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CORRESPONDENCE MEMORANDUM

DATE: November 7, 2014

TO: Group Insurance Board

FROM: Roni Harper, Manager, Optional Insurance Plans and Audits
Mary Statz, Director, Health Benefits and Insurance Plans Bureau

SUBJECT: Standards for Long-Term Care Insurance

Staff recommends the Group Insurance Board (Board) adopt the *Standards for Proposing and Providing Long-Term Care Insurance,* and grant staff the authority to make additional technical changes as necessary.

Purpose
The standards and process for approving Long-Term Care (LTC) insurance policies have been outlined in two documents:

1) *Guidelines for Optional Group Insurance Plans Seeking Group Insurance Board Approval for Payroll Deduction Authorization* (1999 Guidelines and Attachment A), published in 1992 and revised in 1999 to include provisions related to LTC; and
2) In Administrative Rule ETF 41 originally effective November 1, 1991.

The intent of this proposal is to:

- Create separate outlines for:
  a) Standards for the process and benefit expectations for LTC insurance; and
  b) Guidelines for the process and expectations for other employee-pay-all optional insurances, such as dental and vision coverage, which are separately discussed in item 5.B.2.
- Update several of the specific standards related to coverage thresholds in approved LTC insurance policies
- Describe procedural requirements that outline responsibilities of insurers, their agents, employers and the Department of Employee Trust Funds (ETF) to obtain initial approval and for ongoing administration

Reviewed and approved by Lisa Ellinger, Administrator, Division of Insurance Services

Lisa Ellinger

Electronically Signed: 11/12/2014

Board	Mtg Date	Item #
GIB	11.18.14	5B1

Background

The Long-Term Care Insurance Program has been available to state employees on an optional employee-pay-all basis since 1989 under the authority granted to the Board by Wis. Stats. §40.55. State employees, annuitants, their spouse or domestic partner, and their parents are eligible. Premiums for any of those family members listed may be paid for by an employee or an annuitant through payroll deduction or annuity deduction. Policies must be filed with the Office of the Commissioner of Insurance (OCI).

Wis. Admin. Rule ETF 41 was created pursuant to the original legislation that required the Board to provide additional requirements by rule. Statute was subsequently amended to provide that policies may be offered by contracts established by the Board.

Certain ETF 41 provisions have become obsolete, due to changes in the marketplace for LTC insurance. ETF is in the process of repealing ETF 41 and will instead use these proposed standards to update the requirements.

For example, insurers indicate difficulty with the current requirements for inflation protection. Inflation protection is critical to ensure a policy maintains its purchasing power over time. However, it is quite expensive and the industry has struggled to balance the cost of this protection while keeping policies affordable.

Finally, these proposed standards update operational requirements that allow for electronic submission of proposals to make the process more efficient and set expectations that insurers will meet employer payroll system requirements for electronic interfaces.

Discussion

Attached are four documents.

1. Attachment A is the *Guidelines for Optional Group Insurance Plans Seeking Group Insurance Board Approval for Payroll Deduction Authorization.*
2. Attachment B is the Standards for Proposing and Providing Long-Term Care Insurance.
3. Attachment C is a comparison of benefits table for informational purposes comparing provisions in ETF 41, OCI Standards and our proposed provisions.
4. Attachment D is ETF 41, which ETF is proposing to repeal.

Standards for LTC insurance policies

Among the changes in the marketplace for LTC insurance has been the development of policies known as “Partnership Plans” that were created following the federal Deficit Reduction Act of 2005. The Partnership Plan policies have lower inflation protection provisions than ETF 41 currently allows, but they also have certain tax advantages and can be more affordable and flexible in providing choices to members. These proposed Standards use as their basis the requirements set by OCI for policies intended to qualify a policyholder under the state’s Partnership Program. (Section 3.C.1) The proposed

Standards set enhanced requirements beyond the OCI Partnership requirements as outlined below.

It is important to note that most insurance policies will also have riders available that exceed these proposed minimum benefit levels. Shorter elimination periods and higher daily or lifetime benefits can mean substantially higher premiums. The thresholds outlined here describe the basic policy requirements but do not prevent an insurer from offering riders with richer benefits. Policies currently available should meet these minimums.

a) Section 3.C.1.b. Minimum daily benefit-- $120/day for skilled nursing care (SNF), with at least 50% of SNF rate for care provided in home/community

Currently, OCI requires at least $60/day for skilled nursing care, with at least 50% of that daily $60 (or $30/day) payable if care is in the community. Staff recommends that policies under our program should cover approximately half of the current cost of care at a skilled nursing facility in Wisconsin. We recognize the proposed Standards rely on policyholders to have access to other financial resources in order to make the premiums affordable. In 2014, Genworth, a widely recognized source of LTC data, reports the following rates for the cost of care nationally and in Wisconsin.

	National	Wisconsin
SNF care	$212 /day	$239/day
Asst. Living	$116/day	$128/day
Home care	$20-/hour	$20-22/hr.

b) Section 3.C.1.c. Lifetime maximum benefit-- $120,000

OCI minimum standards would allow a lifetime maximum benefit of $60 x 365 days = $21,900 (OCI requires a minimum of one year of coverage, which would not change under this Standard.)
According to industry experts, including executive directors of the American Association of Long-term Care Insurance, the insurance industry does not typically offer a lifetime benefit amount of less than $100,000.

The recommendation of $120,000 would provide coverage for approximately one year in assisted living, minus the elimination period plus one year in a skilled nursing facility based on the 2014 Genworth data noted above.

Assisted Living	$128/day X (365 - 120 days)	$ 31,360
Skilled Nursing Facility	$239/day X 365 days	$ 87,236
		$118,595

c) Section 3.C.1.e. Elimination period—no change recommended, staying at no more than 120 days

The elimination period is the amount of time that must lapse between the day that a member meets the criteria needed for a benefit to be paid and the first day for which payment is made. It is similar to a deductible in health insurance in that it is the portion of the benefit that the member pays first.

The current elimination period in ETF 41 is 120 days and we propose to retain it. We developed it to be consistent with the 120 days of SNF benefit available under the state employee health insurance Uniform Benefits plan. This may help smooth the transition from the health insurance policy to the LTC policy.

d) Section 3.C.3.a. Tax qualification

OCI allows policies that may or may not meet the IRS definition of qualified LTC insurance under Internal Revenue Code 7702B(b). Because Partnership policies must be tax qualified, this standard will also require policies to be tax qualified. Under this provision, all premiums are tax-deductible and benefits paid are not taxed federally.

e) Section 3.C.1.g. Benefit triggers

The proposed Standards have the claim threshold be no more than two (2) Activities of Daily Living (ADL)[1], or cognitive dysfunction that affects safety.

Under current OCI standards, policies may be marketed that require deficiency in three ADLs. A 2-ADL trigger is more advantageous to the policyholder because benefits become effective with fewer deficiencies.

f) Section 3.C.2. Inflation protection

Inflation protection refers to the rate at which the policy's maximum benefit and the daily benefit increase annually. Currently, ETF 41 requires 5% inflation protection to be sold with all policies. The proposed Standards allow a framework based on age at time of purchase, similar to the Wisconsin Partnership thresholds used by OCI, and with benefit growth rates that include options below 5%.

a. Agents would still be required to offer 5% compound inflation protection; the proposed Standards would not require that threshold on all policies sold.

[1] Activities of Daily Living include, at least, bathing, continence, dressing, eating, toileting, and transferring (such as from bed to chair).

b. These proposed Standards would require that compound inflation protection be included up to age 65, instead of up to age 60. According to AARP, the average age at claim for LTC is 78. We believe a policy that allowed simple interest at age 61 could leave a significant gap in coverage for the average claimant when the need for chronic care arrived. The table below shows the increase in maximum benefit for a $120,000 policy under various scenarios.

Age at purchase		Inflation Protection	Increase	Value at age 80
60	$120,000 max pool	3% Simple	$72,000	$192,000
60		3% Compound	$98,491	$218,491
				Value at age 80
65		3% Simple	$54,000	$174,000
65		3% Compound	$68,092	$188,092

*The CPI-U as of September 2014 was 1.7% overall, and 1.7% for medical services, but was 3% for shelter and 2.5% for medical commodities.

There is no objective way to determine how much inflation will increase over the next 20 years. However, we know that inflation is currently at generational lows and that, historically, LTC costs have increased at two to three times the nominal rate of inflation. For example, inflation in the past several years has been quite modest--yet according to Genworth information in 2013, the cost of SNF care increased 6.8% annually in Wisconsin over the previous five years.

Staff continue to believe that members are not well served if they purchase a relatively low-cost policy with the expectation that it will cover their needs years down the road, only to find that its purchasing power has significantly eroded over time.

With the exception of the current Mutual of Omaha policy offered under our program today, insurers have been reluctant to develop policies that meet our current requirements. To provide more choice in this program, we need to give equitable consideration to both cost and coverage. We believe that the Partnership standards, with a few modifications will meet this need.

The proposed inflation protection requirements for the Standards are outlined on page three of Attachment C, Comparison of Benefit Standards for Long-Term Care Insurance, showing how the proposed Standards compare with the Partnership requirements.

Procedural Requirements

The proposed Standards outline requirements for:

- insurers to submit a proposal to ETF,
- ongoing administration, and
- enumerating the administrative responsibilities of ETF, the insurer, agents, and state employers once a policy has been approved.

Specific updates in the process for obtaining Board approval to market a policy include:

- Section 4 Timeframe:
  - Currently, a new insurer proposal (vs. a replacement proposal) must to be submitted **no less than 45 days** prior to the June (now May, as the Board no longer typically meets in June) Board meeting for policy effective dates at the beginning of the following year. Staff proposes this period be **12 weeks**. Additional lead-time is needed to allow for actuarial consultation, consultation with employers and payroll systems, discussions to insure common interpretations of provisions, and assurance that post-approval procedures will be in place.
  - Section 6.A.3. The proposed Standards no longer limit proposals to a specific Board meeting but instead include a period of eight weeks between Board approval and the first enrollment effective date. This period for implementation allows for finalizing print materials and websites, and inclusion or adjustments in state employer payroll and annuity automated systems.
  - Section 6.A.3. The proposed Standards set January 1 as the first day payroll or annuity deduction can begin, following Board approval of the Plan which allows a new plan to be communicated to eligible participants during the annual open enrollment period.
- Section 4.C. Clarifies the elements to include in a proposal, which will be tracked with a uniform checklist, mirroring a process used by OCI.
  - Eliminates the current requirement that a submittal include 20 bound paper copies. Instead specifies that submission should be via electronic means, with itemized exhibits. Allows option for ETF/Board to request paper submittal.
- Section 6.A.4. Requires use of subscriber authorization form (available electronically through ETF) to initiate or change payroll or annuity deduction
- Sections 6.A. and 6.B. Employer and insurer duties:
  - Sets up system for automated payroll deduction.
  - Outlines distribution of annual outreach message to agency employees.
  - Requires Insurers to provide electronic payroll interface, if requested.

Summary and Conclusion:

LTC insurance is much like auto or homeowner's insurance: it costs thousands of dollars over a person's lifetime, and may pay nothing back if never used. But for those

who must make a claim, it covers costs the owner would not have easily met out of pocket. Many individuals will need extended care at some point in their lifetimes.

The benefit levels outlined here are designed to give subscribers choices to forestall institutional LTC and remain in their home or community settings. Under these proposed Standards a middle-income person able to cover half the cost of care from savings will be able to supplement their LTC insurance benefits before needing to enroll in the Medicaid program.

ETF legal counsel has advised that statutory authority given the Secretary would allow these proposed Standards to be implemented, effective January 1, 2015, while we are in the process of repealing ETF 41.

Staff recommends the Board adopt the proposed Standards for Proposing and Providing Long-Term Care Insurance, to be effective January 1, 2015, and grant staff the authority to make additional technical changes as necessary.

Staff will be at the Board meeting to answer any questions.

Attachment A: *Guidelines for Optional Group Insurance Plans Seeking Group Insurance Board Approval for Payroll Deduction Authorization*
Attachment B: Standards for Proposing and Providing Long-Term Care Insurance
Attachment C: Comparison of Benefit Standards for Long-Term Care (LTC) Insurance
Attachment D: ETF 41

GUIDELINES FOR OPTIONAL GROUP INSURANCE PLANS

SEEKING GROUP INSURANCE BOARD APPROVAL

FOR PAYROLL DEDUCTION AUTHORIZATION

Department of Employe Trust Funds
Group Insurance Board

801 West Badger Road
Madison, Wisconsin 53702

July, 1999

Unless specifically provided for under a collective bargaining agreement under Subchapter V of Chapter III, Stats., The Group Insurance Board is charged by s. 40.03 (6), and s. 20.921 (1) (a) 3., Stats., with approving any optional, employee-pay-all group insurance plan that requires premium deduction from state payroll. The Board has established the policy under which it will review each plan in ETF 10.20, Wis. Adm. Code.

The guidelines describe the requirements of the Board, the procedure followed in reviewing a proposal for state payroll deduction authorization, and the requirements for plans that are approved in their on-going relationship with the Board. Plans that fail to meet these requirements may have their payroll deduction request denied or authorization suspended.

Consistent with the Administrative Code, the Board's intent is to approve only those plans that can demonstrate financial stability and broad based community support, and provide coverage that is not readily available through other plans already provided state employees. The Board may approve a plan which provides coverage similar to one already available to state employees if the Board determines that by so doing, the new plan will provide competition resulting in better benefits and/or lower cost.

I. Application Procedure

1. Plans that wish to be considered for payroll deductions must submit a proposal to the Board in the format described in these guidelines under section II "General Requirement."

2. Applicants must provide twenty (20) copies of the proposal. [only if asked to—email attachment is the first step.]

3. Section 10 of the guidelines requires that statistical information be provided as an exhibit. This exhibit must be complete and the information provided may not be deviate from the format of the addendum to these guidelines. The Board reserves the right to request additional information as necessary.

4. The rest of the guidelines allow responses in text to be free form, but each applicant should be as concise and topical as is possible.

5. Proposals that are received 45 days prior to the next scheduled meeting of the Board shall have their proposal considered at that meeting. Proposals received less than 45 days prior to the next meeting shall be considered at the next following meeting of the Board.

   5a. Effective June 29, 1999, the Group Insurance Board will accept Long-Term Care Insurance proposals once each calendar year at the June Board meeting. Proposals must be submitted at least 45 days prior to the Board meeting. If the proposal is approved, the insurer may offer coverage to state eligible on the following January 1.

6. The staff of the Department of Employe Trust Funds, in consultation with the Board's actuary shall prepare a report on the proposal and a recommendation for the Board. A copy of this report will be available to the applicant no later than seven calendar days prior to the meeting at which the Board will consider the proposal.

7. At the meeting, the Board may wish to ask questions about the proposal. Plans which are being considered should have knowledgeable representatives available at the meeting to respond to these questions.

II. General Requirements

1. Statutory authority to conduct business of insurance.

   The Board will only consider those plans which have received State of Wisconsin Insurance Commissioner approval to conduct the business of insurance in this state. Plans should indicate when this authority was received and under which section of state statute the insurer is licensed.

2. Operating experience.

   The Board will consider only plans that have at least one year of operating experience. The Board may waive this requirement, providing the plan can demonstrate that it was designed specifically for the state employe group to fill a need for coverage that is not already available (or adaptable) to state employes.

3. Broad-based community support.

   Unless a plan has successfully demonstrated under #2 above that it was designed specifically for the state group, each proposal must include a list of current corporate (or public employer) clients and the total number of subscribers.

4. Types of plans that are eligible.

   a. The plan must be true group insurance. A plan which consists of individual policies marketed on a group basis is not eligible. This provision does not apply to Long-Term Care Insurance.

   b. The plan must offer coverage that is not adequately provided through other plans currently available to state employes. The Board may waive this restriction in those instances where it is deemed appropriate to have competing plans, when such competition may result in higher quality benefits and/or lower price.

   c. Plan must provide a high premium to payment ratio. Plans that retain more than 25 percent of premium income for purposes other than claim payments will not normally be eligible for consideration unless the high retention ratio is justified.

5. Financial requirements.

   Any organization desiring approval must demonstrate that it has adequate financial resources necessary to carry out its obligations to state employes and dependents who choose to be covered under the plan.

   In determining financial stability, the Board will consider:

   a. Financial soundness of the sponsoring organization. Each organization will be required to submit the initial proposal, information on its current financial condition. Documentation required includes a balance sheet, statement of operations, an

audited financial statement by a certified public accountant in accordance with generally accepted accounting principles, and utilization statistics. (This information shall remain confidential insofar as permitted by Wisconsin law.)

b. Incorporation and regulation under the provisions of Chapter 185 and/or 600 through 646, Wis. Stats., pertaining to insurance plans.

c. Insolvency protection for subscribers consisting of, for example; financial bonds, third party guarantees, reinsurance deposits, automatic conversion rights, or other arrangements which are adequate to the satisfaction of the Board to provide for continuation of benefits until the end of the third month following the month in which insolvency is declared.

6. Marketing and enrollment.

a. Each plan shall submit a general description of its marketing plan. Any promotional material or literature that the plan proposes to distribute to state employes shall first be approved by the Board.

b. Each plan will be required to supply all necessary application forms and reporting forms. State agency payroll representatives will accept applications from enrollees and transmit new applications to the plan. In addition, the payroll representatives will audit the membership lists and report any changes to the plan. The plan should submit a monthly membership list to each state agency to assist the payroll representatives in this task.

c. State agency payroll representatives will be responsible for entering premium deductions into the payroll system. Premium deductions shall take place once each month for coverage in the following month for those on a biweekly payroll, and the next following month for those on a monthly payroll. Each agency shall submit the total premium from that agency to the plan not later than the first calendar day of the coverage month for which that premium is due. Other premium collection schedules may be approved by the Board if there is a demonstrated need.

d. Approved plans will be required to hold an initial open enrollment period for a period of not less than one month nor longer than two months. During this period, any eligible employe shall be allowed to enroll in the plan. No plan will be allowed to apply underwriting standards or restrictions during this open enrollment period. Therefore, each new eligible employe shall be afforded the same opportunity to enroll provided application is made within 30 days of first becoming eligible. (This provision does not apply to Long-Term Care Insurance.)

e. Employes who do not enroll when initially eligible, may be afforded the opportunity to enroll in an open enrollment period specified by the plan or through the application of underwriting standards, provided those standards have been approved by the Board.

f. Approval by the Group Insurance Board under these guidelines authorizes a plan for premium collection through payroll deduction only; it does not guarantee access to all state agencies. Plans that have been approved by the Board will be

expected to execute Group Master contracts with each state agency that wishes to offer the coverage to its employes. A state agency may, at its discretion, choose not to offer a plan even though that plan has received payroll deduction authorization from the Group Insurance Board.

7. Reporting.

   Each plan will be required to annually submit enrollment and utilization statistics and any other requested financial information to the Board in an agreed-upon format. This information will normally be required no later than May 1 of each year, and shall cover the previous coverage year. Failure to submit this information, may at the discretion of the Board, constitute grounds for termination of the plan's payroll deduction authorization.

8. Benefits.

   a. Each plan is required to submit a clear, complete, and understandable description of benefits.

   b. The description of benefits must include a detailed listing of exclusions and limitations.

   c. Benefits may not be changed or added to the plan during the coverage period, unless such change is necessary to comply with state or federal regulations.

   d. Each plan will be required to file with the Board a detailed description of how member complaints will be resolved. In addition, each plan must specify the name and telephone number of the person who will initially receive member complaints.

9. Notification of significant events.

   Each plan shall notify the Board of a "significant event" within thirty (30) calendar days after the plan becomes aware of it. (In the event of insolvency, the Board must be notified immediately.) As used in this provision, a "significant event" is any occurrence or anticipated occurrence which might reasonably be expected to have a material effect upon the plan's ability to meet its obligations, including, but not limited to, any of the following: disposal of major assets; lost of 15% or more of the plan's membership; termination or modification of any contract or subcontract if such termination or modification will have material effect on the plan's obligations; the imposition of, or notice of the intent to impose, a receivership, conservatorship or special regulatory monitoring; the withdrawal of, or notice of intent to withdraw, state licensing, HHS qualifications or any other status under state or federal law; default on a loan or other financial obligations; strikes, slow downs or substantial impairment of the plan's facilities used by the plan in the performance of its contract. The Board shall reserve the right, by contractual agreement, to institute action as it deems necessary to protect the interest of its employes and dependents, as the result of a "significant event."

10. Rate-making process.

    Each plan must submit in its initial proposal, premium rates and a detailed description as to how premium rates are determined. The proposal should also include an explanation of how adverse or favorable experience will be reflected in future rates. The specific rate-

making information requirements are listed as an addendum to these guidelines. This form must be completely filled out and the content may not deviate from the listed requirements. This information will be considered confidential by the Board insofar as is permitted by Wisconsin law. [You may submit a pdf or Word document that includes the information on this form. Please mark any specific document that should be confidential—i.e. proprietary financial data.]

Future premium rate adjustments shall be considered by the Board subject to the following conditions:

a. No rate change shall take effect without approval of the Board.

b. Rates should remain in effect a minimum of one year from date of effectiveness.

c. Plans will be required to notify the Board in writing no later than 60 days prior to the meeting at which the rate change will be considered.

d. A completed rate-making information form shall accompany the notification.

e. The Board will not consider any request for rate change that does not arrive complete and within the time period specified above.

f. The Board will not approve a rate increase that it deems excessive or unreasonable.

11. Fees.

Each initial proposal, will in addition to analysis by the staff of the Board, be reviewed by the Board's consulting actuary. Plans should expect that a fee will be charged for the staff and the actuary's time and expenses. In addition, all actual costs of the staff and the Board's actuary in reviewing claims and premium and other relevant information concerning that plan on an on-going basis after Board authorization is granted may be charged to the insurer. If the time required for this review is minimal, the Board may waive the fee.

[No fee is charged for staff time for initial approval or rate reviews, as of 2013/14]

State of Wisconsin Group Insurance Program

Information Required for

Preliminary Review of Proposal

Proposed Plan: _____ Date: _____

Carrier: _____

Summary description of proposed plan (100 words or less):

_____

_____

_____

_____

_____

_____

_____

Enrollment statistics for this plan as of _____:

	Madison Area	Wisconsin	Nationwide
Number of participating groups			
Employer supported			
Employe pay-all			
Number of individuals covered			
Two largest participating groups			
Group 1 - Name			
- No. of participants			
Group 2 - Name			
- No. of participants			

Five year claim experience for this plan (year 1 is most recent year):

	Year 1	Year 2	Year 3	Year 4	Year 5
Number of participants					
Annual premium income					
Number of claims					
Amount of claims					

Required attachments:

- Financial statement of carrier for last 2 years
- Sample adoption agreement
- Premium schedule
  - When was it last revised?
  - For how long are rates guaranteed?
- References – Name, address and telephone number of 3 largest groups in Wisconsin currently in this plan.
  [include at least one public employee group.]

STANDARDS FOR
PROPOSING AND PROVIDING
LONG-TERM CARE INSURANCE

Department of Employee Trust Funds

Group Insurance Board

801 West Badger Road

Madison, Wisconsin 53702

November 18, 2014

Standards for Proposing and Providing Long-Term Care Insurance

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1. OBJECTIVES

As outlined in Wis. Stat.40.55, the Group Insurance Board (Board) is required to offer long-term care (LTC) insurance to eligible employees and annuitants, and to their spouses, domestic partners and parents. The LTC insurance may be made available based on underwriting to establish each subscriber's initial eligibility and premium levels. The State does not contribute to premiums. For a plan to be considered by the Board it must have been filed with the Office of the Commissioner of Insurance (OCI). These Standards outline the following:

- further qualifications of policies for which a managing general agent (Agent) seeks approval from the Board;
- the procedures for submitting proposals;
- marketing approved insurance; and
- contract features outlining ongoing administrative requirements for plans that receive Board authorization.

In offering LTC insurance that meets standards outlined by the Board, the State seeks to contribute to the objectives established for the public employee trust fund: to aid public employees to protect themselves and their beneficiaries against the financial hardships of old age, disability, illness and accident--thereby promoting economy and efficiency in public service by facilitating the attraction and retention of competent employees and enhancing employee ability to perform their duties, while minimizing the stress of contributing to care of a parent or spouse in need of long-term care.

2. STATUTORY AUTHORITY

Statutory Authority is described in Wis. Stat. Ch. 40.03(6)(a)1., and in Wis. Stat. Ch. 40.55-Long Term Care Coverage, which states in part:

> "… the state shall offer, through the group insurance board, to eligible employees… and to state annuitants long-term care insurance policies which have been filed with the office of the commissioner of insurance and which have been approved for offering under contracts established by the group insurance board."

Rule-making authority is described in Wis. Admin. ETF 10.20, which authorizes approval of plan premiums to be paid through payroll or annuity deduction.

3. STANDARDS FOR PLAN PROVISIONS

A. General standards:

A LTC insurance plan (Plan) approved by the Board must:

1. Demonstrate approval by OCI.
2. Fulfill an important coverage need for eligible subscribers by offering benefits, value, and service not otherwise available under Plans approved by the Board.
3. Demonstrate a history of performance and acceptance by eligible participants and/or a record of positive assessment by other large group entities that make the same or similar Plan available to their employees.

4. Demonstrate ability to manage premiums through automated systems for payroll deduction that interface with State payroll systems for employees and annuitants.

B. Persons eligible to subscribe

1. A Plan approved under these Standards may be marketed to State employees as defined by Wis. Stat. 40.02(25)(bm):
    a) Any employee of the state who received a salary or wages in the previous calendar year
    b) State annuitants under Wis. Stat. 40.02(54m)
    c) Any participant who was formerly employed by the State who received a lump sum if paid as an annuity
    d) Any employee who is a resident of Wisconsin and has filed an application for an immediate annuity, regardless of whether final administration has been taken
2. A Plan may also be marketed to the spouse or domestic partner of an employee or annuitant and to the parents of the employee, spouse or domestic partner. Premiums for policies covering any of these family members may be paid for via payroll or annuity deduction.
3. All of the above comprise a group of **Eligible Chapter 40 Subscribers**. Each applicant may be subject to underwriting, under standards in Wis. Admin Code Ins. 3.46(10)

C. Coverage and costs for marketed plan:

Prior to approval by the Board, a Plan must demonstrate that it has met the uniform product standards and *received approval* from OCI. In addition, to ensure quality and value for eligible subscribers under Wis. Stat. 40.55, the policy, as marketed and sold to Eligible Chapter 40 subscribers, must meet specific standards of benefits and costs as outlined below, at a minimum.

1. Basic Standards – OCI and enhanced standards:

Be approved as a Partnership Plan under Wis. Admin Ins. 3.465. Meet or exceed Plan requirements of OCI or the IIPRC, as outlined in Form Filing Checklist – Long-Term Care Insurance or IIPRC-LTC-I-3-CORE, which include but are not limited to:

a) Cover a full range of care settings and methodologies, from homemaker services to skilled nursing home care
b) Provide a minimum daily benefit for care equal to that prescribed in Ins 3.46(4)(b), or $120/day, whichever is higher.
c) Provide a lifetime maximum benefit of no less than $120,000
d) Cover long-term care without the need for previous hospitalization or prior use of other levels of care
e) Provide care after an elimination *period not to exceed 120 days,* whether or not days are consecutive.
f) Offer non-forfeiture benefit if a policy lapses due to lack of payment.
g) Provide coverage when the subscriber shows deficits in performing 2 (two) or more Activities of Daily Living (ADLs) as defined in Ins 3.46(17), or dementia that affects safety.

2. **Inflation Protection**:
   Policies as marketed to Eligible Chapter 40 Subscribers must include inflation protection as outlined below:
   - **a) Under Age 65:** Automatic annual compounded inflation protection must be included:
     1. Level premiums, with benefits increasing at a rate of at least 3% with guaranteed annual opportunity to adjust the compound inflation rate at minimum .5% intervals up or down (within the range of 3 to 5%) with premium rates for higher amounts based on age at purchase, available until 20 years after purchase or age 76, whichever is earlier OR
     2. At a rate based on changes in the CPI OR
     3. At a rate of 5% for 20 years or until age 76, whichever is earlier
   - **b) At least age 65 but less than 76:** Automatic annual compounded inflation protection described above, OR additional options include:
     1. At least 3% annual simple inflation protection until subscriber attains age 76 AND
     2. Guaranteed bi-annual purchase option of the difference between current value and 5%, for the earlier of 10 years, or until age 76, or subscriber rejects two *non-consecutive* offers
   - **c) At least 76**: Must offer same as above, but inflation protection is not required
3. **Additional standards:**
   - a) Tax consequences: the Policy must meet the federal requirements for tax-qualified LTC policies Ins 3.46(18)(b) and Ins 3.465(3)(b)2.
   - b) Standards for premium increase by class: The Plan must follow provisions in Ins 3.46(19), which outlines what constitutes a substantial premium increase allowing a non-forfeiture opportunity for the policy-holder. In addition, the plan must show procedures to notify the Department of Employee Trust Funds (ETF), as the agent of the Board, at least 60 days before a class rate increase is scheduled to take effect. ETF should have notice no later than the date notices are mailed or posted to subscribers.
   - c) Standards for agent training and compliance with marketing acts and practices as outlined in Ins. 3.46 (23).

4. PROCEDURE FOR SUBMITTING A PROPOSAL

Any Agent seeking Board approval of an LTC insurance policy must first submit a proposal to:

Department of Employee Trust Funds
Attention Optional Plans Program Manager
P.O. Box 7931, Madison, WI 53707-7931.

A fee for administration will be charged.

Time frame: A complete proposal must be submitted no less than 12 weeks prior to the Board meeting at which it will be presented.

Documentation outlined below should be sent via e-mail to ETF's Optional Plan Program Manager initially, with separate attachments. Bound paper copies may be requested by ETF and if so requested must be provided no less than 15 days prior to the Board meeting at which the proposal will be presented.

A. Cover letter from Wisconsin Managing General Agent licensed to market LTC insurance in the state of Wisconsin, outlining:

1. Marketing title/working title of new Plan, and Plan ID registered with OCI
2. Plan identification number and working title of Plan to be replaced
3. Brief narrative description of Plan. Clearly identify how the marketed Plan will conform to Board standards; do not simply submit a brochure used for general, non-Chapter 40 marketing

B. References and contacts:

1. List of contact persons for managing the proposal review on behalf of the Insurer and of the Wisconsin Managing General Agent.
2. Functional web addresses for Insurer and Agent, with links to related plans if possible.
3. List of three current or recent employers from which the Insurer collects LTC insurance premiums via electronic fund transfer, including name and contact information for the employee benefits office of each entity.
   - At least one employer should be a government agency.
   - For participating government groups, list the number of participants enrolled in previous year, and the number with in-force plan
4. Other large groups: at least one as reference, additional list welcome

C. Attachments (use checklist).

1. Plan:
   a) Documentation of approval from OCI
   b) Clearly identify which policy variables apply to Board proposal, in a separate application sample
   c) Complete narrative description of the policy as it will be made available to Eligible Chapter 40 Subscribers. The description of benefits must include a detailed listing of exclusions and limitations.
   d) Premium schedule
   e) Actuarial analysis, sufficient to allow the Board's consulting actuary to review policy variables required under these Standards.
   f) Demonstration of ability to provide adequate customer service

g) A detailed description of the process for an applicant or subscriber to report a complaint with the Agency and Insurer.
h) List of selling agents at the time of the proposal
i) A summary of the Plan suitable for publication for member comment must be provided (may be a sample brochure if it accurately depicts the Plan as presented to the Board.)

2. Clearly mark any sections that should be regarded as confidential.

5. REVIEW PROCESS BY THE DEPARTMENT OF EMPLOYEE TRUST FUNDS

A. ETF staff review the proposal and prepare recommendation to Board. ETF will notify the Agent within 10 days that the submission has been received and accepted as complete. Review by the Board's consulting actuary will range from brief to extensive, based on the features of the plan and clarity of the proposal submitted. The fee for this review will be billed directly to the Managing General Agent by the Board's consulting actuarial firm.
B. The review process may include meetings or conference calls with Insurer and ETF and/or the consulting actuary
C. Any modifications to the proposal must be received by ETF in writing (via email attachment) no later than six weeks prior to the scheduled Board meeting.
D. A spokesperson for the Agent must be present at the Board meeting. The agenda and documents for Board discussion are posted on ETF's website one week before each meeting.
E. Marketing materials, including any content for Internet postings must be approved by ETF to ensure they reflect plan provisions and procedures in this Standard. Approval of marketing materials by the OCI is not a substitute for approval by ETF.

6. ADMINISTRATION OF APPROVED PLANS

A. Duties of Managing General Agent

Upon approval, and before the Agent may market the Plan:

a) Sign Administrative Agreement
b) Provide marketing plan, including final Plan-specific brochure, application, and subscriber contract

2. Must set up payroll deduction procedures in compliance with each state payroll center
3. Enrollment may begin not more than eight weeks after Board approval, with payroll or annuity deduction for premiums effective January 1 of the year following the year the plan was approved.
4. Utilize *Authorization to Deduct Monthly Premium for LTC Insurance* form (ET-2364) or *Retired Public Safety Officer Insurance Premium Deduction - Authorization* form (ET-4330) for all new enrollees and for changes to premiums.
5. Pay annual fee within 30 days of receipt of invoice.
6. Annual reporting to ETF for compilation and review by Board. Data to include, at a minimum:
   a) Number of inquiries

b) Number of inquiries that did not meet the suitability standard, as described in Wis. Admin. Ins. 3.46(16)
c) Number of policies sold
d) Age ranges at time of purchase
e) Employers, if active employees purchased policies
f) Number of employee/retiree/family
g) Premiums total
h) Average premium by gender
i) Age ranges at time of initial claim
j) Number of claims
k) Amount of claims paid
l) Setting of subscribers in claim status (home, assisted living, skilled nursing facility)
m) Number of policies lapsed
n) Other data elements as requested

B. Duties of Employers and Payroll Center Staff

1. Each payroll and benefits office will set up a system to pay premiums via automatic payroll deduction. Upon receipt of subscriber completed *Authorization to Deduct Monthly Premium for LTC Insurance* form (ET-2364), will initiate or adjust premium deductions.
2. Distribute annual outreach message to employees through electronic messaging or newsletter, using content provided by Agent, approved by ETF.

C. Duties of ETF

1. Facilitate Agent's outreach to members:
   a) Provide Agent with a list showing contact information for each state agency and payroll center
   b) Annually review, approve, and distribute text of brief informational outreach message provided by Agent.
   c) Annually prepare census list for direct marketing, if requested by the Managing General Agent.
2. Set up a system to pay premiums via automatic annuity deduction. Upon receipt of subscriber completed *Authorization to Deduct Monthly Premium for LTC Insurance* form (ET-2364) or *Retired Public Safety Officer Insurance Premium Deduction - Authorization* form (ET-4330) for eligible members, implement or change premium deduction.
3. Prepare annual invoice reflecting the direct costs incurred by the Board and its agents (ETF) in administering this LTC insurance for members and employers.

7. ATTACHMENTS

- Checklist for proposals
- List of contacts for ETF
- Sample "Authorization" forms and instructions
- Sample Contract
- Sample Agency Agreement
- Sample annual reporting

Attachment C: Comparison of Benefit Standards for Long-Term Care (LTC) Insurance

	Wisconsin Administrative Rule ETF 41, last updated July 2010 and July 1999	Office of the Commissioner of Insurance (OCI) standards, Wisconsin Administrative INS 3.46 and 3.465	Standards for Proposing and Providing LTC Insurance with Approval by the Group Insurance Board (Board)
Levels of care covered	Purpose includes—"Promote the use of non-institutional care settings." Wis. Admin ETF 41.02(2) Nursing home (NH), home health care agency, or adult day care center. Uses specific definitions, including that home health care be for skilled nursing care through Medicare-approved agency.	Defines NH, home health care, personal care, adult day care, AND assisted living residential facility, with more adaptability. Specifically cannot require home care to be Medicare certified.	Follow OCI standards
Minimum $ benefit	Wis. Admin ETF 41.02(3) Daily-$50 in nursing home; 75% of NH cost for home health agency; 50% of NH cost for adult day care.	Minimum $60 per day ➢ Option to purchase coverage for home or community care that is equal to NH coverage *or* ➢ Community care and home care must be at least 50% of NH coverage.	For NH care = **$120/day**, or OCI, "whichever is higher" Community= 50% of NH base **(i.e.$60/day)**
Lifetime Maximum	Wis. Admin ETF 41.02(2) $36,500 [note- $36,500 ÷50 ÷12 = 24.3 months]	Minimum one year of coverage. $60 x 365 days= $21,900	**$120,000** lifetime maximum (retain minimum one year per OCI)
Requires previous inpatient care?	Not allowed to require one level of care to be contingent on another level	Must provide benefit "Whether or not care is medically necessary, but may require plan of care." Cannot require hospitalization.	OCI standards
Elimination period	Wis. Admin ETF 41.02(6) not more than **120** days total (consecutive or not) must be used before benefit payments begin	Ins 3.46(12) Cannot offer more than 180 days UNLESS clearly also shows alternative with less than 180 days.	Not more than 120 days

Protection against unintended lapse	Allows cancellation for non-payment of premium	Must offer non-forfeiture benefit that provides paid-up insurance if your policy lapses for non-payment	OCI standards
Claim threshold	Wis. Admin ETF 41 silent. Defines 'activities of daily living' (ADL[i]) but does not use the definition in standards.	Deficits in performing 2 or more ADLs [i]or dementia affects safety(IIPRC 2010)	OCI standards
Tax Consequences	Silent	Must meet IRS definition of qualified LTC insurance under IRC 7702B(b)	OCI standards
Complaint/appeal procedure	Guideline requires plan to "file with the Board a detailed description of how member complaints will be resolved," including name and telephone number of contact to receive complaints.	Must describe benefit appeal procedure, and insurer must respond with decision in 30 days	OCI standards
Standards for premium increase by class	None, nor notification to Board or ETF, once plan is approved	Ins 3.46(19) Triggers for substantial premium increase allowing non-forfeiture	OCI, but add requirement to notify ETF Examples: -Under 65 = 50% -Age 65-80= 30% -Over 80 = 10%
Inflation protection	ETF/Board	OCI	**Proposed LTC Standard for Board**
General requirement	41.02(5) (a) Must provide ONE of the following: 1. May purchase additional coverage annually, at least $10/day at price in effect for age 2. Level premium. Benefit increases automatically by a minimum of 10%/yr. for 10 yrs. 3. Level premium. Benefit payable as % of cost of care	Non- Partnership plans: Must OFFER non-partnership: but see also Partnership, next section -Level premiums with benefit increase of 5% compounded annually -Guaranteed purchase option, of difference between current value and at least 5% • Offered annually unless *an* offer was previously rejected	See next section

	4. Daily benefit and lifetime max increase at least 5%, compounded annually, AND guaranteed purchase option (GPO) to increase lifetime max ben. by inflation rate that's *in excess of 5%* , with premiums based on age at time of purchase for additional units 5. If (a)4, must offer GPO at least every 3 yrs. – If rejects 3 consecutive GPO, no more offers [i.e. could hold policy for 9 years, then use GPO, then 9 more years to GPO]	-Benefit covers percent of actual or reasonable charges up to indemnity limit	
"Partnership" **by Age at time of purchase:** Under age 61	41.02(5) *applies to any age, although Board has approved policies that stop guaranteed purchase at age 80.*	Ins 3.465 (5) (Partnership LTC insurance), Automatic annual compounded inflation protection ➢ At a rate of at least 3% compound, *or* ➢ At a rate based on changes in the consumer price index OR ➢ At a rate of at least 3% compound and > Increases automatically unless insured rejects *an* increase [rejection of increase negates Partnership status] and >until insured attains age 76 and >premiums may increase based on age for the additional coverage amounts	**Under Age 65** Automatic annual **compounded inflation protection** must be included: ➢ At a rate of *at least* 3% ***with guaranteed annual opportunity to adjust the compound inflation rate at minimum 1% intervals up or down (within the range of 3 to 5%) with rates for higher amounts based on age at purchase* (see example), *available until 20 years after purchase or age 76, whichever is earlier* OR** ➢ At a rate based on changes in the CPI **OR** ➢ At a rate of 5% for 20 years or until age 76, whichever is earlier

At least age 61 but less than 76		Automatic annual compounded inflation protection described above, *OR* ➢ At least 3% annual simple inflation protection	**At least age 65 but less than 76,** Automatic annual compounded inflation protection described above, OR additional options include: ➢ At least 3% annual simple inflation protection until insured attains age 76 **AND** ○ **Guaranteed bi-annual purchase option for 10 years or until age 76 or rejects two *non-consecutive* offers**
At least age 76		No less restrictive than in all of the above, but Inflation protection is not required	**At least 76**: Must offer same as above, but inflation protection not required

[i] Activities of Daily Living include, at least, bathing, continence, dressing, eating, toileting, and transferring (such as from bed to chair).

ATTACHMENT D

Register July 2010 No. 655

Chapter ETF 41

LONG-TERM CARE INSURANCE

ETF 41.01 Definitions. The following are definitions for words and phrases used in this chapter:

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

(2) "Adult day care center" means an organization that provides a program which:

(a) Meets all applicable state or local laws;

(b) Is staffed by a director and a registered nurse;

(c) Has appropriate access to the services of a dietician, a licensed physical therapist, a licensed speech therapist, and a licensed occupational therapist;

(d) Maintains a client to staff ratio of 8 to one or less;

(e) Operates at least 5 days per week for not less than 6 hours nor more than 12 hours per day;

(f) Maintains a written record of medical services to clients; and,

(g) Has established procedures for obtaining appropriate aid in the event of a medical emergency.

(3) "Board" means the group insurance board created by s. 15.165 (2), Stats.

(4) "Custodial care" means care which can be performed by persons without professional medical training and which is primarily for the purpose of meeting the personal needs of the patient, including feeding and personal hygiene.

(5) "Department" means the department of employee trust funds created by s. 15.16, Stats.

(6) "Elimination period" means the number of days per lifetime for which an insured is receiving care otherwise covered in a nursing home, from a home health agency, or an adult day care center before a benefit is payable.

(7) "Home health agency" means an organization which:

(a) Primarily provides both skilled nursing and other therapeutic services to patients in their homes,

(b) Is certified or licensed as a home health care agency in the state in which it is located, or

(c) Is certified under Medicare.

(8) "Intermediate nursing care" means basic care including physical, emotional, social and other restorative services under periodic medical supervision. This nursing care

requires the skill of the registered nurse in administration, including observation and recording of reactions and symptoms, and supervision of nursing care.

(9) "Level of care" means custodial care, intermediate nursing care, or skilled nursing care.

(10) "Nursing home" means a facility which is licensed as an intermediate or skilled care facility in the state in which it is located.

(11) "Policy" means any long-term care insurance policy offered pursuant to s. 40.55, Stats.

(12) "Skilled nursing care: means care furnished on a physician's orders which requires the skills of professional personnel such as a registered or a licensed practical nurse and is provided either directly by or under the supervision of these personnel.

History: Cr. Register, October, 1991, No. 430, eff. 11-1-91.

ETF 41.02 Standards for long-term care policies.

(1) PURPOSE. This section establishes standards for each long-term care insurance policy available to state employees and state annuitants under s. 40.55, Stats., in order to do all of the following:

(a) Provide employees and annuitants meaningful protection for themselves, their spouses, their domestic partners and their parents from the potentially catastrophic costs of financing long–term care;

(b) Assist in managing the care which may be required; and

(c) Promote the use of non-institutional care settings as an alternative where institutional confinement would otherwise be necessary.

(2) REQUIREMENTS FOR LEVELS AND SETTINGS OF CARE AND DURATION OF BENEFITS. Each policy shall provide coverage for all levels of care provided in a nursing home, through a home health care agency, or in an adult day care center for a minimum lifetime benefit of $36,500. No policy may make payment for any benefit in any setting or at any level of care contingent upon the prior receipt of care in a different setting or at a different level of care.

(3) MINIMUM DAILY BENEFITS. Each policy shall have a minimum daily benefit of $50 per day for care provided in a nursing home and shall provide a minimum of 75% of the daily nursing home benefit per day for care provided through a home health agency and 50% of the daily nursing home benefit for care provided through an adult day care center.

(5) INFLATION PROTECTION.

(a) Each policy shall provide for one of the following:

1. Any insured not receiving benefit payments may purchase additional coverage during an annual enrollment period established by the board in an amount not less than $10 per day at the price then in effect for the insured's age group.

2. Benefits shall increase automatically to a minimum of 10% per year for 10 years.

3. Benefits shall be payable as a percentage of the cost of care.

4. The policy shall increase daily benefits and any benefits remaining toward the policy's maximum benefit level at a rate not less than 5% compounded annually, and shall guarantee the insured the right, without evidence of insurability or health status, to periodically increase daily and remaining lifetime maximum benefit levels by an amount not less than the amount by which the inflation index specified in the policy and approved by DETF exceeds the annually compounded 5%.

(b) For purpose of par. (a) 4., the insurer shall offer the insured the opportunity to secure additional coverage at least once every 3 years. If the offered increase in a daily benefit would be less than $10, the policy may include language that extends

the period beyond 3 years. If the insured declines an offer for additional coverage, the insurer may not offer the additional coverage during that period. If the insured rejects 3 consecutive offers for additional coverage, the insurer is not required to make further offers.

(6) LIMITS ON ELIMINATION PERIODS. No policy may require more than a total of 120 days, whether consecutive or not, to be used before benefit payments begin.

(7) RENEWABILITY. In the event that any policy ceases to be offered under the program of the board, or an insured individual loses eligibility for coverage, the insurer shall offer to all affected insureds an identical continuation policy. No policy or certificate may be canceled or non-renewed by the insurer for any reason other than non-payment of premium.

History: Cr. Register, October, 1991, No. 430, eff. 11-1-91; r. (4), renum. (5) (intro) and (a) to (c) to be (a) and 1. to 3., cr. (5) (a) 4. and (b), Register, July, 1998, No. 511, eff. 8-1-98; **EmR0938: emerg. am. (1) (a), eff. 1-1-10; CR 10-004: am. (1) (a) Register July 2010 No. 655, eff. 8-1-10.**

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