immigration status.

U.S CITIZENSHIP AND IMMIGRATION RULES

When deciding if you are eligible for MassHealth, eligibility is based on the requirements described under each coverage type and program. Citizenship, national status, and immigration status are evaluated to determine eligibility.

- **Qualified Aliens**

    1. *People admitted for legal permanent residence (LPR) under the Immigration and Nationality Act (INA). But see starred (*) paragraph below.

2. *People granted parole for at least one year under section 212(d)(5) of the INA. But see starred (*) paragraph below.
3. *Conditional entrants under section 203(a)(7) of the INA as in effect before April 1, 1980. But see starred (*) paragraph below.
4. People granted asylum under section 208 of the INA.
5. Refugees admitted under section 207 of the INA.
6. People whose deportation has been withheld under section 243(h), or 241(b)(3) of the INA, as provided by section 5562 of the federal Balanced Budget Act of 1997.
7. People who entered as Cuban/Haitian entrants under section 501(e) of the Refugee Education Assistance Act of 1980.
8. Native Americans with at least 50 percent American Indian blood who were born in Canada pursuant to section 289 of the INA or other tribal members born in territories outside of the United States pursuant to 25 U.S.C. 450b(e).
9. Amerasians admitted pursuant to section 584 of Public Law 100-202.
10. Veterans of the United States (U.S.) Armed Forces with an honorable discharge not related to their alien status. (b) Filipino war veterans who fought under U.S. command during WWII. (c) Hmong and Highland Lao veterans who are admitted for legal permanent residence (LPR) and who fought under U.S. command during the Vietnam War. (d) Persons with alien status on active duty in the U.S. Armed Forces, other than active duty for training. (e) The spouse, surviving un-remarried spouse, or unmarried dependent child of the alien described in (a) through (d).
11. Aliens or their unmarried dependent children, as defined in federal law, who have been subjected to battery or extreme cruelty by their spouse, parent, sponsor, or a member of their household, and who no longer live in the same household as the batterer.
12. Victims of severe forms of trafficking.
13. Iraqi Special Immigrants granted special immigrant status under Section 101(a) (27) of the Immigration and Nationality Act pursuant to section 1244 of Public Law 110-181 or section 525 of Public Law 110-161, for a period not to exceed eight months.
14. Afghan Special Immigrants granted special immigrant status under Section 101(a) (27)p of the Immigration and Nationality Act pursuant to section 525 of Public Law 110-161, for a period not to exceed six months.

*People described in 1, 2, and 3 above must have entered the United States before August 22, 1996 or have entered the United States on or after August 22, 1996, and completed the five-year bar, to be eligible for MassHealth Standard, unless they also meet a status in 4 through 14 above.

- **Aliens with Special Status**

People who entered the United States on or after August 22, 1996, and have a status described in 1, 2, or 3 below, and have not completed the five-year bar, or who have entered at any time and are permanently living in the United States under color of law (PRUCOLs) as described in 4 below, cannot get MassHealth Standard. However, they may be eligible for any coverage type except Standard if they meet the rules and income limits for that coverage type, and they may get MassHealth Family Assistance if they meet the rules and income limits for Standard.
In addition, people who meet the rules and income limits of MassHealth Standard and are under the age of 19, or the parent of a child under age 19, or pregnant, can get MassHealth Family Assistance instead of

MassHealth Standard. If they are disabled according to the standards set by federal and state law, they can get MassHealth CommonHealth.

- People admitted for legal permanent residence (LPR) under the INA.
- People granted parole for at least one year under section 212(d)(5) of the INA.
- Conditional entrants under section 203(a)(7) of the INA as in effect before April 1, 1980.
- People permanently living in the United States under color of law (PRUCOLs) as described below:
  a. aliens living in the United States in accordance with an indefinite stay of deportation;
  b. aliens living in the United States in accordance with an indefinite voluntary departure;
  c. aliens and their families who are covered by an approved immediate relative petition, who are entitled to voluntary departure, and whose departure the United States Immigration and Naturalization Service (INS) does not contemplate enforcing;
  d. aliens who have filed applications for adjustment of status that the INS has accepted as "properly filed," and whose departure the INS does not contemplate enforcing;
  e. aliens granted stays of deportation by court order, statute, or regulation, by individual determination of the INS, or relevant INS instructions, and whose departure INS does not contemplate enforcing;
  f. aliens granted voluntary departure by the INS or an Immigration Judge, and whose deportation the INS does not contemplate enforcing;
  g. aliens granted deferred action status;
  h. aliens living under orders of supervision;
  i. aliens who have entered and continuously lived in the United States since before January 1, 1972;
  j. aliens granted suspension of deportation, and whose departure the INS does not contemplate enforcing;
  k. aliens granted temporary protected status (TPS);
  l. aliens who are asylum applicants; and
  m. any other aliens living in the United States with the knowledge and consent of the INS, and whose departure the INS does not contemplate enforcing. (These include permanent nonimmigrants as established by Public Law 99-239, and persons granted Extended Voluntary Departure due to conditions in the alien's home country based on a determination by the Secretary of State.)
  n. If your immigration status is not described above, you may be eligible for MassHealth Limited.

  Note: People who were getting MassHealth, formerly known as Medical Assistance, or CommonHealth on June 30, 1997, may continue to get benefits regardless of immigration status if otherwise eligible.

TECHNICAL ALIGNMENT WITH CURRENT TERMINOLOGY

- References to “INS” are understood to mean the U.S. Department of Homeland Security (DHS).
- Eligibility timeframes for certain special immigrant categories may be extended or modified under federal law.

CHANGES IN LAW AND POLICY

MassHealth eligibility rules, coverage categories, and administrative procedures are subject to change under federal and state law. Eligibility determinations are made based on the rules in effect at the time of application.

ANNEX A.

Important Announcement from MassHealth

New Citizenship Documentation Requirements

New!

Due to a change in Federal law, effective July 1, 2006, MassHealth now requires individuals who state they are U.S. citizens or nationals to provide acceptable documentation of their citizenship and identity when first applying for MassHealth or upon MassHealth redetermination.

- ✓ **Verification of citizenship and identity is a one-time activity.** Members who have verified citizenship and identity satisfactorily will not be asked to do so again.
- ✓ **The new Federal Law does not include changes for documented immigrants,** who must continue to provide proof of their status when they apply for MassHealth.
- ✓ **MassHealth will use electronic data matching to the greatest extent possible and allowable** to assist members with fulfilling this new requirement.

Timeframes:

⇒ **Applicants: MassHealth coverage will not begin until all necessary documentation,** including proof of citizenship and identity, are submitted within the necessary timeframes. MassHealth will inform applicants when documents are due - either 60 or 30 days, depending on coverage type.

- **Time-limited presumptive coverage for pregnant women and children will not be delayed** pending documentation of citizenship and identity, but this documentation must still be submitted within 60 days of application in order for MassHealth benefits to continue.

⇒ **Current members:** MassHealth requires a redetermination of eligibility at least once each year. When a member's redetermination is due, the member will be notified that they have either 60 or 30 days, depending on coverage type, to provide documentation of citizenship and identity. These timeframes may be extended if the member indicates to MassHealth that he or she is making a good faith effort to submit the documentation.

Phone Numbers for Assistance in Obtaining Necessary Documentation:

⇒ **To receive or renew a Passport:** National Passport Information Center, U.S. Department of State: 1-877-487-2778

⇒ **For Certificate of Naturalization or Certificate of U.S. Citizenship:** U.S. Department of Homeland Security: 1-800-375-5283 / TTY 1-800-767-1833

⇒ **For Massachusetts Birth Certificates:** Registry of Vital Records and Statistics, Massachusetts Department of Public Health: 150 Mount Vernon Street, 1st Floor, Dorchester, MA 02125-3105, 617-740-2600

⇒ **For a Massachusetts Driver's License or Massachusetts ID card:** Massachusetts Registry of Motor Vehicles: 617-351-4500 / TTY 617-536-7534 or 1-877-768-8833

⇒ **General questions:** MassHealth Customer Service: 1-800-841-2900 / TTY 1-800-497-4648

Please see next page for acceptable documentation to verify citizenship and identity.

ANNEX B.

U.S. Citizenship/National Status and Identity Requirements for MassHealth/Commonwealth Care Effective 7/1/06 from the Federal Deficit Reduction Act of 2005

Proof of both U.S. Citizenship/National Status and Identity*

* **Exception**: Seniors and disabled persons who get or can get Medicare or Supplemental Security Income (SSI), or disabled persons who get Social Security Disability (SSDI) do NOT have to give proof of their U.S. citizenship/national status and identity. A child born to a mother who was getting MassHealth on the date of the child's birth does not have to give proof of U.S. citizenship/national status and identity.

The following **FIRST-LEVEL DOCUMENTS** may be accepted as proof of **BOTH U.S. citizenship/national status AND identity.** (No other documentation is required.) Individuals born outside the U.S. who were not U.S. citizens/nationals at birth must submit first-level documents or appropriate second-level documents (where applicable for a birth abroad) or, if such documents are not available, affidavits of citizenship. Adopted children born outside the U.S. may establish citizenship under the Child Citizenship Act.

1. **a U.S. passport; or**
2. **a Certificate of Naturalization (DHS Form N-550 or N-570); or**
3. **a Certificate of U.S. Citizenship (DHS Form N-560 or N-561); or**
4. **a document issued by a federally recognized American Indian tribe showing membership or enrollment in, or affiliation with, such tribe.**

OR

Proof of U.S. Citizenship/National Status Only

(Submit documentation from the highest level possible!)

The following **SECOND-LEVEL DOCUMENTS** may be accepted as proof of U.S. citizenship/national status only.

- A U.S. public record of birth (including the 50 states, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam (on or after April 10, 1899), the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986). The individual may also be collectively naturalized under federal regulations. The birth record must have been recorded within 5 years of birth.
- A Report of Birth Abroad of a U.S. Citizen (Form FS-545, Form FS-240, or Form DS-1350)
- A U.S. Citizen ID card (INS Form I-197 or I-179)
- An American Indian Card (I-872 with the classification code KIC) issued by the Department of Homeland Security (DHS) to identify U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border
- Final adoption decree showing the child's name and U.S. place of birth (if adoption is not finalized, a statement from a state-approved adoption agency)
- Evidence of U.S. civil service employment before June 1, 1976
- An official military record showing a U.S. place of birth
- A Northern Mariana Identification Card (I-873) issued by the INS to a collectively naturalized citizen of the United States who was born in the Northern Mariana Islands before November 4, 1986
- Documentary evidence under the Child Citizenship Act for adopted children born outside the U.S.

The following **THIRD-LEVEL DOCUMENTS** may be accepted as proof of U.S. citizenship/national status only.

- Extract of U.S. hospital record of birth on hospital letterhead established at the time of the person's birth that was created 5 years before the initial application date and that indicates a U.S. place of birth. For children under age 16, the hospital record must have been created near the time of birth or 5 years before the application date. A souvenir birth certificate is not acceptable.
- Life, health, or other insurance record showing a U.S. place of birth that was created at least 5 years before the initial application date that indicates a U.S. place of birth. For children under age 16, the document must have been created near the time of birth or 5 years before the application date.
- An official religious record recorded with the religious organization in the U.S. within 3 months of birth showing the birth occurred in the U.S. and showing either the date of birth or the individual's age at the time the record was made. Entries in a family bible are not considered religious records.
- An early school record showing the child's name, U.S. place of birth, date of admission, and date of birth

The following **FOURTH-LEVEL DOCUMENTS** may be accepted as proof of U.S. citizenship/national status only.

- Birth records recorded after the person turned age 5
- Federal or state census record showing U.S. citizenship or a U.S. place of birth and person's age
- Admission papers from a nursing home, skilled-care facility, or other institution that were created at least 5 years before the initial application date and that indicate a U.S. place of birth
- Medical (clinic, doctor, or hospital) record indicating a U.S. place of birth that was created at least 5 years before the initial application date. For children under age 16, the medical record must have been created near the time of birth or 5 years before the application date.
- Other documents that show a U.S. place of birth that were created at least 5 years before the application for MassHealth (For children under age 16, the document must have been created near the time of birth or 5 years before the application date.): Seneca or Navajo Indian tribal census records, U.S. State Vital Statistics official notification of birth registration, an amended U.S. public birth record that was amended more than 5 years after the person's birth, a statement from a physician/midwife who was in attendance at the birth, or the Bureau of Indian Affairs Roll of Alaska Natives
- Written affidavit**

PLUS

Proof of Identity Only

The following documents may be accepted as proof of identity only.

1. A state driver's license containing the individual's photo or other identifying information
2. A government-issued identity card containing the individual's photo or other identifying information
3. Certificate of Indian Blood or other U.S. tribal document with photo or other identifying information
4. U.S. military card or draft record
5. Three or more of the following documents, such as, marriage licenses, divorce decrees, high school diplomas, employer ID cards, and property deeds/titles (This documentation cannot be used if fourth-level documents were submitted as proof of U.S. citizenship/ national status.)
6. School identity card with photo, except for children under age 16
7. Military dependent's identity card
8. U.S. Coast Guard Merchant Mariner card
9. For children under age 16: a clinic, doctor, or hospital record, or a school record, or a day-care or nursery school record that is verified with the school, or a parental, guardian, or caretaker relative affidavit attesting to the child's date and place of birth that is signed under penalty of perjury (cannot be used if an affidavit for citizenship/national status was provided). For children between the ages of 16 and 18, the affidavit can be used where a school photo ID or driver's license with photo is not available in that area until that age.
10. For disabled individuals in residential-care facilities: an affidavit signed under penalty of perjury by the facility director or administrator when the disabled individual does not have or cannot get any identity document listed in 1 through 9 above.

****Affidavits (written statements) of U.S. citizenship/national status should be used only in rare circumstances when the applicant or member is unable to provide evidence of U.S. citizenship/national status from any other source listed.** Two affidavits must be submitted. One of the two affidavits must be from an individual who is **not** related to the applicant or member. Each individual providing an affidavit must have personal knowledge of the event(s) establishing the applicant's or member's claim of U.S. citizenship/national status; for example, the date and place of the applicant's birth in the United States, if applicable. The individuals providing the affidavits must also provide proof of both their own U.S. citizenship/national status and identity for the affidavit to be accepted. If these individuals also know why documentary evidence of the applicant's or member's claim of U.S. citizenship/national status cannot be provided, this should be included in the affidavit. The applicant or member (or other knowledgeable individual) must also provide a separate affidavit explaining why this evidence cannot be provided. Different requirements apply to affidavits of identity for children and institutionalized individuals.

C+I (Rev. 03/10)

MICHIGAN

MICHIGAN

STATE SPECIFIC INFORMATION

LEGISLATION REGARDING ADULT FINANCIAL EXPLOITATION

PURPOSE AND USE OF THIS APPENDIX

This appendix summarizes selected provisions of Michigan law relating to adult financial exploitation. It is provided for informational and educational purposes only and is not intended to serve as legal advice or to replace the application of the law by courts or enforcement agencies.

OVERVIEW OF ADULT FINANCIAL EXPLOITATION IN MICHIGAN

Michigan law prohibits the misuse, theft, or improper control of a vulnerable adult's money or property through fraud, coercion, misrepresentation, or similar conduct. These protections apply regardless of whether the vulnerable adult has been determined by a court to be incapacitated.

The statute reproduced below establishes prohibited conduct, defines key terms, and sets forth criminal penalties based on the value of assets involved and any prior violations.

LEGISLATION REGARDING ADULT FINANCIAL EXPLOITATION

Michigan takes adult financial exploitation very seriously. The following legislation lays out the prohibited conduct, definitions of victims and abusers, and the penalties that can occur.

http://www.legislature.mi.gov/(S(oke4opyzremprcmh34nb42o5))/mileg.aspx?page=GetObject&objectname=mcl-750-174a

THE MICHIGAN PENAL CODE (EXCERPT) ACT 328 OF 1931

750.174a Vulnerable adult; prohibited conduct; violation; penalty; enhanced sentence; exceptions; consecutive sentence; definitions; report by office of services to the aging to department of human services.

Sec. 174a.

(1) A person shall not through fraud, deceit, misrepresentation, coercion, or unjust enrichment obtain or use or attempt to obtain or use a vulnerable adult's money or property to directly or indirectly benefit that person knowing or having reason to know the vulnerable adult is a vulnerable adult.

(2) If the money or property used or obtained, or attempted to be used or obtained, has a value of less than $200.00, the person is guilty of a misdemeanor punishable by imprisonment for not more than 93 days or a fine of not more than $500.00 or 3 times the value of the money or property used or obtained or attempted to be used or obtained, whichever is greater, or both imprisonment and a fine.

(3) If any of the following apply, the person is guilty of a misdemeanor punishable by imprisonment for not more than 1 year or a fine of not more than $2,000.00 or 3 times the value of the money or property used or obtained or attempted to be used or obtained, whichever is greater, or both imprisonment and a fine:

(a) The money or property used or obtained, or attempted to be used or obtained, has a value of $200.00 or more but less than $1,000.00.

(b) The person violates subsection (2) and has 1 or more prior convictions for committing or attempting to commit an offense under this section.

(4) If any of the following apply, the person is guilty of a felony punishable by imprisonment for not more than 5 years or a fine of not more than $10,000.00 or 3 times the value of the money or property used or obtained or attempted to be used or obtained, whichever is greater, or both imprisonment and a fine:

(a) The money or property used or obtained, or attempted to be used or obtained, has a value of $1,000.00 or more but less than $20,000.00.

(b) The person violates subsection (3)(a) and has 1 or more prior convictions for committing or attempting to commit an offense under this section. For purposes of this subdivision, however, a prior conviction does not include a conviction for a violation or attempted violation of subsection (2) or (3)(b).

(5) If any of the following apply, the person is guilty of a felony punishable by imprisonment for not more than 10 years or a fine of not more than $15,000.00 or 3 times the value of the money or property used or obtained or attempted to be used or obtained, whichever is greater, or both imprisonment and a fine:

(a) The money or property used or obtained, or attempted to be used or obtained, has a value of $20,000.00 or more but less than $50,000.00.

(b) The person violates subsection (4)(a) and has 2 or more prior convictions for committing or attempting to commit an offense under this section. For purposes of this subdivision, however, a prior conviction does not include a conviction for a violation or attempted violation of subsection (2) or (3)(b).

(6) If any of the following apply, the person is guilty of a felony punishable by imprisonment for not more than 15 years or a fine of not more than $15,000.00 or 3 times the value of the money or property used or obtained or attempted to be used or obtained, whichever is greater, or both imprisonment and a fine:

(a) The money or property used or obtained, or attempted to be used or obtained, has a value of $50,000.00 or more but less than $100,000.00.

(b) The person violates subsection (5)(a) and has 2 or more prior convictions for committing or attempting to commit an offense under this section. For purposes of this subdivision, however, a prior conviction does not include a conviction for a violation or attempted violation of subsection (2) or (3)(b).

(7) If any of the following apply, the person is guilty of a felony punishable by imprisonment for not more than 20 years or a fine of not more than $50,000.00 or 3 times the value of the money or property used or obtained or attempted to be used or obtained, whichever is greater, or both imprisonment and a fine:

(a) The money or property used or obtained, or attempted to be used or obtained, has a value of $100,000.00 or more.

(b) The person violates subsection (6)(a) and has 2 or more prior convictions for committing or attempting to commit an offense under this section. For purposes of this subdivision, however, a prior conviction does not include a conviction for a violation or attempted violation of subsection (2) or (3)(b).

(8) Except as otherwise provided in this subsection, the values of money or property used or obtained or attempted to be used or obtained in separate incidents pursuant to a scheme or course of conduct within any 12-month period may be aggregated to

determine the total value of money or personal property used or obtained or attempted to be used or obtained. If the scheme or course of conduct is directed against only 1 person, no time limit applies to aggregation under this subsection.

(9) If the prosecuting attorney intends to seek an enhanced sentence based upon the defendant having 1 or more prior convictions, the prosecuting attorney shall include on the complaint and information a statement listing the prior conviction or convictions. The existence of the defendant's prior conviction or convictions shall be determined by the court, without a jury, at sentencing or at a separate hearing for that purpose before sentencing. The existence of a prior conviction may be established by any evidence relevant for that purpose, including, but not limited to, 1 or more of the following:

(a) A copy of the judgment of conviction.

(b) A transcript of a prior trial, plea-taking, or sentencing.

(c) Information contained in a presentence report.

(d) The defendant's statement.

(10) If the sentence for a conviction under this section is enhanced by 1 or more prior convictions, those prior convictions shall not be used to further enhance the sentence for the conviction under section 10, 11, or 12 of chapter IX of the code of criminal procedure, 1927 PA 175, MCL 769.10, 769.11, and 769.12.

(11) A financial institution or a broker or a director, officer, employee, or agent of a financial institution or broker is not in violation of this section while performing duties in the normal course of business of a financial institution or broker or a director, officer, employee, or agent of a financial institution or broker.

(13) The court may order a sentence imposed for a violation of subsection (4), (5), (6), or (7) to be served consecutively to any other sentence imposed for a violation of this section.

(14) This section does not prohibit a person from being charged with, convicted of, or punished for any other violation of law the person commits while violating this section.

(15) As used in this section:

(a) "Broker" means that term as defined in section 8102 of the uniform commercial code, 1962 PA 174, MCL 440.8102.

(b) "Financial institution" means a bank, credit union, saving bank, or a savings and loan chartered under state or federal law or an affiliate of a bank, credit union, saving bank, or savings and loan chartered under state or federal law.

(c) "Vulnerable adult" means that term as defined in section 145m, whether or not the individual has been determined by the court to be incapacitated.

(16) If the office of services to the aging becomes aware of a violation of this section, the office of services to the aging shall promptly report the violation to the department of human services.

History: Add. 2000, Act 222, Eff. Sept. 25, 2000 ;-- Am. 2004, Act 255, Eff. Sept. 1, 2004 ;-- Am. 2012, Act 172, Imd. Eff. June 19, 2012 ;-- Am. 2013, Act 34, Imd. Eff. May 21, 2013

REPORTING AND ENFORCEMENT

Violations of Michigan’s adult financial exploitation laws may be investigated and enforced by law enforcement agencies and other authorized state entities. Certain professionals and agencies may have mandatory reporting obligations under Michigan law.

Individuals who suspect financial exploitation of a vulnerable adult may contact local law enforcement or the Michigan Department of Health and Human Services for guidance on reporting concerns.

MINNESOTA

MINNESOTA

STATE SPECIFIC INFORMATION

PURPOSE AND USE OF THIS DOCUMENT

This document provides general information about Minnesota Medical Assistance (MA) eligibility and the Minnesota Long-Term Care Partnership (LTCP) Program. It is intended for educational and training purposes only and is not intended to determine eligibility for Medical Assistance benefits.

MA eligibility policy is complex and subject to change under federal and state law. Eligibility determinations are made by county agencies based on the rules, policies, and procedures in effect at the time of application.

MA ELIGIBILITY AND THE LTC PARTNERSHIP PROGRAM

This handout is specific to Minnesota MA Eligibility and the Minnesota LTCP Program. Information for this section has been found in the following MN Publications:

- *"Medical Assistance Eligibility and the Long Term Care Partnership in Minnesota", September 2008.*
- *"Minnesota Long Term Care Partnership", www.dhs.state.mn.us*
- *Bulletin 2007-10, State of Minnesota Department of Commerce, October 8, 2007.*
- *Minnesota Statute 60K.365*
- *The Minnesota Department of Human Services (DHS) Minnesota Health Care Program Eligibility Policy Manual (EPM). http://hcopub.dhs.state.mn.us/epm/*

Where appropriate, the information reflects rates, limits, and standards applicable at the time of publication. Many financial thresholds and program standards are adjusted periodically and may differ at the time of application.

PRODUCER TRAINING

An individual may not sell, solicit, or negotiate long-term care insurance unless the individual is licensed as an insurance producer for accident and health or sickness insurance or life insurance and has completed an initial training course and ongoing training every 24 months thereafter. Insurance producers are required to successfully complete training that has been approved by the Minnesota Department of Commerce. The training includes basic information about Medical Assistance (MA) eligibility and asset protection as it relates to the Long Term Care Partnership (LTCP). The initial training course must be no less than eight hours, and the ongoing training course must be no less than four hours every 24 months.

It is important to understand that MA eligibility policy is very complex. It incorporates special regulation and exceptions for certain situations, and regulations change when state and federal legislation is amended. This section of the course provides general eligibility information. This information should not be considered enough to be able to determine if someone may be eligible for MA benefits in Minnesota.

In order to understand how MA eligibility policy would be applied to someone's particular circumstances, the person must submit an application to the county agency and provide all information and verifications necessary to determine eligibility. Inquiries about the MA status of current enrollees must be requested by enrollees or their authorized representatives, or third parties with written consent.

MA regulations vary from state to state. The rules that apply in Minnesota may not apply in other states.

Nonresident Producers: selling partnership policies shall be expected to demonstrate knowledge about unique aspects of the Minnesota medical assistance system. An insurer offering partnership products in Minnesota shall maintain records verifying that its nonresident producers have attained the required training and make that verification available to the commissioner upon request.

UNDERSTANDING MINNESOTA LONG-TERM CARE

MA ELIGIBILITY AND THE MINNESOTA LTCP PROGRAM

Long Term Care Partnership (LTCP)	LTCP is a joint effort between the federal Medicaid Program and LTC insurers. LTCP was developed to encourage people to play for their future Long-term care(LTC) needs, such as residing in a nursing facility or receiving LTC waiver services in a home or commnity-based setting.
	The LTCP involves private LTC insurers, LTC insurance producers (agents and brokers), the Department of Human Services (DHS) and the Department of Commerce. Although the Partnership is overseen by the federal Centers for Medicare and Medicaid Services (CMS), each state has a great deal of autonomy in its administration. In Minnesota, qualified LTCP policies must provide a specific amount of inflation protection based on the person's age when the policy is purchased and must meet other requirements established by state and federal law.
Medical Assistance (MA)	MA is Minnesota's name for the federal Medicaid program. It provides health care services, including long-term care. A person who requests MA payment of LTC services after using some benefits of a qualified LTCP policy may protect assets equal to the amount paid by the policy. More detailed information will be provided about the relationship between MA asset eligibility and how assets can be protected by a LTCP policy.

WHAT QUALIFIES AS PARTNERSHIP IN MINNESOTA

Unlike earlier Partnership programs in other states, Minnesota's program does not require minimum lifetime or daily maximums. To qualify as Minnesota Partnership, long-term care insurance coverage must:

- Meet the requirements for being "tax qualified" as defined in Section 7702B(b) of the Internal Revenue Code
- Meet certain consumer protection requirements in Section 6021(a)(1)(B)(5)(A) of the Deficit Reduction Act, which are taken from the NAIC model act of 2000
- Provide coverage to a person who was a resident of Minnesota when coverage first became effective
- Provide inflation protection if the person is under age 76:
    - For issue ages under 61: If a policy is sold to a person under the age of 61, it must provide compound annual inflation protection. Inflation protection must be continued until at least age 66 to be considered meaningful protection allowing the policy to maintain Partnership status.
    - For issue ages 61 through 75: If a policy is sold to a person aged 61 through 75, the policy must provide some level of inflation protection. Inflation protection must continue for the first five consecutive years following the date of purchase, or until age 76, whichever occurs first, to be considered meaningful protection allowing the policy to maintain Partnership status. After the first five years, a policy sold to a person aged 61 through 75 may, but is not required to, provide inflation protection to maintain Partnership status.
    - For issue ages 76 and over: If a policy is sold to a person aged 76 or older, the policy may, but is not required to, provide some level of inflation protection.

Further details are contained in the Inflation, exchange and notification (http://www.state.mn.us/mn/externalDocs/Commerce/200710_100907043310_bul2007-10.pdf) bulletin issued 10/8/07.

TAX QUALIFIED

The term "qualified long-term care insurance contract" means any insurance contract if—

(A) the only insurance protection provided under such contract is coverage of qualified long-term care services,
(B) such contract does not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount,
(C) such contract is guaranteed renewable,
(D) such contract does not provide for a cash surrender value or other money that can be—
  (i) paid, assigned, or pledged as collateral for a loan, or
  (ii) borrowed,
other than as provided in subparagraph (E) or paragraph (2)(C) which describes that subparagraph (E) shall not apply to any refund on the death of the insured, or on a complete surrender or cancellation of the contract, which cannot exceed the aggregate premiums paid under the contract. Any refund on a complete surrender or cancellation of the contract shall be included in gross income to the extent that any deduction or exclusion was allowable with respect to the premiums.
(E) all refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits, and
(F) such contract meets the requirements of subsection (g).

CONSUMER PROTECTION REQUIREMENTS

All policies sold in Minnesota must contain the following consumer protection features:

- At least one year of nursing home or home health care coverage, including intermediate and custodial care. Health care benefits cannot be limited to "skilled care" only.
- Coverage for Alzheimer's disease.
- An inflation protection option.
- An "outline of coverage" that clearly describes a policy's benefits, limitations, and exclusions, allowing the client to compare the coverage with that of other providers. This must be given to clients at the time of initial solicitation and before they complete the application for insurance.
- If the client purchases a policy that was approved in 2002 or later, it will contain "rate stabilization" provisions that are intended to make rate increases less likely
- If the client purchases a "qualified" policy they must be given the long-term care insurance "shopper's guide" that helps them decide whether long-term care insurance is appropriate for them.
- A "guaranteed renewable" clause, meaning that the policy cannot be cancelled, non-renewed, or otherwise terminated except for non-payment of premium.
- A statement that the client has the right to return the policy for any reason within 30 days after the purchase and to receive a full premium refund.

INFLATION PROTECTION

Minnesota law requires that Minnesota Long Term Care Partnership coverage provide inflation protection based on an insured's age at the time the policy is issued. The prior section described the age breakdown when inflation protection must apply. For the years where inflation protection is required, the protection within the long-term care policy must meet with the following requirements in order to qualify for partnership status:

Adequate Level of Inflation Protection: there must be inflation protection which increases policy benefits at a rate of at least 5% compounded annually to be considered meaningful to allow for reasonably anticipated increases in the costs of LTC services under Minn. Stat. §62S.23

Other Levels of Inflation Protection Subject to Review: Inflation protection in an amount less than 5% compounded annually and/or inflation protection that is tied to a particular index value will be subject to review by the Minnesota Department of Commerce before it will be considered adequate to qualify for Partnership status. The Minnesota Department of Commerce considers the age range of purchasers and the type of long-term care services covered by policy when making its determination whether or not the protection is meaningful to allow for reasonably anticipated increases in the costs of LTC services under Minn. Stat. §62S.23

Schedule of Business Increases: benefit increases for inflation protection must occur no less frequently than annually.

Inflation Protection Increases NOT Subject to Underwriting: increases cannot be contingent on the insured providing evidence of insurability or health status information. This, however, does not alter the ability of an insurer to consider evidence of insurability or health status information at the time the policy or the inflation protection rider is initially underwritten.

Flexibility in Premium Structure: The premium associated with the policy may be;

- Level premium,
- Premium that increases annually, or
- Other premium arrangement set forth by contract.

The additional premium must be no higher than the rate based on the insured's attained age at the time of each offer.

Illustration Requirement if Not Level Premium: if the insured elects a premium other than level premiums, a personalized illustration must be provided at the point of sale that demonstrates the expected pattern of future annual premiums needed to maintain Partnership status until at least age 100. This illustration must include yearly comparison to the premium and the benefits for a policy that includes automatic compound annual inflation protection with level premiums.

Inflation Protection Offers, Disclosure Requirements & Discontinuation of Inflation Protection: The inflation protection may be automatic or the inflation protection may be provided as the result of an annual guaranteed offer by the company. During the previously outlined time frames for which inflation protection is required, each annual guaranteed offer of inflation protection must include disclosure language notifying the insured person of the effect on the policy's Partnership status if the insured fails to maintain inflation protection. Guaranteed offers must be structured so that the inflation protection required for Partnership status is maintained unless the insured formally declines an offer of inflation protection in a written statement or on a form developed by the company for such purpose, In the written statement or form, the insured must acknowledge understanding that the decision to decline inflation protection will result in the loss of the policy's Partnership status, including the asset protections provided by a Partnership policy. A similar written acknowledgment is required if an individual elects to drop a rider that provides automatic inflation protection if such a change would result in the loss of Partnership status.

GENERAL ELIGIBILITY CRITERIA FOR PERSONS REQUESTING MA PAYMENT FOR LTC SERVICES

To be eligible for MA, a person must first fit into an eligibility group, then must meet specific requirements relating to residency, citizenship, immigration status, third party liability, income and asset guidelines. General information about each item is included below, with special emphasis on people who reside in a Long-term Care Facility (LTCF) or receive home and community-based services through a waiver program.

MA eligibility groups in Minnesota include the following:

- Children under the age of 21.
- Parents or relative caretakers of dependent children.
- Pregnant women.
- People age 65 or older.
- People who are blind.
- People with a certified disability.
- Women in need of treatment for certain cancers.

People in a LTCF or receiving home or community-based waiver services are generally either certified as disabled or are age 65 or over. They would be eligible for MA benefits if they meet all other requirements, such as those noted below.

RESIDENCY

Residency rules require that a person lives in Minnesota and intends to remain in the state. However, those rules do not necessarily apply to everyone. A person in an LTCF is considered a resident of the state in which he or she was physically present on the date of the MA application. In addition, MN is not considered the state of residence for:

- A child under 18 whose parent or legal guardian lives in another state.
- A person of any age placed in the LTCF by another state.
- A person who resided in North Dakota prior to nursing home admission. (Per an agreement between the two states, the person remains a North Dakota resident for the first 2 years in a Minnesota nursing facility, and vice versa.)

CITIZENSHIP AND IMMIGRATION STATUS

A person is required to be either a U.S. citizen or a non-citizen with a qualified immigration status. The following must be verified:

- U.S. citizenship and identity when a person declares that he or she is a U.S. citizen.
- Immigration status when the person states that he or she has a non-citizen status. Sponsored non-citizens must also provide information about their sponsors.

THIRD PARTY LIABILITY

The rules state that MA is the payor of last resort. People must provide information about other payment sources, such as other health insurance, Medicare, long-term care insurance, or a liable third party. The other payment source pays their portion of medical expenses before MA payments are made.

COVERAGE FOR PERSONS REQUESTING MA PAYMENT OF LTC SERVICES

The following information will help you see the complexity of MA eligibility rules that are evaluated for each person's circumstances. To be eligible for MA payment of LTC services in Minnesota, a person must:

- Have a **Long Term Care Consultation (LTCC)** which determines he or she needs a level of care provided in either:
    - One of these medical facilities:
        - Nursing facility.
        - Medical hospital.
        - Intermediate Care Facility for Individuals with Intellectual or Developmental Disabilities (ICF/IID).
        - MA-covered bed in a psychiatric hospital or nursing home.

    Or through

    - One of these home and community-based services for elderly or disabled people:
        - Elderly Waiver (EW) program.
        - Community Alternative Care (CAC).
        - Community Alternatives for Disabled Individuals (CADI).
        - Developmental Disabilities (DD).
        - Traumatic Brain Injury (TBI).
- Begin receiving LTC services within the required timeframe following the Long-Term Care Consultation (LTCC), subject to program requirements and individual circumstances.
- Reside in an MA-certified LTCF or receive services under an MA home and community-based waiver services program. This does **not** include placements in facilities that are not Medicaid-certified, such as a Veteran's Administration facility. Also, note that

MA does not consider assisted living facilities to be LTCFs. For MA, people in non-Medicaid-certified facilities are considered community residents.

- Have home equity that does not exceed the applicable home equity limit in effect for the year of application. *(Note: Special rules apply when home equity exceeds the allowable limit or when certain family members do not live in the home.)*
- Disclose any interest in an annuity for self and for spouse, if married. The state must be named as a remainder beneficiary of all annuities owned by the person or spouse.
- Not be in a penalty period for an uncompensated transfer of income or assets. During a penalty period, MA will not pay the cost of LTC services.

  Penalty periods are caused when a person or spouse makes an uncompensated transfer while receiving MA or during a "lookback period" before applying for MA.

  The lookback period is 60 months.

  The penalty period is calculated by dividing the value of the uncompensated transfer by the Statement Average Payment for Skilled Nursing care (SAPSNF) in effect at the time a person requests MA payment of LTC services.

INCOME

People who receive MA benefits do not all have the same income limits or use the same MA budget. A person's MA eligibility group determines the income and budgeting rules, such as the person's:

- Income limits (which are adjusted annually).
- Countable income.
- Excluded income.
- Deductions allowed from total gross countable income.
- Potential MA eligibility if the person's income is over the allowable limit.

This basic budgeting information relates specifically to people in an LTCF or receiving EW services. People who receive home and community-based services through other waiver programs (such as CAC, CADI, DD or TBI) may be eligible for asset protection under the Partnership, but have different MA eligibility rules not addressed in this document. Refer them to their county agencies for information relating to their specific situations.

When looking at MA eligibility, income of just the LTC or EW person is counted in his or her MA-LTC budget. Income of that person's spouse or parent is not counted.

Deductions allowed in an MA budget depend on the person's specific situation, and everyone does not necessarily get the same deductions. General deductions allowed in Minnesota on LTC or EW budgets include:

- Medicare premiums and health insurance premiums not paid by MA.
- An income allocation to a spouse who is living in community and not receiving LTC services if it is determined that the spouse has a financial need.
- Income allocations to certain other family members (subject to very specific limitations).
- Personal needs allowance, which changes annually.
- Home maintenance allowance if a doctor certifies that the person is expected to return to the home in a specific time period.
- Health care expenses that will not be paid by MA or by a third party.

The result of the calculation is the amount that a person must contribute toward the cost of his or her monthly LTC services and is typically paid to the LTCF or EW provider. MA will pay for other covered medical services received by the person.

ASSETS

A person's MA asset limit is determined by his or her eligibility group and household size. In Minnesota, someone in an LTCF or receiving EW services is considered to be an MA household of one with an asset limit of $3,000 in countable assets. People in other eligibility groups or with larger household sizes may have different asset limits.

Excluded assets are not counted towards the MA asset limit. Some excluded assets are one vehicle, some types of trusts, certain funds set aside for burial expenses, some federal payments, household goods, and personal items such as clothing and jewelry. Homestead property is excluded if the person or spouse or certain other family members live there. The homestead is excluded for 6 months from date of permanent LTCF admittance when no spouse or certain other family members live in the home.

Countable assets are available to the person and are counted towards the MA asset limit. Some countable assets are cash, bank accounts, stocks, bonds, non-homestead real property, property agreements like contracts-for-deed, life estate interests, and other liquid assets. The homestead becomes a countable asset 6 months after the person was admitted to the LTCF for a permanent stay when no spouse or certain other family members live in the home.

The county agency must review all verified assets and will determine which assets are:

- Counted toward MA eligibility.
- Excluded and not counted toward MA eligibility.
- Considered protected for a community spouse, if married.
- Protected because the person's LTCP policy has paid some LTC benefits. (This will be explained later)

The county will determine if the person needs to reduce countable assets to the $3,000 asset limit to be eligible for MA payment of LTC services.

ASSETS OF MARRIED COUPLES

A person in an LTCF or receiving EW services is considered a household of one for MA, even if married. He or she has an asset limit of $3,000 in countable assets. However, evaluating assets of a married person is very complicated and several questions need to be addressed.

- Is the spouse also receiving or requesting MA payment of LTC services? If Yes, then each one is treated as a single individual for purposes of the MA eligibility. Each has an asset limit of $3,000 in countable assets.
- Is the spouse living independently in the community and is not requesting or receiving MA payment of LTC services? If Yes, then that spouse is considered a **community spouse** An asset assessment must be completed for the married couple (the LTC spouse and the community spouse).

ASSET ASSESSMENT

In the asset assessment process:

- The married couple reports all assets owned solely by each spouse and jointly by both spouses. This should be done as soon as one spouse requires LTC services that are expected to last at least 30 days, whether or not they are requesting MA at that time.
- The county evaluates all verified assets to determine the amount of countable assets that can be kept by the community spouse. A community spouse may keep either the minimum asset allowance for that year or one-half the total countable marital assets (up to a maximum amount). The minimum and maximum amounts are adjusted annually.
- The county also estimates when the LTC spouse may possibly be eligible to receive MA payment for LTC services.

Two important points to remember:

- Reporting all assets for the assessment ensures that the greatest amount possible will be protected for the community spouse in the future.

- A married couple's asset assessment must be completed before assets are protected under the LTCP. This allows the couple to protect only those assets that are considered available to the LTC spouse.

LONG TERM CARE (LTC PARTNERSHIP PROGRAM AND MA ELIGIBILITY)

The following section explains how Medical Assistance and the Long-Term Care Partnership Program interact with asset protection and estate recovery rules.

ASSET PROTECTION

An LTCP participant in Minnesota:

- Requests MA payment of LTC services either as an elderly or certified disabled person **and**
- Meets all eligibility requirements for MA-LTC **or** meets all the requirements except for the asset limit **and**
- Has a qualified LTCP policy that paid for some LTC costs since July 1, 2006.

Note that MA benefits are not automatic for people with LTCP insurance. Even with asset protection, people must meet all MA-LTC requirements, including the asset limit of $3,000 in countable assets.

To help attain the $3,000 asset limit, an LTCP participant may designate a certain amount of assets for protection. Protected asset(s) will be listed on a form provided by the county agency and the value of each protected asset must be verified.

- Designated assets do not count toward the person's MA asset limit.
- The amount of protected assets equals the amount that the Partnership policy paid for LTC services since July 1, 2006.
- The LTCP participant can protect $1 of assets for every $1 paid by the LTCP insurance.
- The full amount that a person can protect is called his **Protected Asset Limit (PAL)**.

After a person protects an asset, he or she can:

- Keep it. The value will have to be reported each year and will count towards the PAL.
- Give it away. A designated asset may be transferred to any other person without penalty. The value of the asset on the day it is given away will usually count towards the PAL.
- Use it to get another asset. Then the new asset becomes protected and its value will count towards the PAL.
- Spend it on goods or services. For instance, John spends $6,000 from a protected bank account to go on a cruise. That $6,000 will still count towards his PAL.

Once Medical Assistance eligibility is established, a person generally may not change which assets were designated as protected under the Long-Term Care Partnership Program. For example, Marie has a bank account and owns a home. Her PAL allows her to protect just one of them, and she decides to protect her bank account. Marie cannot later change her mind and protect the home instead.

Note that two types of assets cannot be protected under the LTCP. Federal Medicaid rules state that when a person dies, the following assets must be available to reimburse DHS for the amount of MA benefits paid during his or her lifetime:

- Resources in a Special Needs Trust or a Pooled Trust and
- Annuity interests in which Minnesota must be named as a preferred remainder beneficiary.

The Liens and Estate Recovery section will explain what happens to protected assets when the LTCP Participant dies.

DECISIONS ABOUT PROTECTING ASSETS

When a person requests MA payment of LTC services, he or she may:

- Be eligible without having to protect any assets.
- Have assets worth less than his or her PAL.
- Have assets worth more than his or her PAL.

A person does not have to use the maximum amount of asset protection right away. The person who is eligible for MA by protecting just part of the PAL may have options in the future. He or she may choose to protect:

- The increased value of a protected asset.
- A newly acquired asset, such as an inheritance.
- An asset that is normally excluded for MA, such as a home in which a person or spouse lives.
- An asset that was formerly excluded, but became countable. For example, when an excluded home is sold, proceeds from the sale are counted as an asset.

The person whose assets are worth more than the PAL will have to make some decisions. The county will explain which assets are excluded for MA, what amount is considered the spouse's based on the asset assessment, and what amount is counted towards the MA asset limit. The person whose assets exceed the MA limit may either:

- Re-apply for MA-LTC after the LTCP insurance has paid for more care.
- Re-apply for MA-LTC after reducing assets in the future.
- Reduce countable assets right away to become eligible for MA-LTC. The county agency can suggest ways to reduce assets without creating an uncompensated transfer. For example, the person may purchase a TV or new clothing.

WHEN PROTECTED ASSETS INCREASE IN VALUE

Some protected assets will increase in value due to interest or dividends, etc. What happens then depends on the person's PAL and the value of all the protected assets.

- The increase in value will also be protected if total value of all protected assets is still below the PAL.
- If the total value of protected assets is greater than the PAL, the person may have to reduce some assets so countable assets go under the MA asset limit.

WHEN AN MA CLIENT'S LTCP CONTINUES TO PAY BENEFITS

A person's PAL will increase as long as the LTCP insurance continues to pay benefits. Once a year:

- The person will have to report the status and value of all protected assets.
- With the person's permission, the agency will contact the insurance company to find out the value of benefits paid over the past year.
- The county agency will tell the LTCP person if his or her PAL has increased.
- Any increase in the value of protected assets over the past year will be applied to the PAL.
- If additional asset protection remains, the person may protect more assets.

INHERITANCE, LIENS AND ESTATE RECOVERY

Assets protected during a person's lifetime will stay protected after he or she dies. The state or county will not file a claim against a person's protected assets to repay MA for that person's health care. However, as explained below, MA claims may be filed against assets that are not protected.

A lien is usually placed against a person's home or other real property when a person gets MA benefits. A lien may be filed against:

- An interest in a life estate.
- Real property owned solely by one person.
- Real property owned jointly with other person or persons.
- The portion of real property that is not protected because of LTCP insurance.

Liens are not filed if:

- The person is in a long-term care facility nursing home and will return to his own home or
- The person's spouse is residing in the home or
- The home or other property was fully protected because of LTCP insurance.

Sometimes property is worth more than the person is allowed to protect. In that situation, a lien may be filed against the value of property that is higher than the PAL amount. For example, David's property is valued at $200,000. His PAL amount is $150,000 and he chooses to protect $150,000 of his property. When David dies, the $150,000 amount that he protected will stay protected. However, a claim or a lien may be filed against the other $50,000 worth of property.

After an LTCP client dies:

- Assets which were protected during his lifetime are also protected from estate recovery. The state or county will not file a claim against his protected assets to repay MA. However, they may file an MA claim against any assets that were not protected.
- When the person does not protect assets during his lifetime, or when he protects less than his PAL, his personal representative may protect assets during the estate recovery process - up to the total amount of his PAL. See the Anna example below.

What about the protected assets of someone who is married? We know what happens to a protected asset when the person dies, but what happens to that asset when his surviving spouse dies? The answer to this question depends on whether the surviving spouse:

- Had an LTCP policy and
- Received MA-LTC benefits.

Review the Jack and Jill example below.

ESTATE RECOVERY EXAMPLES

ANNA EXAMPLE

Anna's LTCP insurance paid for her LTC for one year before she applied for MA payment of LTC services. At that time her countable assets were below the MA asset limit and she was eligible for MA without protecting any assets. When Anna died, she had received MA-LTC benefits for three years and never designated an asset for protection.

So did Anna or her family lose out on asset protection completely? No. When Anna died, her personal representative was able to protect assets from MA estate recovery, up to her PAL amount.

JACK AND JILL EXAMPLE

Jack and Jill were married. Jack received MA payment for LTC services and protected an asset because of his LTCP. Jack's protected asset remained protected when he died.

Several years after Jack died, Jill entered an LTCF and received MA-LTC benefits. What happens to Jack's protected asset when Jill dies? That depends on whether Jill also protected the asset because of her own LTCP.

- If Jill did not protect the asset because of her own LTCP, a lien or estate recovery claim may be filed against Jack's protected asset to repay Jill's MA costs.
- However, a lien or estate recovery claim will not be filed if Jill also protected that asset because of her own LTCP.

MABEL AND WILMA EXAMPLES

Mabel and Wilma have similar stories. Both women receive LTC services in their own homes. The services are partially covered by a qualified $20,000 LTCP policy. Each woman has used $10,000 of policy benefits. Neither one has resources to pay for services not covered by LTCP insurance.

Both Mabel and Wilma are found eligible for MA payment of LTC services through the Elderly Waiver (EW) program. Their LTCP policies are treated as third party liability and MA pays for services not covered by the LTCP.

When applying for MA, they each own the following assets:

- $2,500 savings account.
- House with an equity value of $50,000.
- Insurance-funded burial.

Each woman's assets are evaluated for MA as follows:

- The savings account is a countable asset, with a value less than her MA-LTC asset limit.
- The insurance-funded burial meets specific guidelines and is excluded for MA.
- The home is excluded because she lives there.

Mabel and Wilma were both found to be eligible for MA payment of LTC services. When MA opened, neither woman chose to protect any assets.

Now their stories become different. Remember, their LTCP policies had a maximum lifetime benefit of $20,000.

Mabel dies after using another $5,000 of LTCP benefits, for total LTC insurance payments of $15,000. Although she could not benefit from the full value of the policy, her personal representative may designate $15,000 of Mabel's assets so they are protected from estate recovery.

Wilma exhausts the remaining $10,000 of her LTCP policy benefits during her first six months of receiving MA payment of LTC services. Although the full $20,000 of her LTCP benefits have been used, Wilma still does not feel a need to designate any assets for protection.

A few months later Wilma's brother dies, leaving her a $10,000 inheritance. Adding her $3,000 savings account to the inheritance gives her countable assets of $13,000. Because this puts her over the $3,000 limit, she designates the $10,000 inheritance as protected under LTCP. Wilma remains eligible for MA payment of LTC services.

One month later she gives the $10,000 protected asset to her granddaughter for college tuition. There is no uncompensated transfer because the $10,000 was an LTCP protected asset. That $10,000 is still counted as a protected asset, even though she gave it away.

When Wilma dies two years later, she owns the insurance-funded burial and her home. Remember, Wilma's $20,000 LTCP policy paid the full amount of benefits for her. So what could happen with her remaining assets?

- Her insurance-funded burial was used in full to cover funeral costs.
- Wilma had protected the $10,000 inheritance during her lifetime.
- So another $10,000 could be protected after she dies.
- Since the home is the sole asset in her estate, her personal representative could protect $10,000 of the home's equity value from estate recovery.
- A claim or a lien could be filed against the remaining equity value of the home.

HOW TO APPLY FOR MINNESOTA HEALTH CARE PROGRAMS

Applications for Minnesota health care programs, including Medical Assistance, may be submitted through the state's health care application systems or through the county agency where the applicant resides.

Applicants may apply online, request assistance from their county agency, or submit a paper application when appropriate. The county agency determines eligibility based on submitted information and required verifications.

Medical Assistance coverage generally begins based on the date a complete application is received, subject to program rules. Applicants may request retroactive coverage for eligible months prior to application, consistent with MA policy.

CHANGES IN LAW AND POLICY

Medical Assistance eligibility standards, financial limits, waiver programs, and Long-Term Care Partnership rules are subject to change under federal and state law. County agencies determine eligibility based on the rules in effect at the time of application.

GENERAL DIFFERENCES IN MEDICAID ELIGIBILITY BETWEEN MINNESOTA AND NEIGHBORING STATES

Medicaid is a federal/state health care program and eligibility regulations differ from state to state. It may be helpful to briefly review the areas of difference, especially if you sell LTC insurance in states other than Minnesota.

HOUSEHOLD SIZE

In Minnesota a person in an LTCF is considered a household of one for MA purposes, even if that person's spouse is also a resident of that facility. A person receiving home and community-based waiver services is also considered a household of one, even if the person has a spouse.

Other states may consider a married person receiving waiver services as a household of two, and both spouses in an LTCF are considered to be a household of two.

ASSETS

In Minnesota a person's asset limit for MA-LTC in Minnesota is $3,000. Other states, such as South Dakota and Wisconsin, follow SSI guidelines, allowing countable assets of $2,000.

In Minnesota a homestead is excluded for a person's first six months in an LTCF unless a physician's statement verifies that the person is expected to return home and/or certain other family members reside in the home. The exclusion begins on the person's date of admission into the facility, not on the date the person applies for MA-LTC. Other states exclude the homestead indefinitely while a person is in a nursing home.

A community spouse's asset allowance is the amount of assets that a community spouse can keep when the LTC spouse applies for MA payment of LTC. Minnesota's community spouse asset allowance is subject to federally established minimum and maximum standards, which are adjusted annually.

The MA-LTC home equity limit in Minnesota is $752,000 (2026). Other states apply different federally established home equity limits.

MA-LTC SCREENING

In Minnesota, people must have a Long-Term Care Consultation (LTCC) to determine their needed level of care. For MA payment, they must begin LTC services within 60 days of the LTCC.

Screening requirements and processes differ from state to state.

INCOME AND DEDUCTIONS

Minnesota provides health care programs for medically needy people whose income is higher than their MA income limit, but their medical costs allow them to spend down to the income standard. Some people may not be eligible for MA in the community because of their income, but may be eligible for MA-LTC because they can spend down by deducting nursing home costs.

Some states do not allow an income spenddown provision.

A Personal Needs Allowance is the amount of monthly income a person receiving MA-LTC can keep for personal needs. The amount of this allowance differs significantly between states.

In Minnesota the Personal Needs Allowance is adjusted annually. In other states it is a fixed amount that is not adjusted on a regular basis.

Minnesota allows some people in an LTCF to deduct a Home Maintenance Allowance for three full calendar months to help maintain their homes in the community. A doctor must certify that the LTCF stay is temporary and the person is expected to return home.

Many other states do not allow this deduction.

LTCP ASSET PROTECTION

Minnesota allows a person with LTCP to protect an amount of assets equal to the benefits paid by the LTCP since July 1, 2006.

Other states have different rules about which benefits paid by LTCP will determine the amount of assets a person can protect under the Partnership.

Minnesota allows MA-LTC clients to accrue asset protection as additional payments are made by their LTCP insurance.

Some states do not allow additional asset protection after a person is enrolled in Medicaid.

OHIO

OHIO

STATE SPECIFIC INFORMATION

PURPOSE AND USE

This document summarizes selected Ohio laws and administrative rules governing long-term care insurance, agent training requirements, and the Ohio Long-Term Care Partnership Program. It is provided for informational and educational purposes only and is not intended to replace the statutes, administrative rules, or regulatory guidance issued by the State of Ohio.

HOW TO USE THIS INFORMATION

The materials reproduced within this document include statutory and regulatory provisions applicable to insurers, insurance agents, and long-term care insurance products.

Applicability of any provision depends on the specific facts, policy form, and timing involved. Compliance determinations and enforcement are made by the Ohio Department of Insurance and other appropriate state authorities.

SCOPE OF TRAINING REQUIREMENTS

The following section summarizes education and training requirements applicable to insurance agents who sell, solicit, or negotiate long-term care insurance in Ohio.

LONG TERM CARE (LTC) TRAINING REQUIREMENT

Persons holding a Life or Accident & Health line of authority who plan to sell, solicit or negotiate longterm care insurance must complete an initial 8-hour LTC course approved by the superintendent. In order to be able to continue selling, soliciting or negotiating long-term care insurance the agent must also complete a 4-hour LTC refresher course approved by the superintendent every renewal period. The initial and on-going LTC course credits count towards the agents 24-hour CE requirement. Initial long term care courses are approved under the LTC-8 course category and on-going long term care courses are approved under the LTC-4 course category.

Agents must complete the initial training prior to selling, soliciting or negotiating long-term care insurance. Failing to complete the initial training or on-going training may jeopardize the agent’s authority to sell long term care insurance.

A resident agent may complete these training requirements in any state provided the Department has approved the course for long term care credit prior to the agent taking the course. The satisfaction of the training requirements in any state will satisfy the training requirements in this state for Ohio non-resident agents.

ORC 5164.86 QUALIFIED LTC INSURANCE PROGRAM ESTABLISHMENT

The Medicaid director shall establish a qualified state long-term care insurance partnership program consistent with the definition of that term in the "Social Security Act," section 1917(b)(1)(C)(iii), 42 U.S.C. 1396p(b)(1)(C)(iii). An individual participating in the program who is subject to the Medicaid estate recovery program instituted under section 5162.21 of the Revised Code shall be eligible for the reduced adjustment or recovery under division (D) of that section.

3923.41 LONG-TERM CARE INSURANCE DEFINITIONS. EFFECTIVE: SEPTEMBER 10, 2007

(A) "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for not less than one year 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. "Long-term care insurance" includes group and individual annuities and life insurance policies or riders that provide directly or supplement long-term care benefits, and policies or riders that provide for payment of benefits based on cognitive impairment or the loss of functional capacity. "Long-term care insurance" includes group and individual policies or riders whether issued by insurers, fraternal benefit societies, or health insuring corporations. "Long-term care insurance" includes qualified long-term care insurance contracts. "Long-term care insurance" does not include any insurance policy that is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

With regard to life insurance, "long-term care insurance" does not include life insurance policies that accelerate the death benefits specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement; that provide the option of a lump sum payment for those benefits; and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

Notwithstanding any other provision contained in sections 3923.41 to 3923.48 of the Revised Code, any product advertised, marketed, or offered as long-term care insurance shall be subject to sections 3923.41 to 3923.48 of the Revised Code.

(B) "Applicant" means either of the following:

(1) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits;

(2) In the case of a group long-term care insurance policy, the proposed certificate holder.

(C) "Certificate" means any certificate issued under a group long-term care insurance policy that has been delivered, issued for delivery, or used in or outside this state.

(D) "Group long-term care insurance" means a long-term care insurance policy that is delivered or issued for delivery in this state to any of the following:

(1) One or more employers or labor organizations, or a trust or the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, established for either of the following:

(a) Employees or former employees or a combination thereof;

(b) Members of the labor organization, or former members of the labor organization, or a combination thereof.

(2) Any professional, trade, or occupational association for its members or former or retired members, or a combination thereof, if the association satisfies both of the following requirements:

(a) It is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation.

(b) It is maintained in good faith for purposes other than obtaining insurance.

(3) An association or trust of the trustees of a fund established, created, or maintained for the benefit of members of one or more associations that meets the requirements of section 3923.43 of the Revised Code;

(4) A group other than as described in divisions (D)(1), (2), and (3) of this section about whom the superintendent of insurance finds that all of the following are true:

(a) The issuance of the group policy is not contrary to the best interest of the public.

(b) The issuance of the group policy would result in economies of acquisition or administration.

(c) The benefits of the group policy are reasonable in relation to the premiums charged.

(E) "Policy" means any policy, contract, rider, or endorsement delivered, issued for delivery, or used in or outside this state by an insurer, fraternal benefit society, or health insuring corporation.

(F)(1) "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means an individual or group insurance contract of which all of the following are true pursuant to division (b) of section 7702B of the "Internal Revenue Code of 1986," 26 U.S.C. 7702B, as amended:

(a) The only insurance protection provided under the contract is coverage of qualified long-term care services including payments made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(b) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the "Social Security Act," 42 U.S.C. 1395 et seq., as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. The contract may pay or reimburse expenses that are reimbursable under Title XVIII of the Social Security Act as a secondary payer. A contract may allow payments to be made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(c) The contract is guaranteed renewable, within the meaning of division (b)(1)(C) of section 7702B of the "Internal Revenue Code of 1986," 26 U.S.C. 7702B, as amended.

(d) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in division (F)(1)(e) of this section.

(e) All refunds of premiums, and all policy holder dividends or similar amounts, under the contract shall be applied to a reduction in future premiums or to increase future benefits, except that a refund in the event of death of the insured or in the event of a complete surrender or cancellation of the contract shall not exceed the aggregate premiums paid under the contract.

(f) The contract meets the consumer protection provisions set forth in division (g) of section 7702B of the "Internal Revenue Code of 1986," 26 U.S.C. 7702B, as amended.

(2) "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" also means the portion of a life insurance contract that provides long-term care insurance coverage by a rider or as part of the contract and that satisfies the requirements of divisions (b) and (e) of section 7702B of the Internal Revenue Code of 1986, 26 U.S.C 7702B, as amended.

(G) "State long-term care partnership program" or "partnership program" means a program established under division (b) of section 1917 of the "Social Security Act," 42 U.S.C. 1396p, as amended.

(H) "Insurance agent" or "agent" means a person licensed under Chapter 3905. of the Revised Code to sell, solicit, or negotiate insurance.

(I) "Insurer" means any person authorized under Title XXXIX of the Revised Code to engage in the business of insurance in this state or any health insuring corporation authorized under Chapter 1751. of the Revised Code to do business in this state that issues long-term care insurance policies or certificates.

3923.42 CITING PROVISIONS - APPLICABILITY. EFFECTIVE: JANUARY 31, 1992

(A) Sections 3923.41 to 3923.48 of the Revised Code may be cited as the "long-term care insurance act."

(B) Sections 3923.41 to 3923.48 of the Revised Code do not supersede the obligations of entities subject to these sections to comply with the substance of other applicable insurance laws insofar as they do not conflict with these sections, except that section 3923.33 and sections 3923.331 to 3923.339 of the Revised Code and rules intended to apply to medicare supplement insurance policies do not apply to long-term care insurance. A policy that is not advertised, marketed, or offered as long-term care insurance need not meet the requirements of sections 3923.41 to 3923.48 of the Revised Code.

3923.43 EVIDENCE TO BE FILED BY LONG-TERM CARE INSURANCE ASSOCIATION. EFFECTIVE: SEPTEMBER 10, 2007

(A) Prior to advertising, marketing, or offering a policy within this state, the association or the insurer of the association described in division (D)(3) of section 3923.41 of the Revised Code, shall file evidence with the superintendent of insurance that the association has at the outset a minimum of one hundred persons and has been organized and maintained in good faith for purposes other than that of obtaining insurance, has been in active existence for at least one year, and has a constitution and bylaws that provide all of the following:

(1) The association holds regular meetings not less than annually to further the purposes of the members;

(2) Except for credit unions, the association collects dues or solicits contributions from members;

(3) The association's members have voting privileges and representation on the governing board and committees of the association.

(B) Thirty days after the evidence filing, the association is deemed to satisfy the organizational requirements listed in division (A) of this section unless the superintendent makes a specific finding that the association does not satisfy the organizational requirements.

3923.44 STANDARDS FOR FULL AND FAIR DISCLOSURE FOR SALE OF LONG-TERM CARE INSURANCE POLICIES. EFFECTIVE: SEPTEMBER 10, 2007

(A) The superintendent of insurance, pursuant to Chapter 119. of the Revised Code, may adopt rules that include standards for full and fair disclosure setting forth the manner, content, and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of coverage, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definitions of terms. Such rules may include provisions related to the state long-term care partnership program, including, but not limited to, requirements related to offers to exchange partnership program policies for previously issued policies and for consumer disclosures related to the state long-term care partnership program.

(B) No long-term care insurance policy shall:

(1) Be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(2) Contain a provision establishing a new waiting period if existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder;

(3) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care;

(4) Use a definition of "preexisting condition" that is more restrictive than the following: "Preexisting condition" means a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services, within six months preceding the effective date of coverage of an insured person.

(5) Exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within six months following the effective date of coverage of an insured person.

(C) The superintendent may extend the limitation periods set forth in divisions (B)(4) and (5) of this section as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(D) "Preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in division (B)(5) of this section expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in division (B)(5) of this section.

(E)(1) No long-term care insurance policy shall do any of the following:

(a) Condition eligibility for any institutional benefits on a requirement of prior hospitalization;

(b) Condition eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care;

(c) Condition eligibility for any institutional benefits, other than waiver of premium or post-confinement, post-acute care, or recuperative benefits, on a requirement of prior institutionalization.

(2) Every long-term care insurance policy that conditions eligibility for noninstitutional benefits on the prior receipt of institutional care is subject to both of the following:

(a) The policy shall not require a prior institutional stay of more than thirty days.

(b) The policy shall provide that eligibility for noninstitutional benefits shall be established by the alternative of a period of hospitalization of not more than three days.

(3) No long-term care insurance policy, except for the policy described in division (E)(2) of this section, shall condition eligibility for noninstitutional benefits on the requirement of prior hospitalization.

(4) No long-term care insurance policy that provides benefits only following institutionalization shall condition the benefits upon admission to a facility for the same or related conditions within a period of less than thirty days after discharge from the institution.

(F) A long-term care insurance policy that provides post-confinement, post-acute care, or recuperative benefits shall state any limitations or conditions on eligibility for benefits, including any required period of prior institutionalization as

permitted in division (E)(1)(c) of this section, in a separate paragraph of the policy or certificate and shall label that paragraph "Limitations or Conditions on Eligibility for Benefits."

(G) The superintendent, pursuant to Chapter 119. of the Revised Code, may adopt rules establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the rule.

(H)(1) A person insured under a long-term care insurance policy may return the policy or certificate in accordance with the procedures and requirements provided for individual policyholders under section 3923.31 of the Revised Code, except that the person has thirty days from the date of delivery to return the policy or certificate and have the premium refunded.

(2) A notice of the policyholder's or certificate holder's rights under division (H)(1) of this section and section 3923.31 of the Revised Code shall be printed prominently on the first page of the policy or certificate or attached to the policy or certificate.

(I) Except as provided in division (M) of this section, an outline of coverage and a notice that consumer information is available from the department of insurance under section 3923.49 of the Revised Code shall be delivered to a prospective applicant for long-term care insurance at the time of the initial solicitation through means that prominently direct the attention of the prospective applicant to the outline of coverage, the purpose of the outline of coverage, and the notice. In the case of agent solicitations, the agent shall deliver the outline of coverage and notice prior to the presentation of an application or enrollment form. In the case of direct response solicitations, the insurer shall deliver the outline of coverage and notice in conjunction with any application or enrollment form. The superintendent shall prescribe by rule the content and format of the outline of coverage and notice, including the style, overall appearance, size, color and prominence of type, and the arrangement of text and captions. The outline of coverage shall include all of the following:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the principal exclusions, reductions, and limitations contained in the policy;

(3) A statement of the terms under which the individual policy or certificate or the group policy or certificate may be renewed and the terms under which cancellation is permitted, including any reservation in the policy of a right to change premiums. Continuation or conversion provisions of group long-term care insurance shall be specifically described.

(4) A description of the terms under which the policy or certificate may be returned and the premium refunded;

(5) A brief description of the relationship of the cost of care and benefits;

(6) A statement that the outline of coverage is a summary of the policy issued or applied for, and that the policy or group master policy should be consulted to determine governing contractual provisions;

(7) A statement that discloses to the policyholder or certificate holder whether the policy is intended to be a federally tax-qualified long-term care insurance contract.

(J) A certificate issued pursuant to a group long-term care insurance policy that is delivered, issued for delivery, or used in or outside this state shall include all of the following:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the principal exclusions, reductions, and limitations contained in the policy;

(3) A statement that the group master policy determines governing contractual provisions.

(K) If an individual life insurance policy provides long-term care benefits within the policy or by rider, a policy summary shall be delivered to an applicant for the policy at the time of policy delivery. In the case of direct response solicitations, the insurer shall deliver the policy summary to the applicant upon the applicant's request. If no such request is made, the

insurer shall deliver the policy summary no later than at the time of policy delivery. In addition to any other information required by this section, the policy summary shall include all of the following:

(1) A statement that explains how the terms of the policy that provide benefits for long-term care insurance affect the other terms of the policy, including how the payment of these benefits would reduce the death benefits payable by the policy;

(2) A description of the amount of benefits for long-term care insurance that is available under the policy, the length of time these benefits could be paid by the policy, and any guaranteed lifetime benefits provided by the policy, for each insured under the policy;

(3) A statement of the exclusions, reductions, and limitations on benefits for long-term care insurance that are contained in the policy;

(4) A statement of the effects of exercising other rights under the policy;

(5) A statement of the guarantees, if any, with respect to the policy costs of providing benefits for long-term care insurance;

(6) A statement of all current and projected maximum lifetime benefits;

(7) A statement of whether long-term care inflation protection is available under the policy.

(L) During the time when a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, the insurer shall provide a monthly report to the policyholder. The report shall include all of the following:

(1) A description of all benefits for long-term care insurance that were paid by the policy during that month;

(2) An explanation of any changes in the policy, including death benefits or cash values due to the payout of long-term care benefits;

(3) A statement of the amount of benefits for long-term care insurance that is still available under the policy.

(M) In case of a policy issued to a group defined in division (D)(1) of section 3923.41 of the Revised Code, an outline of coverage shall not be required to be delivered, provided that the information described in division (I) of this section is contained in other materials relating to enrollment and, upon request, these other materials are made available to the superintendent.

(N)(1) Policies that are intended to qualify under the state long-term care partnership program shall comply with all state and federal requirements applicable to policies issued in connection with the state long-term care partnership program.

(2)(a) For policies intended to qualify under the state long-term care partnership program, the agent or insurer shall deliver to the applicant a long-term care partnership policy disclosure form along with the outline of coverage specified in division (I) of this section.

(b) In the case of a policy issued to a group where an outline of coverage is not delivered, the long-term care partnership policy disclosure form is delivered with enrollment forms.

(c) In the case of a life insurance policy that offers long-term care insurance within the policy or as a rider, the disclosure form is provided with the policy summary.

(O) No insurer shall issue a policy intended to qualify as a state partnership program policy that fails to satisfy the following inflation protection requirements:

(1) For a person who is less than sixty-one years of age as of the date of purchase of the policy, the policy provides annual inflation protection of at least three per cent compounded annually per year or a rate, compounded annually, that is equal to the annual consumer price index.

(2) For a person who is at least sixty-one years of age but less than seventy-six years of age as of the date of purchase of the policy, the policy provides annual inflation protection of at least three per cent simple or a rate equal to the annual consumer price index.

(3) For a person who is at least seventy-six years of age as of the date of purchase of the policy, the policy may provide inflation protection.

(P) As used in this section, "consumer price index" means 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.

(Q) For purposes of division (O) of this section, the superintendent may approve an alternative index to be used in place of the consumer price index.

(R) The superintendent shall prescribe by rule pursuant to Chapter 119. of the Revised Code the content and format of the state long-term care partnership program policy disclosure form required by division (N)(2) of this section.

(S) No policy may be advertised, marketed, or offered as long-term care insurance unless it complies with sections 3923.41 to 3923.48 of the Revised Code.

(T) The superintendent may adopt rules in accordance with Chapter 119. of the Revised Code to establish minimum standards for marketing practices, agent compensation, agent testing, and reporting practices for long-term care insurance.

3923.441 RESCISSION OF LONG-TERM CARE POLICY FOR MISREPRESENTATION.

EFFECTIVE: SEPTEMBER 10, 2007

(A) Except as otherwise provided in division (C) of this section and notwithstanding division (B) of section 3923.04 of the Revised Code, no insurer shall rescind a long-term care insurance policy or certificate or deny an otherwise valid claim based upon a misrepresentation by the applicant without adhering to one of the following:

(1) For a policy or certificate that has been in force for less than six months, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim if the insurer can demonstrate that the insured misrepresented facts that were material to the insurer's offer of coverage to the insured.

(2) For a policy or certificate that has been in force for at least six months but less than two years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim if the insurer can demonstrate that the insured misrepresented facts that were both material to the insurer's offer of coverage to the insured and that pertain to the condition for which the insured sought benefits.

(3) After a policy or certificate has been in force for at least two years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim if the insurer can demonstrate that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health in the insured's application for the policy.

(B) No insurer shall recover from the insured benefits that were paid under a long-term care insurance policy or certificate prior to the rescission of the policy or certificate pursuant to this section.

(C) In the event of the death of the insured, the remaining death benefits under a life insurance policy that accelerates benefits for long-term care are governed by section 3923.04 of the Revised Code.

3923.442 OFFER OF NONFORFEITURE BENEFIT OPTION WITH LONG-TERM CARE POLICY.

EFFECTIVE: SEPTEMBER 10, 2007

(A)(1) Except as provided in division (B) of this section, no insurer shall deliver or issue for delivery a long-term care insurance policy or certificate in this state without offering the policyholder or certificate holder the option of purchasing a nonforfeiture benefit.

(2) An insurer's offer of a nonforfeiture benefit pursuant to this section may be in the form of a rider that is attached to the policy.

(3) If the policyholder or certificate holder declines the nonforfeiture benefit offered pursuant to this section, the insurer shall provide a contingent benefit upon lapse that shall be available for a period of time specified in the policy or certificate following a substantial increase in premium rates.

(B)(1) For a group long-term care insurance policy, the insurer shall make the offer required by division (A) of this section to the group policyholder.

(2) For a group long-term care insurance policy as defined by division (D)(4) of section 3923.41 of the Revised Code, other than to a continuing care retirement community or other similar entity, the insurer shall make the offer required by division (A) of this section to each proposed certificate holder.

(C) The superintendent of insurance may adopt rules specifying the type of nonforfeiture benefits insurers may offer as part of long-term care insurance policies and certificates, the standards for nonforfeiture benefits, and the rules regarding contingent benefit upon lapse, including a determination of the specified period of time during which a contingent benefit upon lapse will be available and the substantial premium rate increase that triggers a contingent benefit upon lapse as described in division (A) of this section.

3923.443 TRAINING REQUIRED FOR AGENTS SELLING LONG-TERM CARE POLICIES.

EFFECTIVE: SEPTEMBER 29, 2013

(A)(1) No agent shall sell, solicit, or negotiate long-term care insurance on or after September 1, 2008, without completing an initial eight-hour partnership program training course as described in division (B) of this section.

(2)(a) Any agent that sells, solicits, or negotiates any long-term care insurance shall complete at least four hours of continuing education in every twenty-four-month period commencing on the first day of January of the year immediately following the year of the issuance of the agent's license.

(b) No agent shall fail to complete the continuing education requirements in division (A)(2)(a) of this section in the twenty-four-month period described in that division.

(B) The initial training course and continuing education required under division (A) of this section may be approved by the superintendent of insurance as continuing education courses under sections 3905.481 to 3905.486 of the Revised Code and shall consist of combined topics related to long-term care insurance, long-term care services, and state long-term care insurance partnership programs, including all of the following:

(1) State and federal regulations and requirements and the relationship between state long-term care insurance partnership programs and other public and private coverage of long-term care services, including medicaid;

(2) Available long-term care services and providers;

(3) Changes or improvements in long-term care services or providers;

(4) Alternatives to the purchase of private long-term care insurance;

(5) The effect of inflation on benefits and the importance of inflation protection;

(6) Consumer suitability standards and guidelines;

(7) Any other topics required by the superintendent.

(C) The initial training and continuing education required by division (A) of this section shall not include training that is specific to a particular insurer or company product or that includes any sales or marketing information, materials, or training other than those required by state or federal law.

(D) A resident agent shall satisfy the training and continuing education required by division (A) of this section by completing long-term care courses that are approved by the superintendent. A nonresident agent may satisfy the training and continuing education required by division (A) of this section by completing the training requirements in any other state, provided that the course is approved for credit by the insurance department of that state prior to the agent taking the course.

(E) Each insurer shall obtain records of the initial training and continuing education completed by agents of that insurer pursuant to division (A) of this section as well as the training completed by the insurer's agents concerning the distribution of the insurer's partnership program policies and shall make those records available to the superintendent upon request.

(F) Each insurer shall maintain records with respect to the training of its agents concerning the distribution of the insurer's partnership program policies. Each insurer shall provide documentation to the superintendent that will allow the superintendent to provide assurance to the medicaid director that agents have received the training required by this section and that agents have demonstrated an understanding of the partnership program policies and their relationship to public and private coverage of long-term care in this state, including medicaid. The superintendent may audit each insurer's records annually to verify that the insurer is maintaining the records required by this division. The superintendent shall make the records provided to the superintendent pursuant to division (E) of this section available to the director.

3923.444 COMPENSATION OF AGENTS SELLING LONG-TERM CARE POLICIES.

EFFECTIVE: SEPTEMBER 10, 2007

(A) No agent or third-party administrator shall field issue a long-term care insurance policy or certificate if the compensation to the agent or third-party administrator is not based on the number of policies or certificates issued.

(B) As used in this section, "field issue" means to issue a policy or certificate pursuant to the underwriting authority granted to an agent or third-party administrator by an insurer using the insurer's underwriting guidelines.

3923.45 FORMS.

EFFECTIVE: SEPTEMBER 14, 1988

The form of all long-term care insurance policies and applications shall be filed and approved in accordance with section 3923.02 of the Revised Code.

3923.46 RATES FOR INDIVIDUAL POLICY.

EFFECTIVE: SEPTEMBER 14, 1988

Premium rates for any individual policy of long-term care insurance shall be filed in accordance with section 3923.021 of the Revised Code.

3923.47 RULES. EFFECTIVE: SEPTEMBER 10, 2007

The superintendent of insurance shall, pursuant to Chapter 119. of the Revised Code, adopt rules to carry out the purposes of sections 3923.41 to 3923.48 of the Revised Code including rules related to the state long-term care partnership program.

3923.48 VIOLATION IS UNFAIR AND DECEPTIVE INSURANCE PRACTICE. EFFECTIVE: AUGUST 14, 1992

Any violation of sections 3923.44 to 3923.46 of the Revised Code is an unfair and deceptive insurance practice under sections 3901.19 to 3901.23 of the Revised Code.

OHIO ADMINISTRATIVE CODE SECTION 3901-4-01 LONG-TERM CARE INSURANCE

EFFECTIVE: NOVEMBER 15, 2018

(A) Purpose

The purpose of this rule is to implement sections 3923.41 to 3923.49 of the Revised Code to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance.

(B) Authority

This regulation is promulgated pursuant to the authority vested in the superintendent under sections 3901.041, 3923.44 and 3923.47 of the Revised Code.

(C) Applicability

Except as otherwise specifically provided, this rule applies to all long-term care insurance policies, including qualified long-term care contracts and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in this state on or after the effective date by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations.

Additionally, this rule is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if:

(1) The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;

(2) The disability income policy is advertised, marketed or offered as insurance for long-term care services; or

(3) Benefits under the policy may commence after the policyholder has reached social security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

(D) Definitions

For the purpose of this rule, the terms "long-term care insurance," "group long-term care insurance," "applicant," "policy" and "certificate" shall have the meanings set forth in section 3923.41 of the Revised Code. In addition, the following definitions apply.

(1) "Association" shall mean any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if such association:

(a) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

(b) Has been maintained in good faith for purposes other than obtaining insurance.

(2) "Exceptional increase" means:

(a) Only those increases filed by an insurer as exceptional for which the superintendent determines the need for the premium rate increase is justified:

(i) Due to changes in laws or regulations applicable to long-term care coverage in this state; or

(ii) Due to increased and unexpected utilization that affects the majority of insurers of similar products.

(b) Except as provided in paragraph (T) of this rule, exceptional increases are subject to the same requirements as other premium rate schedule increases.

(c) The superintendent may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.

(d) The superintendent, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

(3) "Incidental," as used in paragraph (T)(10) of this rule, means that the value of the long-term care benefits provided is less than ten per cent of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

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

(5) "Similar policy forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in section 3923.41 of the Revised Code are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

(E) Policy definitions

No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

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

(2) "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

(3) "Adult day care" means a program for six or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

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

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

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

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

(8) "Eating" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

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

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

(11) "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

(12) "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

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

(14) "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 must be delivered.

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

(16) "Transferring" means moving into or out of a bed, chair or wheelchair.

(17) All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "convalescent nursing home," "personal care facility," "specialized care providers," "assisted living facility" and "home care agency" shall be defined in relation to the 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 must 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 provider of services under another name.

(F) Policy practices and provisions

(1) Renewability. The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of paragraph (I) of this rule.

(a) A policy issued to an individual shall not contain renewal provisions other than "guaranteed renewable" or "noncancellable."

(b) The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(c) The term "noncancellable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

(d) The term "level premium" may only be used when the insurer does not have the right to change the premium.

(e) In addition to the other requirements of this paragraph, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

(2) Limitations and exclusions. A policy may not be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

(a) Preexisting conditions or diseases;

(b) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of alzheimer's disease;

(c) Alcoholism and drug addiction;

(d) Illness, treatment or medical condition arising out of:

(i) War or act of war (whether declared or undeclared);

(ii) Participation in a felony, riot or insurrection;

(iii) Service in the armed forces or units auxiliary thereto;

(iv) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or

(v) Aviation (this exclusion applies only to non-fare-paying passengers).

(e) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under medicare or other governmental program (except medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

(f) Expenses for services or items available or paid under another long-term care insurance or health insurance policy;

(g) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.

(h)

(i) This paragraph is not intended to prohibit exclusions and limitations by type of provider. However, no long term care issuer may deny a claim because services are provided in a state other then the state of policy issue under the following conditions:

(a) When the state other then 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; or

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

(ii) For purposes of this paragraph, "state of policy issue" means the state in which the individual policy or certificate was originally issued.

(i) This paragraph is not intended to prohibit territorial limitations.

(3) Extension of benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

(4) Continuation or conversion

(a) Group long-term care insurance issued in this state on or after the effective date of this paragraph shall provide covered individuals with a basis for continuation or conversion of coverage.

(b) For the purposes of this paragraph, 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 which 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 superintendent shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(c) For the purposes of this paragraph, a "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 which it replaced), for at least six 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.

(d) For the purposes of this paragraph, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the superintendent to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the superintendent, in making a determination as to the

substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(e) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

(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.

(g) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

(i) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(ii) The termination coverage is replaced not later than thirty-one days after termination, by group coverage effective on the day following the termination of coverage:

(a) Providing benefits identical to or benefits determined by the superintendent to be substantially equivalent to or in excess of those provided by the terminating coverage; and

(b) The premium for which is calculated in a manner consistent with the requirements of paragraph (F)(4)(f) of this rule.

(h) Notwithstanding any other provisions of this paragraph, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than one hundred per cent 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 which reflects the reduction in benefits payable.

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

(j) Notwithstanding any provision of this paragraph, 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.

(k) For the purposes of this paragraph a "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.

(5) Discontinuance and replacement

If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

(a) Shall not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

(b) Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

(6)

(a) The premium charged to an insured shall not increase due to either:

(i) The increasing age of the insured at ages beyond sixty-five; or

(ii) The duration the insured has been covered under the policy.

(b) The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under paragraph (AA) of this rule, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

(c) A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under paragraph (AA) of this rule, the initial annual premium shall be based on the reduced benefits.

(7) Electronic enrollment for group polices

(a) In the case of a group defined in division (D) of section 3923.41 of the Revised Code, any requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:

(i) The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

(ii) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and

(iii) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and "privileged information" as defined by division (U) of section 3904.01 of the Revised Code, is maintained.

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

(G) Unintentional lapse

Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

(1)

(a) Notice before lapse or termination. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person

other than myself to receive notice of lapse or termination of this long-term care insurance policy for non-payment of premium. I understand that notice will not be given until thirty days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

The insurer shall notify the insured of the right to change this written designation, no less often than once every two years.

(b) When the policyholder or certificateholder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in paragraph (G)(1)(a) of this rule need not be met until sixty days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

(c) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to paragraph (G)(1)(a) of this rule, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United Sates mail, postage prepaid; and notice may not be given until thirty days after a premium is due and unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.

(2) Reinstatement. In addition to the requirement in paragraph (G)(1) of this rule, a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

(H) Required disclosure provisions

(1) Renewability. Individual long-term care insurance policies shall contain a renewability provision.

(a) The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or noncancellable. This provision shall not apply to policies that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

(b) A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

(2) Riders and endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider or endorsement.

(3) Payment of benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of these terms and an explanation of the terms in its accompanying outline of coverage.

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

(5) Other limitations or conditions on eligibility for benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in divisions (E)(2) and (F) of section 3923.44 of the Revised Code shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

(6) Disclosure of tax consequences. 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 shall not apply to qualified long-term care insurance contracts.

(7) Benefit triggers. Activities of daily living and cognitive impairment shall be used to measure an insured's need for long term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this section. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

(8) A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in paragraph (DD)(5) of this rule that the policy is intended to be a qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended.

(9) A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in paragraph (DD)(5) of this rule that the policy is not intended to be a qualified long-term care insurance contract.

(I) Required disclosure of rating practices to consumers

(1) This paragraph shall apply as follows:

(a) Except as provided in paragraph (I)(1)(b) of this rule, this paragraph applies to any long-term care policy or certificate issued in this state on or after one hundred eighty days after the effective date of this rule.

(b) For certificates issued on or after the effective date of this amended rule under a group long-term care insurance policy as defined in division (D) of section 3923.41 of the Revised Code, which policy was in force at the time this amended rule became effective, the provisions of this paragraph shall apply on the policy anniversary following three hundred sixty-five days after the effective date of this rule.

(2) Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this paragraph to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this paragraph to the applicant no later than at the time of delivery of the policy or certificate.

(a) A statement that the policy may be subject to rate increases in the future;

(b) An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision;

(c) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(d) A general explanation for applying premium rate or rate schedule adjustments that shall include:

(i) A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and

(ii) The right to a revised premium rate or rate schedule as provided in paragraph (I)(2) of this rule if the premium rate or rate schedule is changed;

(e)

(i) Information regarding each premium rate increase on this policy form or similar policy forms over the past ten years for this state or any other state that, at a minimum identifies:

(a) The policy forms for which premium rates have been increased;

(b) The calendar years when the form was available for purchase; and

(c) The amount or per cent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(ii) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

(iii) An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

(iv) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this paragraph or the end of a twenty-four-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with paragraph (I)(2)(e)(i) of this rule.

(v) If the acquiring insurer in paragraph (I)(2)(e)(iv) of this rule files for a subsequent rate increase, even within the twenty-four-month period, on the same policy form acquired from nonaffiliated insurers or block policy forms acquired from nonaffiliated insurers referenced in paragraph (I)(2)(e)(iv) of this rule, the acquiring insurer shall make all disclosures required by paragraph (I)(2) of this rule, including disclosure of the earlier rate increase referenced in paragraph (I)(2)(e)(iv) of this rule.

(3) An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under paragraphs (I)(2)(a) and (I)(2)(e) of this rule. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

(4) An insurer shall use the forms in appendices B and F to this rule to comply with the requirements of paragraphs (I)(1) and (I)(2) of this rule.

(5) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least forty-five days prior to the implementation of the premium rate schedule

increase by the insurer. The notice shall include the information required by paragraph (I)(2) of this rule when the rate increase is implemented.

(J) Initial filing requirements

(1) This paragraph applies to any long-term care policy issued in this state on or after one hundred eighty days after the effective date of this rule.

(2) An insurer shall provide the information listed in this paragraph to the superintendent thirty days prior to making a long-term care insurance form available for sale.

(a) A copy of the disclosure documents required in paragraph (I) of this rule; and

(b) An actuarial certification consisting of at least the following:

(i) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(ii) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(iii) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(iv) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

(a) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(b) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(c) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and

(d) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur;

(i) An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;

(ii) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the superintendent may request a demonstration under paragraph (J)(3) of this rule based on a standard age distribution; and

(v)

(a) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(b) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

(3)

(a) The superintendent may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

(b) In the event the superintendent asks for additional information under this provision, the period in paragraph (J)(2) of this rule does not include the period during which the insurer is preparing the requested information.

(K) Prohibition against post-claims underwriting

(1) All applications for long-term care insurance policies or certificates except those that are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(2)

(a) If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

(b) 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 policy or certificate shall not be rescinded for that condition.

(3) Except for policies or certificates which are guaranteed issue:

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

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

(b) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

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

(c) Prior to issuance of a long-term care policy or certificate to an applicant age eighty or older, the insurer shall obtain one of the following:

(i) A report of a physical examination;

(ii) An assessment of functional capacity;

(iii) An attending physician's statement; or

(iv) Copies of medical records.

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

(5) 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 superintendent in the format prescribed by the national association of insurance commissioners in appendix A to this rule.

(L) Minimum standards for home health and community care benefits in long-term care insurance policies

(1) A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits:

(a) By requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;

(b) By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before home health care services are covered;

(c) By limiting eligible services to services provided by registered nurses or licensed practical nurses;

(d) By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

(e) By excluding coverage for personal care services provided by a home health aide;

(f) By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

(g) By requiring that the insured or claimant have an acute condition before home health care services are covered;

(h) By limiting benefits to services provided by medicare-certified agencies or providers; or

(i) By excluding coverage for adult day care services.

(2) A long-term care insurance policy or certificate, if it provides for home health or community care services, 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 shall not apply to policies or certificates issued to residents of continuing care retirement communities.

(3) Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

(M) Requirement to offer inflation protection

(1) No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at

the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(a) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five per cent;

(b) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five per cent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

(c) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(2) Where the policy is issued to a group, the required offer in paragraph (M)(1) of this rule shall be made to the group policyholder; except, if the policy is issued to a group defined in division (D) of section 3923.41 of the Revised Code other than an employer, labor organization or trust established by one or more employers or labor organizations or a combination thereof, or an association group, and the group is not a continuing care retirement community, the offering shall be made to each proposed certificateholder.

(3) The offer in paragraph (M)(1) of this rule shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

(4)

(a) Insurers shall include the following information in or with the outline of coverage:

(i) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty-year period.

(ii) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(b) An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

(5) Inflation protection benefit increases under a policy which contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

(6) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(7)

(a) Inflation protection as provided in paragraph (M)(1)(a) of this rule shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this paragraph. The rejection may be either in the application or a on a separate form.

(b) The rejection shall be considered a part of the application and shall state:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed plans _____, and I reject inflation protection.

(N) Requirements for application forms and replacement coverage

(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 questions may be used. With regard to a replacement policy issued to a group defined by division (D) of section 3923.41 of the Revised Code, the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement.

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

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

(i) If so, with which company?

(ii) If that policy lapsed, when did it lapse?

(c) Are you covered by medicaid?

(d) 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.

(a) List policies sold that are still in force.

(b) List policies sold in the past five years that are no longer in force.

(3) Solicitations other than direct response. Upon determining that a sale will involve replacement, an insurer; other than an insurer using direct response solicitation methods, or its agent; shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided as shown in appendix I to this rule.

(4) Direct response solicitations. 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 as shown in appendix I to this rule.

(5) Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Notice shall be made within five 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 paragraph 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 rule 3901-6-05 of the Administrative Code. 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.

(O) Reporting requirements

(1) Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a per cent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a per cent of the agent's total annual sales.

(2) Every insurer shall report annually by June thirtieth the ten per cent of its agents with the greatest percentages of lapses and replacements as measured by paragraph (O)(1) of this rule (appendix G to this rule).

(3) 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 agent activities regarding the sale of long-term care insurance.

(4) Every insurer shall report annually by June thirtieth the number of lapsed policies as a per cent of its total annual sales and as a per cent of its total number of policies in force as of the end of the preceding calendar year (appendix G to this rule).

(5) Every insurer shall report annually by June thirtieth the number of replacement policies sold as a per cent of its total annual sales and as a per cent of its total number of policies in force as of the preceding calendar year (appendix G to this rule).

(6) Every insurer shall report annually by June thirtieth, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied (appendix E to this rule).

(7) For purposes of this paragraph:

(a) "Policy" means only long-term care insurance;

(b) Subject to paragraph (O)(7)(c) of this rule, "claim" means a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

(c) "Denied" means the insurer refused to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

(d) "Report" means on a statewide basis.

(8) Reports required under this paragraph shall be filed with the superintendent.

(P) Licensing

A producer is not authorized to sell, solicit or negotiate with respect to long-term care insurance except as authorized by Chapter 3905. of the Revised Code.

(Q) Discretionary powers of superintendent

The superintendent may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this regulation with respect to a specific long-term care insurance policy or certificate upon a written finding that:

(1) The modification or suspension would be in the best interest of the insureds;

(2) The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

(3)

(a) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or

(b) The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

(c) The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

(R) Reserve standards

(1) When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with division (D)(7) of section 3903.72 of the Revised Code. Claim reserves shall also be established in the case when the policy or rider is in claim status.

Reserves for policies and riders subject to this paragraph should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

In the development and calculation of reserves for policies and riders subject to this paragraph, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following;

(a) Definition of insured events;

(b) Covered long-term care facilities;

(c) Existence of home convalescence care coverage;

(d) Definition of facilities;

(e) Existence or absence of barriers to eligibility;

(f) Premium waiver provision;

(g) Renewability;

(h) Ability to raise premiums;

(i) Marketing method;

(j) Underwriting procedures;

(k) Claims adjustment procedures;

(l) Waiting period;

(m) Maximum benefit;

(n) Availability of eligible facilities;

(o) Margins in claim costs;

(p) Optional nature of benefit;

(q) Delay in eligibility for benefit;

(r) Inflation protection provisions; and

(s) Guaranteed insurability option.

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

(2) When long-term care benefits are provided other than as in paragraph (R)(1) of this rule, reserves shall be determined in accordance with rule 3901-3-13 of the Administrative Code.

(S) Loss ratio

(1) This paragraph shall apply to all long-term care insurance policies or certificates except those covered under paragraphs (J) and (T) of this rule.

(2) Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty per cent, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

(a) Statistical credibility of incurred claims experience and earned premiums;

(b) The period for which rates are computed to provide coverage;

(c) Experienced and projected trends;

(d) Concentration of experience within early policy duration;

(e) Expected claim fluctuation;

(f) Experience refunds, adjustments or dividends;

(g) Renewability features;

(h) All appropriate expense factors;

(i) Interest;

(j) Experimental nature of the coverage;

(k) Policy reserves;

(l) Mix of business by risk classification; and

(m) Product features such as long elimination periods, high deductibles and high maximum limits.

(3) Paragraph (S)(2) of this rule shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

(a) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(b) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of sections 3915.071 and 3915.072 of the Revised Code;

(c) The policy meets the disclosure requirements of divisions (K), (L), and (M) of section 3923.44 of the Revised Code.

(d) Any policy illustration that meets the applicable requirements of the rule 3901-6-04 of the Administrative Code; and

(e) An actuarial memorandum is filed with the insurance department that includes:

(i) A description of the basis on which the long-term care rates were determined;

(ii) A description of the basis for the reserves;

(iii) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(iv) A description and a table of each actuarial assumption used. For expenses, an insurer must include per cent of premium dollars per policy and dollars per unit of benefits, if any;

(v) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(vi) The estimated average annual premium per policy and the average issue age;

(vii) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(viii) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

(T) Premium rate schedule increases

(1) This paragraph shall apply as follows:

(a) Except as provided in paragraph (T)(1)(b) of this rule, this paragraph applies to any long-term care policy or certificate issued in this state on or after one hundred eighty days after the effective date of this rule.

(b) For certificates issued on or after the effective date of this amended rule under a group long-term care insurance policy as defined in division (D) of section 3923.41 of the Revised Code, which policy was in force at the time this amended rule became effective, the provisions of this paragraph shall apply on the policy anniversary following three hundred sixty-five days after the effective date of this rule.

(2) An insurer shall provide notice of a pending premium rate schedule increase for a group long-term care policy, including an exceptional increase, to the superintendent at least thirty days prior to the notice to the policyholders. An insurer shall request approval of a pending premium rate schedule increase for an individual long-term care policy, including an exceptional increase, from the superintendent at least thirty days prior to the notice to the policyholders. The notice or request for approval shall include:

(a) Information required by paragraph (I) of this rule;

(b) Certification by a qualified actuary that:

(i) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

(ii) The premium rate filing is in compliance with the provisions of this paragraph;

(c) An actuarial memorandum justifying the rate schedule change request that includes:

(i) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

(a) Annual values for the five years preceding and the three years following the valuation date shall be provided separately;

(b) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(c) The projections shall demonstrate compliance with paragraph (T)(3) of this rule; and

(d) For exceptional increases,

(i) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(ii) In the event the superintendent determines as provided in paragraph (D)(2)(d) of this rule that offsets may exist, the insurer shall use appropriate net projected experience;

(ii) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(iii) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

(iv) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

(v) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates;

(d) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the superintendent; and

(e) Sufficient information for review and approval of the premium rate schedule increase by the superintendent.

(3) All premium rate schedule increases shall be determined in accordance with the following requirements:

(a) Exceptional increases shall provide that seventy per cent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(b) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(i) The accumulated value of the initial earned premium times fifty-eight per cent;

(ii) Eighty-five per cent of the accumulated value of prior premium rate schedule increases on an earned basis;

(iii) The present value of future projected initial earned premiums times fifty-eight per cent; and

(iv) Eighty-five per cent of the present value of future projected premiums not in paragraph (T)(3)(c) of this rule on an earned basis;

(c) In the event that a policy form has both exceptional and other increases, the values in paragraphs (T)(3)(b)(ii) and (T)(3)(b)(iv) of this rule will also include seventy per cent for exceptional rate increase amounts; and

(d) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in rule 3901-3-13 of the Administrative Code. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

(4) For each rate increase that is implemented, the insurer shall file with the superintendent updated projections, as defined in paragraph (T)(2)(c)(i) of this rule, annually for the next three years and include a comparison of actual results to projected values. The superintendent may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in paragraph (T)(11) of this rule, the projections required by this paragraph shall be provided to the policyholder in lieu of filing with the superintendent.

(5) If any premium rate in the revised premium rate schedule is greater than two hundred per cent of the comparable rate in the initial premium schedule, lifetime projections, as defined in paragraph (T)(2)(c)(i) of this rule, shall be filed with the superintendent every five years following the end of the required period in paragraph (T)(4) of this rule. For group insurance policies that meet the conditions in paragraph (T)(11) of this rule, the projections required by this paragraph shall be provided to the policyholder in lieu of filing with the superintendent.

(6)

(a) If the superintendent has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in paragraph (T)(3) of this rule, the superintendent may require the insurer to implement any of the following:

(i) Premium rate schedule adjustments; or

(ii) Other measures to reduce the difference between the projected and actual experience.

(b) In determining whether the actual experience adequately matches the projected experience, consideration should be given to paragraph (T)(2)(c)(v) of this rule, if applicable.

(7) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(a) A plan, subject to superintendent approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the superintendent may impose the condition in paragraph (T)(8) of this rule; and

(b) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to paragraph (T)(3) of this rule had the greater of the original anticipated lifetime loss ratio or fifty-eight per cent been used in the calculations described in paragraphs (T)(3)(a) and (T)(3)(c) of this rule.

(8)

(a) For a rate increase filing that meets the following criteria, the superintendent shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(i) The rate increase is not the first rate increase requested for the specific policy form or forms;

(ii) The rate increase is not an exceptional increase; and

(iii) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(b) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the superintendent may determine that a rate spiral exists. Following the determination that a rate spiral exists, the superintendent may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(i) The offer shall:

(a) Be subject to the approval of the superintendent;

(b) Be based on actuarially sound principles, but not be based on attained age; and

(c) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

(ii) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

(a) The maximum rate increase determined based on the combined experience; and

(b) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten per cent.

(9) If the superintendent determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the superintendent may, in addition to the provisions of paragraph (T)(8) of this rule, prohibit the insurer from either of the following:

(a) Filing and marketing comparable coverage for a period of up to five years; or

(b) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

(10) Paragraphs (T)(1) to (T)(9) of this rule shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in paragraph (D)(3) of this rule, if the policy complies with all of the following provisions:

(a) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(b) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

(i) Sections 3915.071 and 3915.072 of the Revised Code, and

(ii) Section 3915.073 of the Revised Code;

(c) The policy meets the disclosure requirements of divisions (K), (L), and (M) of section 3923.44 of the Revised Code;

(d) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

(i) Policy illustrations as required by rule 3901-6-04 of the Administrative Code;

(e) An actuarial memorandum is filed with the insurance department that includes:

(i) A description of the basis on which the long-term care rates were determined;

(ii) A description of the basis for the reserves;

(iii) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(iv) A description and a table of each actuarial assumption used. For expenses, an insurer must include per cent of premium dollars per policy and dollars per unit of benefits, if any;

(v) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(vi) The estimated average annual premium per policy and the average issue age;

(vii) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting.

Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(viii) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

(11) Paragraphs (T)(6) and (T)(8) of this rule shall not apply to group insurance policies as defined in division (D) of section 3923.41 of the Revised Code, which are issued to an employer, labor organization or trust established by one or more employers or labor organizations or a combination thereof where:

(a) The policies insure two hundred fifty or more persons and the policyholder has five thousand or more eligible employees of a single employer; or

(b) The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than twenty per cent of the total premium for the group in the calendar year prior to the year a rate increase is filed.

(U) Filing requirements for advertising

(1) 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 intended for use in this state whether through written, radio or television medium to the superintendent of insurance of this state for review or approval by the superintendent to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer, health care service plan or other entity for at least three years from the date the advertisement was first used.

(2) The superintendent may exempt from these requirements any advertising form or material when, in the superintendent's opinion, this requirement may not be reasonably applied.

(V) Standards for marketing

(1) Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

(a) Establish marketing procedures and agent training requirements to assure that:

(i) Any marketing activities, including any comparison of policies, by its agents or other producers will be fair and accurate; and

(ii) Excessive insurance is not sold or issued.

(b) Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following:

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

(c) Provide copies of the disclosure forms required in paragraph (I)(3) of this rule (appendices B and F to this rule) to the applicant.

(d) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance, except that in the case of qualified long-term care insurance contracts, an

inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required.

(e) Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this paragraph (V)(1) of this rule.

(f) If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the superintendent, 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.

(g) For long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to paragraph (F)(1)(c) of this rule.

(h) Provide an explanation of contingent benefit upon lapse provided for in paragraph (AA)(4)(c) of this rule and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in paragraph (AA)(4)(d) of this rule.

(2) In addition to the practices prohibited in sections 3901.20 and 3901.21 of the Revised Code, the following acts and practices are prohibited:

(a) 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.

(b) 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.

(c) 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.

(d) Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

(3)

(a) With respect to the obligations set forth in this paragraph, the primary responsibility of an association, as defined in paragraph (D)(1) of this rule, 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.

(b) The insurer shall file with the insurance department the following material:

(i) The policy and certificate,

(ii) A corresponding outline of coverage, and

(iii) All advertisements requested by the insurance department.

(c) The association shall disclose in any long-term care insurance solicitation:

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

(ii) A brief description of the process under which the policies and the insurer issuing the policies were selected.

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

(e) 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.

(f) The association shall also:

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

(ii) Actively monitor the marketing efforts of the insurer and its agents; and

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

(iv) Paragraphs (V)(3)(f)(i) to (V)(3)(f)(iii) of this rule shall not apply to qualified long-term care insurance contracts.

(g) No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the state insurance department the information required in this paragraph.

(h) The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this paragraph.

(i) Failure to comply with the filing and certification requirements of this paragraph constitutes an unfair trade practice.

(W) Suitability

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

(2) Every insurer, health care service plan or other entity marketing long-term care insurance (the "issuer") shall:

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

(b) Train its agents in the use of its suitability standards; and

(c) Maintain a copy of its suitability standards and make them available for inspection upon request by the superintendent.

(3)

(a) To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take the following into consideration:

(i) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(ii) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

(iii) The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

(b) The issuer, and where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in paragraph (W)(3)(a) of this rule. The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in appendix B to this rule, in not less than twelve point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the superintendent.

(c) A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

(d) The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet in appendix B to this rule is prohibited.

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

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

(6) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in appendix C to this rule, in not less than twelve point type.

(7) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to appendix D to this rule. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

(8) The issuer shall report annually to the superintendent the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards and the number of those who chose to confirm after receiving a suitability letter.

(X) Prohibition against preexisting conditions and probationary periods in replacement policies or certificates

If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

(Y) Availability of new services or providers

(1) An insurer shall notify policyholders of the availability of a new long-term care policy series that providers coverage of 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 three hundred sixty-five days of the date the new policy series is made available for sale in this state.

(2) Notwithstanding paragraph (Y)(1) of this rule, notification is not required for any policy issued prior to the effective date of this rule or to any policyholder or certificateholder who is currently eligible for benefits, within an elimination period or on a claim, or who previously has been in claim status, 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.

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

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

(b) 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;

(c) 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; or

(d) By an alternative program developed by the insurer that meets the intent of paragraph (Y) of this rule if the program is filed with and approved by the superintendent.

(4) 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.

(5) Policies issued pursuant to this paragraph shall be considered exchanges and not replacements. These exchanges shall not be subject to paragraphs (N) and (W) of this rule, and the reporting requirements of paragraphs (O)(1) to (O)(5) of this rule.

(6) Where the policy is offered through an employer, labor organization, professional, trade or occupational association, the required notification in paragraph (Y)(1) of this rule shall be made to the offering entity. However, if the policy is issued to a group defined in division (D)(4) of section 3923.41 of the Revised Code, the notification shall be made to each certificateholder.

(7) Nothing in this paragraph 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 currently 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.

(8) Paragraph (Y) of this rule does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(9) Paragraph (Y) of this rule shall become effective on or after three hundred sixty-five days after the effective date of this rule.

(Z) Right to reduce coverage and lower premiums

(1)

(a) 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;

(i) Reducing the maximum benefit; or

(ii) Reducing the daily, weekly or monthly benefit amount.

(b) The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier's administrative processes. An example of a policy design would be a partnership policy which maintains its partnership status by containing certain features as required by state or federal law.

(2) 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.

(3) The age to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force.

(4) 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.

(5) If a policy or certificate is about 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 paragraph (G)(1)(c) of this rule.

(6) Paragraph (Z) of this rule does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(7) The requirements of paragraph (Z) of this rule shall apply to any long-term care policy issued in this state on or after three hundred sixty-five days after the effective date of this rule.

(AA) Nonforfeiture benefit requirement

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

(2) A nonforfeiture benefit shall be offered that complies with the following:

(a) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in paragraph (AA)(5) of this rule; and

(b) The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

(3) If the offer is rejected, the insurer shall provide the contingent benefit upon lapse described in this paragraph. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit upon lapse in paragraph (AA)(4)(d) of this rule shall still apply.

(4)

(a) After rejection of the offer, for individual and group policies without nonforfeiture benefits issued after the effective date of this paragraph, the insurer shall provide a contingent benefit upon lapse.

(b) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(c) A contingent benefit upon lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below stated on the insured's issue age, and the policy or certificate lapses within one hundred twenty days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty days prior to the due date of the premium reflecting the rate increase.

TRIGGERS FOR A SUBSTANTIAL PREMIUM INCREASE

Issue age	Per cent 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%

(d) A contingent benefit upon 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 below based on the insured's issue age, the policy or certificate lapses within one hundred twenty days of the due date of the premium so increased, and the ratio in paragraph (AA)(4)(f)(ii) of this rule is forty per cent or more. Unless otherwise required, policyholders shall be notified at least thirty days prior to the due date of the premium reflecting the rate increase.

Issue Age	Per cent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

This provision shall be in addition to the contingent benefit provided by paragraph (AA)(4)(c) of this rule and where both are triggered, the benefit provided shall be at the option of the insured.

(e) On or before the effective date of a substantial premium increase as defined in paragraph (AA)(4)(c) of this rule, the insurer shall:

(i) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(ii) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of paragraph (AA)(5) of this rule. This option may be elected at any time during the one hundred twenty-day period referenced in paragraph (AA)(4)(c) of this rule; and

(iii) Notify the policyholder or certificateholder that a default or lapse at any time during the one hundred twenty-day period referenced in paragraph (AA)(4)(c) of this rule shall be deemed to be the election of the offer to convert in paragraph (AA)(4)(e)(ii) of this rule unless the automatic option in paragraph (AA)(4)(f)(iii) of this rule applies.

(f) On or before the effective date of a substantial premium increase as defined in paragraph (AA)(4)(d) of this rule, the insurer shall:

(i) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(ii) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety per cent 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 one hundred twenty-day period referenced in paragraph (AA)(4)(d) of this rule; and

(iii) Notify the policyholder or certificateholder that a default or lapse at any time during the one hundred twenty-day period referenced in paragraph (AA)(4)(d) of this rule shall be deemed to be the election of the offer to convert in paragraph (AA)(4)(f)(ii) of this rule if the ratio is forty per cent or more.

(5) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with paragraph (AA)(4)(c) but not paragraph (AA)(4)(d) of this rule, are described in this paragraph:

(a) For purposes of paragraph (AA)(5)(a) of this rule, attained age rating is defined as a schedule of premiums starting from the issue date which increases with age at least one per cent per year prior to age fifty, and at least three per cent per year beyond age fifty.

(b) For purposes of this paragraph, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in paragraph (AA)(5)(c) of this rule.

(c) The standard nonforfeiture credit will be equal to one hundred per cent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty 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 paragraph (AA)(6) of this rule.

(d)

(i) 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 three years as well as thereafter.

(ii) Notwithstanding paragraph (AA)(5)(d)(i) of this rule, for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

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

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

(e) 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.

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

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

(8) The requirements set forth in this paragraph shall become effective three hundred sixty-five days after the effective date of this provision and shall apply as follows:

(a) Except as provided in paragraphs (AA)(8)(b) and (AA)(8)(c) of this rule, the provisions of paragraph (AA) of this rule apply to any long-term care policy issued in this state on or after the effective date of this rule.

(b) For certificates issued on or after the effective date of paragraph (AA) of this rule, under a group long-term care insurance policy as defined in division (D) of section 3923.41 of the Revised Code, which policy was in force at the time this amended rule becomes effective, the provisions of paragraph (AA) of this rule shall not apply.

(c) The last sentence in paragraph (AA)(3) and paragraphs (AA)(4)(d) and (AA)(4)(f) of this rule shall apply to any long-term care insurance policy or certificate issued in this state after one hundred eighty days after the effective date of this rule adopting those provisions, except new certificates on a group policy as defined in division (D)(1) of section 3923.41 of the Revised Code, three hundred sixty-five days after the effective date of this rule adopting those provisions.

(9) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit upon lapse shall be subject to the loss ratio requirements of paragraph (S) or (T) of this rule, whichever is applicable, treating the policy as a whole.

(10) To determine whether contingent nonforfeiture upon lapse provisions are triggered under paragraph (AA)(4)(c) or (AA)(4)(d) of this rule, a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

(11) A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

(a) The nonforfeiture provision shall be appropriately captioned;

(b) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying contracts approved by the superintendent for the same contract form; and

(c) The nonforfeiture provision shall provide at least one of the following:

(i) Reduced paid-up insurance;

(ii) Extended term insurance;

(iii) Shortened benefit period; or

(iv) Other similar offerings approved by the superintendent.

(BB) Standards for benefit triggers

(1) A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

(2)

(a) Activities of daily living shall include at least the following as defined in paragraph (E) of this rule and in the policy:

(i) Bathing;

(ii) Continence;

(iii) Dressing;

(iv) Eating;

(v) Toileting; and

(vi) Transferring;

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

(3) An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in paragraphs (BB)(1) and (BB)(2) of this rule.

(4) For purposes of this paragraph the determination of a deficiency shall not be more restrictive than:

(a) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

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

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

(6) Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

(7) The requirements set forth in this paragraph shall be effective three hundred sixty-five days after the effective date of this provision and shall apply as follows:

(a) Except as provided in paragraph (BB)(7)(b) of this rule, the provisions of this paragraph apply to a long-term care policy issued in this state on or after the effective date of this amended rule.

(b) For certificates issued on or after the effective date of paragraph (BB)(7) of this rule, under a group long-term care insurance policy as defined in division (D) of section 3923.41 of the Revised Code that was in force at the time this amended rule became effective, the provisions of this paragraph shall not apply.

(CC) Additional standards for benefit triggers for qualified long-term care insurance contracts.

(1) For purposes of this paragraph the following definitions apply:

(a) "Qualified long-term care services" means services that meet the requirements of section 7702B(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(b)

(i) "Chronically ill individual" has the meaning prescribed for this term by section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

(a) Being unable to perform (without substantial assistance from another individual) at least two activities of daily living for a period of at least ninety days due to a loss of functional capacity; or

(b) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

(ii) The term "chronically ill individual" shall not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner has certified that the individual meets these requirements.

(c) "Licensed health care practitioner" means a physician, as defined in section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the secretary of the treasury.

(d) "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

(2) A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(3) A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least ninety days due to a loss of functional capacity or to severe cognitive impairment.

(4) Certifications regarding activities of daily living and cognitive impairment required pursuant to paragraph (CC)(3) of this rule shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the secretary of the treasury.

(5) Certifications required pursuant to paragraph (CC)(3) of this rule may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least ninety days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety-day period.

(6) Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

(DD) Standard format outline of coverage

This paragraph of the rule implements, interprets and makes specific, the provisions of division (I) of section 3923.44 of the Revised Code in prescribing a standard format and the content of an outline of coverage.

(1) The outline of coverage shall be a free-standing document, using no smaller than twelve-point type.

(2) The outline of coverage shall contain no material of an advertising nature.

(3) Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

(4) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

(5) Format for outline of coverage is shown in appendix H to this rule.

(EE) Requirement to deliver shopper's guide

(1) A long-term care insurance shopper's guide in the format developed by the national association of insurance commissioners, or a guide developed or approved by the superintendent, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

(a) In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

(b) In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

(2) Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-reference guide, but shall furnish the policy summary required under division (K) of section 3923.44 of the Revised Code.

(FF) Penalties

In addition to any other penalties provided by the laws of this state any insurer and any agent found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three times the amount of any commissions paid for each policy involved in the violation or up to ten thousand dollars, whichever is greater.

(GG) Severability

If any paragraph, term or provision of this rule is adjudged invalid for any reason, the judgment shall not affect, impair or invalidate any other paragraph, term or provision of this rule, but the remaining paragraphs, terms and provisions shall be and continue in full force and effect.

APPENDIX A

APPENDIX B

APPENDIX C

APPENDIX D

APPENDIX E

APPENDIX F

APPENDIX G

APPENDIX H

APPENDIX I

Authorized By: 3901.041, 3923.44, 3923.47
Amplifies: 3923.41 to 3923.49
Five Year Review Date: 7/15/2024
Prior Effective Dates: 1/1/1994, 10/1/1997, 8/12/2002, 11/14/2008

OHIO ADMINISTRATIVE CODE SECTION 3901-4-02 LONG-TERM CARE PARTNERSHIP PROGRAM

EFFECTIVE: NOVEMBER 14, 2021

(A) Purpose

The purpose of this rule is to implement a state long-term care partnership program in Ohio in accordance with sections 3923.41 to 3923.49 and 5164.86 of the Revised Code.

(B) Authority

This rule is promulgated pursuant to the authority vested in the superintendent under sections 3901.041, 3923.44, and 3923.47 of the Revised Code.

(C) Applicability

This rule applies to long-term care insurance that is intended to qualify under the state's long-term care partnership program.

(D) Definitions

For purposes of this rule, the definitions set forth in section 3923.41 of the Revised Code and in rule 3901-4-01 of the Administrative Code shall have the same meaning as if such definitions were fully set forth herein. The term "policy" shall also include a certificate issued as evidence of coverage under a group insurance policy.

(E) Offers of exchange

(1) Within one hundred eighty days of the date that an insurer begins to advertise, market, offer, sell or issue policies that qualify under the state long-term care partnership program, the insurer shall offer, on a one time basis, in writing, to all existing policyholders and certificate holders that were issued long-term care coverage by the insurer on or after August 12, 2002, the option to exchange their existing long-term care coverage for coverage that is intended to qualify under the state's long-term care partnership program (partnership plan). The written offer of exchange may be in electronic or paper copy form and shall include a long-term care partnership program exchange notification, appendix A to this rule, or a form that is substantially similar in content.

(2) An exchange occurs when an insurer offers a policyholder or certificate holder (hereinafter "insured") the option to replace an existing long-term care insurance policy with a policy that qualifies as a partnership plan, and the insured accepts the offer to terminate the existing policy and accepts the new policy. In making an offer to exchange, an insurer shall comply with all of the following requirements:

(a) The offer shall be made on a nondiscriminatory basis without regard to the age or health status of the insured;

(b) The offer shall remain open for a minimum of ninety days from the date of electronic transmission or paper copy mailing by the insurer;

(c) At the time the offer is made, the insurer shall provide the insured a copy of appendix A to this rule or a form that is substantially similar in content; and

(d) The offer and the materials required in paragraph (E)(2)(c) of this rule shall be accessible to insureds in paper copy form upon request.

(3) Notwithstanding paragraphs (E)(1) and (E)(2) of this rule,

(a) An offer to exchange may be deferred for any insured who is currently eligible for benefits under an existing policy or who is subject to an elimination period on a claim, but such deferral shall continue only as long as such eligibility or elimination period exists; and

(b) An offer to exchange does not have to be made if the insured would be required to purchase additional benefits to qualify for the state long-term care partnership program and the insured is not eligible to purchase the additional benefits under the insurers new business, long-term care, underwriting guidelines.

(4) If the new policy has an actuarial value of benefits equal to or lesser than the actuarial value of benefits of the existing policy, then all of the following apply:

(a) The new policy shall not be underwritten; and

(b) The rate 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.

(5) If the new policy has an actuarial value of benefits exceeding the actuarial value of the benefits of the existing policy, then all of the following apply:

(a) The insurer shall apply its new business, long-term care, underwriting guidelines to the increased benefits only; and

(b) The rate charged for the new policy shall be determined using the method set forth in paragraph (E)(4)(b) of this rule for the existing benefits, increased by the rate for the increased benefits using the then current attained age and risk class of the insured for the increased benefits only.

(6)

(a) The new policy offered in an exchange shall be on a form that is currently offered for sale by the insurer in the general market and the effective date of the partnership plan policy shall be the same as the new policy.

(b) For purposes of implementing the exchange requirement set forth in paragraph (E)(1) of this rule, an insurer may also implement exchanges via any policy form that the superintendent has approved as being partnership-qualified, even if that long-term care insurance policy form is no longer offered or marketed. The superintendent may, at the superintendent's sole discretion, extend the one hundred eighty day time period referenced in paragraph (E)(1) of this rule to allow for implementation of exchanges on a long-term care insurance policy form no longer offered or marketed.

(7) In the event of an exchange, the insured shall not lose any rights, benefits or built-up value that has accrued under the original policy with respect to the benefits provided 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.

(8) Insurers may complete an exchange by: issuing a new policy; amending an existing policy with an endorsement or rider; or revising the schedule of benefits.

(9) The requirements of rule 3901-4-01 of the Administrative Code shall apply to exchanges including, but not limited to, the requirements relating to suitability. However, policies issued pursuant to this rule shall not be considered replacements if issued by the same insurer that issued the existing policy and shall therefore not be subject to paragraphs (N) and (O) in rule 3901-4-01 of the Administrative Code replacement standards.

(10) The offer of exchange required by paragraph (E) of this rule only applies to products issued by an insurer that are comparable to the types of policy forms (e.g. group policies or individual policies) offered by the insurer which are qualified as partnership plans. For example, if an insurer offers a comprehensive individual long-term care insurance policy qualified as a partnership plan, it is only required to offer exchanges to comprehensive individual

long-term care insurance policyholders who were issued coverage on or after August 12, 2002. In this example, since only an individual policy is qualified as a partnership plan, exchange offers would not be required to be made to group certificate holders under a group policy.

(11) For those insureds with long-term care insurance policies issued before August 12, 2002, any insurer may offer any insured an option to exchange an existing policy for a policy that qualifies as a state long-term care insurance partnership plan. The requirements set forth in paragraphs (E)(2) to (E)(9) of this rule shall apply to any such exchange.

(F) Filing requirements for long-term care insurance partnership program policies.

(1) Any policy that is intended to qualify as a partnership plan must be filed with the superintendent in accordance with section 3923.02 of the Revised Code prior to use, and such filing shall include the partnership program certification form attached as appendix B to this rule, signed by an officer of the company.

(2) Insurers intending to make use of a previously filed qualifying partnership policy shall submit to the superintendent a partnership program certification form (appendix B to this rule) signed by an officer of the company with respect to each such policy form filed. For each policy form, the partnership program certification form (appendix B to this rule) shall identify the policy by the original form number and filing date.

(3) If an insurer intends to amend a previously filed policy with an endorsement or rider in order to bring the policy into compliance with the partnership program, the insurer shall file the endorsement or rider with the superintendent prior to use, and the filing shall include a partnership program certification form (appendix B to this rule) signed by an officer of the company for each policy to be amended by the endorsement or rider, which shall include the original form number and filing date of the previously filed policy.

(4) Insurers using appendix A or appendix C to this rule do not have to file the forms with the superintendent before use. However, if the insurer modifies the content of appendix A or appendix C to this rule or intends to use another form, even though substantially similar in content, the form must be filed with the superintendent before use.

(G) Modifications to inflation protection

Modification or elimination of inflation protection after the date of purchase as specified in divisions (O)(1) to (O)(3) of section 3923.44 of the Revised Code is not a change that affects the partnership qualified status of a policy that was qualified under the partnership program as of the date of issue.

(H) The partnership program disclosure form

For policies intended to qualify under the partnership program,

(1) The agent or insurer shall give the consumer a partnership disclosure notice, either using appendix C to this rule or a notice substantially similar in content, along with the outline of coverage required by division (I) of section 3923.44 of the Revised Code at the time of solicitation;

(2) In the case of a policy issued to a group where an outline of coverage is not delivered, the agent or insurer shall deliver copies of a partnership disclosure notice, either using appendix C to this rule or a notice substantially similar in content, along with the enrollment forms; or

(3) In the case of a life insurance policy that offers long-term care insurance as a term of the policy or in a rider, the agent or insurer shall give the consumer a partnership disclosure notice, either using appendix C to this rule or a notice substantially similar in content, along with the policy summary at the time of solicitation.

(4) In addition to assuring that either a copy of appendix C to this rule or a notice substantially similar in content is provided to the consumer at the time of the initial solicitation, or to the group at the time the enrollment forms are

delivered, the insurer shall also assure that a copy of appendix C to this rule or a notice substantially similar in content, is provided no later than partnership policy delivery.

(I) Data reporting

Each insurer offering partnership program policies in this state shall make regular reports to the United States secretary of health and human services that include such information as required by law or as the secretary determines is appropriate for the administration of the partnership program.

(J) Severability

If any paragraph, term, or provision of this rule is adjudged invalid for any reason, the judgment shall not affect, impair or invalidate any other paragraph, term, or provision of this rule, but the remaining paragraphs, terms, and provisions shall be and continue in full force and effect.

Authorized By: 3901.041, 3923.44, 3923.47
Amplifies: 3923.41 to 3923.49
Five Year Review Date: 7/15/2024
Prior Effective Dates: 9/10/2007, 1/1/2009, 4/5/2013, 11/15/2018

CHANGES IN LAW AND REGULATION

Ohio statutes, administrative rules, and regulatory interpretations related to long-term care insurance and the Long-Term Care Partnership Program are subject to change.

Compliance with Ohio law is determined based on the requirements in effect at the time of the relevant transaction or activity.

PENNSYLVANIA

PENNSYLVANIA

STATE SPECIFIC INFORMATION

MEDICAID LONG TERM CARE SERVICES

DISCLAIMER

The purpose of this document is to provide a general overview of eligibility for Medicaid Long Term Care (LTC) in Pennsylvania. It is intended to serve as a prerequisite to training required for insurance producers who sell, solicit or negotiate LTC Partnership (LTCP) insurance policies as part of the LTCP Program in Pennsylvania.

This document is **not** to be used to determine eligibility for Medicaid LTC services. Determining eligibility for Medicaid is the responsibility of the Pennsylvania Department of Human Services (DHS) through the local County Assistance Office (CAO). **All Medicaid eligibility determinations shall be made only by the CAOs. Producers should refer consumers to the local CAO or the toll-free DHS Customer Services / Benefit Helpline at 1- 800- 692-7462 for assistance with Medicaid eligibility determinations.**

The information in this document relates primarily to the rules to qualify for Medicaid LTC and the interface with the LTCP program. This document includes Medicaid eligibility rules and dollar limits that are correct at the time of publication. These rules and the dollar amounts change periodically.

OVERVIEW OF MEDICAID

The Medicaid Program provides health care coverage to low income families and certain categories of aged and disabled individuals. Enacted in 1965, the program is jointly financed by Federal and State government. The Federal government through Health and Human Services establishes guidelines for its operation and each State administers its own program and determines eligibility criteria; the type, amount and duration of services; and the rates for payment for services.

Medicaid LTC Services includes services received in an institutional setting or services received under one of the Home and Community Based Services (HCBS) programs.

NOTE: The phrase “Medicaid LTC Services” used in this document refers to individuals receiving Medicaid benefits in either setting unless otherwise noted.

LONG TERM CARE PARTNERSHIP (LTCP) PROGRAM

The LTCP program empowers individuals to plan for and finance for future LTC while reducing the financial strain on the Medicaid Program.

The Pennsylvania LTCP Program is a cooperative effort between private LTC insurers and Medicaid designed to encourage individuals to plan ahead and provide for their long-term health needs. The LTCP Program benefits an individual by allowing the individual to retain resources in an amount equal to the insurance benefits paid under a qualified LTCP insurance policy that they would normally be required to spend on LTC. If the individual needs assistance in paying for LTC and applies for Medicaid, resources protected under Medicaid and Estate Recovery are equivalent to the amount of LTC insurance benefits paid under a LTCP policy.

An individual must still meet other eligibility criteria referenced below (non-financial, financial and medical) to qualify for Medicaid LTC. It is important to note that only resources are protected under a LTCP policy not income. Any pension,

Social Security or other income must be used to help pay for LTC costs. An individual does not have to exhaust their qualified LTCP insurance policy benefits prior to applying for Medicaid LTC Services.

The LTCP program works like this: An individual buys a qualified LTCP policy. If LTC services are needed, the policy helps pay for care and the individual does not have to rely on Medicaid. If she continues to receive LTC services and eventually needs help paying for her care, she can apply for Medicaid LTC to help pay; however, she is not required to spend all her resources in order to qualify for Medicaid. When determining eligibility for Medicaid LTC, resources up to the amount the LTCP policy has paid in benefits will be excluded and the same amount of resources will also be excluded from estate recovery after the individual passes away.

EXAMPLES: Below are three examples illustrating how a LTCP policy works for an individual and interfaces with Medicaid (1) when the policy has exhausted benefits and (2) when the policy is still in force and paying benefits, and (3) when an individual does not own a LTCP policy.

1. Mr. Jones buys a qualified LTC insurance policy that meets the requirements of the LTCP Program. The policy provides for $100,000 in coverage. Several years later, Mr. Jones needs nursing home care following a stroke. The LTCP policy covers most of the costs for three years but the benefits payable under the policy have been exhausted and paid $100,000 for his care. Mr. Jones applies for Medicaid LTC at the local CAO. Applicants normally must spend down most of their available resources to qualify for Medicaid LTC but Mr. Jones is able to preserve $100,000 of his resources and still qualify for Medicaid to help pay for his LTC if he meets the other eligibility criteria (discussed below).

2. Mr. Smith buys a qualified LTC insurance policy that meets the requirements of the LTCP Program. The policy provides for $100,000 in coverage. Several years later, Mr. Smith needs LTC services but also applies for Medicaid to "supplement" payment for his care along with the LTCP insurance benefits. Mr. Smith currently has $100,000 in resources which is the amount of assets he wants to protect. The policy paid out $92,000 in benefits with $8,000 remaining. Mr. Smith meets all the Medicaid LTC eligibility criteria therefore Medicaid along with his LTCP insurance will pay for his monthly long-term care needs. Mr. Smith is able to preserve $92,000 in assets because the LTCP policy he purchased paid $92,000 in benefits.

3. Mr. Miller does not own a LTCP policy but needs LTC services due to an extended illness. Mr. Miller has $100,000 in resources accumulated over the years and would like to preserve his resources to pass on to his heirs. Mr. Miller applies for Medicaid and is determined ineligible for Medicaid LTC until he reduces or spends his resources down to an amount of $8,000 or less.

LONG TERM CARE INSURANCE POLICIES AND "QUALIFIED PARTNERSHIP" POLICIES

Long-term care insurance policies (LTC) are generally designed to provide coverage for long-term care services. However, the benefits provided under each LTC policy may vary due to the options available and benefits selected by the individual purchaser. For example, coverage under a LTC policy may vary based on the setting or services received, reimbursement method or benefit levels.

LTC policies may also be either federally tax-qualified or non-tax-qualified policies. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established federally "tax-qualified" LTC policies. Therefore, LTC policies meeting HIPAA requirements are deemed to be "tax-qualified" and are given favorable tax treatment. Insurers may offer both federally tax-qualified and non-tax-qualified LTC policies.

The Deficit Reduction Act (DRA) of 2005 facilitated the development of LTCP programs in states. The DRA also sets forth conditions that a policy must meet before it can be deemed a "Qualified Partnership" policy. Following are a few key requirements for a Qualified Partnership policy:

- The policy must cover an individual who was a resident of a Qualified Partnership State when coverage first becomes effective.

- The policy must be a federally tax-qualified LTC policy
- The policy must include inflation protection based on the individual's age at the time of purchase:
  - Individuals under age 61 must have annual compound inflation protection
  - Individuals age 61 to 76 must have some level of inflation protection.
  - Individuals age 76 or older must be offered an inflation protection option.

It is important to note that the purchase of a Qualified Partnership policy does **not** guarantee Medicaid eligibility or benefits. Individuals who have Qualified Partnership policies must still meet Medicaid eligibility requirements before they can qualify and receive benefits under Medicaid.

ELIGIBILITY CRITERIA – MEDICAID LTC

An individual applying for Medicaid LTC Services must submit an application to DHS through the local CAO. An individual must meet non-financial and financial criteria requirements and be certified medically eligible to receive LTC payments. DHS determines nonfinancial and financial eligibility. The Pennsylvania Department of Aging through the local Area Agency on Aging (AAA) certifies that an individual is medically eligible for LTC Services.

NON-FINANCIAL CRITERIA

This includes but is not limited to:

- Age
- Social Security Number (Enumeration)
- Residence-No requirement to the length of time an individual resides in PA to be considered a resident. If an individual is admitted to a LTC facility in Pennsylvania and intends to remain in PA, the individual is considered to be a resident of PA. If the individual intends to return to another state he/she is not a resident of PA.
- Citizenship/Identity
- Medical Certification – A Medical Assessment to determine if an individual is in need of LTC Services. This includes a DHS medical assessment form completed by a qualified medical professional usually at the Hospital and/or in the LTC facility and completed by the local AAA which is then forwarded to the CAO.

FINANCIAL CRITERIA

Pennsylvania evaluates financial eligibility for Medicaid Long-Term Care (LTC) Services under two eligibility categories: Categorically Needy Non-Money Payment (NMP) and Medically Needy Only (MNO).

CATEGORICALLY NEEDY NON-MONEY PAYMENT (NMP)

This category generally applies to individuals with income up to a percentage of the federal Supplemental Security Income (SSI) benefit rate and limited resources, as established by the Pennsylvania Department of Human Services (DHS). Resource limits and applicable disregards are determined by DHS policy in effect at the time of application. Individuals requesting Home and Community-Based Services (HCBS) are evaluated only under the Categorically Needy NMP criteria.

MEDICALLY NEEDY ONLY (MNO)

This category applies to individuals with income or resources above Categorically Needy limits who incur significant medical or long-term-care expenses. Eligibility is determined by subtracting allowable deductions and incurred medical expenses from gross income for the applicable budget period, in accordance with DHS standards.
Income and resource limits, budget periods, and allowable deductions are established by DHS and may change periodically.

2025 Income and Resource Limits for Medicaid and Other Health Programs

Income and resource limits, budget periods, and allowable deductions are established by DHS and may change periodically.

INCOME - PAYMENT TOWARDS THE COST OF CARE

An individual receiving Home and Community-Based Services (HCBS) is generally not required to make a payment toward the cost of care.

An individual receiving Medicaid LTC Services in an institutional setting is required to contribute a portion of his or her income toward the cost of care. The monthly payment amount is based on gross monthly income minus allowable deductions, as determined by the County Assistance Office (CAO) in accordance with DHS policy.

Allowable deductions may include, but are not limited to:

- The applicable **Personal Needs Allowance (PNA)**
- Court-ordered **guardian fees**, subject to DHS limits
- The **Community Spouse Monthly Maintenance Needs Allowance (CSMMNA)**, when applicable
- Maintenance allowances for eligible dependents
- Allowable **medical and remedial expenses**
- An approved **Home Maintenance Deduction (HMD)**
- Court-ordered child support

Certain expenses, such as federal or state taxes, union dues, alimony, and health insurance premiums for the community spouse, are not allowable deductions.

Payment calculations and deduction amounts are based on DHS standards in effect at the time of eligibility determination.

The following numerical examples are provided for historical and instructional purposes only and do not reflect current income limits, deductions, payment rates, or eligibility standards.

Step 1: Determining Eligibility

Gross income ($4,796.40 x 6 months)	$28,778.40
Unearned income deduction ($20.00 x 6 months)	- $120.00
Less Medicare premium ($134.00 x 6 months)	- $804.00
Income total	$27,854.40
Less private rate for 6 months ($200 x 180 days)	-$36,000.00

Because Mr. R.'s six-month income after deductions is less than $2,550, he is eligible for MNO benefits.

Step 2: Determining Payment

Monthly income	$4,796.40
Personal Needs Allowance	- $45.00
Net income	$4,751.40
MA LTC rate ($150.00 x 30 days)	$4,500.00
Medicare B premium and insurance premium	+134.00
Monthly medical expenses	$4,634.00
Compare net income to monthly medical expenses	$4,751.40 > $4,634.00

Because Mr. R has more income then he needs to pay his medical expenses he is not eligible for payment from DHS.

NOTE: The CAO will monitor the case to ensure the extra income that is not needed to pay for LTC services, when added to existing resources does not exceed the resource limit.

RESOURCES

The CAO will evaluate each resource owned by the applicant and the spouse of an applicant if a married individual is applying for Medicaid LTC services. The CAO will determine if the resource can be obtained and if the resource should be counted or excluded.

COUNTABLE RESOURCES

Countable resources include but are not limited to:

- Personal property that includes cash, all bank accounts that can be liquidated such as checking, savings and Certificate of Deposit accounts, mutual funds, IRAs and investment accounts, savings bonds etc.
- Life Insurance-applicant and/or a spouse of a married applicant must own policy for the policy to be counted. If the total face value of all insurance policies owned by the same individual is more than $1500, the cash value of the policy and/or policies is/are countable. The first $1000 of the cash value of countable policy/policies is exempt for each insured individual.
- Vehicles (one vehicle is excluded). All vehicles are considered whether they are inspected, licensed, unlicensed or inoperable.
- Real Property Residential. Ownership will have to be reviewed by the CAO. If the applicant intends to return to the residential property, the residential property is excluded at application but may be subject to Medicaid Estate Recovery.

NON-COUNTABLE RESOURCES

Non-countable or exempt resources include but are not limited to:

- Household goods, jewelry, furniture
- One vehicle
- One principal residence, if the individual intends to return to the home and the home equity does not exceed the applicable home equity limit in effect for the year of application, or if a spouse, dependent child, or disabled child resides in the home.
- Burial spaces/plots (subject to limits)
- Life insurance policies are evaluated based on face value and cash surrender value in accordance with DHS policy in effect at the time of application.

Trusts: can be counted and/or excluded as a resource and/or income. Trust documents will be reviewed by the CAO. Trusts are often reviewed by DHS legal counsel if a decision cannot be made by the CAO.

Annuities: In determining Medicaid LTC eligibility, an annuity is evaluated as either qualified or non-qualified.

1. Medicaid Qualified - employer established account or individual retirement plan such as an IRA.
2. Medicaid Non-Qualified – annuity purchased outright by an individual and not part of a retirement plan.

A Medicaid qualified annuity belonging to the community spouse (CS) is not considered an available resource. Medicaid non-qualified annuities belonging to the CS may or may not be treated as an available resource depending on if the income generated from the annuity meets the Community Spouse's Monthly Maintenance Needs Allowance (CSMMNA to be discussed under Spousal Impoverishment section)

As of March 5, 2007, a change in Federal law required that if an applicant or a recipient of Medicaid LTC Services owns an annuity that was purchased on or after February 8, 2006, it must meet the following requirements:

- Is irrevocable and non-assignable;
- Is actuarially sound;
- Provides for payments in equal amounts, with no deferral and no balloon payments made; and
- Names DHS as primary beneficiary for at least the total amount of Medicaid paid on the behalf of the applicant or recipient.

When a CS, minor child or disabled child exist and are named as the primary beneficiary, DHS is named as the beneficiary in the second position.

TRANSFER OF ASSETS

Assets include all income and resources of the individual and of the individual's spouse if the individual applying for Medicaid LTC Services is married.

TRANSFER OF ASSETS FOR LESS THAN FAIR MARKET VALUE (FMV)

If assets were transferred by a Medicaid LTC applicant, the applicant's spouse, or a recipient within the applicable look-back period, the transfer is reviewed to determine whether fair market value (FMV) was received. If FMV was not received, the transfer may result in a **period of ineligibility** during which Medicaid will not pay for LTC Services.

Pennsylvania applies a **60-month look-back period** for transfers of assets for less than fair market value. Transfers that occur within this period are evaluated by the County Assistance Office (CAO).

The length of the period of ineligibility is calculated by dividing the uncompensated value of the transferred assets by the **applicable statewide daily penalty divisor**, as established by the Pennsylvania Department of Human Services (DHS) and adjusted periodically.

The period of ineligibility generally begins when the individual is otherwise eligible for Medicaid LTC Services and is receiving institutional or waiver services.

During a period of ineligibility, the individual may remain eligible for other Medicaid benefits if otherwise eligible; however, Medicaid will not pay for LTC Services during the penalty period. The individual is responsible for the cost of LTC Services provided during this time.

SPOUSAL IMPOVERISHMENT PROTECTION PROVISIONS

Special Medicaid rules apply to married couples to ensure that the spouse who does not require Long Term Care Services (the **community spouse**) does not become impoverished when the other spouse needs Medicaid to help pay for the cost of LTC Services.

Under these provisions, the community spouse may retain a portion of the couple's combined countable resources, referred to as the **protected share**. The protected share is determined based on **federally established minimum and maximum resource standards**, which are adjusted annually and applied by the Pennsylvania Department of Human Services (DHS) at the time of eligibility determination.

When only one spouse is applying for or receiving Medicaid LTC Services, the couple must generally submit a **Resource Assessment Form** so the County Assistance Office (CAO) can determine the total amount of the couple's countable resources and calculate the protected share.

The monthly income needs of the community spouse are addressed through the **Community Spouse Monthly Maintenance Needs Allowance (CSMMNA)**. The CSMMNA represents the amount of monthly income the community spouse is permitted to retain to meet basic living expenses. The minimum and maximum CSMMNA amounts are established by federal and state standards and may change annually.

The community spouse is not required to use his or her own income to help pay for the LTC Services received by the spouse applying for or receiving Medicaid LTC Services.

In certain circumstances, if the community spouse's income is insufficient to meet the CSMMNA, additional resources above the protected share may be used to generate income for the community spouse, in accordance with DHS policy.

If both spouses are applying for or receiving Medicaid LTC Services, spousal impoverishment protections do not apply and each spouse is evaluated as an individual applicant.

If a consumer has questions related to Medicaid LTC eligibility and the current financial limits, they should contact the DHS Customer Service / Benefits Helpline at 1-800-692-7462.

MEDICAID ESTATE RECOVERY PROGRAM

The Medicaid Estate Recovery Program was established under Federal law and requires the DHS to recover specific Medicaid payments from the probate estates of certain Medicaid recipients who have died.

An estate of an individual includes property or assets owned entirely or in part by the deceased. Estate Recovery will only recover property and/or assets belonging to the estate of the deceased.

Medicaid Estate Recovery applies only to the estates of deceased Medicaid recipients:

- age 55 and over
- who received Medicaid LTC Services after August 15, 1994 including nursing facility care, HCBS, hospital and prescription drug services provided while receiving nursing facility care and/or HCBS.

Estate recovery is generally deferred while a surviving spouse is living.

Medicaid Estate Recovery occurs **only** after the death of an individual who meets the criteria above. Questions may also be directed to the Medicaid Estate Recovery hotline at 1-800-528-3708.

NOTE: Insurance benefits paid under a qualified Long-Term Care Partnership policy are excluded from Medicaid estate recovery, consistent with applicable law.

CHANGES IN LAW AND POLICY

Medicaid eligibility standards, financial limits, waiver programs, and Long-Term Care Partnership provisions are subject to change under federal and state law. Eligibility determinations are made by the County Assistance Offices based on the rules and policies in effect at the time of application.

SOUTH CAROLINA

SOUTH CAROLINA

STATE SPECIFIC INFORMATION

LONG TERM CARE PARTNERSHIP AGENT TRAINING GUIDELINES

DISCLAIMER

This document is intended to help readers understand:

- General eligibility policy relating to Medicaid payment of long-term care services in South Carolina, and
- The interaction between South Carolina Medicaid policy and the Long-Term Care Partnership Program in South Carolina

Insurance Producers: To sell Long Term Care Partnership policies in South Carolina, insurance producers must successfully complete training that had been approved by the South Carolina Department of Insurance. The training must include basic information about South Carolina Healthy Connections Medicaid eligibility as it relates to the Long-Term Care Partnership Program.

An individual may not sell, solicit, or negotiate long term insurance unless the individual is licensed as an insurance producer for accident and health or sickness or life. Previously licensed may continue to sell long term care products but must complete a one-time training course by or before June 30, 2009, and ongoing training every 24 months thereafter. Those who were not yet licensed producers as of July 2008 must obtain the initial course before beginning to sell long term insurance products. The one- time training shall be no less than eight hours and the ongoing training shall be no less than four hours. Training can occur in the classroom or online.

South Carolina Medicaid eligibility policy is very complex. It incorporates special regulations and exceptions for various situations, and changes frequently due to legislative regulations. As a result, this document provides basic eligibility information, but not enough for readers to determine if someone may be eligible for Medicaid benefits.

To see how South Carolina Medicaid eligibility policy would be applied to someone's particular circumstances, the person must submit an application to their South Carolina Department of Health and Human Services (SCDHHS) Local Medicaid Eligibility office and provide all information and verifications necessary to determine eligibility. Inquiries about the eligibility status of current beneficiaries must be requested by the beneficiaries or their authorized representatives, or third parties with written consent of the beneficiary.

Training curriculum developers: Information provided in this document may be used as a guide when developing the Long-Term Care insurance producer training. It is not necessary to use this information verbatim, but the training should address the basic elements contained in this document.

This document provides information on one of the subjects that must be included in the training required of individuals seeking approval to sell long-term care insurance policies in South Carolina. Training courses must include all of the topics listed in SC Code 123345.

Information in this document was published September 7, 2012, by the state of South Carolina. LTC Connection has updated the rates and figures as of January 1, 2020. Eligibility determinations are based on the policies, standards, and procedures in effect at the time of application.

INTRODUCTION TO THE LONG-TERM CARE PARTNERSHIP PROGRAM

The Long-Term Care Partnership (LTCP) Program is a joint effort between the federal Medicaid Program and Long-Term Care (LTC) insurers. The Long-Term Care Partnership was developed to encourage people to plan for their future Long-Term Care (LTC) needs, such as residing in a nursing facility or receiving LTC waivered services in a home or community-based setting.

The LTCP involves private LTC insurers, LTC insurance producers (agents and brokers), the South Carolina Department of Health and Human Services (SCDHHS) and the Department of Insurance (DOI). Although the Partnership is overseen by the federal Centers for Medicare and Medicaid Services (CMS), each state has a great deal of autonomy in its administration. In South Carolina, qualified LTCP policies must provide a specific amount of inflation protection based on the person's age when the policy is purchased and must meet other requirements determined by the Department of Insurance.

A person who requests Medicaid assistance of LTC services after exhausting some or all benefits of a qualified LTCP policy may have certain assets "disregarded" equal to the benefits paid by the qualified LTCP policy at the time the person is determined eligible for Medicaid. These assets are not counted when the person's Medicaid eligibility is determined and will not be recovered during estate recovery when the person dies.

GENERAL CRITERIA FOR MEDICAID ELIGIBILITY

To be eligible for Medicaid, a person must fit into an eligibility group and meet specific requirements relating to residency, citizenship, immigration status, third party liability, income, and asset guidelines. General information about each item is included below, with special emphasis on people who reside in a long-term care facility (LTCF) or receive home and community-based services through a waiver program.

Medicaid eligibility groups in South Carolina include the following:

- Children under the age of 21
- Parents or relative caretakers of dependent children
- Pregnant women
- People age 65 or older
- People who are blind
- People with a certified disability
- Women in need of treatment for certain cancers.

People living in a Long-Term Care Facility or receiving Home and Community-Based Services (HCBS) are generally either disabled or are age 65 or over.

Medicaid Residency rules require that a person be a resident of South Carolina and intend to remain in South Carolina. With some exceptions the state of residency for someone in a Long-Term Care Facility is the state in which the person is physically present on the date of application. South Carolina is not considered the state of residence for:

- A child under 18 whose parent or legal guardian lives in another state
- A person of any age placed in the facility by another state

Medicaid Citizenship and Immigration Status rules require a person to be either a U.S. citizen or a noncitizen with a qualified immigration status. The following must be verified:

- U.S. citizenship and identity when a person declares that he or she is a U.S. citizen
- Immigration status when the person states that he or she has a non-citizen status. Sponsored non-citizens must also provide information about their sponsors.

Medicaid Third Party Liability rules state that Medicaid is the payor of last resort. People must provide information about possible payment sources, such as other health insurance, Medicare or a liable third party. The other payment source pays their portion of medical expenses before Medicaid payments are made.

GENERAL CRITERIA FOR MEDICAID PAYMENT OF LTC SERVICES

To be eligible for Medicaid payment of LTC services, a person must:

1. Meet the necessary Level of Care (LOC.) A Level of Care (LOC) is a determination of medical necessity for care. A qualified individual must meet either an Intermediate or Skilled level of care designation. Community Long Term Care (CLTC) or its designee must certify the individual's level of care before Medicaid can pay for long-term care services.
2. Reside in a Long-Term Care Facility or receive services through one of the Home and Community Based Waivers.
3. Meet income and resource guidelines.
4. Have home equity that does not exceed the applicable home equity limit in effect for the year of application, unless a spouse, child under age 21, or a blind or disabled child is lawfully residing in the home.
5. Disclose an interest in an annuity for self and spouse, if married. The state must be named as remainder beneficiary of annuities by the individual or spouse.
6. Not be in a penalty period for an uncompensated transfer of income or assets. A look-back is completed by SCDHHS for the five (5) year period prior to the date of application for services. If it is determined an uncompensated transfer occurred, a penalty period is calculated. During a penalty period, Medicaid will not pay for any Long-Term Care services.

INCOME ELIGIBILITY CRITERIA FOR PEOPLE REQUESTING MA PAYMENT OF LONG-TERM CARE SERVICES

A person's Medicaid eligibility group determines income and budgeting considerations for that person, including:

- Income limits (which are adjusted annually)
- Income which is counted for Medicaid eligibility and that which is excluded
- Deductions allowed from total gross countable income
- Potential Medicaid eligibility if the person's income is over the allowable limit.

Basic budgeting information provided relates specifically to someone in a Nursing Home. People who receive HCBS through other waiver programs may be eligible for the Partnership but will have different eligibility rules not addressed in this document. It is recommended that they contact their local eligibility office for information relating to their specific situations.

When looking at Medicaid eligibility, income of just the individual in the Nursing Home is counted. Income of a spouse or parent is not counted.

Deductions allowed for institutionalized individuals depend on his or her specific situation. Every deduction is not allowed for each person. General deductions include:

- Health insurance premiums
- An income allocation to a community spouse
- An income allocation to certain other family members (subject to specific limitations)
- Personal needs
- Home maintenance if the person is expected to return to the home within six (6) months
- Health care expenses not paid by Medicaid or a third party.

After allowing applicable deductions, the result is the amount a person must contribute toward the cost of his or her monthly LTC services and is typically paid to the Nursing Home. Medicaid will pay for all other covered services received by the person.

Allowable deductions and deduction amounts are established by SCDHHS policy and may change.

ASSET ELIGIBILITY CRITERIA FOR PEOPLE REQUESTING MEDICAID PAYMENT OF LONG-TERM CARE SERVICES

A person's eligibility group and household size determine his or her asset limit for Medicaid. A resident of a Nursing Facility or someone receiving HCBS is considered a household size of one. He or she has an asset limit of $2,000 in countable assets.

Countable assets are those which are available to the person and are not specifically excluded by the Medicaid program. Examples of countable assets include cash, bank accounts, stocks, bonds, and non-homestead real property.

Excluded assets are not counted toward a person's asset limit. Examples of excluded assets include homestead property in which the person or spouse or certain other family members live, some trusts, certain funds set aside for burial expenses, and one vehicle.

The local eligibility office will review all verified assets and determine which ones are:

- Counted toward Medicaid eligibility
- Excluded and not counted toward Medicaid eligibility
- Determined to be protected for the community spouse, if married
- Protected because benefits of an LTCP policy have been exhausted. (explained later)

The county will also determine if a person needs to reduce assets to the $2,000 asset limit allowed for someone residing in a Nursing Home or receiving HCBS.

Assets of Married Couples

A person residing in a Long-Term Care Facility or receiving HCBS is considered a household of one and has an asset limit of $2,000, whether the person is married or unmarried. However, evaluating assets of the married person is more complicated and several questions need to be addressed.

- Is the spouse also receiving or requesting Medicaid payment of Nursing Home services? If yes, then each one is treated as a single individual for purposes of the Medicaid eligibility and each has an asset limit of $2,000 in countable assets.
- Is the spouse living independently in the community? If yes, then that spouse is considered a **community spouse** and the local eligibility office must consider special rules of spousal impoverishment.

Spousal impoverishment regulations require that the couple (the institutionalized spouse and the community spouse) complete an **asset assessment** of their total marital assets.

In an asset assessment, the married couple reports all assets owned by either spouse individually and by both spouses jointly. The eligibility worker then evaluates the reported assets to determine:

- The amount of countable assets that can be kept by the community spouse and not counted towards the institutionalized spouse's Medicaid eligibility and
- When the institutionalized spouse may possibly be eligible to receive Medicaid payment for LTC services.

A community spouse is allowed to keep up to $66,480. At the initial determination the assets are considered together, and the couple cannot exceed $66,480 in total countable assets. Within 90 days of approval, the assets must be separated so that the institutionalized spouse has no more than $2,000 and the community spouse has no more than $66,480 in countable assets.

SOUTH CAROLINA MEDICAID ESTATE RECOVERY

In August of 1993, Congress passed a law that requires states to recover amounts that Medicaid has paid for certain recipients. In South Carolina the Estate Recovery Program went into effect on July 1, 1994. The state will recover amounts paid by Medicaid for services received July 1, 1994 or later.

Estate recovery applies to the following beneficiaries:

- A person who was 55 years of age or older when he or she received medical assistance consisting of nursing facility services, home and community-based service care to include prescriptions and hospital stays associated with either of these services paid by Medicaid; or
- A person of any age who was an inpatient in a nursing facility, Intermediate Care Facility for Individuals with Intellectual or Developmental Disabilities (ICF/IID), or long term care facility at the time of death; and, who was required to pay most of his/her monthly income to the facility toward the cost of care.

Recovery may be made only after the death of the decedent's surviving spouse, if one exists, and only at a time when the decedent has no surviving child under age twenty- one or no child who is blind or permanently and totally disabled as defined in Title XVI of the Social Security Act.

Recovery must be waived by the department upon proof of undue hardship, asserted by an heir or devisee of the property claimed pursuant to 42 U.S.C. 1396p(b)(3) and in accordance with the guidance issued by the Secretary of the United States Department of Health and Human Services in the State Medicaid Manual as incorporated into the state plan. The department shall publish and maintain such guidance on the department's web site.

Estate Recovery Process

When a beneficiary dies, the state files a claim with the probate court against the beneficiary's estate to recover amounts paid by Medicaid for the deceased beneficiary's medical care. An estate is all real and personal property and other assets of the deceased person (recipient) as defined in South Carolina State Law. This claim will be similar to claims for funeral expenses, attorney's fees to administer the estate, and tax. This claim will need to be satisfied in order to close the estate; however, it may not require the selling of the decedent's home and land if there are other assets available to pay the Medicaid claim. In the event other assets are insufficient to repay the Medicaid claim and/or other expenses of the estate, the Personal Representative (Administrator, Executor, and Executrix) may choose other options to repay the Medicaid debt. The state is not interested in taking title to anyone's home.

For example, John Doe was in a nursing home for the month of July. He died August 3. Medicaid paid $2,000 for his care in July and August. His estate is worth $50,000. Medicaid will recover only $2,000 from his estate, after claims with higher priority (i.e., mortgage, funeral expenses, and probate fees) are paid.

In another example, Joe Smith has been on Medicaid for years. Medicaid has spent $25,000 on the medical services he received since he was age 55. His estate is worth $20,000. The Medicaid program will recover from the remainder of the estate, after claims with higher priority are paid.

Exceptions and special cases:

- Estate recovery must be deferred if the beneficiary is survived by a spouse or a child under the age of 21, blind, or permanently disabled.
- Estate recovery may be waived if it would create an undue hardship.
- Estate recovery may exempt some or all assets of a Medicaid beneficiary who is covered under a Qualified Long-Term Care Partnership (QLTCP) Insurance Policy. Estate recovery will not seek adjustment or recovery from the beneficiary's estate to the extent benefits were paid under the QLTCP policy.

Estate Recovery Hardship

(1) With respect to the decedent's home property, if the decedent could have transferred the home property on or after the date of his or her Medicaid application without incurring a penalty under 42 U.S.C. Section 1396p(c) if the property could have been transferred without penalty to a:
   (a) Surviving sibling of the decedent who possessed an equity interest in the property and who lived in the home for a period of at least one year immediately prior to the date the decedent was institutionalized; or
   (b) Surviving child of the deceased who lived in the home for a period of at least two years immediately before the decedent became institutionalized and who provided care which allowed the decedent to delay institutionalization. Does not apply to a child under the age of 21, or a child who is blind or disabled.

However, hardship under this item only applies if the individual to whom the property could have been transferred without penalty is actually residing in the home, at the time the hardship is claimed and this hardship status only protects a homestead of modest value. A homestead of modest value is defined as fifty percent (50%) or less of the average price of homes in the county where the homestead is located as of the date of the beneficiary's death. To the extent the value of the home property exceeds this modest value, that portion is subject to recovery by the department.

(2) With respect to the decedent's home and one acre of land surrounding the house, if an immediate family member:
(a) Has resided in the home for at least two years immediately prior to the recipient's death;
(b) Is actually residing in the home at the time the hardship is claimed;
(c) Owns no other real property or agrees to sell all other interest in real property and give the proceeds to the department; and
(d) Has annual gross family income that does not exceed one hundred eighty- five percent of the federal poverty guidelines.

(3) With respect to a sole income producing asset:
(a) An immediate family member's annual gross family income would fall below the federal poverty guidelines or immediate family member agrees to pay all income in excess of one hundred eighty-five percent of the federal poverty guidelines to the department.

INTERACTION BETWEEN THE LONG-TERM CARE PARTNERSHIP PROGRAM AND MEDICAID ELIGIBILITY

1. A LTCP participant in South Carolina is someone who either:
   - Requests Medicaid payment of Long-Term Care services after exhausting all benefits of a qualified LTCP policy, or
   - Exhausts all benefits of a LTCP policy while receiving Medicaid payment of
   - LTC services, or
   - Receives Medicaid payment of LTC services and dies before the LTCP policy benefits are exhausted.

2. In determining Medicaid eligibility, SCDHHS will disregard an individual's assets in an amount equal to the amount of payments made by the individual's qualifying LTCP policy for services covered under the policy. Documentation of the amount in benefits paid will have to be provided.

3. An LTCP participant receives the following benefits during his or her lifetime:
   - Assets may be designated for protection in an amount equal to the total amount of LTC services paid by the qualified LTCP policy
   - Designated assets are not counted toward the Medicaid asset limit
   - The designated assets may be transferred to any other person without penalty.

4. After the LTCP participant is deceased:
   - Assets which were designated as protected during the person's lifetime are also protected from estate recovery
   - When the amount of assets protected during the person's lifetime was less than total benefits paid by the LTCP policy, additional assets may be protected in the estate recovery process - up to the total amount paid by the LTCP policy
   - If no assets were protected during the person's lifetime, the personal representative may designate assets to protect from estate recovery equal to the total amount paid by the LTCP policy - even if LTCP policy benefits were not completely exhausted.

5. Owning a LTCP policy does not guarantee eligibility for Medicaid, even if the policy holder exhausts all benefits. Individuals must still meet all other Medicaid eligibility requirements. The LTCP allows policy holders to have a portion of their assets disregarded (not counted) during the eligibility process and subsequently protected from

estate recovery. REMINDER: Only SCDHHS can determine whether a person will qualify for Medicaid. Agents should be careful not to advise regarding eligibility requirements or whether a person will be eligible for Medicaid.

Two types of assets cannot be protected under the LTCP Program. Federal Medicaid rules require that when a person dies, the following assets must be available to reimburse SCDHHS for the amount of Medicaid benefits paid during his or her lifetime:

- Resources in a Special Needs Trust or a Pooled Trust and
- Annuity interests in which South Carolina must be named as a preferred remainder beneficiary.

HOW TO APPLY FOR SOUTH CAROLINA MEDICAID PROGRAMS

A person may apply for any of the South Carolina health care programs by completing an application. Applications may be submitted online through South Carolina's Medicaid application systems or with assistance from a local eligibility office. Applications can be obtained by contacting any local eligibility office or by visiting the agency website: www.scdhhs.gov

- People may request an application form by:
  - Calling the Member Services Call Center at (888) 549-0820.
  - Visiting or calling their local eligibility office
  - Visiting the agency website at www.scdhhs.gov
- A complete signed and dated application can be faxed or mailed to the local eligibility office
- People may ask the local eligibility office to help them complete the application and contact third parties for required information and/or verifications.
- Health Care coverage generally begins in the month that the county receives a completed, signed and dated application.
- People may ask that Medical Assistance coverage begin up to three months before the date they apply.

SOUTH DAKOTA

SOUTH DAKOTA

STATE SPECIFIC INFORMATION

MEDICAL ELIGIBILITY AND THE SOUTH DAKOTA LONG-TERM CARE (LTC) PARTNERSHIP PROGRAM

PURPOSE AND USE

This document provides general information about South Dakota Medicaid eligibility for Long-Term Care (LTC) services and the interaction with the Long-Term Care Partnership (LTCP) Program. It is intended for educational and training purposes only and is not intended to determine eligibility or to replace guidance issued by the South Dakota Department of Social Services (DSS).

Eligibility determinations are made by DSS based on the rules, policies, and procedures in effect at the time of application.

INTRODUCTION

The South Dakota LTC Partnership Program is a joint effort between private long-term care insurers, the Department of Social Services, and the Division of Insurance to encourage people to plan for their potential long-term care needs and expenses.

In order to participate in the South Dakota LTC Partnership Program, a person must have purchased and received the benefits of a qualified Partnership policy. A qualified Partnership policy must meet all of the rules set out by the South Dakota Division of insurance including a specific amount of inflation protection based on the person's age at the time he or she purchases the policy.

The South Dakota LTC Partnership Program benefits a person by protecting assets in an amount equal to the benefits utilized under a qualified Partnership program if the person ever applies for and qualifies for SD LTC Medicaid. These assets are protected because the DSS will not count the value of the individual's assets when determining eligibility and if they are retained by the individual, DSS will not claim them during estate recovery.

This training will provide you with:

- A discussion of the general eligibility criteria for SD LTC Medicaid and the payment of LTC services.
- An explanation of the interaction between DSS and the South Dakota LTC Partnership Program.
- Information about how people can apply for SD LTC Medicaid.

The material presented here is a general guide to understanding payment of long-term care and the interaction between SD LTC Medicaid and the South Dakota LTC Partnership Program. LTC Medicaid eligibility policy is very complex and has many exceptions and special rules for various situations therefore this material should not be used to determine if an individual is eligible for South Dakota Medicaid. Inquiries about individual who is enrolled in SD Medicaid must be made by that individual or the individual's authorized representative to the Long-Term Care Benefits Specialist who maintains the individual's case. Inquiries about how eligibility policy would be applied to a specific individual's circumstances cannot be provided in advance of the individual filing an application and providing the information necessary to determine his or her eligibility.

Please refer specific questions regarding eligibility to your local Department of Social Services.
http://dss.sd.gov/offices/

GENERAL ELIGIBILITY CRITERIA FOR LTC MEDICAID

1. **South Dakota Residence**
   Federal residence rules require that an applicant must be a South Dakota resident and must intend to remain in South Dakota. The state of residence for people who live in a LTC facility is the state in which they are physically present with intent to remain on the date of application for Medicaid.

2. **Citizen and Immigration Status**
   To be eligible for SD LTC Medicaid, a person must be either a U.S citizen or a non-citizen with a qualified immigration status.

3. **Eligible Population**
   Residents of medical institutions (includes nursing facilities) for over 30 consecutive days and individuals receiving Home and Community Based Services (HCBS) Waiver services.

4. **Third Party Liability**
   Medicaid is typically the payer of last resort.
   - People with other health care coverage or who have another party liable for their medical expenses will have medical costs paid by those sources first before Medicaid pays claims.
   - People are required to cooperate with providing information regarding other payment sources. This includes long term care insurance.

5. **Specific Requirements for LTC Medicaid**
   A person must:
   - Be aged, blind or disabled
   - Have a Medical Review Team (MRT) or Utilization Review Team (URT) review that determines the person requires a level of care provided in a LTC facility
     - The MRT or URT determines a person's need for long-term care in one of the following medical facilities:
       - A nursing facility
       - An Intermediate Care Facility for Individuals with Intellectual or Developmental Disabilities (ICF/IID)
       - Assisted Living
       - Swing-bed
     - The MRT or URT determines if the person qualifies to receive home and community based services through waiver programs. These services are provided to individuals who would otherwise be institutionalized in a Medicaid funded hospital, nursing facility, or an Intermediate Care Facility for Individuals with Intellectual or Developmental Disabilities (ICF/IID). The waiver programs are:
       - Developmentally Disabled - waiver for people with developmental disabilities providing service coordination, habilitation, supported employment services, nursing, and specialized medical equipment, supplies and drugs.
       - Family Support – services provided to eligible families of children or adults with a developmental disability such as Down's syndrome, an intellectual disability, autism or cerebral palsy. The developmentally disabled individual lives in the family home on a full time basis.
       - Adult Services and Aging Waiver - services provided to maintain eligible aged and physically disabled individuals at home, thus preventing or reducing unnecessary institutional care including homemaker services, private duty nursing, adult day care, emergency response systems, meals, specialized medical equipment and medication services in an assisted living arrangement.
       - Assistive Daily Living Services – a program specifically for persons who are diagnosed as having quadriplegia that may allow individuals to live independently in their own homes with the assistance of the following services: case management, consumer preparation, personal attendant, and ancillary services.

- Be a resident of a LTC facility or qualify to receive home and community-based services under one of the Medicaid waiver programs
  - A LTC facility does not include placements in facilities that are not Medicaid-certified.
- Have home equity that does not exceed the applicable home equity interest limit in effect for the year of application, unless a spouse, a child under age 21, or a blind or disabled child is lawfully residing in the home.
- Not be in a penalty period for a transfer of income or assets for less than fair market value.
  - Penalty periods are assessed when a person or the person's spouse, or someone acting on their behalf, transfer assets for less than fair market value during a specified period of time (called the look-back period) prior to a person requesting SD LTC Medicaid or anytime while the person is receiving SD LTC Medicaid.
    Some Exceptions Exist – Transfer of the home to one of the following people will NOT prevent or delay LTC eligibility:
    - Spouse
    - Son or daughter under age 21
    - Son or daughter meeting Social Security Administration definition of disability or blindness
    - Son/daughter who lived in the home at least 2 years prior to parent entering a medical facility and who provided care to prevent earlier nursing home care
    - Brother/sister who has an equity interest in the home and who resided in the home at least 1 year prior to the individual entering a medical facility
  - The look back period for the transfer of assets is 60 months.
  - The penalty period is calculated by dividing the value of the assets transferred by the Statewide Average Payment for Skilled Nursing Care in effect at the time a person requests LTC Medicaid. This calculation results in a number of days during which the person is ineligible for SD LTC Medicaid to cover the cost of nursing home or waiver services.
  - The penalty period begins when the person applies for and is otherwise eligible to receive SD LTC Medicaid but for the penalty period, or the day after a prior penalty period has ended, whichever is later. For people receiving SD LTC Medicaid at the time of the transfer, the penalty period begins the month following the month in which the transfer occurred or the date after a prior period of ineligibility ends, whichever is later.
  - Disclose any annuity interests, and if married, annuity interests of a spouse and name the State as a remainder beneficiary of any annuity owned by the person or person's spouse. This provision applies regardless of whether the annuity is irrevocable or treated as an asset, whether annuitized or not. NOTE: Depending on the terms of the annuity and applicable policy, annuities may be treated as countable resources and/or a source of countable income.

6. **Suitability of a Partnership Sale and Important Consumer Disclosures**
   - Purchase of a LTC Partnership policy is not a guarantee of eligibility for SD LTC Medicaid nor is it a guarantee of any ability to disregard assets for purposes of Medicaid eligibility.
   - The Partnership program protects assets not income so the state's rules for income limits or contributions to costs of care in excess of a certain allowed amount still apply.

FINANCIAL ELIGIBILITY CRITERIA FOR PEOPLE REQUESTING SD LTC MEDICAID

INCOME

To qualify for South Dakota Medicaid payment of Long-Term Care (LTC) services, an individual's gross monthly income must not exceed **300 percent of the SSI Standard Benefit Amount**.

For **2026**, this income limit is **$2,982 per month**. If an individual's income exceeds this limit, eligibility may be established through the use of a properly drafted **income trust**, in accordance with state policy.

When only one spouse is applying for Medicaid LTC services, **only the applicant's income is considered** for purposes of determining income eligibility.

EXAMPLES OF INCOME:

Social Security or SSI
VA Benefits
Railroad Retirement
Some Interest/Dividends
Trust Income
Inheritance
Workman's Compensation
Pensions/Income
Unemployment Benefits
Life Insurance Proceeds
Earnings / Rent Income

INCOME NOT COUNTED IN THE GROSS INCOME LIMITS

County assistance

Income tax or sales tax refunds

Veteran's aid/attendance; some other VA payments

Dividends paid on life insurance policies

Irregular (receipt is unexpected) and infrequent income (received once a quarter from same source)

- If earned income – amount is less than $30 a quarter
- If unearned income – amount is less than $60 a quarter

ASSETS

INDIVIDUAL RESOURCE LIMIT

An individual applying for Medicaid LTC services may generally have no more than **$2,000** in countable resources, subject to applicable exclusions under state and federal law.

HOME EQUITY

An applicant may own a principal residence that is excluded from countable resources if the applicant intends to return home and the **equity interest does not exceed the applicable home equity limit in effect for the year of application**, unless a spouse, a child under age 21, or a blind or disabled child is lawfully residing in the home.

EXAMPLES OF COUNTABLE ASSETS:

Bank Accounts / Bonds
Stocks / Annuities (whether annuitized or not)
Certificate of Deposits
Contract For Deeds
Real Property
Available Trust Funds

COMMON ASSETS NOT COUNTED IN LIMITS:

- Most home property if the individual plans to return home or if it is occupied by the spouse
- Most household/personal items
- One vehicle used for transportation
- Certain pre-paid burial contracts

ASSET TREATMENT FOR MARRIED COUPLES

When one spouse applies for Medicaid LTC services and the other spouse remains in the community, **spousal impoverishment protections** apply to prevent the community spouse from becoming impoverished.

Under these rules, the community spouse may retain a portion of the couple's combined countable resources, commonly referred to as the **protected share**. The protected share is determined under **federally established minimum and maximum standards**, which are adjusted annually and applied by the South Dakota Department of Social Services (DSS) at the time of eligibility determination.

The monthly income needs of the community spouse are addressed through the **Community Spouse Monthly Maintenance Needs Allowance (CSMMNA)**, which allows the community spouse to retain a minimum level of monthly income for basic living expenses. CSMMNA amounts are established under federal and state guidelines and may change annually.

The community spouse is not required to contribute his or her own income toward the cost of care for the spouse receiving Medicaid LTC services.

If both spouses are applying for or receiving Medicaid LTC services, spousal impoverishment protections do not apply, and each spouse is evaluated as an individual applicant.

THE "PROTECTED SHARE" FOR THE COMMUNITY SPOUSE

For 2026, the federally established CSRA range is **$32,532 to $162,660**.

Examples:

1) Combined assets of the couple are $28,000.
   - One-half of assets = $14,000
   - This is **below the minimum CSRA**, so the community spouse is entitled to the **minimum CSRA of $32,532**
   - Because total assets ($28,000) are **less than the minimum CSRA**, all assets may be allocated to the community spouse
   - The institutionalized spouse has **$0 ≤ $2,000**

   Result: There IS Medicaid asset eligibility for the spouse in the nursing facility or waiver program

2) Combined assets of the couple are $100,000.
   - One-half of assets = $50,000
   - $50,000 is **within the CSRA range**
   - Community spouse protected share = **$50,000**
   - Remaining assets = $50,000
   - Institutionalized spouse may retain **$2,000**
   - Excess assets = **$48,000**

   Result: No Medicaid asset eligibility until **$48,000** is spent down

3) Combined assets of the couple are $350,000.
   - One-half of assets = $175,000
   - This exceeds the **maximum CSRA**
   - Community spouse protected share = **$162,660**
   - Remaining assets = $187,340
   - Institutionalized spouse may retain **$2,000**
   - Excess assets = **$185,340**

   Result: No Medicaid asset eligibility until excess assets are spent down.

4) Combined assets of the couple are $18,000.
   - One-half of assets = $9,000
   - This is **below the minimum CSRA**

- Community spouse protected share = **$32,532**
- Total assets ($18,000) are **fully allocable to the community spouse**
- Institutionalized spouse has **$0 ≤ $2,000**

Result: There IS Medicaid asset eligibility for the spouse in the nursing facility or waiver program

ESTABLISHING "PROTECTED SHARE"

To determine the "protected share" of the couple's combined assets for the community spouse, a Resource Assessment is completed based on the following:

- Assets existing at 12:01 am on the day the spouse entered the medical facility (hospital; nursing home if not in hospital first; or began receiving Waiver Services).
- "Countable" assets of the couple, regardless of ownership.

  (Prenuptial agreements are not recognized when looking at the total assets for couple.)

COMMON ASSETS NOT COUNTED IN "PROTECTED SHARE"

- Home property occupied by the community spouse.
- Most household goods/personal effects.
- One vehicle used for transportation.
- Certain prepaid burial contracts

Assessment of assets may be done when one spouse enters a hospital/nursing home even though there may be no immediate plans to apply for Medicaid assistance. (The advantage of NOT waiting is the ability to provide the necessary verification of the couple's assets the month the one spouse entered the hospital/nursing home.

TRANSFER OF ASSETS

South Dakota applies a **60-month look-back period** to transfers of assets made by a Medicaid LTC applicant or the applicant's spouse. Transfers for less than fair market value made during this period may result in a **penalty period of ineligibility** during which Medicaid will not pay for LTC services.

The length of the penalty period is calculated by dividing the uncompensated value of the transferred assets by the **statewide average monthly cost of nursing facility care**, as determined by DSS and adjusted periodically.

The penalty period generally begins when the individual has applied for Medicaid LTC services, is otherwise eligible, and is receiving institutional or waiver services.

HOME AND COMMUNITY-BASED SERVICES (WAIVERS)

South Dakota Medicaid may provide Long-Term Care services through institutional care or approved **Home and Community-Based Services (HCBS) waiver programs**, depending on medical need and program availability.

Eligibility for Medicaid does not guarantee immediate access to waiver services. **Waiver availability, covered services, and enrollment procedures are subject to change**, and waiting lists may apply. Applicants should consult DSS for current program information.

INTERACTION BETWEEN THE LTC PARTNERSHIP PROGRAM AND SD LTC MEDICAID

1. **How Asset Protection Works Under the LTC Partnership**
   South Dakota's LTC Medicaid program accepts a LTC policyholder as a LTC Partnership participant when a person requests LTC Medicaid.
   A person who qualifies for participation in the Partnership program does not have to exhaust the benefits of his LTC policy, but will only receive a dollar-for-dollar disregard of the benefits used up to the point of application for SD LTC Medicaid.
   Once identified the Partnership provides the participant with the following benefits:

- DSS does not count the value of assets equal to the amount of benefits paid by the Partnership Policy toward the asset limit for Medicaid eligibility.
- DSS allows the person to transfer the disregarded assets to another person without penalty.
- DSS protects disregarded assets from estate recovery.

For example: A single individual has a Partnership Policy that has paid out $100,000 in benefits. The individual will be eligible for LTC Medicaid when he/she has $102,000 in assets instead of the $2,000 limit.

After becoming eligible, the individual gives $20,000 to his child. No penalty period is incurred due to this transfer. Upon the individual's death, the DSS Office of Recoveries and Fraud Investigation will only seek recovery if the estate is valued at over $80,000.

2. **Interaction of Partnership Protection with other Medicaid Rules**
The LTC Partnership affects some Medicaid rules discussed above. Partnership participation affects the following:

Third party liability: Benefits under a Partnership policy that is available while a person is receiving Medicaid payment of LTC services are treated as third party liability.

Protected share under spousal impoverishment rules: The protected share for a married couple is completed before the evaluation of assets for protection under the LTC Partnership program. This allows the full protection under the LTC Partnership program to be applied to the assets considered available to the LTC spouse.

Transfers for less than fair market value: People who transfer assets protected under the Partnership program are not subject to penalty

HOW TO APPLY FOR SD LTC MEDICAID

A person may apply for any of the South Dakota health care programs by completing a South Dakota Application for Long Term Care or Related Medicaid (DSS EA 240)

- A person may request an application form by:
  - Visiting or calling their local office DSS Office. https://dss.sd.gov/findyourlocaloffice/default.aspx
- A person may complete an application by visiting the following site: https://dss.sd.gov/economicassistance/medical_eligibility.aspx
- The application can be completed online, faxed, or sent to their local office.
- A person may request help from the DSS in completing the application process, which includes help filling out the application form and contacting third parties to get needed information and/or verifications.
- DSS will verify the benefits paid by a LTC Partnership Plan at the time of application for LTC Medicaid.

CHANGES IN LAW AND POLICY

Medicaid eligibility rules, financial standards, waiver programs, and Long-Term Care Partnership requirements are subject to change under federal and state law. Eligibility determinations are made by the South Dakota Department of Social Services based on the standards in effect at the time of application.

TENNESSEE

TENNESSEE

STATE SPECIFIC INFORMATION

LONG TERM CARE PARTNERSHIP AGENT TRAINING

INTRODUCTION TO THE LONG-TERM CARE PARTNERSHIP PROGRAM

The Long-Term Care Partnership (LTCP) Program is a joint effort between the federal Medicaid Program and Long Term Care (LTC) insurers. The Long-Term Care Partnership was developed to encourage people to plan for their future LTC needs, such as residing in a nursing facility or receiving LTC services in a home or community-based setting.

The LTCP involves private LTC insurers, LTC insurance producers (agents and brokers), the Bureau of TennCare, the Department of Human Services (DHS) and the Department of Commerce and Insurance (TDCI). Although the Partnership is overseen by the federal Centers for Medicare and Medicaid Services (CMS), each state has a great deal of autonomy in its administration. In Tennessee, qualified LTCP policies must provide a specific amount of inflation protection based on the person's age when the policy is purchased and must meet other requirements determined by the TDCI.

TennCare is Tennessee's Medicaid Program. In order to participate in TennCare's LTCP program, a person must have purchased and received the benefits of a qualified Partnership policy.

A person who requests TennCare payment of LTC services after exhausting some or all benefits of a qualified LTCP policy may have certain assets "disregarded" equal to the benefits paid by the qualified LTCP policy at the time the person is determined eligible for TennCare. These assets are not counted when the person's TennCare eligibility is determined and will not be recovered during estate recovery when the person dies.

NOTE: TENNCARE ELIGIBILITY RULES AND FINANCIAL STANDARDS ARE SUBJECT TO CHANGE. ELIGIBILITY DETERMINATIONS ARE MADE BY DHS BASED ON THE RULES AND POLICIES IN EFFECT AT THE TIME OF APPLICATION.

GENERAL CRITERIA FOR TENNCARE LTC ELIGIBILITY

To be eligible for TennCare, a person must qualify in one of the eligibility groups that is covered under the TennCare Medicaid program and meet specific requirements relating to residency, citizenship, income and resources. To be eligible for TennCare payment of LTC services, a person must meet **all** of the following criteria:

a) Have a Pre-Admission Evaluation (PAE) that determines a need for a level of care provided in one of these settings:

1) Nursing facility

2) Intermediate Care Facility for Individuals with Intellectual or Developmental Disabilities (ICF/IID)

A person who meets the level of care and eligibility requirements for care in a nursing facility or ICF- MR may then be able to choose to receive LTC services in an alternative home and community based setting such as an HCBS Waiver program.

b) Reside in a TennCare-certified Long Term Care facility or receive TennCare home and community- based LTC services under a federally approved waiver program.

c) Meet income and resource guidelines.

d) Disclose an interest in an annuity for self and spouse, if married. The state must be named as remainder beneficiary of annuities owned by the person or spouse.

e) Not be in a penalty period for an uncompensated transfer of income or assets. During a penalty period, TennCare will not pay the cost of LTC services.

f) Have home equity that does not exceed the applicable home equity limit in effect for the year of application, unless a spouse, child under age 21, or a blind or disabled child is lawfully residing in the home.

INTERACTION BETWEEN THE LTCP PROGRAM AND TENNCARE ELIGIBILITY

1) A LTCP participant in Tennessee is someone who either:
   - Requests TennCare payment of LTC services after exhausting all benefits of a qualified LTCP policy, OR
   - Exhausts all benefits of a LTCP policy while receiving TennCare payment of LTC services, OR
   - Receives TennCare payment of LTC services and dies before the LTCP policy benefits are exhausted.

2) In determination of eligibility for TennCare, DHS shall disregard an individual's assets in an amount equal to the following:
   - The amount of payments made by the individual's qualifying LTC policy for services covered under the policy

   TennCare applicants will be required to submit written proof of benefits paid from their LTCP policies.

3) An LTCP participant receives the following benefits during his or her lifetime:
   - Assets may be designated for disregard in an amount equal to the benefits paid out by the qualified LTCP policy as of the date of application for Medicaid eligibility.
   - Designated assets are not counted toward the TennCare asset limit for eligibility purposes.
   - The designated assets may be transferred to any other person without penalty.
   - Additional benefits paid by the qualified LTCP policy after application for Medicaid eligibility shall not be disregarded in future review and/or determination of Medicaid eligibility.

4) After the LTCP participant is deceased:
   - Assets which were disregarded for purposes of Medicaid eligibility determination during the person's lifetime are also protected from estate recovery.
   - When the amount of assets disregarded during the person's lifetime was less than total benefits paid by the LTCP policy, additional assets may be protected in the estate recovery process up to the amount of payments made by the individual's qualifying LTC policy for services covered under the policy.
   - If no assets were disregarded during the person's lifetime, the personal representative may designate assets to protect from estate recovery up to the lesser of the two options specified above - even if LTCP policy benefits were not completely exhausted.

5) TennCare is typically the payor of last resort. Individuals with other health care coverage or who have another party liable for their medical expenses will have medical costs paid by those sources first before TennCare pays claims. Individuals are required to cooperate with providing information regarding other payment sources. This includes long-term care insurance.

   LTC insurance benefits may not be used to offset the amount the person is required to contribute, pursuant to federal post-eligibility provisions, to the cost of TennCare- reimbursed LTC services (known as "patient liability"), but rather, must be used to help offset the cost of LTC services that would otherwise be reimbursable by TennCare. Thus, both the LTC insurance benefits and patient liability reduce the TennCare payment for LTC services.

6) It is the responsibility of the LTCP policy holder to inform the DHS eligibility worker that he has a Partnership policy.

7) When should an individual apply for TennCare?
   - If the LTCP policy holder exhausts the benefits of his LTCP policy.

- When the Partnership policyholder/spouse/family/friend feels that the policyholder can no longer afford to pay for the cost of care.

8) Does a LTCP policy guarantee access to TennCare?
NO! Owning a LTCP policy does NOT guarantee access to TennCare – even if the policy holder exhausts his benefits. Individuals still must meet all other TennCare eligibility requirements in order to be eligible. The Partnership allows policy holders to have a portion of their assets disregarded (i.e., not counted) during the eligibility determination process and subsequently protected from estate recovery (dollar for dollar the amount of benefits paid out by the qualified LTCP policy).

REMINDER: ONLY DHS CAN DETERMINE WHETHER A PERSON WILL QUALIFY FOR TENNCARE. AGENTS SHOULD BE CAREFUL NOT TO ADVISE REGARDING ELIGIBILITY REQUIREMENTS OR WHETHER A PERSON WILL BE ELIGIBLE FOR TENNCARE.

HOW TO APPLY FOR TENNCARE

There are three ways you can apply for TennCare Medicaid and Medicare Savings Programs (MSP). You can apply online, over the phone, or with a paper application.

ONLINE

To apply online, you can use our self-service portal, called TennCare Connect, at TennCareConnect.TN.gov. You can create an account, apply for coverage, check your status, report changes, read letters, and more!
For more information about what you can do with a TennCare Connect account, go to the TennCare Connect Instructional Videos webpage.

OVER THE PHONE

To apply over the phone, call TennCare Connect at 855-259-0701. Do you have a hearing or speech problem, have questions, or need help? Call the Tennessee Relay Service (TNRS) at 800-848-0298 and ask them to connect you to TennCare Connect.

PAPER APPLICATION

To apply with a paper application, print out an English Paper Application **or** Spanish Paper Application. You can also apply online at TennCareConnect.TN.gov.

If you need extra pages to add more family members, you can print out the English Extra Pages for Additional Family Members **or** the Spanish Extra Pages for Additional Family Members. They can also apply online at TennCareConnect.TN.gov.

There are two ways to send in your paper application, but you only need to choose one:
1. Mail it to:
TennCare Connect
P.O. Box 305240
Nashville, TN 37230-5240

2. Fax it to: 1-855-315-0669. Be sure to keep the page that says your fax went through.

Do you need help in person? You can get help from your local Department of Health (DOH). To find your local DOH office, go to the Local and Regional Health Departments webpage.

VERMONT

VERMONT

STATE SPECIFIC INFORMATION

TRAINING REQUIREMENT FOR VERMONT PRODUCERS

An agent of producer selling, soliciting or negotiating the sale of any long-term care insurance policy must complete one, eight (8) hour course specific to long-term care, not less than two hours of which shall contain Vermont-specific information including Vermont Medicaid information. The Vermont-specific information can be part of an eight-hour course or may be provided as a separate course.

VERMONT MEDICAID

Green Mountain Care is the official state center for Vermont health insurance plans and coverage. Information about their programs can be found at https://dvha.vermont.gov/members/

Eligibility for Vermont Medicaid is based on income and resources. Vermonters enrolled in Medicare may also be eligible for Medicaid under certain circumstances. Coverage includes most services such as doctor visits, hospital care, prescription medicines, vision and dental care, long-term care, and physical therapy. Fees for Medicaid may include co-payments for outpatient services, prescription medicines and dentist visits. Co-payments are not required for those:

- under the age of 21
- pregnant women
- women in the 60 day post pregnancy period
- individuals in nursing facilities

For current Vermont Medicaid eligibility standards, premiums, and program information, visit the official Green Mountain Care website or contact Member Services. Medicaid eligibility determinations are made by the appropriate Vermont agency based on the rules and standards in effect at the time of application.

VERMONT LONG-TERM CARE MEDICAID

Vermont's Long-Term Care Medicaid Program includes: Choices for Care, Developmental Disabilities Home and Community Based Services, Brain Injury Program and Intensive Home and Community Based Treatment. It assists Vermont residents pay for LTC in a location of their preference, including:

- the home or home of another person;
- an approved residential care home or assisted-living facility; or
- an approved nursing home.

ELIGIBILITY

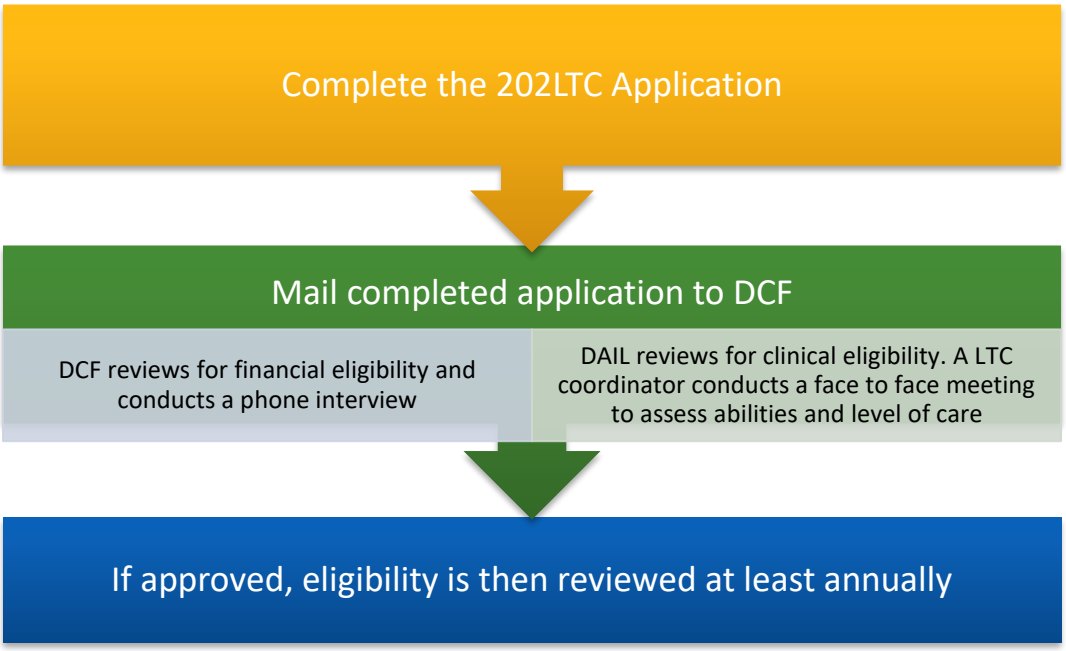
To be eligible, you must:

- Be a Vermont resident;
- Be at least 65 years, at least 18 years old with a physical disability, or eligible for Medicaid under Medicaid for Chidlren and Adults rules;
- Meet the financial criteria; and
- Meet the clinical criteria for nursing home level of care.

For more information on Choices for Care, Developmental Disabilities Home and Community Based Services, and Brain Injury Program, visit the Disabilities, Aging and Independent Living website.

For more information on Intensive Home and Community Based Treatment, visit the Department of Mental Health website.

APPLICATION PROCESS



CONTACT INFORMATION FOR THE APPLICATION PROCESS

How to complete the 202LTC application form:

- To print a copy, click on: Application for Long-Term Care Medicaid; or
- Call 1-802-476-0100 or toll-free 1-833-840-0061 and ask that a 202LTC be mailed to you.

Once completed, mail your application to:

Green Mountain Care
Application and Document Processing Center
280 State Drive
Waterbury, VT 05671-1500

SERVICES BY LOCATION

Home-Based

- Case management
- Personal care services
- Adult day centers
- Respite for unpaid caregivers
- Companionship
- Emergency response
- Assistive devices
- Home modifications

Residential Care Homes/Assisted-Living Facilities

- Case management
- Nursing overview & assessment
- Personal care services
- Medication management
- Recreational activities
- 24/7 onsite supervision
- Laundry services
- Housekeeping services

Nursing Homes

- Room and board
- Skilled nursing & assessment
- Personal care
- Medication management
- Pharmacy services
- Social worker
- Recreational activities
- 24/7 onsite nursing care & supervision
- Laundry and housekeeping services
- Transportation services
- Physical, occupational, & speech therapy
- Nutrition and dietary services

INFORMATION RESOURCES

If you have questions about financial eligibility, call ESD's Benefits Service Center at 1-800-479-6151. Stay on the line. Wait to hear what number to push to speak to an agent. The agent will transfer you to a long-term-care worker who can help.

If you have questions about clinical eligibility, call the DAIL Long-Term Care coordinator in your area of the state.

If you want more detailed information about Choices for Care

- read the Participant Handbook (http://ddas.vermont.gov/ddas-publications/publications-cfc/choices-for-care-participant-handbook)
- go to the DAIL Choices for Care website at: http://www.ddas.vermont.gov/ddas-programs/programs-cfc/programs-cfc-default-page

VERMONT LONG-TERM CARE PARTNERSHIP (RULE H-2009-1; APPENDIX H)

PARTNERSHIP PROGRAM NOTICE

This Notice explains how the Vermont Long-Term Care Partnership Program works and provides important consumer information regarding the policies that are certified as Partnership Policies.

THE VERMONT LONG-TERM CARE PARTNERSHIP PROGRAM

Some long-term care insurance policies sold in Vermont may qualify for the Vermont Long-Term Care 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 that qualify as Partnership Policies may protect the policyholder's assets through a feature known as "Asset Disregard" under Vermont's Medicaid program.

ASSET PROTECTION

Long-term care insurance helps individuals prepare for future long-term care needs. Qualified Partnership Policies provide an additional level of protection. In particular, such policies may permit individuals to protect resources under Vermont’s Medicaid Program if assistance is ever needed under that program and the individual would be otherwise eligible for the Vermont Medicaid program.

In addition, if these specific protected resources are still in existence when the individual dies and they are part of the decedent's probate estate, they will not be recoverable under state law. The resource, eligibility and estate recovery provisions of the Vermont Medicaid Program permit the disregard of an amount of assets which is equal to the amount of insurance benefits you have received from your qualified Partnership Policy. For example, if you receive $200,000 of insurance benefits from your qualified Partnership Policy, you would be able to retain $200,000 of resources and still be eligible for long-term care services provided under the Medicaid Program. This disregard is above and beyond the resources normally permitted to be retained by an individual and still qualify for Medicaid. (Note: special rules may apply to persons whose home equity exceeds the applicable home equity limit in effect for the year of application.) This protection of assets applies to individuals in need of long- term care services both in the community or residing in a long-term care facility.

It is important to understand that all other Medicaid eligibility criteria will apply at the time you apply for Medicaid. ***The purchase of a Partnership Policy does not automatically qualify you for Medicaid.*** In addition, please note that Medicaid eligibility requirements may change over time.

Asset Disregard is not available under a long-term care insurance policy that is not a Partnership Policy. Therefore, you should consider if Asset Disregard is important to you, and whether a Partnership Policy meets your needs.

ASSET DISREGARD

Long-term care insurance helps individuals prepare for future long-term care needs. Qualified Partnership Policies provide an additional level of protection. In particular, such policies may permit individuals to protect resources under Vermont’s Medicaid Program if assistance is ever needed under that program and the individual would be otherwise eligible for the Vermont Medicaid program.

Some long-term care insurance policies sold in Vermont qualify for the Vermont Long-Term Care Partnership Program. 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 that qualify as Partnership Policies may be entitled to special treatment, and in particular an "Asset Disregard," under Vermont's Medicaid program.

Asset Disregard. Asset disregard means that an amount of the policyholder's assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy 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 qualified Partnership Policy without affecting the person's eligibility for Medicaid. In addition, if these specific protected resources are still in existence when the individual dies and they are part of the decedent's probate estate, they will not be recoverable under state law.

The resource, eligibility and estate recovery provisions of the Vermont Medicaid Program permit the disregard of an amount of assets which is equal to the amount of insurance benefits you have received from your qualified Partnership Policy. For example, if you receive $200,000 of insurance benefits from your qualified Partnership Policy, you would be able to retain $200,000 of resources and still be eligible for long-term care services provided under the Medicaid Program. This disregard is above and beyond the resources normally permitted to be retained by an individual and still qualify for Medicaid. (Note: special rules may apply to persons whose home equity exceeds the applicable home equity limit in effect for the year of application.) This protection of assets applies to individuals in need of long-term care services both in the community or residing in a long-term care facility.

It is important to understand that all other Medicaid eligibility criteria will apply at the time you apply for Medicaid. ***The purchase of a Partnership Policy does not automatically qualify you for Medicaid.*** In addition, please note that Medicaid eligibility requirements may change over time.

PARTNERSHIP POLICY REQUIREMENTS

For a policy to be considered a Qualified state long-term care insurance Partnership Policy, it must meet the following requirements:

- The policy covers an insured who was a resident of Vermont (or a Partnership State) when coverage first became effective under the policy.
- be a tax-qualified policy under Section 7702(B)(b) of the Internal Revenue
- Code of 1986; as amended, and was issued no earlier than the effective date of Vermont's plan amendment required by section 6021 of the Deficit Reduction Act of 2005.
- The policy must meet all of the applicable requirements including the consumer protection standards of the National Association of Insurance Commissioners long-term care insurance model act and model regulation as those requirements are set forth in Section 1917(b)(5)(A) of the Social Security Act (42 USC Section 1396p(b)(5)(A)).
- meets the following inflation protection requirements:
    - For ages 60 or younger, the policy must provide Compound annual inflation protection
    - For ages 61 to 65, the policy must provide some level of inflation protection
    - For purchasers between ages 66 and 75, the policy must offer inflation protection in accordance with applicable state and federal standards.
    - For ages 76 and older, the policy does not have to provide inflation protection.

PARTNERSHIP POLICY DISQUALIFICATION

If you make certain types of changes to a Partnership Policy, such changes could affect whether or not the policy continues to qualify as a Partnership Policy. If you purchase a Partnership Policy and later decide to make *any* changes, you should first consult with [carrier 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 Partnership Policy, you would not receive beneficial treatment of your policy under the Medicaid program of that state. The information contained in this disclosure is based on current Vermont and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your policy under Vermont's Medicaid program.

If you make any changes to your policy, such changes could affect whether your policy continues to be a Partnership Policy. ***Before you make any changes, you should consult with [insert name of carrier] 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 Partnership Policy, you would not receive beneficial treatment of your policy under the Medicaid program of that State. The information contained in this Notice is based on current State and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your policy under Vermont's Medicaid program.

ADDITIONAL CONSUMER PROTECTIONS

In addition to providing asset protection, a qualified Partnership Policy has other important features. Partnership Policies must be qualified long-term care insurance contracts under Federal tax law. As such the insurance benefits you receive from the policy generally will be subject to beneficial income tax treatment. (Please note that a policy can be a tax qualified long-term care insurance contract under Federal tax law, with the same beneficial income tax treatment, even if it is not a Partnership Policy.) In addition, if you were under age 76 when you purchased your qualified Partnership Policy, it must provide inflation protection to help protect against potential future increases in the cost of long-term care. (Purchasers over the age of 76 must be offered the option of purchasing a policy with inflation protection).

Additional Information. If you have questions regarding the insurance policy please contact your carrier. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Vermont Health Access Member Services at 1-800-250-8427.

Drafting Note: This form is intended for use with individual long-term care insurance. The insurer may modify these forms for use with group long-term care insurance without filing with the Department so long as no substantive revisions are made. For example, the term "policy" may be replaced with "certificate" or "coverage," and the term "policyholder" may be replaced with "certificate holder."

VIRGINIA

VIRGINIA

STATE SPECIFIC INFORMATION

VIRGINIA PARTNERSHIP POLICIES

The state of Virginia LTC Partnership program became effective on September 1, 2007. These are the rules that have been developed as part of this implementation.

The following information was compiled based on information published in the following sources:

- *Administrative Letter 2007-3 dated May 1, 2007, as released by the State Corporation Commission Bureau of Insurance of the Commonwealth of Virginia.*
- *Virginia Administrative Code, Title 14, Agency No. 5, State Corporation Commission, Bureau of Insurance, Life and Health Chapter 200, Rules Governing Long-Term Care Insurance (14VAC 5-200-205)*
- *Virginia Long-Term Care Insurance Partnership,* https://www.dss.virginia.gov/

AGENT TRAINING

The State Corporation Commission adopted revisions to the Rules Governing Long-Term Care Insurance, 14 VAC 5-200-10 et seq., (the Rules). The Rules were revised primarily to address requirements necessary to establish a Public-Private Long-Term Care Partnership Program (Partnership Program), between the Commonwealth of Virginia and private insurance companies. The revisions to the Rules became effective September 1, 2007, concurrent with the implementation date of the Partnership Program in Virginia. The purpose of this document is to provide general guidance to companies that are offering Long-Term Care Partnership policies (Partnership Policies), in Virginia. This document focuses only on two processes related to the sale of Partnership Policies in Virginia – agent training and Partnership Product qualification. Insurers are expected and required to review the revised Rules in their entirety to ensure that they are compliant with all the requirements in the Rules, including those that may not necessarily relate directly to the Partnership Program.

Resident Agents: licensed agents in Virginia may not sell a Partnership Policy unless and until they have received the requisite eight (8) hours of initial training addressed in the Rules at 14 VAC 5-200-205 E. Thereafter, agent must receive at least four (4) hours of ongoing training every twenty-four (24) months. All training must be approved by the Insurance Continuing Education (CE) Board and must, at a minimum, consist of the specific topics identified in the Rules. Insurers are responsible for ensuring that their agents are appropriately trained, maintaining documentation of such training, and to produce training records should the Bureau request it. Agents who meet said Partnership training requirements will be considered “qualified” to sell Partnership policies.

Nonresident Agents: those nonresident agents who comply with their home state requirement need only take a two-hour Virginia specific course to meet the requirement in Virginia.

Lapsed Agents: agents who fail to complete the ongoing four hours of training within 24 months must again complete the initial 8 hours of training.

INITIAL TRAINING

- All training shall be approved as continuing education by the Insurance Continuing Education Board in accordance with Section 38.2-1867 of the Code of Virginia.
- 14 VAC 5-200-205 E 3(a): an agent must complete a course that consists of at least two (2) hours, covering the topics identified in this section of the regulation which specifies training on state and federal regulations and requirements and the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services, including Medicaid
- 14 VAC 5-200-205 E 3(b through f): an agent must complete recent relevant training to satisfy all or part of the remaining six (6) hours of the initial training requirement, on the topics identified in this section of the regulation which specifies training in: available long-term care services and providers, changes or improvements in long-term care services or providers, alternatives to the purchase of private long-term care insurance, the effect of inflation on benefits and the importance of inflation protection, and consumer suitability standards and guidelines.

ONGOING TRAINING

The four (4) hours of ongoing training must, at a minimum, consist of two (2) hours relating to the topics identified in section (a) as described above, and two (2) hours relating to the topics identified in section (b) through (f) as described above.

PARTNERSHIP PRODUCT REQUIREMENTS

To be designated as a LTC Partnership-eligible policy in Virginia, a policy must meet the following requirements as specified in 12VAC30-40-290:

The policy covers an insured who was a resident of the Commonwealth of Virginia (a Partnership State) when coverage first became effective under the policy.

The policy is a qualified long-term care insurance policy as defined in § 7702B(b) of the Internal Revenue Code of 1986 and was issued no earlier than September 1, 2007.

The policy meets all the applicable requirements of this chapter and the requirements of the National Association of Insurance Commissioners long-term care insurance model act and model regulation as those requirements are set forth in § 1917(b)(5)(A) of the Social Security Act (42 USC § 1396p(b)(5)(A)).

The policy provides the following inflation protections:

- If the policy is sold to an individual who has not attained age 61 as of the date of purchase, the policy shall provide a compound annual inflation protection feature at least equivalent to the provisions of 14VAC5-200-100;
- If the policy is sold to an individual who has attained age 61 but has not attained age 76 as of the date of purchase, the policy shall provide an inflation protection feature at least equivalent to the provisions of 14VAC5-200-100;
- If the policy is sold to an individual who has attained age 76 as of the date of purchase, the policy may provide inflation protection, but shall at least comply with the provisions of 14VAC5-200-100.

Inflation protection requirements vary based on the insured's age at purchase and must meet the minimum standards established by Virginia law and regulation.

DISCLOSURE AND NOTICES

An insurer or its agent, soliciting or offering to sell a policy that is intended to qualify as a partnership policy, shall provide to each prospective applicant a Partnership Program Notice (Form 200-A), outlining the requirements and benefits of a partnership policy. A similar notice may be used if approved by the commission. This notice is to be provided along with the required Outline of Coverage.

Insurers shall include the following information in or with the Outline of Coverage:

1. A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period.
2. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

Any partnership policy issued or issued for delivery in the Commonwealth of Virginia shall include a Partnership Disclosure Notice (Form 200-B) explaining the benefits associated with a partnership policy and indicating that at the time of issue, the policy is a qualified state long-term care insurance partnership policy. A similar notice may be used if approved by the commission. The Partnership Disclosure Notice shall also include a statement indicating that by purchasing this partnership policy, the insured does not automatically qualify for Medicaid.

INSURER'S PRODUCT OFFERINGS FOR PARTNERSHIP

A partnership policy issued or issued for delivery in Virginia must be approved by the Commission in accordance with §38.2-316 of the Code of Virginia, and all applicable statutes and rules. Policies submitted for approval as Partnership Policies must also be accompanied by a Partnership Certification Form (Form 200-C), or a similar form filed and approved by the commission.

Insurers requesting the use of a previously approved LTC policy can submit the Partnership Certification Form, a copy of the previously approved policy or certificate, the approval date, and a notation that this previously approved policy with the new LTC Partnership requirements.

INSURER RESPONSIBILITIES

- Agent training shall be verified by the insurer offering a partnership policy to ensure an agent has receive the training required by 14 VAC 5-200-205 E before the agent is permitted to sell, solicit or negotiate the insurer's partnership policy.
- Each insurer shall maintain records with respect to the training of its agents qualified to sell, solicit or negotiate partnership policies, to include training received and that the agent has demonstrated an understanding of the partnership policies and their relationship to public and private coverage of long-term care, including Medicaid, in this Commonwealth. These records shall be maintained for a period of not less than five years and shall be made available to the commission upon request.
- Each insurer issuing a LTC Partnership policy shall provide regular reports to the United States Secretary of Health and Human Services (HHs) in accordance with regulations that provide notification of the date benefits were paid, the amount paid, the date the policy terminates, and such other information as the Secretary determines may be appropriate to the administration of partnerships.

THE VIRGINIA LTC PARTNERSHIP POLICY

This program is designed to reward Virginia residents who plan ahead for their future long-term care needs. The program protects personal assets should there be a need to apply for Medicaid. The program is an alliance between private insurance companies and the state government to protect Virginia residents from depleting their savings and assets to pay for long-term care. The Virginia LTC Partnership Policies and non-Partnership LTC insurance policies are similar. Partnership policies have the added benefit of allowing policyholders to protect a portion of their assets if they choose to apply for Medicaid using dollar-for-dollar asset protection.

DOLLAR-FOR-DOLLAR ASSET PROTECTION

For every dollar that a LTC Partnership Policy pays out in benefits, a dollar of assets can be protected for purposes of determining Medicaid eligibility. For example, if the policyholder were to receive $75,000 in benefits, the policyholder could then apply to Virginia's Medicaid program for assistance and still keep $75,000 in assets (in addition to the $2,000 everyone is allowed to keep and any other asset allowances under Medicaid). This feature is NOT available under non-qualified Partnership Policies.

The amount of the dollar-for-dollar asset protection is calculated based on:

- The amount of benefits paid by the LTC insurance company on the policyholder's behalf.
- It is not necessarily equal to the amount of the premiums paid or the maximum benefit.

INFLATION PROTECTION

The following is a breakdown of the minimums referred to previously with regard to 14VAC 5-200-100.

An insurer must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

1. Increases benefit levels annually, in a manner so that the increases are compounded annually, at a rate not less than 5.0%;
2. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status; so long as the option for the previous period has not been

declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5.0% for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

3. Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

When the policy is a group policy, the required offer shall be made to each proposed certificate holder; except if the policy is issued to a continuing care retirement community the offering shall be made to the group policyholder.

The offer shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

IMPORTANCE OF THE POLICY ISSUE DATE

All Partnership policies must be issued after the program start date of September 1, 2007. No existing LTC policies will be “grandfathered” into the program.

RECIPROCITY

Virginia participates in the national Long-Term Care Partnership reciprocity agreement. Most, but not all states, are participating in this agreement. Under this agreement, policies will include dollar-for-dollar asset protection in other states. Applicants must still meet the Medicaid requirements in the state of application.

CARRIERS APPROVED TO SOLICIT LONG TERM CARE PARTNERSHIP POLICIES

To view the most up to date list of carriers who have been approved in Virginia to offer Partnership policies, visit this website: Virginia-approved carriers (available through the State Corporation Commission)

DATES OF NOTE

State Plan Amendment Approval Date: December 19, 2006

State Plan Amendment Effective Date: January 1, 2007

Partnership Program Implementation Date: September 1, 2007

THE VIRGINIA MEDICAID PROGRAM

The Virginia Medicaid program is administered by the Department of Medical Assistance Services (DMAS). The program is authorized under Title XIX of the Social Security Act providing coverage of medical services for disabled and low income individuals. It is a program financed by the state and federal governments and then administered by the state for coverage of medical services for specific groups of low-income people within the guidelines established at the federal level. Federal financial assistance is provided to states. The federal match rate is based on the state’s per capita income. The federal match rate for Virginia is currently 50%, meaning that for every dollar expended in the Medicaid program, 50 cents is from the federal government and 50 cents is from the state’s general fund.

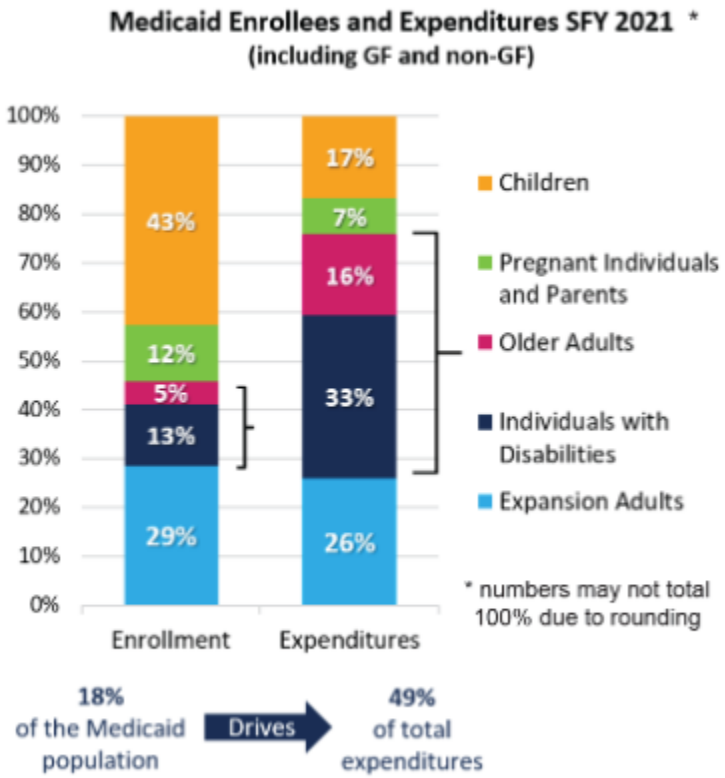
Medicaid is the largest healthcare program in Virginia. It provides for five distinct healthcare policy roles:

1. Ensuring access to healthcare for low-income pregnant women and children through prenatal care, delivery, and comprehensive coverage for children.
2. Provides access to care for low-income adults with children by establishing a set of mandatory and optional health care benefits.
3. Provides for chronic and long-term care needs of seniors and individuals with disabilities through institutional and community-based care services.
4. Finances the safety net for the uninsured who are not Medicaid eligible through community health centers and disproportionate share funding to hospitals.
5. Fills gaps in Medicare coverage for "dual eligible" through payment for Medicare premiums and deductibles, nursing home benefits, medical equipment, and some pharmacy costs.

INDIVIDUALS COVERED BY MEDICAID

Medicaid eligibility is primarily for individuals such as low-income children, pregnant women, the elderly, persons with disabilities, and parents meeting specific income thresholds. States establish their own income and asset eligibility criteria and in Virginia, income and resource requirements will vary by category.

Most of Virginia's Medicaid dollars are spent on care for older adults and individuals with disabilities.



Source: Medicaid at a Glance, https://dmas.virginia.gov/about-us/medicaid-at-a-glance/

SERVICES COVERED UNDER MEDICAID

The Virginia Medicaid program covers all of the federally mandated services, including, but not limited to:

- Inpatient and outpatient hospital services
- Emergency hospital services
- Physician and nurse midwife services
- Federally qualified health centers and rural health clinic services
- Laboratories and x-ray services
- Transportation services
- Family planning services and supplies
- Nursing facility services
- Home health services (nurse, aide), and
- Early and Periodic Screening Diagnosis, and treatment program for children (EPSDT)

Optional Services also including, but not limited to:

- Certified pediatric nurse and family nurse practitioner services
- Routine dental care (includes adults starting July 1, 2021)
- Prescription drugs
- Rehabilitation services such as physical therapy (PT), occupational therapy (OT), and speech language pathology (SLP) services
- Home health services (PT, OT, SLP)
- Hospice
- Behavioral health services
- 12-Month Postpartum Coverage
- Some substance abuse services, and
- Intermediate Care Facilities for Individuals with Intellectual or Developmental Disabilities (ICF/IID)

MEDICAID FUNDED LONG-TERM CARE SERVICES

Medicaid is the main source of funding for long-term care services in Virginia. Medicaid covers services for low income seniors and individuals with disabilities in both institutional and community-based settings. Those who need long-term care services must meet both financial and functional eligibility criteria to qualify for Medicaid funded long-term care.

NON-FINANCIAL ELIGIBILITY REQUIREMENTS

To be eligible for Medicaid payment of long-term care, an individual must be eligible for Medicaid. Non-financial eligibility requirements apply to all Medicaid applicants and recipients, including those individuals in long-term care. These requirements include citizenship/alienage, Virginia residency, social security number, assignment of rights, application for other benefits, institutional status, and covered groups eligibility.

FACILITY CARE

Virginia Medicaid provides benefits for care in a medical institution to persons whose physical or mental condition requires nursing supervision and assistance with activities of daily living. As some institutions have both medical and residential sections, note that an individual in the residential portion of the institution is a resident of a residential facility and not a patient in a medical facility, whereas the individual in the medical section of the institution is a patient in a medical facility.

INELIGIBLE INDIVIDUALS

- Individuals under the age of 65 who are patients in an institution for mental diseases are not eligible for Medicaid unless they are under age 22 and receiving inpatient psychiatric services.

TYPES OF MEDICAL INSTITUTIONS

- Chronic Disease Hospitals (aka "long-stay hospitals")
    - Hospital for Sick Children in Washington DC
    - Lake Taylor Hospital in Norfolk, VA
- Hospitals and/or Training Centers for the Intellectually Disabled
- Institutions for Mental Diseases (IMDs)
- Intermediate Care Facility (ICF)
- Nursing Facility
- Rehabilitation Hospitals

COMMUNITY-BASED CARE WAIVER SERVICES

Virginia Medicaid provides coverage for long-term care in a community-based setting to individuals whose mental or physical condition requires nursing supervision and assistance with activities of daily living. Medicaid beneficiaries also receive coverage through these waiver programs. The program provides community-based long-term care services as an alternative to institutionalization. The following is a list of programs available to beneficiaries who meet the criteria:

- Commonwealth Coordinated Care Plus Waiver
- Community Living Waiver (Formerly Intellectual Disabilities Waiver)
- Family and Individual Supports Waiver (Formerly the Individual Family Development Disabilities Support Waiver)
- Building Independence Waiver (Formerly the Day Support Waiver for Individuals with Intellectual Disabilities)
- Children's Mental Health Program – Not Medicaid CBC
- Program for All Inclusive Care for the Elderly (PACE) (described below)

PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

This program is an alternative delivery option for long-term care recipients. It is designed specifically to allow Medicaid eligible individuals, 55 and up, meeting the nursing facility criteria, to access comprehensive coordinated care in their homes and communities.

While PACE is not a HCBS Waiver program, the preadmission screening, financial eligibility and post eligibility requirements for individuals enrolled in PACE are the same as those for individuals enrolled in the CCC Plus (formerly EDCD) Waiver.

FINANCIAL ELIGIBILITY REQUIREMENTS

An individual who is authorized to receive Long Term Care Services and Support (LTSS) must meet the financial eligibility requirements that are specific to institutionalized individuals. Any individual whose Medicaid eligibility was determined prior to receiving LTSS must have their financial eligibility evaluated and determined including asset transfer evaluation, home ownership and other resource evaluation. Financial eligibility requirements for an individual will differ depending on the individual's covered group, marital status and type of long-term care.

INCOME

Income includes earned income, such as wages and self-employment, as well as other income such as Social Security, retirement pensions, Veteran's benefits, child support, etc. All sources of income are added together and compared against the income limit to determine eligibility.

Income limits vary according to the covered group and the type of coverage. For some groups, the income limits vary depending on the county or city where you reside. Total "gross income" is evaluated; deductions are allowed according to the Medicaid policy, and the amount of income remaining is then compared to the appropriated Medicaid limit.

RESOURCES (ASSETS)

Resources include money on hand, in the bank and in a safe deposit box, stocks, bonds, certificates of deposit, trusts, or pre-paid burial plans. Resources also include cars, boats, life insurance policies, and real property. Not all resources are counted when determining eligibility for Medicaid. Example: all vehicles must be reported, but one vehicle is not a countable resource for Medicaid purposes. Resources that are sold or given away for less than what they are worth can cause ineligibility for Medicaid coverage of long-term care services for a defined period of time.

LONG-TERM CARE (LTC) ASSET TRANSFER

Applicants for LTC services under Medicaid are required to disclose all transfers of assets (resources) that occurred within the **five years prior**. This includes but is not limited to; transferring the title of a vehicle, removing your name from a property deed, setting up a trust, or giving away money. Those individuals who sell, give away, or dispose of assets without receiving adequate compensation may be deemed ineligible for Medicaid payment of long-term care services for a period of time. This can be overcome should the Medicaid program determine that the denial of Medicaid eligibility would cause an undue hardship. Be aware that transfers occurring after enrollment in Medicaid may also result in a penalty for payment of long-term care services.

SPECIAL RULES FOR MARRIED INDIVIDUALS WHO NEED LONG TERM CARE

Medicaid has special rules in place to determine the eligibility of an individual when the individual receives long-term care and the spouse does not. These rules are considered "spousal impoverishment protections". Under this rule a certain amount of resources and income are evaluated to determine how much can be reserved for the spouse who remains at home without having an impact on the Medicaid eligibility of the other spouse.

APPLYING FOR MEDICAID

A common question arises as to when a partnership policyholder should apply for Medicaid. Virginia lists three points to address this issue:

1. Anytime: Everyone in the state of Virginia has the right to apply for Medicaid at anytime
2. Exhaustion of Benefits: when the partnership policyholder has exhausted the benefits of their LTC partnership policy
3. Hardship and Need: when the partnership policyholder, their family/spouse, feels that the individual is experiencing difficulty and hardship paying for care.

Note: Exhaustion of the LTC Partnership policy does NOT mean that an individual will automatically qualify for Medicaid. The individual must be eligible in order to qualify for coverage.

UNDERSTANDING MEDICAID AND PARTNERSHIP

The purchase of a LTC Partnership policy does NOT guarantee access to Medicaid. In the state of Virginia the following is true with regard to Medicaid:

- Medicaid eligibility is extremely complex and must be determined on an individual, case-by-case basis
- Medicaid eligibility determinations are completed by the applicant's local department of social services
- Medicaid has both financial and non-financial requirements
- Financial requirements involve the evaluation of both income and resources (assets)
- Non-financial requirements include Virginia residency, proof of citizenship and identity, provision of a Social Security number, and meeting the required level of care for LTC services.
- Medicaid eligibility has special rules for married people, especially important when only one spouse is receiving LTC services.
- Medicaid eligibility has special rules that apply to home property in which the applicant resides, vehicles, and burial arrangements.

FOR ADDITIONAL INFORMATION:

Virginia Department of Medical Assistance Services (DMAS)
600 East Broad Street
Richmond, VA 23219

Phone: 833-522-5582
TDD: 888-221-1590

www.coverva.org

WASHINGTON

WASHINGTON

STATE SPECIFIC INFORMATION

RULES AND REGULATIONS FOR LTC

PURPOSE

This document reproduces selected Washington statutes and administrative rules governing long-term care insurance policies, including Long-Term Care Partnership policies. These provisions are provided for reference and training purposes only. Medicaid eligibility determinations are made by the appropriate Washington agency based on the rules in effect at the time of application.

Subsequent long-term care insurance policies issued on or after January 1, 2009, are governed primarily by Chapter 48.83 RCW and Chapter 284-83 WAC. 48.83 RCW is implemented by WAC 284-83.

CHAPTER 48.84 RCW: LONG TERM CARE INSURANCE ACT

NOTES: *Long-term care insurance plans for eligible public employees: RCW **41.05.065**.*

RCW 48.84.010 GENERAL PROVISIONS, INTENT.

This chapter may be known and cited as the "long-term care insurance act" and is intended to govern the content and sale of long-term care insurance and long-term care benefit contracts issued before January 1, 2009, as defined in this chapter. This chapter shall be liberally construed to promote the public interest in protecting purchasers of long-term care insurance from unfair or deceptive sales, marketing, and advertising practices. The provisions of this chapter shall apply in addition to other requirements of Title 48 RCW.

[2008 c 145 § 19; 1986 c 170 § 1.]

Effective date—2008 c 145: See RCW 48.83.901.

RCW 48.84.020 DEFINITIONS.

Unless the context requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Long-term care insurance" or "long-term care benefit contract" means any insurance policy or benefit contract primarily advertised, marketed, offered, or designed to provide coverage or services for either institutional or community-based convalescent, custodial, chronic, or terminally ill care. Such terms do not include and this chapter shall not apply to policies or contracts governed by chapter 48.66 RCW and continuing care retirement communities.

(2) "Loss ratio" means the incurred claims plus or minus the increase or decrease in reserves as a percentage of the earned premiums, or the projected incurred claims plus or minus the increase or decrease in projected reserves as a percentage of projected earned premiums, as defined by the commissioner.

(3) "Preexisting condition" means a covered person's medical condition that caused that person to have received medical advice or treatment during the specified time period before the effective date of coverage.

(4) "Medicare" means Title XVIII of the United States social security act, or its successor program.

(5) "Medicaid" means Title XIX of the United States social security act, or its successor program.

(6) "Nursing home" means a nursing home as defined in RCW **18.51.010**.

[1986 c 170 § 2.]

RCW 48.84.030 RULES—BENEFITS-PREMIUMS RATIO, COVERAGE LIMITATIONS.

(1) The commissioner shall adopt rules requiring reasonable benefits in relation to the premium or price charged for long-term care policies and contracts which rules may include but are not limited to the establishment of minimum loss ratios.

(2) In addition, the commissioner may adopt rules establishing standards for long-term care coverage benefit limitations, exclusions, exceptions, and reductions and for policy or contract renewability.

[1986 c 170 § 3.]

RCW 48.84.040 POLICIES AND CONTRACTS—PROHIBITED PROVISIONS.

No long-term care insurance policy or benefit contract may:

(1) Use riders, waivers, endorsements, or any similar method to limit or reduce coverage or benefits;

(2) Indemnify against losses resulting from sickness on a different basis than losses resulting from accidents;

(3) Be canceled, nonrenewed, or segregated at the time of rerating solely on the grounds of the age or the deterioration of the mental or physical health of the covered person;

(4) Exclude or limit coverage for preexisting conditions for a period of more than one year prior to the effective date of the policy or contract or more than six months after the effective date of the policy or contract;

(5) Differentiate benefit amounts on the basis of the type or level of nursing home care provided;

(6) Contain a provision establishing any new waiting period in the event an existing policy or contract is converted to a new or other form within the same company.

[1986 c 170 § 4.]

RCW 48.84.050 DISCLOSURE RULES—REQUIRED PROVISIONS IN POLICY OR CONTRACT.

(1) The commissioner shall adopt rules requiring disclosure to consumers of the level, type, and amount of benefits provided and the limitations, exclusions, and exceptions contained in a long-term care insurance policy or contract. In adopting such rules the commissioner shall require an understandable disclosure to consumers of any cost for services that the consumer will be responsible for in utilizing benefits covered under the policy or contract.

(2) Each long-term care insurance policy or contract shall include a provision, prominently displayed on the first page of the policy or contract, stating in substance that the person to whom the policy or contract is sold shall be permitted to return the policy or contract within thirty days of its delivery. In the case of policies or contracts solicited and sold by mail, the person may return the policy or contract within sixty days. Once the policy or contract has been returned, the person may have the premium refunded if, after examination of the policy or contract, the person is not satisfied with it for any reason. An additional ten percent penalty shall be added to any premium refund due which is not paid within thirty days of return of the policy or contract to the insurer or insurance producer. If a person, pursuant to such notice, returns the policy or contract to the insurer at its branch or home office, or to the insurance producer from whom the policy or contract was purchased, the policy or contract shall be void from its inception, and the parties shall be in the same position as if no policy or contract had been issued.

(3) No later than January 1, 2010, or when the insurer has used all of its existing paper long-term care insurance policy forms which were in its possession on July 1, 2009, whichever is earlier, the notice required by subsection (2) of this section shall use the term insurance producer in place of agent.

[2008 c 217 § 67; 1986 c 170 § 5.]

NOTES: Severability—Effective date—2008 c 217: See notes following RCW **48.03.020**.

RCW 48.84.060 PROHIBITED PRACTICES.

No insurance producer or other representative of an insurer, contractor, or other organization selling or offering long-term care insurance policies or benefit contracts may: (1) Complete the medical history portion of any form or application for the purchase of such policy or contract; (2) knowingly sell a long-term care policy or contract to any person who is receiving Medicaid; or (3) use or engage in any unfair or deceptive act or practice in the advertising, sale, or marketing of long-term care policies or contracts.

[2008 c 217 § 68; 1986 c 170 § 6.]

NOTES: Severability—Effective date—2008 c 217: See notes following RCW **48.03.020**.

RCW 48.84.070 SEPARATION OF DATA REGARDING CERTAIN POLICIES.

Commencing with reports for accounting periods beginning on or after January 1, 1988, all insurers, fraternal benefit societies, health care services contractors, and health maintenance organizations shall, for reporting and recordkeeping purposes, separate data concerning long-term care insurance policies and contracts from data concerning other insurance policies and contracts.

[1986 c 170 § 7.]

RCW 48.84.910 EFFECTIVE DATE, APPLICATION—1986 C 170.

RCW **48.84.060** shall take effect on November 1, 1986, and the commissioner shall adopt all rules necessary to implement RCW**48.84.060** by its effective date including rules prohibiting particular unfair or deceptive acts and practices in the advertising, sale, and marketing of long-term care policies and contracts. The commissioner shall adopt all rules necessary to implement the remaining sections of this chapter by July 1, 1987, and the remaining sections of this chapter shall apply to policies and contracts issued on or after January 1, 1988.

[1986 c 170 § 10.]

CHAPTER 284-83 WAC: LONG TERM CARE INSURANCE RULES

WAC 284-83-005 APPLICABILITY AND SCOPE.

(1) Except as otherwise specifically provided, this chapter applies to all long-term care insurance policies delivered or issued for delivery in this state on or after January 1, 2009, including qualified long-term care policies and life insurance policies that accelerate benefits for long-term care. This chapter applies to insurance companies, fraternal benefit societies, health care service contractors, health maintenance organizations and all similar entities (collectively called "issuers" in this chapter).

(2) Some sections of this chapter apply only to qualified long-term care insurance policies, as provided for by the Health Insurance Portability and Accountability Act of 1996 and by Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

(3) This chapter applies to policies delivered or issued for delivery in this state having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if:

(a) The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;

(b) The disability income policy is advertised, marketed or offered as insurance for long-term care services; or

(c) Benefits under the policy commence after the policyholder has reached Social Security's normal retirement age, unless the benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

WAC 284-83-010 DEFINITIONS AND STANDARDS.

For the purpose of this chapter, the following definitions and standards apply, unless the context clearly requires otherwise.

(1) "Certificate" has the meaning set forth in RCW 48.83.020(2).

(2) "Exceptional increase" means only those increases filed by the issuer as exceptional for which the commissioner determines the need for the premium rate increase is justified due to changes in laws or regulations applicable to long-term care coverage in this state; or due to increased and unexpected utilization that affects the majority of issuers of similar products. Except as provided in WAC 284-83-090, exceptional increases are subject to the same requirements as other premium rate schedule increases. The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase. The commissioner, in determining that the necessary basis for an exceptional increase exists, must also determine any potential offsets to higher claims costs.

(3) "Incidental," as used in WAC 284-83-090, means a value of the long-term care benefits provided that is less than ten percent of the total value of the benefits provided over the life of the policy. These values must be measured as of the date of issue. In simple cases where the base policy and the long-term care benefits have separately identifiable premiums, the premiums can be directly compared. In other cases, annual cost of insurance charges might be available for comparison. Some cases may involve comparison of present value of benefits.

(4) "Group long-term care insurance" has the meaning set forth in RCW 48.83.020(6).

(5) "Guaranteed renewable" means that renewal of a long-term care insurance policy cannot be declined by the issuer for any reason except nonpayment of premiums, but the issuer can revise rates on a class basis.

(6) "Insured" means any beneficiary or owner of a long-term care policy regardless of the type of issuer.

(7) "Issuer" has the meaning set forth in RCW 48.83.020(4).

(8) "Noncancellable" means that renewal of a long-term care insurance policy cannot be declined and rates cannot be revised by the issuer.

(9) "Policy" has the meaning set forth in RCW 48.83.020(7), unless the context clearly indicates otherwise, and includes certificates issued under a group policy.

(10) "Qualified actuary" means a member in good standing of the American Academy of Actuaries.

(11) "Qualified long-term care insurance" has the meaning set forth in RCW 48.83.020(8).

(12) "Similar policy forms" means all of the long-term care insurance policies and certificates issued by the issuer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in RCW 48.83.020 (6)(a) are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: Institutional long-term care benefits only, noninstitutional long-term care benefits only, or comprehensive long-term care benefits.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-010, filed 11/24/08, effective 12/25/08.]

WAC 284-83-015 STANDARDS FOR POLICY DEFINITIONS AND TERMS.

A long-term care insurance policy or certificate delivered or issued for delivery in this state must not use the following terms unless the terms are defined in the policy or certificate and the definitions satisfy the following standards. This section specifies minimum standards for several terms commonly found in long-term care insurance policies, while allowing some flexibility in the definitions themselves.

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

(2) "Acute condition" means that the individual is medically unstable. An individual with an acute condition requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

(3) "Adult day care" or "adult day health care" means a program of social or health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

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

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

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

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

(8) "Eating" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

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

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

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

(12) "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

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

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

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

(16) "Transferring" means moving into or out of a bed, chair or wheelchair.

(17) "Skilled nursing facility," "nursing facility," "extended care facility," "convalescent nursing home," "personal care facility," "specialized care providers," "assisted living facility," "home care agency" and terms used to identify other providers of services must be defined in relation to the 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 must also state what requirements a provider must meet in lieu of licensure, certification or registration if 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 if the state licenses, certifies or registers the provider of services under another name.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-015, filed 11/24/08, effective 12/25/08.]

WAC 284-83-020 STANDARDS FOR POLICY PROVISIONS.

The following standards for policy provisions apply to all long-term care insurance policies delivered or issued for delivery in this state.

(1) Renewability. The terms "guaranteed renewable" and "noncancellable" must not be used in any individual long-term care insurance policy or certificate without further explanatory language in accordance with the disclosure requirements of WAC 284-83-035.

(a) A policy or certificate issued to an individual must not contain renewal provisions other than "guaranteed renewable" or "noncancellable."

(b) The term "guaranteed renewable" may be used only if the insured has the right to continue the long-term care insurance in force by the timely payment of premiums, if the issuer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and the issuer cannot decline to renew, except that rates may be revised by the issuer on a class basis.

(c) The term "noncancellable" may be used only if the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the issuer has no right to unilaterally make any change in any provision of the insurance and has no right to unilaterally make any change in the premium rate.

(d) The term "level premium" may be used only if the issuer does not have the right to change the premium.

(e) In addition to the other requirements of this subsection, a qualified long-term care insurance policy or certificate must be guaranteed renewable, within the meaning of Section 7702B (b)(1)(C) of the Internal Revenue Code of 1986, as amended.

(2) Limitations and exclusions. A long-term care policy or certificate shall not be delivered or issued for delivery in this state as long-term care insurance if it limits or excludes coverage by type of illness, treatment, medical condition or accident, except for the following permitted exclusions:

(a) Preexisting conditions or diseases;

(b) Alcoholism and drug addiction;

(c) Illness, treatment or medical condition arising out of war or act of:

(i) War (whether declared or undeclared);

(ii) Participation in a felony, riot or insurrection;

(iii) Service in the armed forces or units auxiliary thereto;

(iv) Suicide (while sane or insane), attempted suicide, or intentionally self-inflicted injury; or

(v) Aviation (this exclusion applies only to nonfare-paying passengers);

(d) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under medicare or other governmental program (except medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance;

(e) Expenses for services or items available or paid under another long-term care insurance or health insurance policy;

(f) In the case of a qualified long-term care insurance policy only, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount;

(g) Issuers may not prohibit, exclude or limit services based on type of provider or limit a coverage if services are provided in a state other than the state where the policy was originally issued, except:

(i) When the state other than the state of policy issue does not have the provider licensing, certification, or registration required in the policy, unless the provider satisfies the policy requirements outlined for providers in lieu of licensure certificate or registration; or

(ii) When the state other than the state of policy issue licenses, certifies or registers the provider under another name.

(iii) Issuers may exclude or limit payment for services provided outside the United States or permit or limit benefit levels to reflect legitimate variations or differences in provider rates, but issuers must cover services that would be covered in the state of issue irrespective of any licensing, registration or certification requirements for providers in the other state. In other words, if the claim would be approved but for the licensing issue, the claim must be approved for payment.

(3) Extension of benefits. Termination of long-term care insurance must be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

(4) Continuation or conversion. Group long-term care insurance issued in this state on or after January 1, 2009, must provide covered individuals with a basis for continuation or conversion of coverage.

(a) For the purposes of 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 which is subject only to the continued timely payment of premium when due.

(i) 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.

(ii) The commissioner will make a determination as to the substantial equivalency of benefits, and in doing so, will take into consideration the differences between managed care and nonmanaged care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(b) For the purposes of this section, "a 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 which it replaced), for at least six months immediately prior to termination, is entitled to the issuance of a converted policy by the issuer under whose group policy he or she is covered, without evidence of insurability.

(c) For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. If the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities the commissioner, in making a determination as to the substantial equivalency of benefits, will take into consideration the differences between managed care and nonmanaged care plans, including, but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.

(d) Written application for the converted policy must be made and the first premium due, if any, must be paid as directed by the issuer not later than thirty-one days after termination of coverage under the group policy. The converted policy must be issued effective on the day following the termination of coverage under the group policy, and must be renewable annually.

(e) Except where the group policy from which conversion is made replaces previous group coverage, the premium for the converted policy must be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. If the group policy from which conversion is made replaces previous group coverage, the premium for the converted policy must be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(f) Continuation of coverage or issuance of a converted policy is mandatory, except where:

(i) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(ii) The terminating coverage is replaced not later than thirty-one days after termination by group coverage effective on the day following the termination of coverage and the replacement coverage provides benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and the premium is calculated in a manner consistent with the requirements of (e) of this subsection.

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

(h) The 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, do not exceed those that would have been payable had the individual's coverage under the group policy remained in full force and effect.

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

(5) Discontinuance and replacement. If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding issuer must offer coverage to all insured persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the issuer and premiums charged to persons under the new group policy:

(a) Must not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

(b) Must not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

(6)(a) The premium charged to the insured must not increase due to either the increasing age of the insured at ages beyond sixty-five or the duration the insured has been covered under the policy.

(b) The purchase of additional coverage shall not be considered a premium rate increase; but for purposes of the calculation required under WAC 284-83-090, the portion of the premium attributable to the additional coverage must be added to and considered part of the initial annual premium.

(c) A reduction in benefits shall not be considered a premium change; but for purposes of the calculation required under WAC 284-83-090, the initial annual premium must be based on the reduced benefits.

(7) Electronic enrollment for group policies.

(a) In the case of a group, as defined in RCW 48.83.020 (6)(a), any requirement that a signature of the insured be obtained by an insurance producer or issuer will be deemed satisfied only if:

(i) The consent is obtained by telephonic or electronic enrollment by the group policyholder or issuer and verification of enrollment information is provided to the insured;

(ii) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and

(iii) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information is maintained.

(b) Upon request of the commissioner, the issuer must make available records that demonstrate the issuer's ability to confirm enrollment and coverage amounts.

(8) Each long-term care policy delivered or issued for delivery to any person in this state must clearly indicate on its first page that it is a "long-term care insurance" policy.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-020, filed 11/24/08, effective 12/25/08.]

WAC 284-83-025 UNINTENTIONAL LAPSE.

As a protection against unintentional lapse, each issuer offering long-term care insurance must comply with all of the following:

(1)(a) Notice before lapse or termination. No individual long-term care policy or certificate may be issued until the issuer has received from the applicant either a written designation of at least one person in addition to the applicant to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice.

(i) The applicant has the right to designate at least one person to receive the notice of termination, in addition to the insured.

(ii) Designation does not constitute acceptance of any liability on the third party for services provided to the insured.

(iii) The form used for the written designation must provide space clearly designated for listing at least one person.

(iv) The designation must include each person's full name and home address.

(v) If the applicant elects not to designate an additional person, the waiver must state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty days after a premium is due and unpaid. I elect not to designate a person to receive this notice."

(vi) No less frequently than once every year the issuer must notify the insured of the right to change this written designation or to add a lapse designee, if the insured has not already designated a lapse designee.

(A) Issuers must print this notice in not less than twelve point type either:

(I) On the front side of the first page of the billing statement; or

(II) On a separate document that is not printed on the billing statement.

(B) If the insured has named a lapse designee for the account, then the issuer must print on the notice the name and contact information that the issuer has on record for the lapse designee.

(b) When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in (a) of this subsection need not be met until sixty days after the policyholder or certificate holder is no longer on the payment plan. The application or enrollment form for such policies or certificates must clearly show the payment plan selected by the applicant.

(c) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the issuer, at least thirty days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to (a) of this subsection, at the address provided by the insured for purposes of receiving notice of lapse or termination.

(i) Issuers must be able to show:

(A) Proof that they produced the notice;

(B) Proof that they sent the notice;

(C) The name and address of the person or persons to whom they sent the notice. The address may consist of either:

(I) A physical mailing address; or

(II) An electronic mailing address for delivery by electronic means under the requirements of RCW 48.185.005;

(D) The date that they sent the notice.

(ii) Upon request of the commissioner, to verify that they sent the notice, issuers must be able to provide:

(A) An attestation from the person who sent the notice or supervised sending the notice; or

(B) Proof of sending the notice, which regardless of delivery method, may consist of, but is not limited to a confirmation document that shows the date the issuer mailed the item, the name and address of the insured, and the lapse designee if the insured has named a lapse designee for the policy. Delivery of the notice may occur using one of these or similar methods:

(I) Certified mail, which may be proven by obtaining a certificate of mailing from the United States Postal Service;

(II) A commercial delivery service;

(III) First class United States mail, postage prepaid; or

(IV) Proof of delivery by electronic means under the requirements of RCW 48.185.005.

(iii) If the insured has an insurance producer of record, then the issuer must also provide notice to the insured's producer of record within seventy-two hours after the issuer sends the notice to the insured and to the lapse designee, if the insured has named a lapse designee for the policy. In sending this notice, issuers must comply with the mailing requirements in (c)(ii) of this subsection.

(iv) An issuer may not give notice until thirty days after a premium is due and unpaid. Notice is deemed to have been given as of five business days after the date that the issuer sent the notice.

(v) Upon the request of the commissioner, issuers must be able to demonstrate that they use due diligence to attempt to locate policyholders or named lapse designees when they receive notification of nondelivery of lapse notices.

(2) Reinstatement. In addition to the requirements in subsection (1) of this section, a long-term care insurance policy or certificate must include a provision that provides for reinstatement of coverage in the event of lapse if the issuer receives proof, as per the standards stated in (b) of this subsection, that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the policy's grace period expired.

(a) Reinstatement must be available to the insured if requested within five months after lapse. When appropriate, issuers may collect past due premiums as part of the reinstatement process as set forth in the policy or certificate.

(b) The standard of proof of cognitive impairment or loss of functional capacity must not be more stringent than the benefit eligibility criteria for cognitive impairment or the loss of functional capacity contained in the policy or certificate.

[Statutory Authority: RCW 48.02.060, 48.83.170 and 48.84.030. WSR 17-03-089 (Matter No. R 2013-29), § 284-83-025, filed 1/13/17, effective 7/1/17. Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-025, filed 11/24/08, effective 12/25/08.]

WAC 284-83-030 REQUIRED DISCLOSURE PROVISIONS.

(1) Renewability. Long-term care insurance policies must contain a renewability provision.

(a) The renewability provision must be appropriately captioned, must appear on the first page of the policy, and must clearly state that the coverage is guaranteed renewable or noncancellable. This provision does not apply to policies that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder, such as long-term care policies which are part of or combined with life insurance policies because life insurance policies generally do not contain renewability provisions.

(b) A long-term care insurance policy or certificate, other than one where the issuer does not have the right to change the premium, must include a statement that premium rates may change.

(2) Riders and endorsements.

(a) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after the date of issue, or at reinstatement or renewal, that reduce or eliminate benefits or coverage in the policy must require signed acceptance by the individual insured.

(b) After the date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in a writing signed by the insured, except when the increase in benefits or coverage is required by law.

(c) If a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge must be set forth in the policy, rider or endorsement.

(3) Payment of benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import, must include a definition and explanation of the terms in its accompanying outline of coverage, as set forth in WAC 284-83-145.

(4) Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations must appear as a separate paragraph of the policy or certificate and must be labeled as "preexisting condition limitations."

(5) Other limitations or conditions on eligibility for benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited under chapter 48.83 RCW, must set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and must label that paragraph "limitations or conditions on eligibility for benefits."

(6) Disclosure of tax consequences. At the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted, a life insurance policy or certificate that provides an accelerated benefit for long-term care must disclose that receipt of the accelerated benefits may be taxable and that assistance should be sought from a personal tax advisor. The disclosure statement must be prominently displayed on the first page of the policy, certificate or rider and any other related documents. This subsection does not apply to qualified long-term care insurance policies.

(7) Benefit triggers. Activities of daily living and cognitive impairment shall be used to measure the insured's need for long-term care and must be described in the policy or certificate in a separate paragraph labeled "eligibility for the payment of benefits." Any additional benefit triggers must be explained in the same section.

(a) If benefit triggers differ for different benefits, a clear explanation of the benefit trigger must accompany each benefit description.

(b) If an attending physician or other specified person is required to certify a certain level of functional dependency in order for the insured to be eligible for benefits, this must be specified.

(8) A qualified long-term care insurance policy must include a disclosure statement in the policy and in the outline of coverage, as set forth in WAC 284-83-145, that the policy is intended to be a qualified long-term care insurance policy under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

(9) A nonqualified long-term care insurance policy must include a disclosure statement in the policy and in the outline of coverage, as set forth in WAC 284-83-145, that the policy is not intended to be a qualified long-term care insurance policy.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-030, filed 11/24/08, effective 12/25/08.]

WAC 284-83-035 REQUIRED DISCLOSURE OF RATING PRACTICES TO CONSUMERS.

(1)(a) Except as provided in (b) of this subsection, this section applies to any long-term care policy or certificate issued for delivery in this state on or after January 1, 2009.

(b) Certificates issued on or after January 1, 2009, under a group long-term care insurance policy as defined in RCW 48.83.020 (6)(a), that were in force prior to January 1, 2009, the provisions of this section apply on the policy anniversary first following January 1, 2009.

(2) Except for policies for which no applicable premium rate or rate schedule increases can be made, the issuer must provide all of the information listed in this subsection to the applicant at the time of application or enrollment. If the method of application does not allow for delivery at that time, the issuer must provide all of the information listed in this section to the applicant no later than at the time of delivery of the policy or certificate. For example, a method of delivery that does not allow for all listed information to be provided at time of application or enrollment is an application by mail.

(a) A statement that the policy may be subject to rate increases in the future;

(b) An explanation of potential future premium rate revisions, and the policyholder's or certificate holder's option in the event of a premium rate revision;

(c) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(d) A general explanation for applying premium rate or rate schedule including:

(i) A description of when premium rate or rate schedule adjustments will be effective (for example, next anniversary date or next billing date); and

(ii) The right to a revised premium rate or rate schedule as provided for in (c) of this subsection if the premium rate or rate schedule is changed;

(e)(i) Information regarding each premium rate increase on this policy form or similar policy forms over the past ten years for this state or any other state that, at a minimum, identifies:

(A) The policy forms for which premium rates have been increased;

(B) The calendar years when the form was available for purchase; and

(C) The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(ii) The issuer, in a fair manner, may provide additional explanatory information related to the rate increases.

(iii) The issuer may exclude from the disclosure, premium rate increases that only apply to blocks of business acquired from other nonaffiliated issuers or the long-term care policies acquired from other nonaffiliated issuers when those increases occurred prior to the acquisition.

(iv) If the acquiring issuer files for a rate increase on a long-term care policy form acquired from a nonaffiliated issuer or a block of policy forms acquired from a nonaffiliated issuer on or before the later of January 1, 2009, or the end of a twenty-four-month period following the acquisition of the block or policies, the acquiring issuer may exclude that rate increase from the disclosure; however, the nonaffiliated selling issuer must include the disclosure of that rate increase in accordance with (e)(i) of this subsection.

(v) If the acquiring issuer in (e)(iv) of this subsection files for a subsequent rate increase at any time (including during the twenty-four-month period following the acquisition of the block or policies) on the same policy form acquired from a nonaffiliated issuer or block of policy forms acquired from a nonaffiliated issuer referenced in (e)(iv) of this subsection, the acquiring issuer must make all disclosures required by (e) of this subsection, including disclosure of the earlier rate increase.

(vi) If the policy is for employer-group coverage, the disclosures in this subsection need to be made only to the employer if the employer is paying the entire premium and no contributions or coverage elections are made by individual employees.

(3) The applicant must sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the issuer made the disclosure required under subsection (2)(a) and (e) of this section. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant must sign no later than at the time of delivery of the policy or certificate.

(4) The forms provided in WAC 284-83-170 and 284-83-190 must be used by the issuer to comply with the requirements of subsections (2) and (3) of this section.

(5) The issuer must provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, as applicable, at least forty-five days prior to the implementation of any premium rate schedule increase by the issuer. The notice must include the information required by subsection (2) of this section when the rate increase is implemented.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-035, filed 11/24/08, effective 12/25/08.]

WAC 284-83-040 INITIAL RATE FILING REQUIREMENTS.

The issuer must provide the following information to the commissioner no fewer than thirty days prior to making a long-term care insurance form available for sale in this state:

(1) A copy of each disclosure document required in WAC 284-83-035; and

(2) An actuarial certification consisting of at least the following:

(a) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(b) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(c) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(d) A complete description of the basis for policy reserves that are anticipated to be held under the form, including:

(i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(ii) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(iii) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating, where permitted); and

(iv) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or, if such a statement cannot be made, a complete description of the situations where this does not occur;

(A) An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;

(B) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration based on a standard age distribution; and

(e)(i) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the issuer except for reasonable differences attributable to benefits; or

(ii) A comparison of the premium schedules for similar policy forms that are currently available from the issuer with an explanation of the differences.

(3)(a) The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration must include:

(i) Premium and claim experience on similar policy forms, adjusted for any premium or benefit differences;

(ii) Relevant and credible data from other studies; or

(iii) Both (a)(i) and (ii) of this subsection.

(b) In the event the commissioner asks for additional information, the period in subsection (2) of this section does not include the period during which the issuer is preparing the requested information.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-040, filed 11/24/08, effective 12/25/08.]

WAC 284-83-045 PROHIBITION AGAINST POST-CLAIMS UNDERWRITING.

(1) All applications for long-term care insurance policies or certificates except those that are guaranteed issue must contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(2)(a) If an application for long-term care insurance includes a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the prescribed medications.

(b) If the medications listed in the application were known by the issuer, or should have been known by the issuer at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate cannot be rescinded based on that condition.

(3) Except for policies or certificates which are guaranteed issue:

(a) The following language must be set out conspicuously and in close conjunction with the applicant's signature block on the application for a long-term care insurance policy or certificate:

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

(b) The following language, or language substantially similar to the following, must be set out conspicuously on every long-term care insurance policy or certificate at the time of delivery:

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

(c) Prior to issuance of a long-term care policy or certificate to an applicant age eighty or older, the issuer must obtain one of the following:

(i) A report of a physical examination;

(ii) An assessment of functional capacity;

(iii) An attending physician's statement; or

(iv) Copies of the applicant's medical records.

(4) A copy of the completed application or enrollment form (whichever is applicable) must 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.

(5) Every issuer or other entity selling or issuing long-term care insurance benefits must maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily requested, and must annually furnish this information to the commissioner. The format is prescribed by the National Association Of Insurance Commissioners, and is set forth in WAC 284-83-165.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-045, filed 11/24/08, effective 12/25/08.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 284-83-050 MINIMUM STANDARDS FOR HOME HEALTH AND COMMUNITY CARE BENEFITS IN LONG-TERM CARE INSURANCE POLICIES.

(1) If a long-term care insurance policy or certificate provides benefits for home health care or community care services, it must not limit or exclude benefits:

(a) By requiring that the insured or claimant would need care in a nursing facility if home health care services were not provided;

(b) By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community, or institutional setting before home health care services are covered;

(c) By limiting eligible services to services provided by registered nurses or licensed practical nurses;

(d) By requiring that a nurse or therapist provide services covered under the policy that can be provided by a home health aide or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

(e) By excluding coverage for personal care services provided by a home health aide;

(f) By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

(g) By requiring that the insured or claimant have an acute condition before home health care services are covered;

(h) By limiting benefits to services provided by medicare-certified agencies or providers; or

(i) By excluding coverage for adult day care services.

(2) If a long-term care insurance policy or certificate provides for home health or community care services, it must 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 does not apply to policies or certificates issued to residents of continuing care retirement communities.

(3) Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

(a) This permits the home health care benefits to be counted toward the maximum length of long-term care coverage under the policy.

(b) Home health care benefits must not be restricted to a period of time which would make the benefit illusory. For example, fewer than three hundred sixty-five benefit days and less than a twenty-five dollar daily maximum benefit are considered illusory home health care benefits.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-050, filed 11/24/08, effective 12/25/08.]

WAC 284-83-055 REQUIREMENT TO OFFER INFLATION PROTECTION.

(1) No issuer may offer a long-term care insurance policy in this state unless the issuer also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Issuers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(a) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate of not less than five percent.

(b) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit must be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made.

(c) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(2) If the policy is issued to a group, the required offer in subsection (1) of this section must be made to the group policyholder; however, if the policy is issued to a group defined in RCW 48.83.020 (6)(d), other than to a continuing care retirement community, the offering must be made to each proposed certificate holder.

(3) The offer in subsection (1) of this section is not required of life insurance policies or riders containing accelerated long-term care benefits.

(4)(a) Issuers must include the following information in or with the outline of coverage:

(i) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison must show benefit levels over at least a twenty-year period; and

(ii) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(b) The issuer may use a reasonable hypothetical or a graphic demonstration for the purposes of this disclosure. For example, meaningful benefit minimums or durations could be demonstrated by showing increases to attained age, for a period such as at least twenty years, for some multiple of the policy's maximum benefit, or throughout the period of coverage.

(5) Inflation protection benefit increases under a policy that includes these benefits must continue without regard to the insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

(6) An offer of inflation protection that provides for automatic benefit increases must include an offer of a premium which the issuer expects to remain constant. Unless the premium is guaranteed to remain constant, the offer must disclose in a conspicuous manner that the premium may change in the future.

(7)(a) Inflation protection as provided in subsection (1)(a) of this section must be included in any long-term care insurance policy unless the issuer obtains a rejection of inflation protection signed by the policyholder. The rejection may be either part of the application or on a separate form.

(b) The rejection is considered a part of the application.

(c) The following language, or language substantially similar to the following, must be set out conspicuously on the rejection:

"I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection."

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-055, filed 11/24/08, effective 12/25/08.]

WAC 284-83-060 REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE.

(1) Application forms must include 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 health or long-term care policy or certificate presently in force.

(a) A supplementary application or other form, signed by the applicant and insurance producer, except where the coverage is sold without an insurance producer, containing the questions may be used. With regard to a replacement policy issued to a group defined by RCW 48.83.020 (6)(a), the required questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificate holder has been notified of the replacement.

(b) The following questions, or words substantially similar to the following, must be used:

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

(ii) Did you have another long-term care insurance policy or certificate in force during the last twelve months? If so, with which company? If that policy lapsed, when did it lapse?

(iii) Are you covered by medicaid?

(iv) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?"

(2) Insurance producers must list any other health insurance policies they have sold to the applicant that are still in force and any similar policies sold in the past five years that are no longer in force.

(3) Solicitations other than direct response. Upon determining that a sale will involve replacement, the issuer, other than an issuer using direct response solicitation methods, or its insurance producer, must furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of health care or long-term care coverage. One copy of the notice must be retained by the applicant and an additional copy must be signed by the applicant and must be retained by the issuer. The notice set forth in WAC 284-83-063 must be used.

(4) Direct response solicitations. Issuers using direct response solicitation methods must deliver a notice regarding replacement of health or long-term care coverage to the applicant upon issuance of the policy. The required notice set forth in WAC 284-83-067 must be used.

(5) If replacement is intended, the replacing issuer must notify the existing issuer of the proposed replacement in writing. The existing policy must be identified by the issuer, including the name of the insured and policy number or address plus zip code.

Notice must be made within five working days after the date the application is received by the issuer or the date the policy is issued, whichever is sooner.

(6) Life insurance policies that accelerate benefits for long-term care must comply with this section if the policy being replaced is a long-term care insurance policy.

(a) If the policy being replaced is a life insurance policy, the issuer must comply with the replacement requirements of WAC 284-23-400 through 284-23-485.

(b) If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing issuer must comply with both the long-term care and the life insurance replacement requirements.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-060, filed 11/24/08, effective 12/25/08.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 284-83-063 NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE MARKETED BY AN INSURANCE PRODUCER.

The following notice is required in WAC **284-83-060**(3):

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL [ACCIDENT AND SICKNESS] [HEALTH] 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] [health] 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 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all [accident and sickness] [health] 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 [INSURANCE PRODUCER 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 appointed [insurance producer] 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 [Insurance Producer] or Other Representative)

[Typed Name and Address of [Insurance Producer]]

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

(Applicant's Signature) (Date)

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.010(5). WSR 11-01-159 (Matter No. R 2010-09), § 284-83-063, filed 12/22/10, effective 1/22/11. Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-063, filed 11/24/08, effective 12/25/08.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 284-83-067 NOTICE TO APPLICANT REGARDING REPLACEMENT OF DIRECT MARKETED INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE.

The following notice is required by WAC 284-83-060(4):

NOTICE TO APPLICANT REGARDING REPLACEMENT OF [ACCIDENT AND SICKNESS] [HEALTH] 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] [health] 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 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

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

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

(2) 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] [insurance producer] 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]

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-067, filed 11/24/08, effective 12/25/08.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 284-83-070 REPORTING REQUIREMENTS.

(1) Every issuer must maintain records for each insurance producer of that producer's amount of replacement sales as a percent of the insurance producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the insurance producer as a percent of the insurance producer's total annual sales.

(2) Every issuer must report annually by June 30 the ten percent of its insurance producers with the highest percentages of lapses and replacements as measured by subsection (1) of this section on the form set forth in WAC 284-83-195.

(3) 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 insurance producer activities regarding the sale of long-term care insurance.

(4) Every issuer must 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 on the form set forth in WAC 284-83-195.

(5) Every issuer must 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 on the form set forth in WAC 284-83-195.

(6) Every issuer must report annually by June 30, for qualified long-term care insurance policies, the number of claims denied for each class of business, expressed as a percentage of claims denied on the form set forth in WAC 284-83-185.

(7) As used in this section:

(a) "Policy" refers only to long-term care insurance policies;

(b) "Claim" means a request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

(c) "Denied" means that the issuer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

(d) "Report" means on a statewide basis.

(8) Reports required under this section must be filed with the commissioner.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-070, filed 11/24/08, effective 12/25/08.]

WAC 284-83-075 DISCRETIONARY POWERS OF COMMISSIONER.

Upon written request and after an administrative hearing, the commissioner may enter an order to modify or suspend a specific provision or provisions of this chapter with respect to a specific long-term care insurance policy or certificate upon a written finding that:

(1) The modification or suspension would be in the best interest of the insureds;

(2) The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

(3)(a) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or

(b) The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

(c) The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-075, filed 11/24/08, effective 12/25/08.]

WAC 284-83-080 RESERVE STANDARDS.

(1) If long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits must be determined in accordance with RCW 48.74.030 (1)(g). Claim reserves must also be established in the case when the policy or rider is in claim status. Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits; however, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit. In the development and calculation of reserves for policies and riders subject to this subsection, due regard must be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

(a) Definition of insured events;

(b) Covered long-term care facilities;

(c) Existence of home convalescence care coverage;

(d) Definition of facilities;

(e) Existence or absence of barriers to eligibility;

(f) Premium waiver provision;

(g) Renewability;

(h) Ability to raise premiums;

(i) Marketing method;

(j) Underwriting procedures;

(k) Claims adjustment procedures;

(l) Waiting period;

(m) Maximum benefit;

(n) Availability of eligible facilities;

(o) Margins in claim costs;

(p) Optional nature of benefit;

(q) Delay in eligibility for benefit;

(r) Inflation protection provisions; and

(s) Guaranteed insurability option.

(2) If long-term care benefits are provided other than as provided in subsection (1) of this section, reserves must be determined in accordance with the accounting practices and procedures manuals adopted by the National Association Of Insurance Commissioners, unless otherwise provided by law, as required by RCW 48.05.073.

(3) Any applicable valuation morbidity table must be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-080, filed 11/24/08, effective 12/25/08.]

WAC 284-83-090 PREMIUM RATE SCHEDULE INCREASES.

(1)(a) Except as provided in (b) of this subsection, this section applies to any long-term care policy or certificate issued in this state on or after January 1, 2009.

(b) For certificates issued on or after January 1, 2009, under a group long-term care insurance policy as defined in RCW 48.83.020 (6)(a), which policy was in force before January 1, 2009, the provisions of this section apply on the first policy anniversary following January 1, 2009.

(2) The issuer must provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least thirty days prior to giving the notice to the policyholders and must include:

(a) Information required by WAC 284-83-035;

(b) Certification by a qualified actuary that:

(i) If the requested premium rate schedule increase is implemented and the underlying assumptions which reflect moderately adverse conditions are realized, no further premium rate schedule increases are anticipated;

(ii) The premium rate filing is in compliance with the provisions of this section;

(c) An actuarial memorandum justifying the rate schedule change request that includes:

(i) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase, and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale.

(A) Annual values for the five years preceding and the three years following the valuation date must be provided separately.

(B) The projections must include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase.

(C) The projections must demonstrate compliance with subsection (3) of this section.

(D) For exceptional increases:

(I) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(II) In the event the commissioner determines that offsets may exist, the issuer must use appropriate net projected experience;

(ii) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(iii) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the issuer have been relied on by the actuary;

(iv) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

(v) Composite rates reflecting projections of new certificates, if it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase;

(d) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

(e) Sufficient information for review of the premium rate schedule increase by the commissioner.

(3) All premium rate schedule increases must be determined in accordance with the following requirements:

(a) Exceptional increases must provide that seventy percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(b) Premium rate schedule increases must be calculated so that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(i) The accumulated value of the initial earned premium times fifty-eight percent;

(ii) Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis;

(iii) The present value of future projected initial earned premiums times fifty-eight percent; and

(iv) Eighty-five percent of the present value of future projected premiums not in (b)(iii) of this subsection on an earned basis;

(c) In the event that a policy form has both exceptional and other increases, the values in (b)(ii) and (iv) of this subsection will also include seventy percent for exceptional rate increase amounts; and

(d) All present and accumulated values used to determine rate increases must use the maximum valuation interest rate for policy reserves as specified in the accounting practices and procedures manuals adopted by the National Association Of Insurance Commissioners, except as otherwise provided by RCW 48.05.073. The actuary must disclose as part of the actuarial memorandum the use of any appropriate averages.

(4) For each rate increase that is implemented, the issuer must file for review by the commissioner updated projections, as defined in subsection (2)(c)(i) of this section, annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions set forth in subsection (11) of this section, the projections required by this subsection may be provided to the policyholder in lieu of filing with the commissioner.

(5) If any premium rate in the revised premium rate schedule is greater than two hundred percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in subsection (2)(c)(i) of this section, must be filed for review by the commissioner every five years following the end of the required period in subsection (4) of this section. For group insurance policies that meet the conditions in subsection (11) of this section, the projections required by this subsection may be provided to the policyholder in lieu of filing with the commissioner.

(6)(a) If the commissioner determines that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection (3) of this section, the commissioner may require the issuer to implement either premium rate schedule adjustments or other measures to reduce the difference between the projected and actual experience.

(b) In determining whether the actual experience adequately matches the projected experience, consideration should be given to subsection (2)(c)(v) of this section, as applicable.

(c) For purposes of this section:

(i) The term "adequately match the projected experience" requires more than a comparison between actual and projected incurred claims. Other assumptions should be taken into consideration, including lapse rates (including mortality), interest rates, margins for moderately adverse conditions, or any other assumptions used in the pricing of the product.

(ii) It is to be expected that the actual experience will not exactly match the issuer's projections. During the period that projections are monitored, the commissioner will determine whether there is an adequate match if the differences in earned premiums and incurred claims are not in the same direction (both actual values higher or lower than projections) or the difference as a percentage of the projected is not of the same order.

(7) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the issuer must file:

(a) A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form, requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in subsection (8) of this section; and

(b) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection (8) of this section, had the greater of the original anticipated lifetime loss ratio or fifty-eight percent been used in the calculations described in subsection (3)(b)(i) and (iii) of this section.

(8)(a) For a rate increase filing that meets the following criteria for all policies included in the filing, the commissioner must review the projected lapse rates and past lapse rates during the twelve months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(i) The rate increase is not the first rate increase requested for the specific policy form or forms;

(ii) The rate increase is not an exceptional increase; and

(iii) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(b) If significant adverse lapsation has occurred, is anticipated in the filing, or is evidenced in the actual results as presented in the updated projections provided by the issuer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the issuer to offer all in-force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the issuer or its affiliates without underwriting.

(i) The offer shall:

(A) Be subject to the approval of the commissioner;

(B) Be based on actuarially sound principles, but not be based on attained age; and

(C) Provide that maximum benefits under any new policy accepted by the insured must be reduced by comparable benefits already paid under the existing policy.

(ii) The issuer must maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase will be limited to the lesser of:

(A) The maximum rate increase determined based on the combined experience; and

(B) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent.

(9) If the commissioner determines that the issuer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, in addition to the provisions of subsection (8) of this section, the commissioner may prohibit the issuer from either of the following:

(a) Filing and marketing comparable coverage for a period of up to five years; or

(b) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

(10) Subsections (1) through (9) of this section do not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in WAC 284-83-010, if the policy complies with all of the following provisions:

(a) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(b) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements (as applicable) in any of the following:

(i) Chapter 48.76 RCW;

(ii) RCW 48.23.420 through 48.23.450; and

(iii) RCW 48.18A.050;

(c) The policy meets the disclosure requirements of RCW 48.83.070(2) and 48.83.080;

(d) The portion of the policy that provides insurance benefits other than long-term care coverage meets the applicable requirements in the following:

(i) Policy illustrations as required by chapter 48.23A RCW;

(ii) Disclosure requirements in WAC 284-23-300 through 284-23-370; and

(iii) Disclosure requirements in RCW 48.18A.030;

(e) An actuarial memorandum is filed with the insurance department that includes:

(i) A description of the basis on which the long-term care rates were determined;

(ii) A description of the basis for the reserves;

(iii) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(iv) A description and a table of each actuarial assumption used. For expenses, the issuer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(v) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(vi) The estimated average annual premium per policy and the average issue age;

(vii) A statement as to whether underwriting is performed at the time of application. The statement must indicate whether underwriting is used and, if used, the statement must include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement must indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(viii) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

(11) Subsections (6) and (8) of this section do not apply to group insurance policies as defined in RCW 48.83.020 (6)(a), if:

(a) The policies insure two hundred fifty or more persons and the policyholder has five thousand or more eligible employees of a single employer; or

(b) The policyholder, and not the certificate holder, pays a material portion of the premium, which must not be less than twenty percent of the total premium for the group in the calendar year prior to the year a rate increase is filed.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-090, filed 11/24/08, effective 12/25/08.]

WAC 284-83-095 FILING REQUIREMENTS.

Prior to offering group long-term care insurance to a resident of this state pursuant to RCW 48.83.030, the issuer or similar organization must file with the commissioner evidence that the group policy or certificate has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those of this state.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-095, filed 11/24/08, effective 12/25/08.]

WAC 284-83-100 FILING REQUIREMENTS FOR ADVERTISING.

(1) Every issuer or other entity issuing long-term care insurance in this state must provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio or television medium for review by the commissioner. In addition, a copy of all advertisements must be retained by the issuer for at least three years after the date the advertisement was first used.

(2) The commissioner may exempt from these requirements any advertising form or material when, in the commissioner's opinion, this requirement may not be reasonably applied.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-100, filed 11/24/08, effective 12/25/08.]

WAC 284-83-105 STANDARDS FOR MARKETING.

(1) Every issuer or entity marketing long-term care insurance coverage in this state, directly or through its insurance producers, must:

(a) Establish marketing procedures and insurance producer training requirements to ensure that:

(i) Any marketing activities, including any comparison of policies, by its insurance producers, other representatives, or employees are fair and accurate; and

(ii) Excessive insurance is not sold or issued.

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

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

(c) Provide copies of the disclosure forms required in WAC 284-83-035(3), 284-83-170 and 284-83-190 to the applicant.

(d) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has health or long-term care insurance and the types and amounts of any such insurance. For qualified long-term care insurance policies, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has health care coverage is not required.

(e) Every issuer or other entity marketing long-term care insurance must establish auditable procedures for verifying compliance with this subsection.

(f) If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by its commissioner, at time of solicitation for long-term care insurance the issuer must provide written notice to the prospective policyholder and certificate holder that the counseling program is available and provide its name, address and telephone number.

(g) For long-term care insurance policies, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to WAC 284-83-020 (1)(c).

(h) Provide an explanation of contingent benefit upon lapse provided for in WAC 284-83-130 (4)(c) and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in WAC 284-83-130 (4)(d).

(2) In addition to the practices prohibited in chapters 48.30 RCW and 284-30 WAC, the following acts and practices are prohibited:

(a) Twisting, as defined in RCW 48.30.180.

(b) 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.

(c) 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 producer or insurance company.

(d) Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

(3)(a) With respect to the obligations set forth in this subsection, the primary responsibility of an association, as defined in RCW 48.83.020 (6)(b), when endorsing or selling long-term care insurance must be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations must provide objective information regarding long-term care insurance policies or certificates endorsed or sold by the associations to ensure that members of the associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

(b) The issuer must file with the commissioner the following material:

(i) The policy and certificate;

(ii) A corresponding outline of coverage; and

(iii) All advertisements requested by the commissioner.

(c) The association must disclose in any long-term care insurance solicitation:

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

(ii) A brief description of the process under which the policies and the issuer issuing the policies were selected.

(d) If the association and the issuer have interlocking directorates or trustee arrangements, the association must disclose that fact to its members.

(e) The board of directors of associations selling or endorsing long-term care insurance policies or certificates must review and approve the insurance policies as well as the compensation arrangements made with the issuer.

(f) The association must also:

(i) At the time of the association's decision to endorse the selling of long-term care insurance policies or certificates, engage the services of a person with expertise in long-term care insurance not affiliated with the issuer to conduct an examination of the policies (including its benefits, features, and rates) and update the examination thereafter in the event of material change;

(ii) Actively monitor the marketing efforts of the issuer and its producers; and

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

Subsections (3)(f)(i) through (f)(iii) of this section do not apply to qualified long-term care insurance policies.

(g) No group long-term care insurance policy or certificate may be issued to an association unless the issuer files with the commissioner the information required in this subsection.

(h) The issuer must not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the issuer certifies annually that the association has complied with the requirements set forth in this section.

(i) Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-105, filed 11/24/08, effective 12/25/08.]

WAC 284-83-110 SUITABILITY.

(1) This section does not apply to life insurance policies that accelerate benefits for long-term care.

(2) Every issuer or other entity marketing long-term care insurance must:

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

(b) Train its insurance producers in the use of its suitability standards; and

(c) Maintain a copy of its suitability standards and make it available for inspection upon request by the commissioner.

(3)(a) To determine whether the applicant meets the standards developed by the issuer, the insurance producer and the issuer must develop procedures that take the following into consideration:

(i) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(ii) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

(iii) The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

(b) The issuer, and if an insurance producer is involved, the insurance producer must make reasonable efforts to obtain the information set out in subsection (2)(a) of this section. The efforts must include presentation to the applicant, at or prior to application, the "long-term care insurance personal worksheet." The personal worksheet used by the issuer must contain, at a minimum, the information in the format set forth in WAC 284-83-170, in not less than twelve point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the form of the issuer's personal worksheet must be filed with the commissioner.

(c) Except for sales of employer-group long-term care insurance to employees and their spouses, a completed personal worksheet must be returned to the issuer prior to the issuer's consideration of the applicant for coverage.

(d) The sale, distribution, use or dissemination in any way by the issuer or insurance producer of information obtained through the personal worksheet is prohibited.

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

(5) Insurance producers must use the suitability standards developed by the issuer in all marketing or solicitation of long-term care insurance.

(6) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "things you should know before you buy long-term care insurance" must be provided. The form must be in the format set forth in WAC 284-83-175, in not less than twelve point type.

(7) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer may send the applicant a letter similar to the form set forth in WAC 284-83-180. If the applicant declines to provide financial information, the issuer may use another method to verify the applicant's intent. The applicant's returned letter or a record of the alternative method of verification must be made part of the applicant's file.

(8) The issuer must report annually to the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of applicants who chose to confirm after receiving a suitability letter.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-110, filed 11/24/08, effective 12/25/08.]

WAC 284-83-115 PROHIBITION AGAINST PREEXISTING CONDITIONS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES.

If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing issuer must waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-115, filed 11/24/08, effective 12/25/08.]

WAC 284-83-120 AVAILABILITY OF NEW SERVICES OR PROVIDERS.

(1) The issuer must notify policyholders of the availability of a new long-term policy series that provides coverage for new long-term care services or providers material in nature and not previously available through the issuer to the general public. The notice must be provided within twelve months after the date the new policy series is made available for sale in this state. Changes to policy structure or benefits or provisions that are minor in nature are not "new long-term care services or providers material in nature." Examples of when notification need not be provided include changes in elimination periods, benefit periods or benefit amounts.

(2) Notwithstanding subsection (1) of this section, notification is not required for any long-term care insurance policy issued prior to January 1, 2009, or to any policyholder or certificate holder who is currently eligible for benefits, within an elimination period or on a claim, previously had been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy series. The issuer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium in order to add the new services or providers.

(3) The issuer must make the new coverage available in one of the following ways:

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

(b) By exchanging the existing policy or certificate for one with an issue age based on the attained 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 must be based on premiums paid or reserves held for the prior policy or certificate;

(c) By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status is 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; or

(d) By an alternative program developed by the issuer that meets the intent of this section if the program is filed with and approved by the commissioner.

(4) The issuer is not required to notify its policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of this subsection, "limited distribution channel" means distribution through a discrete entity,

such as a financial institution or brokerage, through which specialized products are made available that are not available for sale to the general public. Policyholders that purchase a new proprietary policy must 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.

(5) Policies issued pursuant to this section will be considered exchanges and not replacements. These exchanges are not subject to WAC 284-83-060 and 284-83-110, and the reporting requirements of WAC 284-83-065 (1) through (5).

(6)(a) If the policy is offered through an employer, labor organization, professional, trade or occupational association, the required notification in subsection (1) of this section must be made to the offering entity.

(b) If the policy is issued to a group defined in RCW 48.83.020 (6)(d), the notification must be made to each certificate holder.

(7) Nothing in this section prohibits the issuer from offering any policy, rider, certificate or coverage change to any policyholder or certificate holder. Upon request, any policyholder may apply for currently available coverage that includes the new services or providers. The issuer may require the policyholder to meet all eligibility requirements, including underwriting and payment of the required premium to add new services or providers.

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

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-120, filed 11/24/08, effective 12/25/08.]

WAC 284-83-125 RIGHT TO REDUCE COVERAGE AND LOWER PREMIUMS.

(1)(a) Every long-term care insurance policy and certificate must include a provision that allows the policyholder or certificate holder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:

(i) Reducing the maximum benefit; or

(ii) Reducing the daily, weekly or monthly benefit amount.

(b) The issuer may also offer other reduction options that are consistent with the policy or certificate design or the issuer's administrative processes.

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

(3) The age to determine the premium for the reduced coverage must be based on the age used to determine the premiums for the coverage currently in force.

(4) The issuer 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.

(5) If a policy or certificate is about to lapse, the issuer must provide a written reminder to the policyholder or certificate holder of his or her right to reduce coverage and premiums in the notice required by WAC 284-83-025 (1)(c).

(6) Compliance with this section may be accomplished by policy replacement, exchange or by adding the required provision via amendment or endorsement to the policy.

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

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-125, filed 11/24/08, effective 12/25/08.]

WAC 284-83-130 NONFORFEITURE BENEFIT REQUIREMENT.

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

(2) To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of RCW **48.83.120**:

(a) A policy or certificate offered with nonforfeiture benefits must have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage issued by the issuer without nonforfeiture benefits. The nonforfeiture benefit included in the offer must be the benefit described in subsection (5) of this section; and

(b) The offer must be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

(3) If the offer required to be made under RCW 48.83.120 is rejected, the issuer must provide the contingent benefit upon lapse described in this section. The contingent benefit on lapse in subsection (4)(d) of this section applies even if this offer is accepted for a policy with a fixed or limited premium paying period.

(4)(a) After rejection of the offer required under RCW 48.83.120, for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the issuer must provide a contingent benefit upon lapse.

(b) If a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate must provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(c) A contingent benefit on lapse must be triggered every time the issuer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in the following table based on the insured's issue age, and the policy or certificate lapses within one hundred twenty days after the due date of the premium so increased. Unless otherwise required, policyholders must be notified at least thirty days prior to the date the premium reflecting the rate increase is due.

Triggers for a Substantial Premium Increase

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

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
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%

(d) A contingent benefit on lapse must also be triggered for policies with a fixed or limited premium paying period every time the issuer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in the following table based on the insured's issue age, the policy or certificate lapses within one hundred twenty days after the due date of the premium so increased, and the ratio in (f)(ii) of this subsection is forty percent or more. Unless otherwise required, policyholders must be notified at least thirty days prior to the date the premium reflecting the rate increase is due. This requirement is in addition to the contingent benefit provided by subsection (3) of this section and if both are triggered, the benefit provided must be at the option of the insured.

Triggers for a Substantial Premium Increase

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

(e) On or before the effective date of a substantial premium increase as defined in (c) of this subsection, the issuer must:

(i) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(ii) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection (5) of this section. This option may be elected at any time during the one hundred twenty-day period provided for in (c) of this subsection; and

(iii) Notify the policyholder or certificate holder that a default or lapse at any time during the one hundred twenty-day period provided for in (c) of this subsection will be deemed to be the election of the offer to convert in (e)(ii) of this subsection unless the automatic option in (f)(iii) of this subsection applies.

(f) On or before the effective date of a substantial premium increase as defined in (d) of this subsection, the issuer must:

(i) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(ii) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent 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 one hundred twenty-day period provided for in (d) of this subsection; and

(iii) Notify the policyholder or certificate holder that a default or lapse at any time during the one hundred twenty-day period provided for in (d) of this subsection will be deemed to be the election of the offer to convert in (f)(ii) of this subsection if the ratio is forty percent or more.

(5) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with subsection (4)(c) but not (d) of this subsection, are described in this subsection:

(a) For purposes of this subsection, "attained age rating" is defined as a schedule of premiums starting from the issue date which increases age at least one percent per year prior to age fifty, and at least three percent per year beyond age fifty.

(b) For purposes of this subsection, the nonforfeiture benefit must be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits must be determined as specified in (c) of this subsection.

(c) The standard nonforfeiture credit will be equal to one hundred percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The issuer 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 must not be less than thirty 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 subsection (6) of this section.

(d)(i) The nonforfeiture benefit must begin no later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse must be effective during the first three years as well as thereafter.

(ii) Notwithstanding (d)(i) of this subsection, for a policy or certificate with attained age rating, the nonforfeiture benefit must begin on the earlier of:

(A) The end of the tenth year following the policy or certificate issue date; or

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

(e) 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.

(6) All benefits paid by the issuer while the policy or certificate is in premium-paying status or in paid-up status must not exceed the maximum benefits that would be payable if the policy or certificate had remained in premium-paying status.

(7) No difference in the minimum nonforfeiture benefits as required under this section for group and individual policies is permitted.

(8) The requirements set forth in this section must become effective twelve months after adoption of this provision and must apply as follows:

(a) Except as provided in (b) and (c) of this subsection, this section applies to any long-term care policy issued in this state on or after January 1, 2009.

(b) This section does not apply to certificates issued on or after the effective date of this section under a group long-term care insurance policy as defined in RCW **48.83.020** (6)(a), if policy was in force on January 1, 2009.

(c) The last sentence in subsection (3) of this section and subsection (4)(d) and (f) of this section apply to any long-term care insurance policy or certificate issued in this state six months after their adoption, except as to new certificates on a group policy as defined in RCW**48.83.020** (6)(a), those sentences apply to any long-term care insurance policy or certificate issued in this state one year after adoption.

(9) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse is subject to the loss ratio requirements of WAC **284-83-085** or **284-83-090**, whichever is applicable, treating the policy as a whole.

(10) To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection (4)(c) or (d) of this section, a replacing issuer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another issuer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original issuer.

(11) A nonforfeiture benefit for qualified long-term care insurance policies that are level premium policies must be offered and must meet the following requirements:

(a) The nonforfeiture provision must be appropriately captioned;

(b) The nonforfeiture provision must provide a benefit available in the event of a default in the payment of any premiums and must state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying policies approved by the commissioner for the same policy form; and

(c) The nonforfeiture provision must provide at least one of the following:

(i) Reduced paid-up insurance;

(ii) Extended term insurance;

(iii) Shortened benefit period; or

(iv) Other similar offerings approved by the commissioner.

WAC 284-83-135 STANDARDS FOR BENEFIT TRIGGERS.

(1) A long-term care insurance policy must condition the payment of benefits on a determination of the insured's ability to perform activities of daily living or on cognitive impairment of the insured. Eligibility for the payment of benefits must not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

(2)(a) Activities of daily living must include at least the following, as defined in WAC 284-83-015, and must be defined in the policy:

(i) Bathing;

(ii) Continence;

(iii) Dressing;

(iv) Eating;

(v) Toileting; and

(vi) Transferring;

(b) Issuers may use activities of daily living to trigger covered benefits in addition to those contained in subsection (1)(a) of this section only if they are defined in the policy.

(3) The issuer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions must not restrict, and must not be in lieu of, the requirements contained in subsections (1) and (2) of this section.

(4) For purposes of this section the determination of a deficiency must not be more restrictive than:

(a) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

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

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

(6) Long-term care insurance policies must include a clear description of the process for appealing and resolving benefit determinations.

(7)(a) Except as provided in (b) of this subsection, the provisions of this section apply to a long-term care policy issued in this state on or after January 1, 2009.

(b) The provisions of this section do not apply to certificates issued on or after the effective date of this section under a group long-term care insurance policy as defined in RCW 48.83.020 (6)(a) that were in force on January 1, 2009.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-135, filed 11/24/08, effective 12/25/08.]

WAC 284-83-140 QUALIFIED LONG-TERM CARE INSURANCE POLICIES -- ADDITIONAL STANDARDS FOR BENEFIT TRIGGERS.

(1) For purposes of this section the following definitions apply:

(a) "Qualified long-term care services" means services that meet the requirements of Section 7702B (c)(1) of the Internal Revenue Code of 1986, as amended, including: Necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and

rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(b)(i) "Chronically ill individual" has the meaning of Section 7702B (c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

(A) Being unable to perform (without substantial assistance from another individual) at least two activities of daily living for a period of at least ninety days due to a loss of functional capacity; or

(B) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

(ii) The term "chronically ill individual" does not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner certified that the individual meets these requirements.

(c) "Licensed health care practitioner" means a physician, as defined in Section 1861 (r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the federal Secretary of the Treasury.

(d) "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

(2) A qualified long-term care insurance policy must pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(3) A qualified long-term care insurance policy must condition the payment of benefits on a determination that the insured is a chronically ill individual as defined in subsection (1)(b)(i) of this section.

(4) Certifications regarding activities of daily living and cognitive impairment required pursuant to subsection (3) of this section must be performed by a licensed or certified physician, registered professional nurse, licensed social worker, or other individual who meet requirements prescribed by the federal Secretary of the Treasury.

(5) Certifications required pursuant to subsection (3) of this section may be performed by a licensed health care professional at the direction of the issuer as is reasonably necessary with respect to a specific claim; except that when a licensed health care practitioner has certified that the insured is unable to perform activities of daily living for an expected period of at least ninety days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety-day period.

(6) Qualified long-term care insurance policies must include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

[Statutory Authority: RCW 48.02.060 and 48.85.030. WSR 11-22-068 (Matter No. R 2011-08), § 284-83-140, filed 10/31/11, effective 12/1/11. Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-140, filed 11/24/08, effective 12/25/08.]

WAC 284-83-145 STANDARD FORMAT OUTLINE OF COVERAGE.

The following standards apply to the format and outline of coverage to be used in this state.

(1) The outline of coverage must be a free-standing document, using no smaller than ten-point type.

(2) The outline of coverage must contain no material of an advertising nature.

(3) Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

(4) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

(5) The following format for outline of coverage must be used in this state:

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

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

1. This policy is [an individual policy of insurance] [a group policy] which 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 policy, 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 policy 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 policy under Section 7702B(b) of the Internal Revenue Code of 1986 as amended. Benefits received under the [POLICY] [CERTIFICATE]may be taxable as income.

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

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

(1) Policies and certificates that are guaranteed renewable must 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 noncancelable must contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELABLE. This means that you have the right, subject to the terms of your policy, to continue this policy if 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 insurance producers] neither [insert company name] nor its [agents] [insurance producers] 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) [Noninstitutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

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

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

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Noneligible facilities and provider;

(c) Noneligible 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 6 above.]

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

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

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

(b) Any automatic benefit adjustment provisions;

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

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

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

12. ALZHEIMER'S DISEASE AND OTHER 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 which 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 which corresponds to each benefit option.]

14. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-145, filed 11/24/08, effective 12/25/08.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 284-83-150 REQUIREMENT TO DELIVER SHOPPER'S GUIDE.

(1) A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the commissioner, must be provided to all prospective applicants of a long-term care insurance policy or certificate.

(a) In the case of solicitations by an insurance producer, the insurance producer must deliver the shopper's guide prior to the presentation of an application or enrollment form.

(b) In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

(2) Issuers or insurance producers of life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the shopper's guide, but must furnish the policy summary required by RCW 48.83.070(2).

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-150, filed 11/24/08, effective 12/25/08.]

WAC 284-83-155 PROHIBITED PRACTICES.

The following practices are prohibited:

(1) No insurance producer or other representative of the issuer may complete the medical history portion of any form or application, including an electronic application, for the purchase of a long-term care policy.

(2) No issuer or insurance producer or other representative of the issuer may knowingly sell a long-term care policy to any person who is receiving medicaid.

(3) No issuer or insurance producer or other representative of the issuer may use or engage in any unfair or deceptive act or practice in the advertising, sale or marketing of long-term care policies.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-155, filed 11/24/08, effective 12/25/08.]

WAC 284-83-165 FORM FOR REPORTING RESCISSION OF LONG-TERM CARE POLICIES.

The following form must be used by issuers to annually report rescission of long-term care policies.

RESCISSION REPORTING FORM FOR LONG-TERM CARE POLICIES FOR THE STATE

OF___ FOR THE REPORTING YEAR 20[ ]

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

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

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-165, filed 11/24/08, effective 12/25/08.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 284-83-170 FORM OF PERSONAL WORKSHEET.

The following form of personal worksheet must be used by issuers in the sale of long-term care insurance policies.

Long-Term Care Insurance

Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _____

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

Type of Policy (noncancelable or guaranteed renewable): _____

The Company's Right to Increase Premiums: _____

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Issuers must use appropriate bracketed statement. Rate guarantees must not be shown on this form.]

Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in 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 ten years.] [The company has raised its premium rates on this policy form or similar policy forms in the last ten years. Following is a summary of the rate increases.]

Questions Related to Your Income

How will you pay each year's premium?

□ From my Income □ From my Savings/Investments □ My Family will Pay

[□ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?]

Note: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancelable policy.

What is your annual income? (check one) □ Under $10,000 □ $[10-20,000] □ $[20-30,000] □ $[30-50,000] □ Over $50,000

Note: The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)

□ No change □ Increase □ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) □ Yes □ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

□ From my Income □ From my Savings/Investments □ My Family will Pay

The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

Note: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.

What elimination period are you considering? Number of days ___ Approximate cost $___ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

□ From my Income □ From my Savings/Investments □ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

□ Under $20,000 □ $20,000-$30,000 □ $30,000-$50,000 □ Over $50,000

How do you expect your assets to change over the next ten years? (check one)

□ Stay about the same □ Increase □ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

□ The answers to the questions above describe my financial situation.

OR

□ I choose not to complete this information.

(Check one.)

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

Signed: _____

(Applicant) (Date)

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

Signed: _____

[(Agent)] [(Insurance Producer)] (Date)

[Agent's] [Insurance Producer's] Printed Name:_____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My [agent] [insurance producer] has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____]

(Applicant) (Date)

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

The company may contact you to verify your answers.

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

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-170, filed 11/24/08, effective 12/25/08.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 284-83-175 DISCLOSURE FORM.

The following form of disclosure must be used in this state.

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 this bullet; for noncancelable policies, delete the second sentence only.

The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare Medicare does **not** pay for most long-term care.

Medicaid Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.

Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.

When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.

Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Facilities Some long-term care insurance policies 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 into 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.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-175, filed 11/24/08, effective 12/25/08.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 284-83-180 RESPONSE LETTER.

The following form of response letter must be used in this state.

Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, 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 long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

Note: Choose the paragraph that applies.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

□ **Yes,** [although my worksheet indicates that long-term care 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 [issuer] at [address] by [date].

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-180, filed 11/24/08, effective 12/25/08.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

284-83-185 SAMPLE CLAIMS DENIAL REPORTING FORM.

The following form for reporting claims denials must be used in this state.

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 Data1**
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 Policy2		
9	• Provider/Facility Not Qualified Under the Policy3		
10	• Benefit Eligibility Criteria Not Met4		
11	• Other		

Footnotes:

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.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-185, filed 11/24/08, effective 12/25/08.]

WAC 284-83-190 POTENTIAL RATE INCREASE DISCLOSURE FORM.

The following form must be used in this state to disclose a potential rate increase.

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.

Issuers must provide all of the following information to the applicant:

Long-Term Care Insurance

Potential Rate Increase Disclosure Form

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 product may be increased in the future. Your rates CANNOT 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 a 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 WAC 284-83-130 (4)(d) and (f) are 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.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-190, filed 11/24/08, effective 12/25/08.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 284-83-195 FORM FOR REPORTING REPLACEMENT AND LAPSE OF LONG-TERM CARE INSURANCE POLICIES.

The following form must be used in this state to report replacements and lapses of long-term care insurance.

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 issuer must maintain records for each [agent] [insurance producer] on that [agent's] [insurance producer's] amount of long-term care insurance replacement sales as a percent of the [agent's] [insurance producer's] total annual sales and the amount of lapses of long-term care insurance policies sold by the [agent] [insurance producer] as a percent of the [agent's] [insurance producer's] total annual sales. The tables below should be used to report the ten percent of the issuer's [agents] [insurance producers] with the greatest percentages of replacements and lapses.

Listing of the 10% of [Agents] [Insurance Producers] with the Greatest Percentage of Replacements

[Agent's] [Insurance Producer's] Name	Number of Policies Sold by This [Agent] [Insurance Producer]	Number of Policies Replaced by This [Agent] [Insurance Producer]	Number of Replacements as % of Number Sold by This [Agent] [Insurance Producer]

Listing of the 10% of [Agents] [Insurance Producers] with the Greatest Percentage of Lapses

[Agent's] [Insurance Producer's] Name	Number of Policies Sold by This [Agent] [Insurance Producer]	Number of Policies Lapsed by This [Agent] [Insurance Producer]	Number of Lapses as % of Number Sold by This [Agent] [Insurance Producer]

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)

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-195, filed 11/24/08, effective 12/25/08.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 284-83-210 DEFINITIONS.

For purposes of WAC 284-83-210 through **284-83-250**:

(1) "Actual loss ratio" means a retrospective calculation and calculated as the benefits incurred divided by the "premiums earned," both measured from the beginning of the calculating period to the date of the loss ratio calculations.

(2) "Benefits incurred" means the claims incurred plus any increase (or less any decrease) in the reserves.

(3) "Calculating period" means the time span over which the actuary expects the premium rates, whether level or increasing, to remain adequate in accordance with the actuary's best estimate of future experience and during which the actuary does not expect to request a rate increase.

(4) "Claims incurred" means:

(a) Claims paid during the accounting period; plus

(b) The change in the liability for claims which have been reported but not paid; plus

(c) The change in the liability for claims which have not been reported but which may reasonably be expected.

Claims incurred does not include expenses incurred in processing the claims, home office or field overhead, acquisition and selling costs, taxes or other expenses, contributions to surplus, or profit.

(5) "Expected loss ratio" means a prospective calculation calculated as the projected benefits incurred divided by the projected premiums earned and based on the actuary's best projections of the future experience within the calculating period.

(6) "Overall loss ratio" means the benefits incurred divided by the premiums earned over the entire calculating period; it may involve both retrospective and prospective data.

(7) "Premium" means all sums charged, received or deposited as consideration for a long-term care insurance policy and includes any assessment, membership, contract, survey, inspection, service, or similar fees or charges paid.

(8) "Premiums earned" means the premiums, less experience credits, refunds or dividends, applicable to an accounting period whether received before, during or after such period.

(9) "Reserves" includes:

(a) Active life disability reserves;

(b) Additional reserves whether for a specific liability purpose or not;

(c) Contingency reserves;

(d) Reserves for select morbidity experience; and

(e) Increased reserves which may be required by the commissioner.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-210, filed 11/24/08, effective 12/25/08.]

WAC 284-83-220 GROUPING OF POLICY FORMS FOR PURPOSES OF RATE MAKING AND REQUESTS FOR RATE INCREASE.

(1) The actuary responsible for setting premium rates must group similar policy forms, including forms no longer being marketed, in the pricing calculations.

(a) The grouping must be satisfactory to the commissioner, who may rely on the judgment of the pricing actuary.

(b) Factors that must be considered include similar claims experience, types of benefits, reserves, margins for contingencies, expenses and profit, and equity between policyholders.

(c) A grouping must enhance statistical reliability and improve the likelihood of premium adequacy without introducing elements of discrimination in violation of RCW **48.18.480**.

(d) A grouping is not required to include forms issued by health care service contractors or health maintenance organizations before January 1, 1988.

(2) Persons insured under similar policy forms must be grouped at the time of ratemaking in accord with RCW **48.18.480** because they are expected to have substantially like insuring, risk and exposure factors and expense elements.

(a) The morbidity and mortality experience of these insureds, as a group, will deteriorate over time.

(b) A form may not be withdrawn from its assigned grouping by reason only of the deteriorating health of the people insured thereunder, as provided for in RCW **48.83.170**.

(3) One or more of the policy forms grouped for ratemaking purposes, by random chance, may experience significantly higher or more frequent claims than the other forms. A form may not deviate from the assigned grouping of policy forms for pricing purposes at the time of requesting a rate increase unless the actuary can justify to the satisfaction of the commissioner that a different grouping is more equitable because of some previously unrecognized and nonrandom distinction between forms or between groups of insureds.

(4) Successive generic policy forms and policy forms of similar benefits covering generations of policyholders must be combined in the calculation of premium rates and loss ratios.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-220, filed 11/24/08, effective 12/25/08.]

WAC 284-83-225 SEPARATION OF DATA REGARDING CERTAIN POLICIES.

For reporting and record-keeping purposes, commencing with reports for accounting periods beginning on or after January 1, 2009, all issuers must separate data concerning long-term care insurance policies from data concerning other insurance policies.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-225, filed 11/24/08, effective 12/25/08.]

WAC 284-83-230 LOSS RATIO REQUIREMENTS FOR LONG-TERM CARE INSURANCE FORMS.

The following standards and requirements apply to long-term care insurance forms:

(1) Benefits for individual long-term care insurance forms will be deemed reasonable in relation to the premiums if the overall loss ratio is at least sixty percent over a calculating period chosen by the issuer and satisfactory to the commissioner.

(2) Benefits for group long-term care insurance forms will be deemed reasonable in relation to the premiums if the overall loss ratio is at least seventy percent over a calculating period chosen by the issuer and satisfactory to the commissioner.

(3) The calculating period may vary with the benefit and renewal provisions. The issuer may be required to demonstrate the reasonableness of the calculating period chosen by the actuary responsible for the premium calculations. A brief explanation of the selected calculating period must accompany the filing.

(4) Policy forms, the benefits of which are particularly exposed to the effects of inflation and whose premium income may be particularly vulnerable to an eroding persistency and other similar forces, must use a relatively short calculating period reflecting the uncertainties of estimating the risks involved.

(a) Policy forms based on more dependable statistics may employ a longer calculating period.

(b) The calculating period may be the lifetime of the policy for guaranteed renewable and noncancelable policy forms if these forms provide benefits which are supported by reliable statistics and which are protected from inflationary or eroding forces by such factors as fixed dollar coverages, inside benefit limits, or the inherent nature of the benefits.

(c) The calculating period may be as short as one year for coverages that are based on statistics of minimal reliability or which are highly exposed to inflation.

(5) A request for a rate increase to be effective at the end of the calculating period must include a comparison of the actual to the expected loss ratios, must employ any accumulation of reserves in the determination of rates for the new calculating period, and must account for the maintenance of such reserves for future needs. The request for the rate increase must be further documented by the expected loss ratio for the new calculating period.

(6) A request for a rate increase submitted during the calculating period must include a comparison of the actual to the expected loss ratios, a demonstration of any contributions to and support from the reserves, and must account for the maintenance of such reserves for future needs. If the experience justifies a premium increase, it will be deemed that the calculating period has prematurely been brought to an end. The rate increase must further be documented by the expected loss ratio for the next calculating period.

(7) Issuers must review their experience periodically and file appropriate rate revisions in a timely manner to reduce the necessity of later filing of exceptionally large rate increases.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-230, filed 11/24/08, effective 12/25/08.]

WAC 284-83-240 EXPERIENCE RECORDS.

Issuers must maintain records of earned premiums and incurred benefits for each policy year for each contract, rider, endorsement and similar form which is combined for purposes of premium calculations, including the reserves. Records must be maintained of the experience expected in the premium calculations. Notwithstanding the foregoing, with proper justification, the commissioner may accept approximation of policy year experience based on calendar year data.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-240, filed 11/24/08, effective 12/25/08.]

WAC 284-83-245 EVALUATING EXPERIENCE DATA.

In determining the credibility and appropriateness of experience data, due consideration will be given by the commissioner to all relevant factors including:

(1) Statistical credibility of premiums and benefits such as low exposure or low loss frequency;

(2) Past and projected trends relative to the kind of coverage, such as inflation in medical expenses, economic cycles affecting disability income experience, inflation in expense charges and others;

(3) The concentration of experience at early policy durations where select morbidity and preliminary term reserves are applicable and where loss ratios are expected to be substantially higher or lower than in later policy durations;

(4) The mix of business by risk classification;

(5) The expected lapses and anti-selection at the time of rate increases.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-245, filed 11/24/08, effective 12/25/08.]

WAC 284-83-250 LIFE INSURANCE POLICIES THAT ACCELERATE BENEFITS FOR LONG-TERM CARE.

(1) WAC **284-83-210** through **284-83-245** do not apply to life insurance policies that accelerate benefits for long-term care.

(2) A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

(a) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(b) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of chapter **48.76** RCW;

(c) The policy meets the disclosure requirements of RCW **48.83.070**(2) and **48.83.080**;

(d) Any policy illustration that meets the applicable requirements of the chapter **48.23A** RCW; and

(e) An actuarial memorandum is filed with the insurance department that includes:

(i) A description of the basis on which the long-term care rates were determined;

(ii) A description of the basis for the reserves;

(iii) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(iv) A description and a table of each actuarial assumption used. For expenses, the issuer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(v) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(vi) The estimated average annual premium per policy and the average issue age;

(vii) A statement as to whether underwriting is performed at the time of application. The statement must indicate whether underwriting is used and, if used, the statement must include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement must indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(viii) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-250, filed 11/24/08, effective 12/25/08.]

WAC 284-83-300 STANDARDS FOR PROTECTING PATIENT PRIVACY RIGHTS.

Issuers must adopt and use administrative, business, and operational practices and procedures designed to protect an insured's right to privacy granted under chapter **70.02** RCW and federal laws and regulations. For example, issuers must not disclose the insured's health information without the written authorization of the insured, except where the recipient needs to know the information, such as:

(1) To any person, health care provider or health care facility that the issuer reasonably believes is providing health care to the insured;

(2) To any other person who requires health care information to provide planning, quality assurance, peer review, or administrative, legal, financial, billing or actuarial services;

(3) To assist a health care provider or health care facility in the delivery of health care and the issuer reasonably believes that the recipient will not use or disclose the health care information for any purpose other than the delivery of health care and will take appropriate steps to protect the information;

(4) To a health care provider or health care facility reasonably believed to have previously provided health care to the insured to the extent necessary to provide health care services, unless the insured has instructed the health care provider or health care facility in writing not to make the disclosure.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-300, filed 11/24/08, effective 12/25/08.]

WAC 284-83-310 RIGHT OF INSUREDS TO RECEIVE CONFIDENTIAL HEALTH SERVICES.

Issuers must adopt and use administrative, business, and operational practices and procedures to protect the insured's right to confidential health care services.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-310, filed 11/24/08, effective 12/25/08.]

WAC 284-83-320 STANDARDS FOR THE ISSUER'S TIMELY REVIEW OF A CLAIM DENIAL.

The following administrative, business, and operational standards must be used by issuers to ensure timely review of a claim denial.

(1) Issuers must have a fully operational, comprehensive claims denial review process.

(2) Issuers must implement procedures for registering and responding to oral and written requests for review of a claim denial in a timely and thorough manner.

(3) Issuers must provide written notice to the insured, to the insured's designated representative, and to the insured's provider of its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to or continued stay in a health care facility or any other long-term care services or benefits.

(4) Issuers must process as an appeal an enrollee's written or oral request that the issuer reconsider its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to, or continued stay in, a health care facility. The issuer must not require that the insured file a complaint prior to seeking appeal of any such decision.

(5) The issuer must:

(a) Provide written notice to the insured when the appeal is received;

(b) Assist the insured with the appeal process;

(c) Make its decision regarding the appeal within thirty days after the date the appeal is received, except when a determination is made that the issuer's action must be expedited;

(d) Cooperate with a representative authorized in writing by the insured;

(e) Consider all information submitted by the insured;

(f) Investigate and resolve the appeal; and

(g) Provide written notice of its resolution of the appeal to the insured and, with the permission of the insured, to the insured's providers, that:

(i) Explains the issuer's decision and the supporting coverage or clinical reasons for the decision; and

(ii) If applicable, explains any further appeal process, including, if applicable, information about how to exercise the insured's rights to a second opinion and how to continue receiving or reinstate services.

(6) An appeal must be expedited if the insured's provider or the insured's medical director reasonably determines that following the appeal process, response timelines could seriously jeopardize the insured's life, health, or ability to regain maximum function. The decision regarding an expedited appeal must be made within seventy-two hours after the time the appeal is received by the issuer.

(7) If the insured requests that the issuer reconsider its decision to modify, reduce, or terminate an otherwise covered health care service, and if the issuer's decision is based on the issuer's determination that the health service or level of health service is no longer covered, the issuer must continue to provide the health service until the appeal is resolved.

(8) Issuers must provide a clear explanation of their grievance processes and procedures at the time of application and upon request of the insured.

(9) Issuers must ensure that their grievance processes and procedures are accessible to insureds who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file a grievance.

(10) Issuers must track each appeal until final resolution and, upon request, make available to the commissioner a log of all appeals and grievances.

(11) Issuers must establish a process to identify and track problems encountered by enrollees when filing claims denials and, where appropriate, to make reasonable modifications to their appeals and grievance processes and procedures.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-320, filed 11/24/08, effective 12/25/08.]

WAC 284-83-325 PROMPT PAYMENT OF CLEAN CLAIMS.

(1) The purpose of this section is to effectuate RCW 48.83.090 and 48.83.170 by establishing prompt payment requirements for long-term care insurance.

(2) For purposes of this section, the following definitions apply:

(a) "Claim" means a request for payment of benefits under an in-force policy, regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.

(b) "Clean claim" means a claim that has no defect or impropriety, including any lack of required substantiating documentation, such as satisfactory evidence of expenses incurred, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

(3) Within thirty business days after receipt of a claim for benefits under a long-term care insurance policy or certificate, an insurer must pay such a claim if it is a clean claim, or send a written notice acknowledging the date of receipt of the claim and one of the following:

(a) The insurer is declining to pay all or part of the claim and the specific reason(s) for the denial; or

(b) That additional information is necessary to determine if all or any part of the claim is payable and the specific additional information that is necessary.

(4) Within thirty business days after receipt of all the requested additional information, an insurer must pay a claim for benefits under a long-term care insurance policy or certificate if it is a clean claim, or send a written notice that the insurer is declining to pay all or part of the claim, and the specific reason or reasons for denial.

(5) If an insurer fails to comply with subsection (3) or (4) of this section, such insurer must pay interest at the rate of one percent per month on the amount of the claim that should have been paid but that remains unpaid for forty-five business days after the receipt of the claim with respect to subsection (3) of this section or all requested additional information with respect to subsection (4) of this section. The interest payable pursuant to this subsection must be included in any late reimbursement without requiring the person who filed the original claim to make any additional claim for such interest.

(6) The provisions of this section do not apply where the insurer has a reasonable basis supported by specific information that such claim was fraudulently submitted.

[Statutory Authority: RCW 48.02.060 and 48.83.170(3). WSR 13-24-111 (Matter No. R 2013-16), § 284-83-325, filed 12/4/13, effective 1/4/14.]

WAC 284-83-350 STANDARD APPLIED IF THERE IS A CONFLICT BETWEEN A MASTER POLICY AND CERTIFICATE OF INSURANCE.

If there is a discrepancy between a description of the terms and conditions of insurance between the master policy and any certificate issued under that master policy, the description most favorable to the insured must be used by the issuer and governs the matter.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-350, filed 11/24/08, effective 12/25/08.

WAC 284-83-400 PURPOSE AND AUTHORITY.

WAC 284-83-400 THROUGH 284-83-420 IS ADOPTED PURSUANT TO RCW 48.85.030 AND 48.85.040. THE PURPOSE OF THESE SECTIONS IS TO EFFECTUATE CHAPTER 48.85 RCW, THE WASHINGTON LONG-TERM CARE PARTNERSHIP ACT. PURSUANT TO RCW 48.85.030, THESE SECTIONS ESTABLISH MINIMUM STANDARDS AND DISCLOSURE REQUIREMENTS TO BE MET BY INSURERS, HEALTH CARE SERVICE CONTRACTORS, HEALTH MAINTENANCE ORGANIZATIONS, AND FRATERNAL BENEFIT SOCIETIES WITH RESPECT TO LONG-TERM CARE PARTNERSHIP INSURANCE POLICIES TO INCLUDE: CONTRACTS, CERTIFICATES, RIDERS, AND ENDORSEMENTS.

[STATUTORY AUTHORITY: RCW 48.02.060 AND 48.85.030. WSR 11-22-068 (MATTER NO. R 2011-08), § 284-83-400, FILED 10/31/11, EFFECTIVE 12/1/11.]

WAC 284-83-405 APPLICABILITY AND SCOPE.

(1) WAC 284-83-400 through 284-83-420 applies to any qualified long-term care insurance partnership policy, as defined by federal law and this chapter.

(2) These sections do not apply to medicare supplement policies regulated under chapters 48.66 RCW and 284-55 or 284-66 WAC; policies or contracts between a continuing care retirement community and its residents; or to long-term care insurance policies that are not intended to provide asset protection under chapter 48.85 RCW.

(3) Policies that do not meet the requirements of the Washington Long-Term Care Partnership Act and the requirements of this chapter may not be advertised, issued or delivered in this state as partnership policies.

[Statutory Authority: RCW 48.02.060 and 48.85.030. WSR 11-22-068 (Matter No. R 2011-08), § 284-83-405, filed 10/31/11, effective 12/1/11.]

WAC 284-83-410 MINIMUM STANDARDS FOR LONG-TERM CARE PARTNERSHIP POLICIES.

Every long-term care partnership policy must meet the standards for long-term care policies or contracts in chapters 48.83 and 48.85 RCW and this chapter, unless specifically provided otherwise.

(1) As used in WAC 284-83-400 through 284-83-420, "qualified long-term care partnership policy" or "partnership policy" means a long-term care policy that meets all of the following additional requirements:

(a) The policy was issued on or after January 1, 2012, or exchanged as provided in WAC 284-83-415 on or after January 1, 2012, and covers an insured who was a resident of this state or of another state that has entered into a reciprocal agreement with this state when coverage first became effective under the policy.

(b) The policy is a tax qualified long-term care insurance policy as defined in Section 7702B(b) of the Internal Revenue Code of 1986 (26 U.S.C. 7702B(b)).

(c) The policy provides at least the following levels of inflation protection:

(i) If the policy is sold to an individual who has not attained age sixty-one as of the date of purchase, the policy must provide automatic annual compounded inflation increases at a rate not less than three percent or automatic annual compounded inflation increases at a rate based on changes in the consumer price index.

(ii) If the policy is sold to an individual who has attained age sixty-one but has not attained age seventy-six as of the date of purchase, the policy must provide automatic simple inflation increases at a rate not less than three percent or automatic inflation increases at a rate based on changes in the consumer price index.

(iii) If the policy is sold to an individual who has attained age seventy-six as of the date of purchase, the policy may, but is not required to, provide automatic inflation increases at a rate based on changes in the consumer price index.

(iv) If the change in the consumer price index is a negative number for the time period in question, the carrier may not apply the change in the index to reduce the benefit payable under the partnership policy. However, the carrier may offset this negative number against the next annual increase in the consumer price index to reduce the automatic inflation increase which would otherwise occur during that year. If the negative consumer price index exceeds the next annual increase in the consumer price index, it may be offset against multiple annual increases, the net effect of which may never be less than zero.

(v) For purposes of this section, "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.

(2) Issuers must file a long-term care insurance policy for approval for use as a partnership policy. The long-term care Partnership Policy Certification Form must be completed and accompany the request for approval. The form is available on the commissioner's web site: www.insurance.wa.gov.

(3) Issuers requesting to make use of a previously approved policy form as a qualified state long-term care partnership policy must:

(a) Submit to the commissioner a Partnership Policy Certification Form signed by an officer of the company; and

(b) File for approval an amendatory rider or endorsement indicating the policy is partnership qualified.

(4) An issuer or its agent, soliciting or offering to sell a policy that is intended to qualify as a partnership policy, must provide to each prospective applicant a Partnership Program Notice found on the commissioner's web site: www.insurance.wa.gov, outlining

the requirements and benefits of a partnership policy. The Partnership Program Notice must be provided with the required outline of coverage.

(5) A partnership policy issued for delivery in Washington must be accompanied by a Partnership Status Disclosure Notice found on the commissioner's web site: www.insurance.wa.gov, explaining the benefits associated with a partnership policy and indicating that at the time issued, the policy is a qualified Washington state long-term care insurance partnership policy. The Partnership Disclosure Notice must also include a statement indicating that by purchasing this partnership policy, the insured does not automatically qualify for medicaid.

[Statutory Authority: RCW 48.02.060 and 48.85.030. WSR 12-18-049 (Matter No. R 2012-15), § 284-83-410, filed 8/30/12, effective 9/30/12; WSR 11-22-068 (Matter No. R 2011-08), § 284-83-410, filed 10/31/11, effective 12/1/11.]

WAC 284-83-415 LONG-TERM CARE PARTNERSHIP POLICY EXCHANGE OR REPLACEMENT.

(1) Within one year of the date that an issuer begins to advertise, market, offer, or sell policies that qualify under the Washington state long-term care partnership program, the issuer must offer to all of its current policyholders and certificate holders the opportunity to exchange their existing long-term policy for a policy that is intended to qualify under the state's long-term care partnership program provided that:

(a) The existing long-term care policy was issued on or after February 8, 2006; and

(b) The existing long-term care policy is the type certified by the issuer for purposes of the state long-term care partnership program.

(2) In making an offer to exchange, an issuer must comply with the following requirements:

(a) The offer must be made on a nondiscriminatory basis without regard to the age or health status of the insured; and

(b) The offer must remain open for a minimum of ninety days from the date of mailing by the issuer.

(3) An exchange occurs when an issuer offers a policyholder or certificate holder (hereinafter "insured") the option to replace an existing long-term care insurance policy with a policy that qualifies as a long-term care partnership policy, and the insured accepts the offer to terminate the existing policy and accepts the new policy.

(4) Notwithstanding subsections (1), (2), and (3) of this section:

(a) An offer to exchange may be deferred for any insured who is currently eligible for benefits under an existing policy or who is subject to an elimination period on a claim, but such deferral shall continue only as long as such eligibility or elimination period exists; and

(b) An offer to exchange does not have to be made if the insured would be required to purchase additional benefits to qualify for the state long-term care partnership program and the insured is not eligible to purchase the additional benefits under the issuer's long-term care underwriting guidelines.

(5) If the partnership policy has an actuarial value of benefits equal to or lesser than the actuarial value of benefits of the existing policy, then the following requirements apply:

(a) The partnership policy must not be underwritten; and

(b) The rate charged for the partnership 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.

(6) If the partnership policy has an actuarial value of benefits exceeding the actuarial value of the benefits of the existing policy, then the following requirements apply:

(a) The issuer must apply its long-term care underwriting guidelines to the increased benefits only; and

(b) The rate charged for the partnership policy must be determined using the method set forth in subsection (5)(b) of this section for the existing benefits, increased by the rate for the increased benefits using the then current attained age and risk class of the insured for the increased benefits only.

(7) The partnership policy offered in an exchange must be on a form that is currently offered for sale by the issuer in the general market.

(8) In the event of an exchange, the insured must not lose any rights, benefits, or built-up value that has accrued under the original policy with respect to the benefits provided under the original policy including, but not limited to, rights established because of the lapse of time related to preexisting condition exclusions, elimination periods, or incontestability clauses.

(9) Issuers may complete an exchange by either issuing a new policy or by amending an existing policy with an endorsement or rider. An issuer must file such endorsement or rider for approval prior to issue.

(10) For those insureds with long-term care policies issued before February 8, 2006, an issuer may offer an insured the option to exchange an existing policy for a policy that qualifies as a Washington state long-term partnership policy. The requirements set forth in subsections (2) through (9) of this section apply to any such exchange.

(11) Policies issued pursuant to this section shall be considered exchanges and not replacements and are not subject to WAC 284-83-060 through 284-83-070.

[Statutory Authority: RCW 48.02.060 and 48.85.030. WSR 11-22-068 (Matter No. R 2011-08), § 284-83-415, filed 10/31/11, effective 12/1/11.]

WAC 284-83-420 REPORTING.

ALL ISSUERS OF QUALIFIED LONG-TERM CARE PARTNERSHIP POLICIES MUST PROVIDE REGULAR REPORTS TO THE UNITED STATES SECRETARY OF HEALTH AND HUMAN SERVICES IN ACCORDANCE WITH REGULATIONS OF THE SECRETARY. THESE REPORTS INCLUDE NOTIFICATION REGARDING WHEN BENEFITS PROVIDED UNDER THE POLICY HAVE BEEN PAID AND THE AMOUNT OF SUCH BENEFITS PAID, NOTIFICATION REGARDING WHEN THE POLICY OTHERWISE TERMINATES, AND SUCH OTHER INFORMATION AS THE SECRETARY DETERMINES MAY BE APPROPRIATE TO THE ADMINISTRATION OF PARTNERSHIP POLICIES.
[STATUTORY AUTHORITY: RCW 48.02.060 AND 48.85.030. WSR 11-22-068 (MATTER NO. R 2011-08), § 284-83-420, FILED 10/31/11, EFFECTIVE 12/1/11.]

WAC 284-83-425 PRODUCER EDUCATION.

Prior to selling, soliciting, or negotiating, or continuing to sell, solicit, or negotiate long-term care partnership policies in this state, all licensed producers must meet the education requirements in RCW 48.83.130(2).

[Statutory Authority: RCW 48.02.060 and 48.85.030. WSR 11-22-068 (Matter No. R 2011-08), § 284-83-425, filed 10/31/11, effective 12/1/11.]

CHAPTER 48.85 RCW: WASHINGTON LONG-TERM CARE PARTNERSHIP

RCW 48.85.010 WASHINGTON LONG-TERM CARE PARTNERSHIP PROGRAM—GENERALLY.

The department of social and health services shall, in conjunction with the office of the insurance commissioner, coordinate a long-term care insurance program entitled the Washington long-term care partnership, whereby private insurance and medicaid funds shall be used to finance long-term care. For individuals purchasing a long-term care insurance policy or contract governed by chapter 48.84 or 48.83 RCW and meeting the criteria prescribed in this chapter, and any other terms as specified by the office of the insurance commissioner and the department of social and health services, this program shall allow for the exclusion of some or all of the individual's assets in determination of medicaid eligibility as approved by the centers for medicare and medicaid services.

[2012 c 211 § 9; 2008 c 145 § 21; 1995 1st sp.s. c 18 § 76; 1993 c 492 § 458.]

NOTES:

Effective date—2008 c 145: See RCW 48.83.901.

Conflict with federal requirements—Severability—Effective date—1995 1st sp.s. c 18: See notes following RCW 74.39A.030.

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

RCW 48.85.020 PROTECTION OF ASSETS -- FEDERAL APPROVAL -- RULES.

The department of social and health services shall seek approval from the centers for medicare and medicaid services to allow the protection of an individual's assets as provided in this chapter. The department shall adopt all rules necessary to implement the

Washington long-term care partnership program, which rules shall permit the exclusion of all or some of an individual's assets in a manner specified by the department in a determination of medicaid eligibility to the extent that private long-term care insurance provides payment or benefits for services.

[2012 c 211 § 10; 1995 1st sp.s. c 18 § 77; 1993 c 492 § 459.]

NOTES:

Conflict with federal requirements—Severability—Effective date—1995 1st sp.s. c 18: See notes following RCW 74.39A.030.

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

RCW 48.85.030 INSURANCE POLICY CRITERIA -- RULES.

(1) The insurance commissioner shall adopt rules defining the criteria that qualified long-term care partnership insurance policies must meet to satisfy the requirements of this chapter. The rules shall incorporate any requirements set forth by chapter 48.83 RCW and the deficit reduction act of 2005 for qualified long-term care partnership insurance policies purchased for the purposes of this chapter.

(2) Insurers offering long-term care policies for the purposes of this chapter shall demonstrate to the satisfaction of the insurance commissioner that they:

(a) Have procedures to provide notice to each purchaser of the long-term care consumer education program;

(b) Have procedures that provide for the keeping of individual policy records and procedures for the explanation of coverage and benefits identifying those payments or services available under the policy that meet the purposes of this chapter;

(c) Agree to provide the insurance commissioner any required annual report containing information derived from the long-term care partnership long-term care insurance uniform data set as specified by the office of the insurance commissioner.

[2011 c 47 § 12; 1995 1st sp.s. c 18 § 78; 1993 c 492 § 460.]

NOTES:

Conflict with federal requirements—Severability—Effective date—1995 1st sp.s. c 18: See notes following RCW 74.39A.030.

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

48.85.040 CONSUMER EDUCATION PROGRAM.

The insurance commissioner shall, with the cooperation of the department of social and health services and members of the long-term care insurance industry, develop a consumer education program designed to educate consumers as to the need for long-term care, methods for financing long-term care, the availability of long-term care insurance, and the availability and eligibility requirements of the asset protection program provided under this chapter.

[1995 1st sp.s. c 18 § 79; 1993 c 492 § 461.]

NOTES:

Conflict with federal requirements—Severability—Effective date—1995 1st sp.s. c 18: See notes following RCW 74.39A.030.

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

48.85.900 SHORT TITLE -- SEVERABILITY -- SAVINGS -- CAPTIONS NOT LAW -- RESERVATION OF LEGISLATIVE POWER -- EFFECTIVE DATES -- 1993 C 492.

See RCW 43.72.910 through 43.72.915.

LTCP LTC ELIGIBILITY

What is long-term care?

For the purposes of Medicaid eligibility, long-term care is for individuals residing in a Medical institution (primarily nursing homes) for 30 days or more or on a Home and Community Based Waiver.

"Institutionalized client" means a client who has attained institutional status as described in WAC182-513-1320 "**Institutional services"**. Means services paid for by Medicaid or state funds and provided in a medical institution, through a Home and Community Based (HCB) Waiver, or Program of All-Inclusive Care for the Elderly (PACE).

"Home and Community Based Services" (HCBS) means services provided in the home or a residential setting to individuals assessed by the department.

"Home and Community Based (HCB) Waiver Programs" means Section 1915 (c) of the Social Security Act enables states to request a waiver of applicable federal Medicaid requirements to provide enhanced community support services to those Medicaid beneficiaries who would otherwise require institutional care.

Eligibility Requirements:

Eligibility requirements for long-term care are found in WAC182-513-1315

Some of the key requirements are:

- Identity and citizenship requirements
- Furnish a valid social security number
- Be a Washington resident
- Meet aged, blind or disabled criteria
- Income and resource guidelines
- Institutional Medicaid is subject to penalties for resource transfers described in WAC182-513-1363
- Home equity cannot exceed $595,000 as described in WAC182-513-1350
- Declaration of interest in an annuity and naming the State of Washington as a remainder beneficiary as described in WAC182-516-0201

Resource standards for long-term care

- WAC 182-513-1350 describes resource eligibility for long-term care.
- $2,000 applicant
- $3,000 couple both applying in the same month

Income

- Countable income is compared to 300% of the Federal Benefit Rate (FBR). The 2020 rate is $2,349 and may also be called the SIL (Special Income Level).
- Individuals with income at or below are eligible for categorically needy (CN) medical coverage.
- Individuals with countable income over 300% of the FBR may be eligible for medically needy (MN) coverage based on the projected monthly cost of care in the facility or at home.
- Clients must contribute income after allowable deductions towards the costs of their care. See Long-term Services and Supports (LTCC) Manual - Standards

LTC Partnership – Background

- Section 6021 of the 2005 Deficit Reduction Act expands LTC Partnership opportunities for States by effectively lifting the moratorium on expansion imposed by the Omnibus Budget Reconciliation Act (OBRA) 1993.
- DRA provides for a unique Medicaid/private insurance model designed to attract consumers who might not otherwise purchase LTC insurance by allowing them to protect a specified level of assets.
- Considered by many States as a critical link in helping citizens plan for their own future.
- Help States offset rising Medicaid costs for LTC by shifting costs to private insurance
- Discourage impermissible transfers of assets to qualify for Medicaid.
- Consumers can protect assets for estate planning and inheritance purposes.

LTC Partnership in Washington

- Washington State uses the dollar for dollar resource protection model. An individual can protect $1 in resource for every $1 paid out by the LTC partnership policy.
- Individuals would need to meet all other Medicaid eligibility rules, but will be able to bank additional resources based on the amount the LTC policy has paid.
- Resources banked due to a qualified LTC partnership policy are not subject to Estate Recovery. This includes all or part of the value of a primary residence that is excluded for medicaid eligibility but would not be excluded from estate recovery at the time of a medicaid recipient's death.
- Individuals with a LTC Partnership Policy must submit a DSHS 10-438 LTCP Asset Designation form to Washington State Medicaid at the time of application and at each annual review in order to designate assets as protected based on the dollar amount paid for services by the LTC Partnership Policy. This will track protected assets for both LTC Medicaid eligibility and Estate Recovery purposes.

LTC Partnership - Reciprocity

Health and Human Services (HHS) published the reciprocity standards in the Federal Register. These are effective 1/1/2009. Provisions require:

- Benefits paid under a LTCP policy will be treated the same by all states.
    - All States will be subject to the standards unless the State notifies the Secretary in writing of the desire to opt out.
    - All states will implement a dollar for dollar disregard
    - Policies will be treated uniformly regardless of where purchased
    - Exempt protected assets from Estate Recovery.

Washington accepts approved LTC partnership policies purchased in other states with the exception of states that originally implemented the long-term care partnership program under OBRA legislation in 1993 who did not choose the dollar for dollar asset protection model. For example, New York chose to implement a total asset protection model so policies purchased in New York since 1993 would not meet Washington State's requirements.

Resources and LTC Partnership – Example#1

- Individual with a LTC partnership has $50,000 in liquid resources and an excluded home.
- The LTC partnership insurance has paid $48,000 in benefits. Total policy pays $150,000 in benefits.
- Individual meets general Medicaid requirements and is allowed to keep $2,000 in resources for Medicaid plus $48,000 based on the amount the LTC partnership has paid.
- As the partnership pays, the individual is allowed to save additional resources dollar for dollar.

Resources and LTC Partnership – Example#2

- Resources banked due to a LTC partnership is not subject to Estate Recovery as indicated in chapter 388-527 WAC.
- This would include part of all value of a home that is excluded for Medicaid eligibility but not excluded from Estate Recovery at death.
- Based on the previous example If the individual's excluded home is worth $100,000 and the partnership pays out a total of the $150,000 benefit during the lifetime, the value of the home may be banked and would not be subject to Estate Recovery.

More Information on Long-Term Care Eligibility in Washington State

- Long-Term Services and Supports (LTSS) Manual
- Questions and Answers on the COPES Program
- Questions and Answers on Medicaid for Nursing Home Residents
- Aging and Long-Term Support Administration
- Medicaid and Long-Term Care Services for Adults
- Washington Administrative Code (WAC)

WISCONSIN

WISCONSIN

STATE SPECIFIC INFORMATION

LONG-TERM CARE INSURANCE PARTNERSHIP PROGRAM WI MEDICAID TRAINING – PART I

INTRODUCTION TO THE WI LONG-TERM CARE INSURANCE PARTNERSHIP PROGRAM AND THE WISCONSIN MEDICAID PROGRAM: AN OVERVIEW

WHY IS THIS TRAINING IMPORTANT TO ME?

This Training is Important to You because…

- The WI Long-Term Care Insurance Partnership (LTCIP) program creates a new role for you to play relative to your clients and the WI Medicaid program.
- This training is intended to help you learn that role by gaining an understanding of WI Medicaid and
- How WI Medicaid relates to the WI Long-Term Care Insurance Partnership (LTCIP) program.
- Becoming familiar with this relationship is the key to knowing how low-income WI residents can benefit most from participating in the WI LTCIP program.

INTRODUCTION TO THE WI LONG TERM CARE INSURANCE PARTNERSHIP PROGRAM

The WI Long Term Care Insurance Partnership (LTCIP) Program is a joint effort between the federal Medicaid Program, long-term care insurers, and the State of Wisconsin.

The purpose of the WI LTCIP program is to encourage people to plan for future long-term care needs, such as:

1. Residing in a nursing facility

OR

2. Receiving long-term care services in one's home or another community-based setting.

In Wisconsin, the LTCIP Program Includes:

- ❑ Private Long-Term Care Insurers
- ❑ Long-Term Care Insurance Producers (agents and brokers)
- ❑ The Department of Health Services (DHS)
- ❑ The Office of the Commissioner of Insurance (OCI)

At the federal level, the LTCIP program is overseen by the federal Centers for Medicare and Medicaid Services (CMS).

Under the WI LTCIP program, an amount equal to the amount of benefits that an individual receives under a

qualifying LTCIP insurance policy is excluded when determining:

- ❑ The individual's resources for purposes of determining WI Medicaid eligibility and
- ❑ The amount to be recovered from the individual's estate if the individual receives WI Medicaid benefits

INTRO RECAP

- ❑ Participation in the WI LTCIP program can affect the low income person's WI Medicaid eligibility and estate planning.
- ❑ Some low income people who wish to participate in the WI LTCIP program may already be eligible for WI Medicaid.
- ❑ Some will become eligible for WI Medicaid at some point after they begin participating in the WI LTCIP program.

It is important to understand the precise relationship between the WI LTCIP program and WI Medicaid so that:

- ❑ You can provide sound advice to low income people who inquire about the WI LTCIP program and
- ❑ You can also accurately explain to low income people the potential benefit of participating in the WI LTCIP program relative to qualifying for WI Medicaid and protecting their estate.

THE WISCONSIN MEDICAID PROGRAM: AN OVERVIEW

- What is WI Medicaid?
- What is WI Family Care?
- What is WI Family Care Partnership?
- What is Institutional Medicaid?
- How Can Consumers Learn About Long-Term Care Options in WI?

WHAT IS WI MEDICAID?

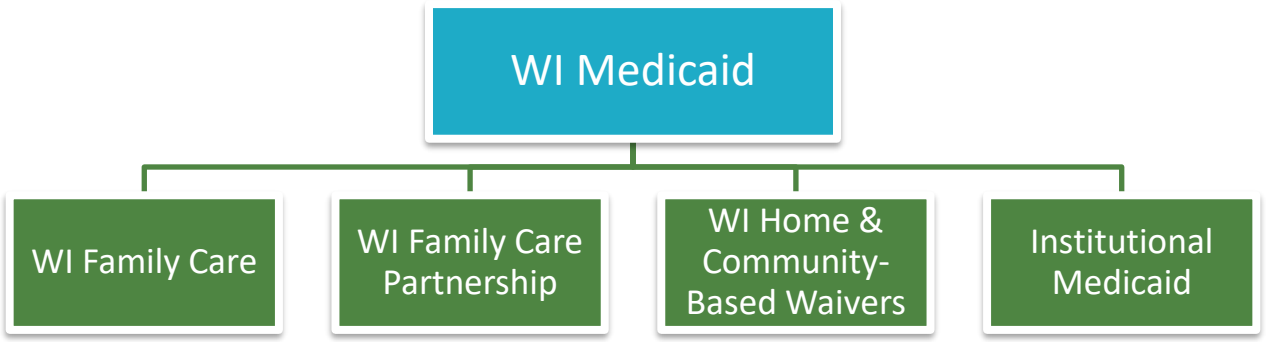
And more importantly….Why do I need to know about WI Medicaid?

It is Important to Know About WI Medicaid because…

- ❑ You will consider selling qualified WI LTCIP policies to people who may become, or who perhaps already are, eligible for WI Medicaid.
- ❑ The amount of benefits paid by a qualified WI LTCIP policy could have an effect on a person's eligibility for WI Medicaid, as well as his/her estate planning. Part II of this training explains this in detail.
- ❑ You will need to understand this potential effect before you sell the policy so that you can explain it to the person who is considering purchasing the policy.

AND Because…

- ❑ When one of your clients does apply for WI Medicaid, you will be asked to verify the qualified policy's payout amount as part of the WI Medicaid application process. Part II of this training explains this in detail.
- ❑ You may also be asked to verify the qualified policy's premium amount. Part II of this training explains this in detail.
- ❑ To fulfill this new role, you will need to understand some WI Medicaid basics.



- WI Medicaid covers certain acute, primary and long-term care services.
- Institutional Medicaid, the WI Medicaid Home- and Community-Based Waivers, WI Family Care and WI Family Care Partnership comprise the four main ways that WI Medicaid delivers long-term care.
- Of these, WI Family Care and WI Family Care Partnership are designed specifically to allow functionally impaired elderly and disabled persons to remain in their homes and communities. (Note: Wisconsin delivers most Medicaid long-term care services through Family Care, Family Care Partnership, and related managed care programs.)

WI Medicaid is paid for in part by the federal government and in part by state government.

The benefits that WI Medicaid will pay for are established by the federal government and certain additional benefits that WI has chosen to cover. WI Medicaid has very specific financial limits for persons applying for coverage.

MEDICAID APPLICATIONS

Applications for WI Medicaid are accepted at county government human service agencies. WI Medicaid eligibility is reviewed annually.

MEDICAID REIMBURSEMENT

WI Medicaid will reimburse covered services provided by WI Medicaid certified providers. Not all service providers will accept WI Medicaid as payment. WI Medicaid reimbursement is often lower than market rates.

MEDICAID AND PAYMENT FOR SERVICES

- ❑ Payment goes directly to certified service provider.
- ❑ Other insurance carrier must be billed first before WI Medicaid will consider for payment.
- ❑ As payer of last resort, WI Medicaid pays what is not covered by other insurance (e.g. Medicare or private health insurance).

If a person moves to a nursing home or receives home health services on a private pay/insured basis, can no longer pay, and becomes eligible for WI Medicaid, WI Medicaid is not obligated to pay for services from that provider unless:

a. the provider is WI Medicaid certified and
b. the person has a need for that level of care, as determined by the State of Wisconsin

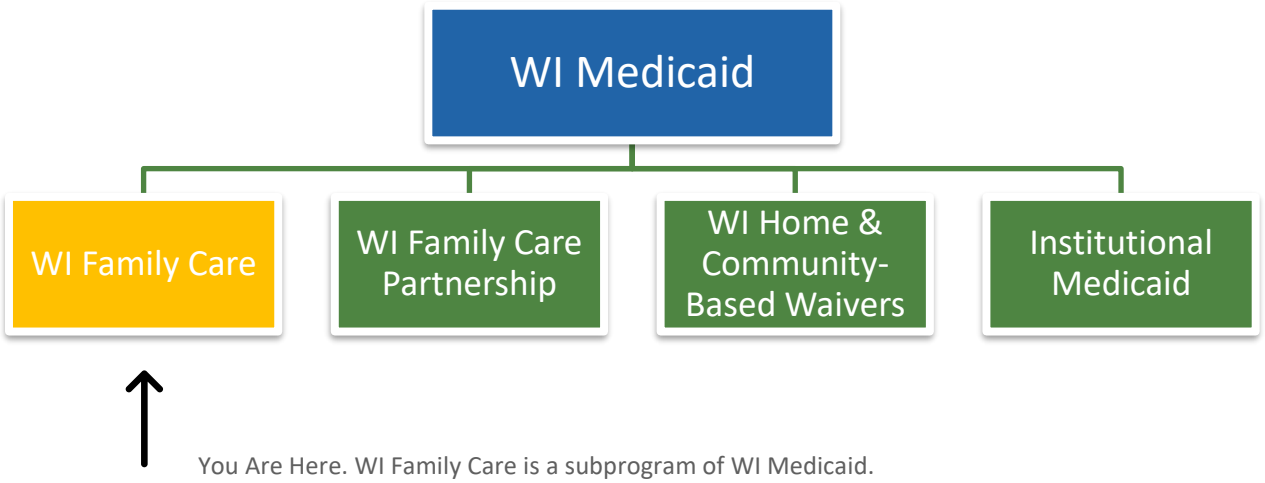
Individuals in WI Medicaid are entitled to covered acute, primary and long-term care services including:

- Physician
- Hospital
- Durable medical equipment (wheelchairs; hospital beds)
- Home health (nursing)
- Medical supplies
- Nursing facility (skilled and intermediate care nursing homes)
- Occupational therapy
- Personal care (assistance with bathing, dressing, toileting, eating, etc.)
- Pharmacy and prescription drugs
- Physical therapy
- Speech and language therapy
- Transportation for medical visit

WHAT IS WI MEDICAID? RECAP

- ❑ WI Medicaid is a publicly-subsidized, means tested program that pays for certain acute, primary and long-term care services for low income elderly and disabled persons.
- ❑ In addition to covering institutional settings, WI Medicaid offers several unique subprograms specifically designed to allow functionally impaired elderly and disabled persons to remain in their homes and communities.
- ❑ WI Medicaid reimburses only service providers who are certified by the WI Medicaid program.
- ❑ WI Medicaid-covered long-term care services may also be covered by a qualified WI LTCIP program policy.
- ❑ WI Medicaid is the "payer of last resort," meaning that WI Medicaid will reimburse a claim for covered services only after all other payment sources have been billed.
- ❑ The amount of benefits paid by a qualified WI LTCIP program policy may affect the elderly or disabled person's WI Medicaid eligibility and estate planning.
- ❑ Long-term care insurers need to understand these and other WI Medicaid policy fundamentals, which are based on federal and state law, in order to better serve their customers.

WHAT IS WI FAMILY CARE?



WI Family Care is a public program unique to Wisconsin.

This program offers a full range of managed long-term care services to people who need a nursing home level of care, but who wish to live in their own home or another community-based setting.

To join WI family care, a person…

- ❑ must be financially eligible for WI Medicaid
- ❑ must be functionally eligible for WI family care (i.e., must meet a certain level of functional impairment)
- ❑ must pay "cost share" (determined based on a sliding fee schedule) if income is above a certain level

FUNCTIONAL SCREENING PROCESS

- ❑ Extensive interview which gathers medical information
- ❑ Establishes a level of care necessary for health and safety
- ❑ Establishes whether the person's functional impairments qualify him/her to receive the WI Family Care benefit

NETWORK OF PROVIDERS

- ❑ Participants cannot necessarily choose an out-of-network provider, unless it is necessary for quality of care or quality of life
- ❑ Network providers focus on enabling people to live at home or an apartment-like setting of their choice
- ❑ Quality of care is assured by the state of Wisconsin
- ❑ The WI Family Care benefit for community-based long-term care is more extensive than would be available to persons qualifying only for WI Medicaid.
- ❑ WI Family Care members can access any long-term care benefit that they need, based on joint decisions with the care team.

- ❑ WI Family Care does not cover acute and primary care services, but such services are covered by the WI Medicaid program and, for those eligible, by Medicare.

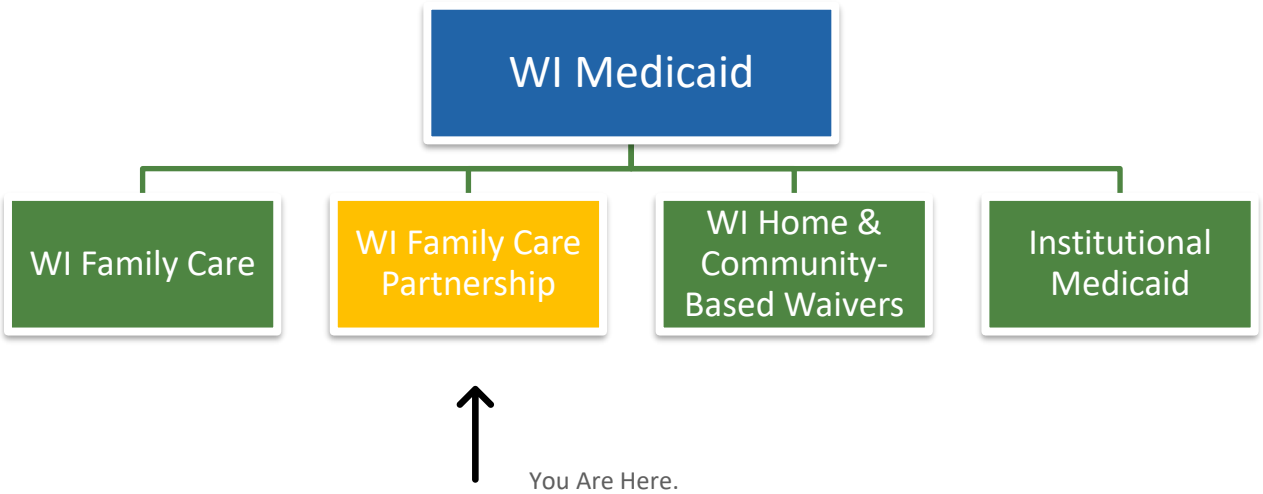
WI FAMILY CARE BENEFITS INCLUDE:

- Adaptive Aids (general and vehicle)
- Adult Day Care
- Alcohol and Other Drug Abuse Day Treatment Services
- Care/Case Management (including Assessment and Case Planning)
- Communication Aids/Interpreter Services
- Consumer Education and Training
- Counseling and Therapeutic Resources
- Day Services/Treatment
- Durable Medical Equipment, except for hearing aids and prosthetics
- Home Health
- Home Modifications
- Housing Counseling
- Meals: home delivered
- Medical Supplies
- Mental Health Day Treatment
- Nursing Facility
- Nursing Services (including respiratory care)
- Occupational Therapy
- Personal Care (assistance with bathing, eating, toileting, dressing)
- Personal Emergency Response System Services
- Physical Therapy
- Relocation Services (from nursing home to community)
- Residential Services: Certified Residential Care Apartment Complex (RCAC)
- Community-Based Residential Facility (CBRF)
- Adult Family Home
- Respite Care (for care givers and members)
- Specialized Medical Supplies
- Speech and Language Pathology Services
- Supportive Home Care
- Transportation (limited to certain needs)

WHAT IS WI FAMILY CARE? RECAP

- ❑ WI Family Care is a managed long- term care option for WI Medicaid eligible individuals who have a certain level of functional impairment and who prefer to live in a community- based setting rather than a nursing home.
- ❑ The amount of benefits paid by a qualified WI LTCIP program policy may affect a person's WI Medicaid eligibility and, therefore, his/her eligibility to enroll in WI Family Care.
- ❑ You may be asked to document the amount of benefits paid by the qualified WI LTCIP program policy when a person applies for WI Family Care.
- ❑ The premiums associated with a qualified WI LTCIP program policy may affect the amount that a person must pay monthly to remain enrolled in WI Family Care.
- ❑ You may be asked to document the amount of the premium paid by the individual for coverage under the qualified WI LTCIP program policy.

WHAT IS WI FAMILY CARE PARTNERSHIP?



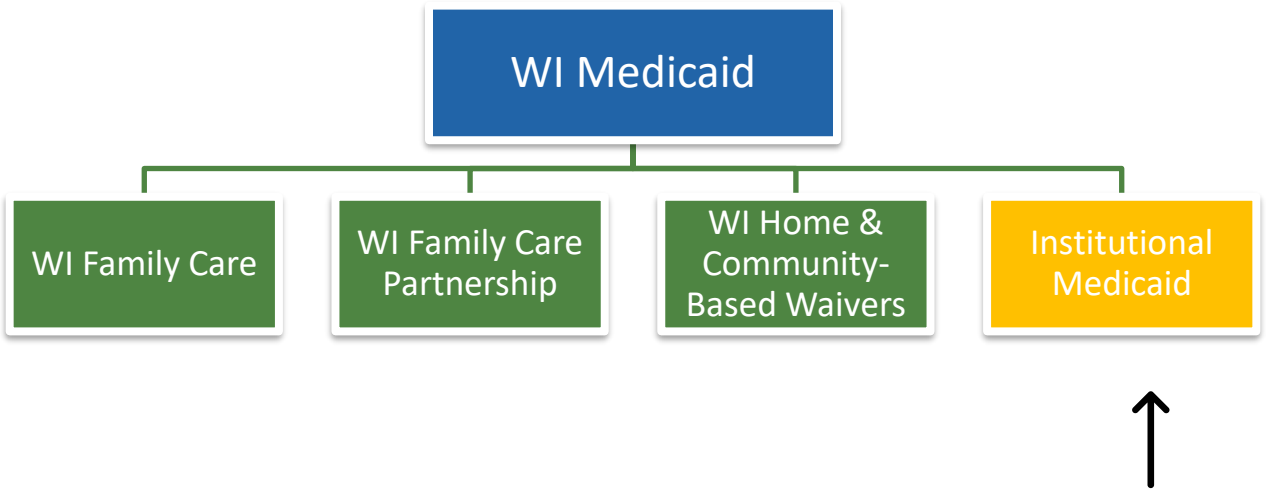
WI Family Care Partnership is a subprogram of WI Medicaid.

- ❑ This program is not to be confused with the WI Long-Term Care Insurance Partnership Program.
- ❑ The WI Family Care Partnership program is a managed care program like the rest of WI Family Care, offering the long-term care services listed previously. Additionally, Partnership offers acute and primary care and provides a more medically oriented care team that works in close consultation with the physician.
- ❑ To join WI Family Care Partnership, people must be financially eligible for Medicaid.
- ❑ People with incomes above the eligible income level may be required to pay a cost-share.
- ❑ WI Family Care Partnership members must require the equivalent of a nursing home level of care, as determined by the functional screen.

WHAT IS WI FAMILY CARE PARTNERSHIP? RECAP

- ❑ WI Family Care Partnership is another managed long-term care option for WI Medicaid eligible individuals who require a nursing home level of care, but who prefer to live in a community- based setting rather than a nursing home.
- ❑ The amount of benefits paid by a qualified WI LTCIP program policy may affect a person's WI Medicaid eligibility and, therefore, his/her eligibility to enroll in WI Family Care Partnership.
- ❑ You may be asked to document the amount of benefits paid by the qualified LTCIP program policy when a person applies for WI Family Care Partnership.
- ❑ The premiums associated with a qualified WI LTCIP program policy may affect the amount that a person must pay monthly to remain enrolled in WI Family Care Partnership.
- ❑ You may be asked to document the amount of the premium paid by the individual for coverage under the qualified WI LTCIP program policy.

WHAT IS INSTITUTIONAL MEDICAID?



Institutional Medicaid is a subprogram of WI Medicaid.

Institutional Medicaid provides a full range of medical services for those who reside in a medical care facility including skilled nursing facilities (SNF), intermediate care facilities (ICF), and hospitals.

- ❑ To be eligible for Institutional Medicaid, the person must have resided in a medical facility for at least 30 days and meet certain WI Medicaid financial requirements.
- ❑ To remain eligible for Institutional Medicaid, the person must contribute toward the cost of their care ("patient liability"), an amount determined based on income.

WHAT IS INSTITUTIONAL MEDICAID? RECAP

- ❑ Institutional Medicaid is a long-term care option for WI Medicaid eligible individuals who have resided in a medical facility for at least 30 days.
- ❑ The amount of benefits paid by a qualified WI LTCIP program policy may affect a person's eligibility for Institutional Medicaid.
- ❑ You may be asked to document the amount of benefits paid by the qualified WI LTCIP program policy when a person applies for Institutional Medicaid.
- ❑ The premiums associated with a qualified WI LTCIP program policy may affect the amount that a person must pay monthly to remain eligible for Institutional Medicaid.
- ❑ You may be asked to document the amount of the premium paid by the individual for coverage under the qualified WI LTCIP program policy.

HOW CAN CONSUMERS LEARN ABOUT THE LONG-TERM CARE OPTIONS IN WISCONSIN?

AGING AND DISABILITY RESOURCE CENTERS OR ADRCS

- ❑ These agencies are "one-stop" sources of information and advice about long-term care, aging and disability in Wisconsin, and specifically in that county.
- ❑ Where none exist, there are county offices on aging.
- ❑ Refer your clients to their local ADRC (or aging office) when they have questions about long-term

care, aging, or disability.

INFORMATION AND ASSISTANCE SPECIALISTS

These specialists maintain up-to-date data bases about all programs and resources, and can assist people to problem-solve when a relative has a need for care, service or financial support.

BENEFIT SPECIALIST

- ❑ Each ADRC has a Benefit Specialist to help cut the "red tape" of Social Security, Medicare, Part D prescription plans, etc.
- ❑ Benefit specialists also assist consumers with problems related to private insurance, financial abuse and Medicare fraud.
- ❑ The ADRC is under contract with the state of Wisconsin.
- ❑ A strong culture of customer service is expected.
- ❑ There is no charge for the services of the ADRC.
- ❑ Families can make contact by telephone from anywhere in the country, or on-line using an internet search engine to locate information on "Wisconsin ADRCs".

For a listing of ADRCs, go to the DHS website: https://www.dhs.wisconsin.gov/adrc/index.htm

- ❑ Refer your clients to their local ADRC (or aging office) when they have questions about long-term care, aging, or disability.

HOW CAN CONSUMERS LEARN ABOUT THE LONG-TERM CARE OPTIONS IN WI? RECAP

- ❑ The information provided about WI's long-term care options in this training document is at a relatively high level.
- ❑ Much more detailed information is available to consumers and their families through WI's Aging and Disability Resource Centers (ADRCs).
- ❑ Long-term care insurers should understand the role of ADRCs and be able to refer their clients to ADRCs as appropriate.

LONG-TERM CARE INSURANCE PARTNERSHIP PROGRAM
WI MEDICAID TRAINING – PART II

WI MEDICAID ELIGIBILITY

- ❑ General Eligibility Requirements for WI Medicaid
- ❑ Detailed Eligibility Requirements for WI Medicaid Payment of Long- Term Care
- ❑ WI Estate Recovery
- ❑ How Asset Protection Works under the WI LTCIP Program
- ❑ How to Apply for WI Medicaid

WHY IS IT IMPORTANT FOR YOU TO KNOW ABOUT WI MEDICAID?

It is Important for You to Know About WI Medicaid because…

1. Wisconsin statute intends that you gain a thorough understanding of the relationship between the qualified WI LTCIP policies that you market and the WI Medicaid program. [s. 49.45 (31) (c)]
2. This relationship is grounded in WI Medicaid eligibility and estate recovery policy.
3. You need this understanding to fulfill your obligation to explain to consumers the protections offered by qualified WI LTCIP policies.

GENERAL ELIGIBILITY REQUIREMENTS FOR WI MEDICAID

To be eligible for WI Medicaid:

- ❑ A person must meet both non- financial and financial requirements.
- ❑ A person must fit into a general eligibility group and meet specific requirements relating to residency, citizenship, immigration status, third party liability, income and assets.

General WI Medicaid eligibility groups include the following:

- People age 65 or older
- People who are blind
- People with a certified disability

A person must be a Wisconsin resident to be eligible for WI Medicaid. S/he must:

- ❑ Be physically present in Wisconsin (there is no required length of time the person has to have been physically present), and
- ❑ Express intent to reside in Wisconsin.

Federal Citizenship and Immigration Status rules require a person to be either a U.S. citizen or a non-citizen with a qualified immigration status.

WI Medicaid Third Party Liability rules state:

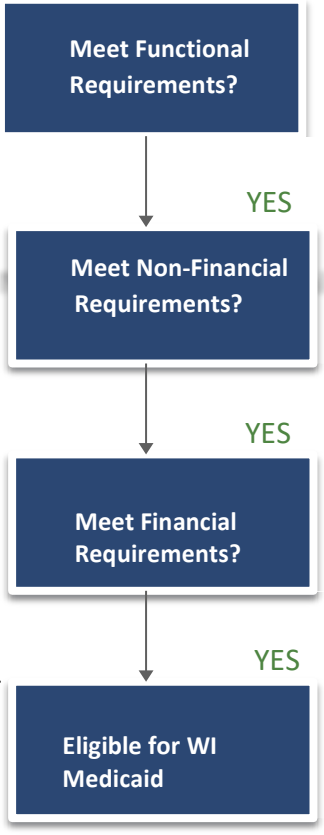
- ❑ People must provide information about possible payment sources, such as other health insurance, Medicare or another liable third party (such as a qualified WI LTCIP policy).
- ❑ Other payment source pays their portion of medical expenses before WI Medicaid payments are made.

GENERAL ELIGIBILITY REQUIREMENTS FOR WI MEDICAID RECAP

- ❑ WI Medicaid eligibility policy is complicated, but it can be viewed as having two distinct components: financial and non-financial requirements.
- ❑ Together, WI Medicaid's financial and non-financial requirements dictate whether a person will qualify to receive the WI Medicaid benefit.
- ❑ WI Medicaid's financial requirements relate to the maximum amount of income and assets a person may have and still be found eligible for the program.
- ❑ Non-financial requirements relate to things such as the person's age, disability status, living arrangement, residency, citizenship, etc.
- ❑ Understanding this general framework will allow long-term care insurers to better grasp key details associated with WI Medicaid eligibility policy and its relationship to the WI LTCIP program.

ELIGIBILITY REQUIREMENTS FOR WI MEDICAID PAYMENT OF LONG-TERM CARE

THE BASICS:



The Long-Term Care subprograms of WI Medicaid generally have functional eligibility requirements. If a person meets these functional

requirements…

Non-financial factors (such as citizenship, WI residency, age, etc.) will be tested. If a person is non- financially eligible…

Financial factors (assets, income, cost share) will be tested. Persons who are functionally, non-financially, and financially eligible…

can have their care paid for by WI Medicaid.

The next slides focus on the financial basics, establishing the groundwork necessary to grasp the asset protection provisions of the WI LTCIP program.

KEY POINTS:

- ❑ The relationship between the WI LTCIP program and WI Medicaid is grounded in WI Medicaid financial eligibility requirements and, ultimately, in WI Estate Recovery policy.
- ❑ Therefore, some background information on both WI Medicaid financial eligibility and estate recovery is necessary.

To receive comprehensive long-term care benefits through WI Medicaid, the person must:

- ❑ meet the program's functional requirements
- ❑ meet the program's non-financial requirements
- ❑ meet the program's financial requirements
- ❑ contribute toward cost of care

The WI LTCIP program directly affects WI Medicaid financial requirements (i.e., the income test, the asset test and the cost share calculation).

FINANCIAL REQUIREMENTS: INCOME TEST

- ❑ When looking at WI Medicaid eligibility for payment of long-term care services, only the income of the elderly or disabled applicant is counted in determining his or her budget.
- ❑ The income of that person's spouse or parent is not counted.

An applicant's gross monthly income, minus certain "credits" is compared to the income limit associated with the program for which the person is applying.

Under certain circumstances, the premium associated with the qualified WI LTCIP policy could be one of the "credits" deducted from gross income to help the person qualify for WI Medicaid payment of long-term care.

If the person qualifies on the basis of his/her income, a separate calculation is performed to determine the amount the individual must contribute toward the cost of his or her long-term care services each month.

FINANCIAL REQUIREMENTS: COST SHARE

The cost share calculation starts with the applicant's gross monthly income and subtracts various deductions or credits. Each possible deduction is not allowed for each person.

General deductions include:

- ❑ Medicare premiums and health insurance premiums not paid by Medicaid (this includes WI LTCIP policy premiums)
- ❑ An income allocation to a spouse who is living in the community, if it is determined that the spouse has a financial need
- ❑ An income allocation to certain other family members (subject to specific limitations)
- ❑ Personal needs (an amount which changes annually)
- ❑ Health care expenses not paid by WI Medicaid or a third party

After allowing applicable income deductions, the result is the amount a person must contribute toward the cost of his or her services monthly. It is typically paid to the WI Family Care (or WI Family Care Partnership) managed care organization, or the medical care facility (for Institutional Medicaid).

FINANCIAL REQUIREMENTS: ASSET TEST

ASSET LIMIT:

The asset limit for a person applying for WI Medicaid payment of LTC services is $2,000. If the person applying has a spouse living in the community, the spouse will be able to keep assets substantially above the $2,000 limit without affecting the applicant's eligibility. This policy is often referred to as "Spousal Impoverishment Protection".

COUNTABLE ASSETS:

- ❑ Countable assets are those which are available to the person and are not specifically excluded by the WI Medicaid program.
- ❑ Not all assets are countable.

COUNTABLE ASSETS INCLUDE:

- cash
- checking accounts
- savings accounts
- certificates of deposit
- life insurance policies
- stocks
- bonds
- non-homestead real property
- property agreements like contracts-for- deed
- other liquid assets

EXCLUDED ASSETS INCLUDE:

- homestead property in which the person or spouse or certain other family members live
- some trusts
- certain funds set aside for burial expenses
- one vehicle
- some federal payments
- household goods
- personal items (such as clothing and jewelry)

The county agency will review all verified assets and determine the amount:

- ❑ Counted toward WI Medicaid eligibility
- ❑ Excluded and not counted toward WI Medicaid eligibility (including the amount of verified benefits paid out by a qualified WI LTCIP policy)
- ❑ Determined to be protected for the community spouse, if married

SPOUSAL IMPOVERISHMENT ASSET PROTECTIONS:

WI Medicaid provides special financial protection to allow the spouse and dependent children of the applicant for LTC Services to retain both assets and income that are above regular WI Medicaid financial limits.

- ❑ For long-term care cases where one spouse is still living in the community, special asset protection provisions apply at application.
- ❑ An Asset Assessment is conducted by the county agency to establish the asset limit/test that the person will have to pass when applying for WI Medicaid.

ASSET ASSESSMENT:

- ❑ Person is required to provide documentation of assets that s/he owned with his/her spouse on the date of first continuous period of institutionalization for 30 days or more OR
- ❑ the date of initial request for WI Family Care (including WI Family Care Partnership), whichever occurs earlier.

SPOUSAL IMPOVERISHMENT AND COMMUNITY SPOUSE ASSET SHARE (CSAS):

When one spouse applies for or receives Medicaid-funded Long-Term Care services and the other spouse remains in the community, spousal impoverishment protections apply to prevent the community spouse from becoming impoverished.

Under these provisions, the couple's combined countable assets are assessed as of the applicable asset snapshot date. The community spouse is permitted to retain a portion of those assets, referred to as the Community Spouse Asset Share (CSAS).

DETERMINATION OF THE CSAS

The CSAS is generally calculated as one-half of the couple's combined countable assets, subject to federally established minimum and maximum standards that are adjusted annually. Wisconsin applies these federal standards at the time of Medicaid eligibility determination.

If one-half of the couple's combined assets is less than the federal minimum, the community spouse is entitled to retain the minimum CSAS.

If one-half of the couple's combined assets exceeds the federal maximum, the community spouse's protected share is limited to the maximum CSAS.

ASSET ELIGIBILITY AFTER CSAS ALLOCATION

After the CSAS is allocated to the community spouse, the spouse receiving Long-Term Care services may retain up to $2,000 in countable assets. Medicaid asset eligibility exists only when remaining countable assets attributable to the institutionalized spouse do not exceed this limit.

If total countable assets exceed the amounts permitted under these rules, excess assets must be reduced before Medicaid eligibility for Long-Term Care services can be established.

INCOME OF THE COMMUNITY SPOUSE

The income of the community spouse is not required to be used to pay for the cost of Long-Term Care services received by the institutionalized spouse. Income needs of the community spouse are addressed separately through the Community Spouse Monthly Maintenance Needs Allowance (CSMMNA), which is determined under federal and state standards and may change annually.

If both spouses are applying for or receiving Medicaid-funded Long-Term Care services, spousal impoverishment protections do not apply, and each spouse is evaluated as an individual applicant.

TRANSFER OF ASSETS AND DIVESTMENT PENALTIES

Wisconsin applies a 60-month look-back period to transfers of assets made by a Medicaid applicant or the applicant's spouse. Transfers for less than fair market value made during this period are reviewed to determine whether a divestment penalty applies.

DIVESTMENT PENALTY PERIOD

If a divestment is identified, Medicaid will impose a period of ineligibility for payment of Long-Term Care services. The length of the penalty period is calculated by dividing the uncompensated value of the transferred assets by the statewide average daily cost of nursing facility services, as established by policy and adjusted periodically.

START OF THE PENALTY PERIOD

The divestment penalty period generally begins when the individual:

- Has applied for Medicaid Long-Term Care services,
- Is otherwise eligible for Medicaid, and
- Is receiving institutional or Home and Community-Based Long-Term Care services,
- But for the transfer of assets.

During a divestment penalty period, the individual may remain eligible for other Medicaid benefits if otherwise eligible; however, Medicaid will not pay for Long-Term Care services during the penalty period. The individual is responsible for the cost of Long-Term Care services provided during this time.

Certain transfers are excluded from penalty consideration, including those specifically permitted under federal and state Medicaid law.

ELIGIBILITY REQUIREMENTS FOR WI MEDICAID PAYMENT OF LONG-TERM CARE RECAP

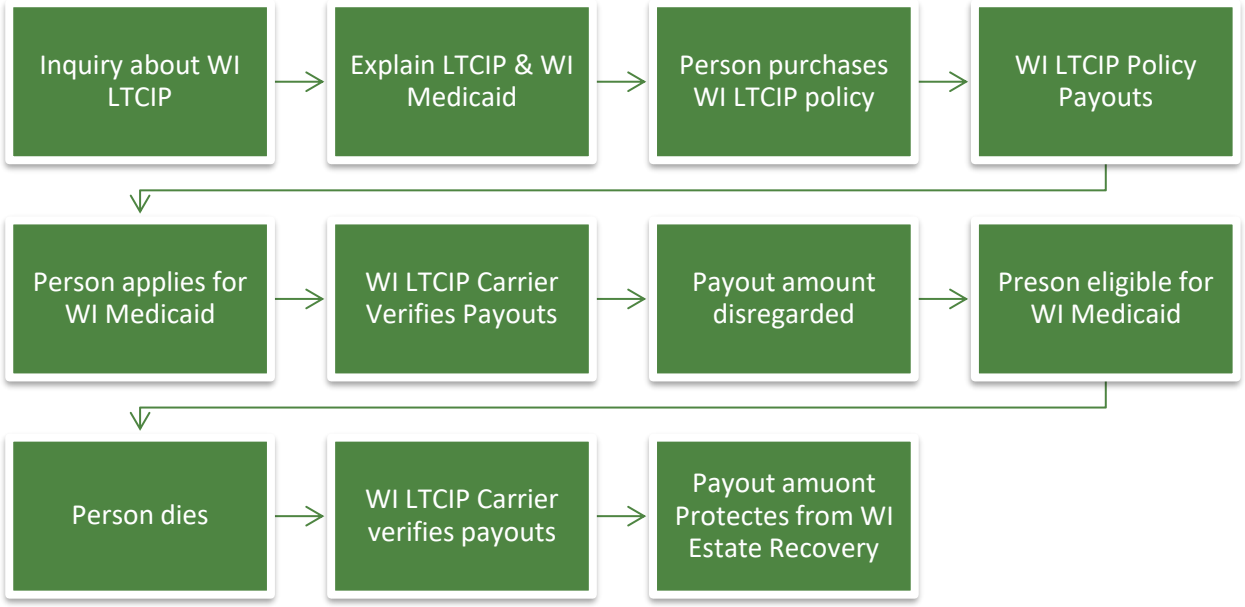
- ❑ Institutional Medicaid and home- and community-based services delivered through Wisconsin's long-term care programs, including Family Care and Family Care Partnership, comprise the primary ways Wisconsin provides Medicaid long-term care services.
- ❑ WI LTCIP program participants are most likely to access WI Medicaid long-term care services through one of these programs.

Each of these programs:

- ❑ Serves individuals requiring a nursing home level of care
- ❑ Applies an income limit that is significantly higher than the limits associated with other kinds of WI Medicaid
- ❑ Requires the eligible person to contribute toward the cost of his/her long-term care, based on his/her income
- ❑ Offers significant asset protections for the community spouse
- ❑ Includes penalties for those who dispose of assets for less than fair market value

HOW ASSET PROTECTION WORKS UNDER THE WI LTCIP PROGRAM

OVERVIEW



A WI LTCIP program participant receives the following benefits during his or her lifetime:

Assets may be disregarded up to the total amount of long-term care services paid by the qualified WI LTCIP policy. The disregarded amount is not counted toward the WI Medicaid asset limit.

- ❑ The amount paid out under a qualified WI LTCIP policy must be verified before it can be disregarded for Medicaid eligibility (or estate recovery) purposes.
- ❑ Adequate verification consists of documentation from the qualified WI LTCIP policy carrier specifying the amount paid in benefits as of the date of the documentation (on carrier letterhead, signed by a carrier representative).
- ❑ The carrier must provide adequate verification to the client, the client's representative, or the county agency, or DHS upon request.

After the WI LTCIP program participant is deceased:

The maximum amount that can be protected from estate recovery under the WI LTCIP program is the verified amount of benefits paid out by the qualified WI LTCIP policy.

When the amount of assets disregarded during the person's lifetime due to verified payouts under a qualified WI LTCIP policy is less than total benefits paid by the qualified WI LTCIP policy, additional assets may be protected in the estate recovery process - up to the verified total amount paid by the qualified WI LTCIP policy.

Following are some examples that depict the interaction between the following programs:

- ❑ WI LTCIP program
- ❑ WI Medicaid
- ❑ WI Estate Recovery

WI LTCIP ASSET PROTECTION FOR WI MEDICAID ELIGIBILITY

The following examples are illustrative only and are intended to demonstrate how asset disregard under the WI LTCIP program operates. They do not reflect current Medicaid financial limits.

Example 1: "WI LTCIP Policy Benefits Not Exhausted"

Ruth is a resident of a medical care facility. She has no spouse. Her qualified $90,000 LTCIP policy has been paying for her care. When Ruth applies for WI Medicaid payment of long-term care services, she verifies that her qualified WI LTCIP policy has paid out $80,000 in policy benefits.

Ruth owns the following countable assets:

- ❑ $5,000 savings account
- ❑ $6,000 checking account
- ❑ $70,000 equity value in recreational lakeshore property

The worker determines that Ruth's total countable assets equal $81,000 ($5,000 + $6,000 + $70,000). Her WI Medicaid asset limit is $2,000; however, because $80,000 has been paid out by Ruth's qualified WI LTCIP policy, an additional $80,000 in countable assets may be disregarded.

In essence then, Ruth's WI Medicaid asset limit is $82,000. Ruth passes the asset test for WI Medicaid because, at $81,000, the value of her countable assets totals less than her asset limit. (Of course, Ruth's income would still need to be tested.)

If Ruth were to pass away the next day, $80,000 of her assets would be protected from estate recovery. The $2,000 basic asset allowance/limit does NOT apply after death and the $2,000 is subject to recovery.

Example 2: "WI LTCIP Policy Benefits Exhausted"

A year later, Ruth's eligibility for WI Medicaid is reviewed. At that time, she verifies that she has exhausted her qualified LTCIP policy benefit, which has paid out the full $90,000.

Ruth owns the following countable assets:

- ❑ $4,000 savings account
- ❑ $7,000 checking account
- ❑ $80,000 equity value in recreational lakeshore property

The worker determines that Ruth's total countable assets equal $91,000 ($4,000 + $7,000 + $80,000). Her WI Medicaid asset limit is $2,000; however, because $90,000 has been paid out by Ruth's qualified LTCIP policy, an additional $90,000 in countable assets may be disregarded.

In essence then, Ruth's WI Medicaid asset limit is $92,000. Ruth continues to qualify for WI Medicaid because, at $91,000, the value of her countable assets totals less than her asset limit.

If Ruth were to pass away the next day, $90,000 of her assets would be protected from estate recovery. The $2,000 basic asset allowance/limit does not apply after death and is subject to recovery.

Example 3: "WI LTCIP and Spousal Impoverishment Protections"

Ruth is applying for WI Family Care benefits. She and her spouse reside in their home and have $100,000 in countable assets. Her qualified $80,000 LTCIP policy has been paying for long-term care she has received in her home and is now exhausted. When Ruth applies for WI Family Care payment of long- term care services, she verifies that her LTCIP policy has paid out $80,000 in benefits.

Because Ruth is living with her husband, Spousal Impoverishment Protections apply. Under Spousal Impoverishment policy, Ruth's WI Medicaid asset limit is $52,000 (i.e., CSAS plus $2000). However, $80,000 is added to this to reflect the amount of benefits paid by her qualified LTCIP policy. Therefore, when Ruth applies for WI Family Care, her asset limit is $132,000.

Within one year of applying, Ruth must transfer her assets to her spouse sufficient to allow her to qualify at an asset limit of $82,000 (i.e., the LTCIP policy pay out amount plus the regular WI Medicaid asset limit of $2000).

WI LTCIP ASSET PROTECTION FOR ESTATE RECOVERY

Example 4:

Ruth is a WI Medicaid eligible resident of a medical care facility. Her qualified $90,000 LTCIP policy has been paying for her care. As of her last WI Medicaid review, the policy had paid out $70,000, an amount disregarded in determining her continued WI Medicaid eligibility.

Ten months after her last WI Medicaid review, Ruth dies. Ruth's representatives verify that, during those ten months, her qualified LTCIP policy paid out an additional $10,000 toward her long-term care.

Ruth's estate can protect a total of $80,000 (i.e., the total amount paid out by the qualified policy) from estate recovery.

HOW ASSET PROTECTION WORKS UNDER THE WI LTCIP PROGRAM RECAP

- ❑ When determining WI Medicaid eligibility, assets may be disregarded in an amount equal to the verified total amount of long-term care services paid by the qualified WI LTCIP policy.
- ❑ These disregarded assets are not counted toward the WI Medicaid asset limit.
- ❑ Assets may be protected from estate recovery in an amount equal to the verified total amount of long-term care services paid by the qualified WI LTCIP policy.

At the request of the WI Medicaid recipient or their representative, the WI LTCIP policy carrier must provide documentation which details date(s) and amount(s) paid in benefits by the policy. The WI Medicaid recipient or his/her representative must provide this documentation to the income maintenance agency worker or estate recovery staff to determine and verify the asset disregard/protection.

HOW TO APPLY FOR WI MEDICAID PROGRAMS

A person can apply for WI Medicaid in person, by mail, by telephone, or using a web-based internet application. Application forms and instructions are available on-line through the following link:

https://www.dhs.wisconsin.gov/forms/f1/f10101.pdf

People who are age 65 or older, blind, or disabled should use form F-10101 to apply for WI Medicaid.

ACCESS is an online tool that allows people to apply for benefits, check the status of benefits, or report changes in circumstances to their worker. ACCESS is available online at:

access.wisconsin.gov

An online ACCESS application is the same as a paper application.

HOW TO APPLY FOR WISCONSIN MEDICAID PROGRAMS RECAP

Application forms and instructions are available on-line through the following link:

https://www.dhs.wisconsin.gov/forms/f1/f10101.pdf

LONG-TERM CARE INSURANCE PARTNERSHIP PROGRAM
WI MEDICAID TRAINING – PART III

WI ESTATE RECOVERY

For current information regarding the Wisconsin Estate Recovery, access the internet at:
https://www.dhs.wisconsin.gov/medicaid/erp.htm

- ❑ What is WI Estate Recovery?
- ❑ What Services Does Wisconsin Recover?
- ❑ When Does the State Not Recover Medicaid Benefits?
- ❑ Updates Effective August 1, 2014

WHAT IS WI ESTATE RECOVERY?

- ❑ Wisconsin Medicaid Estate Recovery seeks repayment for the cost of certain long term care services paid for by Medicaid and BadgerCare Plus, and all services paid for by the Wisconsin Chronic Disease Program (WCDP).
- ❑ Recovery is made from the estate of recipients and from liens placed on their homes.
- ❑ The money recovered is returned to the program and used to pay for care for other members.
- ❑ Note that Wisconsin, unlike some other states, does not recover for ALL services that are paid by WI Medicaid.
- ❑ The amount Wisconsin can recover is limited to the amount paid by WI Medicaid for certain long-term care services.
- ❑ The amount of assets disregarded for WI Medicaid eligibility purposes due to verified payouts under a qualified WI LTCIP policy are protected from estate recovery except for the basic $2,000 asset allowance/limit that all persons receive while they are alive.
- ❑ This $2,000 asset disregard may be subject to recovery when the person is no longer alive.

The long-term care services for which the program seeks repayment mainly include nursing home services, community-based waiver services and certain other long- term care services received in the community by a person at least age 55 or older.

With the new WI LTCIP qualifying policies, the amount of assets that are protected due to verified payouts are not subject to estate recovery.

WHAT IS WI ESTATE RECOVERY? RECAP

- ❑ The Wisconsin Medicaid Estate Recovery Program seeks repayment for the cost of certain long term care services paid for by Medicaid on behalf of recipients.
- ❑ Recovery is made from the estates of recipients and from liens placed on their homes.
- ❑ The money recovered is returned to the WI Medicaid Program and used to pay for care for other WI Medicaid recipients.

The amount of assets that are protected due to verified payouts from a qualified WI LTCIP policy are also protected from estate recovery.

WHAT SERVICES DOES WISCONSIN RECOVER?

As noted previously, Wisconsin does not recover for all services provided to a WI Medicaid recipient.

Wisconsin recovers all the costs for a recipient (of any age) for the period of time in a nursing home or inpatient (more than 30 days) in a hospital, as long as the recipient was considered permanently institutionalized. Wisconsin also recovers all costs from any nursing home for a recipient over the age of 55, even if it was a short-term stay in a nursing home.

Wisconsin seeks to recover services that are generally thought of as "long-term care services" for anyone age 55 and older, living in the community.

Services that a recipient age 55 and older may receive in the community, subject to recovery, include the following:

- Skilled nursing services
- Home health aide services
- Home health therapy and speech pathology services
- Private duty nursing services
- Personal care services

Wisconsin also seeks to recover benefits paid for any recipient age 55 and older in a WI Medicaid Waiver program, including but not limited to WI Family Care, WI Family Care Partnership, Community Options Waiver, Community Integration Programs IA, IB, and II, Brain Injury Waiver and Community Supported Living Arrangements.

The benefits recovered for a Medicaid Waiver recipient age 55 and older are:

- ❑ All services received through the home and community-based Waiver program (i.e., WI Family Care and WI Family Care Partnership).
- ❑ All inpatient hospital services and all prescription drugs received while the recipient was eligible for a Waiver program.

An individual who receives all or a combination of the services listed previously may have the amount paid by WI Medicaid for those services recovered from his or her estate, or through a lien while the recipient is alive - except for an amount equal to the verified payouts under a qualified WI LTCIP policy.

Example 1:

Ruth was in the WI Family Care Program. She received services through Family Care that were not eligible for payment by her qualified WI LTCIP policy (worth $100,000). She passed away and WI Family Care had paid out $50,000 in services over the course of three years. WI Estate recovery would file a claim against her estate which includes her home valued at over $100,000.

When the home in her estate sells, the state would collect on its $50,000 claim, assuming sufficient funds were available to first pay other priority claims. She was not able to protect any assets as the qualified WI LTCIP policy did not pay out any benefits to protect her assets.

Example 2:

Millie was also in the WI Family Care Program. At the time she applied for WI Family Care, $25,000 had been

paid out in benefits by her qualifying WI LTCIP program policy; hence $25,000 of her countable assets were disregarded. She owned her own home worth $150,000. Because she lived in her home, the home remained an exempt asset for purposes of eligibility.

At the time of Millie's death, $60,000 had been paid out by the WI LTCIP program policy, however, WI Family Care had paid out $90,000 in WI Medicaid benefits. WI Estate recovery would file a claim in her estate for $90,000, however, $60,000 would be protected from recovery. Annie had a qualified WI LTCIP policy worth $200,000.

Example 3:

Annie had a qualified WI LTCIP policy worth $200,000. She had cash assets of $50,000 and a home valued at $150,000 that she lived in. She received $50,000 in benefits from her qualified WI LTCIP policy and then applied for WI Medicaid in a Home-and-Community Based Waiver program. Her qualified WI LTCIP policy had verified pay-outs of $50,000 at the time of her initial eligibility determination for the Waiver program.

The policy continued to pay benefits while she lived in the community and then she moved into the nursing home. While she was in the nursing home, the qualified policy had verified pay-outs to the maximum benefits - $200,000; hence the verified $200,000 would be exempted at the time of recovery from her estate.

WHAT SERVICES DOES WISCONSIN RECOVER? RECAP

WI Medicaid recipients who are any of the following may be subject to WI estate recovery provisions:

- ❑ nursing home residents
- ❑ institutionalized persons who received inpatient hospital benefits
- ❑ persons age 55 and older who reside in the community

WHEN DOES THE STATE NOT RECOVER BENEFITS?

- ❑ The state may not seek recovery of any WI Medicaid benefits from a recipient's liquid estate assets while the recipient's spouse or a minor or disabled, or blind child survives the recipient, regardless of any qualified WI LTCIP policy. However, if the recipient's estate includes a home, the state will receive a lien for the amount that exceeds the verified payouts under a qualified WI LTCIP policy.
- ❑ Repayment from the lien will be delayed until after the death of the surviving spouse and any minor, disabled, or blind children.

If the state is granted a lien as noted above, through the estate on the home of a surviving spouse, minor, disabled or blind child of a WI Medicaid recipient and if that property is sold for fair market value while the spouse, minor, disabled or blind child lives, the state will release its lien and no recovery will be made, regardless of the existence of a qualified WI LTCIP policy.

The state may not file a claim on the estate of the surviving spouse to recover WI Medicaid benefits paid on behalf of the pre-deceased recipient.

If a qualified policy has paid out verified benefits in an amount that is equal to or more than the remaining assets of a deceased WI Medicaid recipient, then the state can make no recovery as the assets are protected because of the WI LTCIP policy.

Example 4:

Maynard lived in a nursing home. His wife, Millie, continues to live in their jointly owned home. At the time he applied for WI Medicaid, he had only $2,000 in cash which was exempted for eligibility purposes. Within one year of becoming eligible for MA, their home was transferred solely to Millie. Maynard had a WI LTCIP qualifying policy worth $100,000 that paid most of the cost of the nursing home until it was exhausted.

Then, WI Medicaid paid for his nursing home care for the next two years until he passed away (WI Medicaid paid ($150,000). The state would file a claim against his estate assets (which are minimal) for $150,000, however, because there is no home in his estate and only liquid assets, the state would make no recovery because **Millie is a surviving spouse.**

WHEN DOES THE STATE NOT RECOVER BENEFITS? RECAP

- ❑ The state may not seek recovery of any WI Medicaid benefits from a recipient's estate while the recipient's spouse or a minor, disabled, or blind child survives the recipient.
- ❑ The state may not file a claim on the estate of the surviving spouse to recover WI Medicaid benefits paid on behalf of the recipient.

The verified amount of benefits paid by the qualified WI LTCIP policy are protected from estate recovery. The WI LTCIP policy carrier must provide documentation which specifies the amount paid in benefits as of the date of the documentation.

UPDATES THAT TOOK EFFECT AUGUST 1, 2014

Beginning August 1, 2014, certain new assets and services became part of the Estate Recovery Program.

Assets

The assets below are part of the Estate Recovery Program:

- **Joint Tenancy Property:** Repayment will be made after the member passes away from joint tenancies created on and after August 1, 2014. Repayment will be made from the interest in the property that the member has at the time the member passes away. Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) liens will continue to be filed on joint tenancy homes and repayment will be made from joint accounts at financial institutions, no matter when the joint tenancy was created.
- **Life Estates:** Repayment will be made from a life tenant's interest in life estates that are created on and after August 1, 2014.
- **Life Insurance Policies:** Repayment will be made from a member's life insurance policy, no matter who is named as the beneficiary, for life insurance policies created on and after August 1, 2014.
- **Marital Property:** Repayment will be made from 50 percent of the surviving spouse's estate.
- **Revocable Trusts:** Repayment will be made after the member passes away from revocable trusts created on and after August 1, 2014. A TEFRA lien will continue to be filed on a home in revocable trust regardless of when the trust was created.
- **Tax Equity and Fiscal Responsibility Act of 1982 Liens:** Repayment will be made through TEFRA liens placed on life estates that are created on and after August 1, 2014.
- **Other Non-probate Property:** Repayment will be made from non-probate property not listed above for any member who passes away on or after August 1, 2014.

These assets will be used as repayment for members who pass away on and after August 1, 2014.

Services

The cost of the services below will now be included in the amount that the Estate Recovery Program will seek repayment for:

- **All services received while participating in a long term care program:** Repayment will be made for all services received on and after August 1, 2014, by a member age 55 years and older participating in a long term care program. This includes members participating in home and community-based waiver programs, and the Program of All-Inclusive Care for the Elderly (PACE).
- **Capitation payments:** Repayment will be made for the entire capitation payment made to a managed care organization (MCO) beginning August 1, 2014, for a member participating in a long term care program.

Repayment of these services applies to services received and capitation payments made on and after August 1, 2014, for any member age 55 and older participating in a long term care program. Long term care programs include all home and community-based programs and PACE.