CHAPTER 72
LONG-TERM CARE ASSET PRESERVATION PROGRAM

191—72.1(249G) Purpose. The purpose of this chapter is to establish minimum standards for long-term care insurance policies and certificates to qualify for participation in the Iowa long-term care asset preservation program; establish documentation and reporting requirements for issuers of policies or certificates to qualify under the Iowa long-term care asset preservation program; provide full disclosures in the sale of long-term care insurance policies and certificates which qualify under the Iowa long-term care asset preservation program; and facilitate public understanding regarding long-term care insurance and long-term care insurance policies and certificates which qualify under the Iowa long-term care asset preservation program.

191—72.2(249G) Applicability and scope. The requirements of this chapter apply to any long-term care insurance policy or certificate authorized for sale by the division of insurance as qualifying under the Iowa long-term care asset preservation program under Iowa Code chapter 249G.

191—72.3(249G) Definitions.

"Asset disregard" means a $1 increase in the amount of assets an individual who purchases a certified long-term care policy may retain, upon qualification for Medicaid, for each $1 of benefit paid out under the individual's certified long-term care policy for Medicaid-eligible long-term care services in determining eligibility for the Medicaid program.

"Asset protection" means the right extended by 441 IAC 75.5(5) to beneficiaries of certified long-term care insurance policies and certificates to an asset disregard under the Iowa long-term care asset preservation program.

"Authorized designee" means any person designated in writing to the insurance company by the policyholder or certificate holder of a certified long-term care policy or certificate for purposes of notification under paragraph 72.7(1)*"h."*

"Average daily private pay rate" means the average statewide cost of nursing facility services to a private pay resident as determined by the department of human services in 441 IAC 75.23(3). The average statewide private pay rate is set annually on July 1 for one year by the Iowa department of human services.

"Case management" includes, but is not limited to, the development of a comprehensive individualized assessment and care plan and, as needed, coordination of appropriate services and the monitoring of the delivery of such services.

"Case management agency" means an agency or other entity approved by the Iowa department of human services as meeting Medicaid case management standards.

"Certificate" means any certificate delivered or issued for delivery in this state under a group long-term care policy.

"Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

"Certificate holder" means an owner of a certified long-term care insurance certificate or the beneficiary of a certified long-term care certificate.

"Certified long-term care insurance policy or certificate" means any long-term care insurance policy or certificate certified for sale to Iowa residents by the division of insurance as meeting standards promulgated under rules 191—72.6(249G) and 191—72.7(249G).

"Cognitive impairment" means confusion or disorientation resulting from a deterioration or loss of intellectual capacity that is not related to or a result of mental illness but which can result from Alzheimer's disease or similar forms of senility or irreversible dementia. This deterioration or loss of intellectual capacity is established through use of standardized tests that reliably measure impairment in the following areas:

1. Short-term or long-term memory.
2. Orientation as to person, place, and time.

3. Deductive or abstract reasoning.

Cognitive impairment must result in an individual's requiring 24-hour-a-day supervision or direct assistance to maintain the individual's safety.

"Complex, yet stable medical condition" means that the individual requires 24-hour-a-day professional nursing observation or professional nursing intervention more than once a day in a setting other than an acute care wing of a hospital.

"Deficiency in activity of daily living" means that the individual cannot perform one or more of the following six activities of daily living without direct assistance:

1. Bathing, meaning cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, reaching head and body parts for soaping, rinsing, and drying.
2. Dressing, meaning putting on and taking off, fastening and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.
3. Toileting, meaning getting on and off toilet or commode and emptying commode, managing clothing and wiping and cleaning body after toileting, and assistance with using and emptying bedpans and urinals.
4. Transferring, meaning moving from one sitting or lying position to another sitting or lying position, e.g., from bed to or from a wheelchair or sofa, coming to a standing position or repositioning to promote circulation and prevent skin breakdown.
5. Continence, meaning the ability to control bowel and bladder as well as use ostomy or catheter receptacles and apply diapers and disposable barrier pads.
6. Eating, meaning reaching for, picking up, grasping utensil and cup; getting food on utensil, bringing food, utensil, cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meal.

"Department of human services" means the Iowa division of medical services.

"Direct assistance" means that the individual cannot perform an activity of daily living safely or appropriately without continual help or oversight. Direct assistance may vary from requiring a person to physically stand by or set up the activity to the activity being totally performed by others.

"Formal long-term care services" means long-term care service for which the provider is paid.

"Home health care services" means:

1. Part-time or intermittent skilled nursing services by licensed nursing personnel provided by a home health agency or by a registered nurse or a licensed vocational nurse, when a case management provider agency has determined that no home health agency exists in the area;
2. Home health aide services provided by a home health agency;
3. Physical therapy, occupational therapy, or speech therapy and audiology services provided by a home health agency; and
4. Medical social services by a social worker or social work assistant provided by a home health agency.

"Homemaker services incidental to personal care" means the policyholder or certificate holder is eligible to receive homemaker services if personal care is being received. Homemaker services incidental to personal care are limited to the following:

1. Domestic or cleaning services;
2. Laundry services;
3. Reasonable food shopping and errands;
4. Meal preparation and cleanup;
5. Transportation assistance to and from medical appointments; and
6. Heavy cleaning which involves thorough cleaning of the home to remove hazardous debris or dirt.

A certified long-term care insurance policy or certificate shall not, if it provides homemaker services incidental to personal care, limit or exclude benefits by requiring that the provision of such services be at

a level of certification or licensure greater than that required by the eligible service or by limiting benefits to services provided by Medicare-certified agencies or providers.

"Informal long-term care services" means long-term care services for which the provider is not paid.

"Insured event" means the insured is eligible to receive insurance benefits and to have these benefits qualify for an asset disregard if any one of the following criteria is met:

1. The insured has at least two deficiencies in activities of daily living (ADLs) (to qualify for home-and community-based services including, but not limited to, home health care, adult day health/social care, personal care, homemaker services incidental to personal care, respite care and residential care facility) or three deficiencies in activities of daily living (ADLs) (to qualify for nursing facility care); or
2. The insured has a cognitive impairment; or
3. The insured has a complex, yet stable medical condition.

"Integrated benefits" means the benefits contained in the policy or certificate can be used interchangeably among the various covered home- or community-based or nursing facility benefits, and there is no limit on the use of any specific covered benefit, except for monthly limits that may be set for home-and community-based care benefits and per diem limits that may be set on nursing facility services.

"Issuer" means:

1. Insurance companies;
2. Fraternal benefit societies;
3. Prepaid health care delivery plans;
4. Health care service plans;
5. Health maintenance organizations; and
6. Any other entity delivering or issuing for delivery in this state, long-term care policies or certificates.

"Long-term care asset preservation program" means the program authorized in Iowa Code chapter 249G.

"Medicaid-eligible long-term care services" include:

1. Long-term care services available under Iowa's state Medicaid plan, including care in a licensed nursing facility and home health nursing and home health aide services provided by a home health agency.
2. Long-term care services covered under the Medicaid home- and community-based services waiver for the aged and disabled, as defined in paragraph 72.7(1)*"d."*

"Medicaid waiver" refers to the home- and community-based services waiver for the aged and disabled approved by the United States Department of Health and Human Services Health Care Financing Administration under the provisions of Section 1915(c) of the Social Security Act which allows Iowa to provide certain community and in-home services not covered in the state Medicaid plan, which are instrumental in the avoidance or delay of institutionalization. Iowa's Medicaid waiver services include:

1. Case management;
2. Homemaker;
3. Respite care;
4. Attendant care;
5. Adult day care; and
6. Other services which, independent of the preceding home- and community-based services, are essential to prevent institutionalization.

"Personal care services" means:

1. Ambulation assistance, including help in walking or moving around (e.g., wheelchair) inside the home, changing locations in a room, moving from room to room to gain access for the purpose of engaging in other activities. Ambulation assistance does not include movement solely for the purpose of exercise.
2. Bathing and grooming including cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, reaching

head and body parts for soaping, rinsing, and drying. Grooming includes hair combing and brushing, shampooing, oral hygiene, shaving and fingernail and toenail care.

3. Dressing includes putting on and taking off, fastening and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.

4. Bowel, bladder and menstrual care including assisting the person on and off toilet or commode and emptying commode, managing clothing and wiping and cleaning body after toileting, assistance with using and emptying bedpans, ostomy or catheter receptacles and urinals, application of diapers and disposable barrier pads.

5. Reposition, transfer skin care, and range of motion exercises, including moving from one sitting or lying position to another sitting or lying position, e.g., from bed to or from a wheelchair or sofa, coming to a standing position or rubbing skin and repositioning to promote circulation and prevent skin breakdown. Motion exercises shall include the carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function, improve gait, maintain strength or endurance, passive exercises to maintain range of motion in paralyzed extremities, and assistive walking.

6. Feeding and hydration assistance including reaching for, picking up, grasping utensil and cup; getting food on utensil; bringing food, utensil, cup to mouth, and manipulating food on plate; cleaning face and hands as necessary following meal.

7. Assistance with self-administration of medications.

8. A certified long-term care insurance policy or certificate shall not, if it provides personal care services, limit or exclude benefits by requiring that the provision of personal care be at a level of certification or licensure greater than that required by the eligible service, or by limiting benefits to services provided by Medicare-certified agencies or providers.

"Plan of care" means a written individualized plan of services approved by a case management provider agency which specifies the type, frequency, and providers of all formal and informal long-term care services required for the individual and the cost, if any, of any formal long-term care services prescribed. Changes in the plan of care must be documented to show that such alterations are required by changes in the client's medical situation, functional or cognitive abilities, behavioral abilities or the availability of social supports.

"Preadmission screening program" means the program which requires that each person seeking admission to a nursing facility must be screened and approved for admission by the Iowa Foundation of Medical Care in accordance with 441 IAC 81.3(249A).

"Qualified insured" means the following:

1. An individual who by reason of age is eligible for parts "A" and "B" of the Medicare program (42 U.S.C. 1395 et seq.) who is either:

- The beneficiary of a certified long-term care policy or certificate approved by the division of insurance; or
- Enrolled in a prepaid health care delivery plan that provides long-term care services and qualifies under this rule; or

2. An individual who is eligible for an asset disregard under a certified long-term care policy or certificate. An individual does not have to be a qualified insured to purchase a certified long-term care policy or certificate.

"Quarterly/annually" refers to periods aligning with the state fiscal year of July 1 to June 30.

"Service summary" means a written summary, prepared by an issuer for a qualified insured, which identifies the following:

1. The specific certified policy or certificate.
2. The total benefits paid for services to date.
3. The amount of benefits qualifying for asset protection.

191—72.4(249G) Qualification of long-term care insurance policies and certificates. No long-term care insurance policy or certificate shall qualify for participation in the Iowa long-term care asset preservation program unless the long-term care insurance policy or certificate complies with this

chapter. Long-term care insurance policies and certificates in force on July 1, 1994, may, with the signed acceptance of the policyholder or certificate holder, be amended to meet the requirements for qualification.

191—72.5(249G) Standards for marketing. No long-term care insurance policy or certificate which does not meet the requirements of this chapter and has not been approved by the division of insurance as a certified long-term care insurance policy or certificate may be advertised, solicited, or issued for delivery in this state as a certified long-term care insurance policy or certificate. Each issuer seeking to qualify a long-term care policy or certificate for participation in the Iowa long-term care asset preservation program must do the following:

72.5(1) Provide the consumer, prior to presentation of an application for long-term care insurance, information regarding the availability of consumer information and public education provided by the Senior Health Insurance Information Program using the form developed by the division.

72.5(2) Use applications to be signed by the applicant which indicate, as described as follows, that the applicant:

a. Received a complete description of the Iowa long-term care asset preservation program in a format prescribed by the commissioner, including an explanation of asset protection provided by the program and how it is achieved and the insurance division's Senior Health Insurance Information Program consumer information telephone number.

b. Received a description of the issuer's certified long-term care policy or certificate benefit option meeting the requirements of subrule 72.6(2).

c. Received a statement regarding Medicaid eligibility and benefits that shall be in the following format:

NOTICE TO APPLICANT
REGARDING MEDICAID ELIGIBILITY

I understand that eligibility for Medicaid is not automatic; an application is necessary. My insurance company will send me quarterly statements showing how much asset protection I have earned. This permanent asset protection is in addition to any asset exemptions available to any Iowan applying for Medicaid. I understand that should I wish to apply for public assistance it is my responsibility to apply for Medicaid. I further understand that before receiving Medicaid I will first have to use any additional assets I have not protected. I will also need to meet Medicaid's criteria for medical necessity which may be different from the eligibility criteria used by my private insurance. Once I become a Medicaid recipient, I understand that I may have to apply a portion of my income toward the cost of my care, and that Medicaid services at that time may not be the same services I was receiving under my private long-term care insurance.

____
(Signature of Applicant(s))

d. Agrees to the release of information by the issuer to the state as may be needed to evaluate the Iowa long-term care asset preservation program and document a claim for Medicaid asset protection, in the following format:

CONSENT AND AUTHORIZATION
TO RELEASE INFORMATION

I hereby agree to the release of all records and information pertaining to this long-term care policy or certificate by the [insert issuer name] to the Iowa department of human services for the purposes of documenting a claim for asset protection under the state Medicaid program, evaluating the Iowa long-term care asset preservation program, and meeting Medicaid audit requirements.

I understand that the information contained in these records will be used for no purpose other than those stated above, and will be kept strictly confidential by the state of Iowa.

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(Signature of Applicant(s))

e. Received a description regarding mandatory inflation protection that shall be in the following format:

NOTICE TO APPLICANT REGARDING
MANDATORY INFLATION PROTECTION

In order for this long-term care policy [certificate] to remain certified by the state of Iowa and qualify to provide asset protection for the state Medicaid program, daily coverage benefits must meet or exceed standards established by the state of Iowa. Depending on the option you choose to automatically inflate daily coverage benefits, premiums may rise over the life of the policy [certificate]. [Insert issuer name] will provide you with a graphic comparison showing the differences in premiums and benefits, over at least a 20-year period, between a policy that increases benefits over the policy period and a policy that does not increase benefits. Failure to maintain the required daily coverage benefits will result in the policy [certificate] losing its certified status and no longer being allowed to provide asset protection. It is [insert issuer name]'s responsibility to automatically inflate coverage benefit levels in order to maintain certified status; it is your responsibility to make premium payments in order to maintain certified status.

f. Received a graphic comparison showing the differences in premiums and benefits, over at least a 20-year period, between a policy or certificate that increases benefits over the policy or certificate period and a policy or certificate that does not increase benefits.

72.5(3) Report to the commissioner of the division of insurance all sales involving replacement of existing policies and certificates by certified policies or certificates within 30 days of the issue date of the newly issued certified policy or certificate. The report shall include the following:

a. The name and address of the insured.

b. The name of the company whose policy or certificate is being replaced.

c. The name of the producer replacing the coverage.

This report shall also include a comparison of the coverage issued with that being replaced, including a comparison of premiums and an explanation of how the replacement was beneficial to the insured. The replacing issuer shall not cancel, nonrenew, or rescind a replacement policy or certificate for any reason other than nonpayment of premium, material misrepresentation, or fraud.

72.5(4) Provide producer training as follows:

a. Provide written evidence to the division of insurance that procedures are in place to ensure that no producer will be authorized to market, sell, solicit, or otherwise contact any person for the purpose of marketing a certified long-term care insurance policy or certificate unless the producer has completed training covering at least the division's eight-credit outline on the Iowa long-term care asset preservation program.

b. Issuers shall provide written evidence to the division of insurance that procedures are in place to ensure that no producer will be authorized to market, sell, solicit, or otherwise contact any person for the purpose of marketing a certified long-term care insurance policy or certificate unless, on an annual basis, the producer completes two hours of continuing education training specifically covering the Iowa long-term care asset preservation program and Medicaid.

c. Issuers shall use only curriculum and instructors approved by the division of insurance. Coursework must be completed in a classroom setting and may not be completed on a "take-home" basis.

d. Issuers shall submit training courses used for continuing education for approval to the outside vendor under contract with the division of insurance at least 30 days prior to the beginning of the course. Requests received later may be disapproved.

72.5(5) Include a statement on the outline of coverage, the policy or certificate application, and the front page of the policy or certificate in bold type and in a separate box as follows: "THIS POLICY [CERTIFICATE] QUALIFIES UNDER THE IOWA LONG-TERM CARE INSURANCE PROGRAM FOR MEDICAID ASSET PROTECTION. THIS POLICY [CERTIFICATE] MAY PROVIDE

BENEFITS IN EXCESS OF THE ASSET PROTECTION PROVIDED IN THE IOWA LONG-TERM CARE ASSET PRESERVATION PROGRAM."

72.5(6) Long-term care insurance policies or certificates sold after July 1, 1994, that are not certified under the Iowa long-term care asset preservation program must include a statement on the outline of coverage, the policy or certificate application, and the front page of the policy or certificate in bold type and in a separate box as follows: "THIS POLICY [CERTIFICATE] DOES NOT QUALIFY FOR MEDICAID ASSET PROTECTION UNDER THE IOWA LONG-TERM CARE ASSET PRESERVATION PROGRAM. HOWEVER, THIS POLICY [CERTIFICATE] IS AN APPROVED LONG-TERM CARE INSURANCE POLICY [CERTIFICATE] UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE IOWA LONG-TERM CARE ASSET PRESERVATION PROGRAM, CALL THE SENIOR HEALTH INSURANCE INFORMATION PROGRAM OF THE DIVISION OF INSURANCE AT 1-515-281-5705."

72.5(7) Provide that no qualified long-term care policy or certificate form shall be sold, transferred, or otherwise ceded to another issuer without first having obtained approval from the commissioner.

72.5(8) Except as provided in this subrule, an issuer shall continue to make available for purchase any qualified policy form or certificate form issued that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months. The following describe the process and result of discontinuing the availability of a policy form or certificate form:

An issuer may discontinue the availability of a policy form or certificate form if the issuer provides the commissioner, in writing, its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. The following shall be considered a discontinuance of the availability of a policy form or certificate form:

a. The sale or other transfer of a qualified policy form or certificate form to another issuer.

b. A change in the rating structure or methodology unless the issuer complies with the following requirements.

(1) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

(2) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential which is in the public interest.

(3) An issuer that discontinues the availability of a policy form or certificate form under this subrule shall not file for approval of a new long-term care policy form or certificate form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate. This clause does not apply if: an issuer discontinues a policy form or certificate form as the result of changes to this rule; or all existing policyholders and certificate holders of a discontinued policy form or certificate form are given the opportunity to purchase the new policy form or certificate form without regard to health status, claims experience, or age. Issuers are not required to make this offer to policyholders or certificate holders receiving benefits under the discontinued policy form or certificate form.

191—72.6(249G) Minimum benefit standards for qualifying policies and certificates. No long-term care insurance policy or certificate may be advertised, solicited, or issued for delivery in this state as a qualified long-term care insurance policy or certificate which does not meet the minimum benefit standards in this rule, and which has not been approved by the division of insurance as a qualified long-term care insurance policy or certificate. These minimum standards do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards. These standards are in addition to all other requirements for long-term care insurance policies or certificates. In order to qualify

for participation in the Iowa long-term care asset preservation program, a long-term care insurance policy or certificate shall meet the following:

72.6(1) Contain a "benefit amount maximum" equivalent to at least 365 times the minimum daily nursing facility benefit defined in 72.6(6)*"a."*

72.6(2) Offer a maximum benefit amount option equivalent to 365 times the minimum daily nursing facility benefit defined in 72.6(6)*"a."* Issuers may offer other benefit amount options in addition to this minimum benefit amount option.

72.6(3) Provide that maximum benefits be available in dollars and not in days of care.

72.6(4) Include a provision of inflation protection which satisfies at least one of the following criteria:

a. The policy or certificate covers at least 80 percent but not more than 110 percent of the average daily private pay rate.

b. The policy or certificate provides for automatic increases in the per diem dollar level in accordance with either the consumer price index or at 5 percent each year over the previous year for each year that the contract is in force.

c. The policy or certificate provides the following:

(1) Annual per diem upgrades on a guaranteed issue basis at premiums based on the age of the policyholder or certificate holder at the time of the issuance of the qualified policy or certificate.

(2) Unless the insured takes positive action to decline them, these upgrades automatically increase the level of daily coverage to meet or exceed the minimum inflation adjusted daily benefit. The minimum inflation adjusted daily benefit is defined as the amount or amounts derived by taking the minimum daily benefit for nursing facility care at the time of purchase as specified in 72.6(6)*"a"* and inflating it by the consumer price index or by at least 5 percent each year over the previous year for each year that the contract is in force. The schedule of minimum per diem dollar amount increases shall be updated and maintained at the division of insurance.

(3) The issuer shall notify those policyholders or certificate holders choosing the upgrade option when the upgrades are automatically effective and what the increased premium, if any, will be. The issuer shall also provide to the policyholder or certificate holder, at the time of the upgrade, the opportunity to decline the upgrade.

(4) The issuer shall notify the policyholder or certificate holder when the insurance policy or certificate will lose its qualification status if the annual per diem benefit upgrade is declined. A qualified policy or certificate containing this inflation protection provision will remain qualified as long as the insured's daily benefit amount equals or exceeds the minimum inflation adjusted daily benefit.

72.6(5) Provide that the unused maximum benefit amount of the policy or certificate increase proportionately with the inflation protection requirements of 72.6(4).

72.6(6) At a minimum, upon the initial effective date, provide the following:

a. A daily nursing facility benefit of at least 80 percent of the average daily private pay rate in nursing facilities rounded to the next highest $5 increment. No policy or certificate need pay benefits in excess of the actual charges.

b. A daily home- and community-based benefit of at least 50 percent of the daily nursing facility benefit contained in the policy or certificate. No policy or certificate need pay benefits in excess of the actual charges.

c. The daily home- and community-based benefit shall not exceed the daily nursing facility benefit.

72.6(7) If issued on an expense incurred basis, provide benefits which are equal to at least 80 percent of the per diem cost incurred by the insured.

191—72.7(249G) Required policy and certificate provisions.

72.7(1) All qualified policies and certificates shall meet the following requirements:

a. Have premiums:

(1) Based on the issue age of the applicant; or

(2) Level for the life of the policy or certificate with an adjustment only for the increased benefits resulting from the inflation protection requirements of subrule 72.6(4). Nothing in this rule shall preclude

an issuer from reducing premiums of a policy or certificate or using a policy form or certificate form in which the premiums are no longer required to be paid after a specified period of time.

b. Not have premiums based on the attained age of the insured.

c. Include a provision that the policy or certificate will utilize the "insured event" criteria, defined in 72.3(249G) for determining eligibility for benefits and for determining the amount of asset disregard. Approval for admission to a nursing facility under the "preadmission screening program," as defined in 72.3(249G) shall be deemed sufficient but not necessary to meet this insured event criteria.

d. Include a provision that policy or certificate benefits can be used to purchase nursing facility care or home- and community-based care. Home- and community-based care shall include, at a minimum, but not be limited to, the following:

(1) Home health nursing.

(2) Home health aide services.

(3) Attendant care.

(4) Respite care.

(5) Adult day care services.

All home- and community-based services shall include case management services delivered by a case management agency. An asset disregard will be provided for all benefits used by qualified insureds to purchase "Medicaid-eligible long-term care services" as defined in 72.3(249G).

e. Include a provision which allows for a 30-day period within which coverage may be canceled by the applicant by delivering or mailing the evidence of coverage to the issuer or the producer through whom it was effected for a full refund of any premium that was paid. The policy or certificate shall have a notice prominently printed on the first page of the policy or certificate, or attached thereto, stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate to the issuer or its producer for cancellation within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

f. Include a provision which, in the event the qualified policy or certificate is about to lapse or the policy or certificate is about to lose qualification status under 72.6(4)*"c"*(4), offers the policyholder or certificate holder the option to reduce coverage to a lower benefit amount. However, this benefit amount offer, plus the amount of benefits used to date, cannot be less than the minimum benefit amount requirement specified in 72.6(1). The issuer need only allow this offer to be exercised one time. Premiums shall be based on the age of the policyholder or certificate holder at the time of the issuance of the original qualified policy or certificate.

g. Include a provision which, in the event a policyholder or certificate holder lapses a qualified policy or certificate and retains a nonforfeiture benefit, the policy or certificate will maintain its qualification status only so long as the minimum inflation adjusted daily benefit, as defined in 72.6(4)*"c"*(2), is met or exceeded or the policy or certificate pays at least 80 percent of actual or reasonable charges, and the total of the benefit amount paid to date and the benefit amount available is not less than 365 times the minimum inflation adjusted daily benefit. If at any point while in a nonforfeiture benefit the criteria in this paragraph are not met, the policy or certificate will lose its qualification status and the issuer shall notify the policyholder or certificate holder and the department of insurance of the loss of qualification.

h. Include a provision that, upon sale of a qualified long-term care insurance policy or certificate, the issuer shall do the following:

(1) Offer to collect and store the name and address of an individual designated as an authorized designee by the purchaser to be notified when a policy or certificate lapse is imminent. The issuer must obtain a signed statement from purchasers who do not choose to designate an authorized designee that they have been offered this opportunity and declined. It shall be the issuer's responsibility to notify such designee prior to canceling a policy or certificate due to lack of premium payment. The designee notification shall occur no sooner than 30 days after the beginning of the 30-day grace period for premium payments. The issuer shall permit the policyholder or certificate holder to periodically update the authorized designee. 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 authorized designee 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 30 days after a premium is due and unpaid. I elect not to designate any person to receive the notice.

(2) Provide at least a five-month guaranteed reinstatement period for a policyholder or certificate holder whose policy or certificate has lapsed due to nonpayment of premium, who has a cognitive impairment, and who has paid all due and unpaid premiums. The reinstated policy or certificate shall have the same benefits, terms, and premiums as the policy or certificate which lapsed.

i. Include a provision that benefits shall only be paid after the payment of all other benefits to which the policyholder or certificate holder is otherwise entitled, excluding Medicaid. The issuer shall make reasonable efforts to determine whether benefits are available from other policies or certificates or from Medicare. An asset disregard will only be provided for benefits the issuer can document were used to purchase Medicaid-eligible long-term care services as defined in 72.3(249G) for a qualified insured.

j. Include a provision that the policy form shall not be changed or otherwise modified without the signed acceptance of the policyholder, or include a provision that the certificate form issued under a group long-term care policy shall not be changed or otherwise modified without the signed acceptance of the certificate holder.

72.7(2) Reserved.

191—72.8(249G) Prohibited provisions in certified policies or certificates. The following provisions may not be included in a certified policy or certificate: a restoration of benefits; a second elimination period; any cap on the daily (as opposed to monthly) home- and community-based care benefits.

191—72.9(249G) Reporting requirements. Unless otherwise noted, the requirements of this rule refer to issuer documentation and reporting requirements for qualified policies and certificates. The reports shall be submitted for each person entitled to benefits under a qualified policy or certificate. Each issuer shall do the following:

72.9(1) Maintain a registry and submit on a quarterly basis and in a format specified by the state of Iowa, a report to the department of human services that will include the following information on all individuals who purchased a qualified policy or certificate during the reporting period:

a. Name, address, telephone number, date of birth, sex, marital status, and social security number.

b. Policy or certificate identification information, including the following:

(1) The policy or certificate form number.

(2) The policy or certificate number.

(3) The policy or certificate category.

(4) The effective date of coverage.

c. Policy or certificate elimination period in days by type of service.

d. The maximum daily benefit for nursing facility care and for home- and community-based care.

e. Maximum lifetime benefit amounts.

f. Any options and riders in force.

g. Purchase type (upgrade, conversion or new issue).

h. Method used for calculation of the inflation protection benefit.

i. For expense incurred policies or certificates, the percentage of expenses payable.

j. The annual premium for the policy or certificate, the premium mode (monthly, bank draft, quarterly), and the type of premium calculation (level, issue age, other).

72.9(2) Maintain a registry and submit on a quarterly basis and in a format specified by the state of Iowa a report to the department of human services that will include the following information on all individuals who have changed or amended qualified policies or certificates during the reporting period:

a. Name, address, telephone number, and social security number.

b. Effective date of the policy or certificate change or coverage amendment.

c. A description of the new policy or certificate or amended policy or certificate as described in 72.9(1).

72.9(3) Maintain a registry and submit on a quarterly basis and in a format specified by the state of Iowa a report to the department of human services that will include the following information on all individuals who dropped their policies or certificates during the reporting period:

a. Name, address, telephone number, and social security number.

b. The date the policy or certificate was dropped.

c. The reason the policy or certificate was dropped, including any of the following:

(1) Death of insured.

(2) Converted policy or certificate.

(3) Maximum benefits expended.

(4) Recision.

(5) Voluntarily.

(6) Qualification of the policy or certificate lost.

(7) Other.

(8) Unknown.

72.9(4) Maintain a registry and submit on a quarterly basis in a format specified by the state of Iowa a report to the department of human services that will include the following information on all individuals who are denied a qualified policy or certificate during the reporting period:

a. Name, address, telephone number, date of birth, sex, marital status and social security number.

b. Reason for denial of the application, including the following:

(1) Application was not complete.

(2) Age was not in allowable range.

(3) Eligibility for Medicaid.

(4) Medical or other reasons.

(5) Other.

72.9(5) Maintain a registry and submit on a quarterly basis and in a format specified by the state of Iowa a report to the department of human services that will include the following information on all individuals who were assessed for long-term care and benefit eligibility during the reporting period:

a. Name, address, telephone number, and social security number.

b. Date the assessment was conducted.

c. Name, address, and telephone number of the person or company that performed the assessment and whether the claimant was found eligible for long-term care services and for asset protection.

d. A listing of the insured event criteria met for all persons assessed, including complex, unstable medical conditions, deficiencies in activities of daily living, and cognitive impairment.

72.9(6) Maintain a registry and submit on a quarterly basis and in a format specified by the state of Iowa a report to the department of human services that will include the following information on each service used and benefits claimed during the reporting period for each insured:

a. Name, address, telephone number, and social security number.

b. Whether the policyholder or certificate holder was currently enrolled in Medicare Parts A and B (42 U.S.C. 1395 et seq.) and either:

(1) A beneficiary of a Medicare supplement insurance policy or certificate approved by the division of insurance.

(2) Enrolled in a prepaid health care delivery plan that provides acute care and preventive service; or

(3) Covered under a contract under Section 1876 or 1833 of the Social Security Act (42 U.S.C. 1395 et seq.).

c. Service or procedure code.

d. Whether the claim for the service was denied or approved.

e. Start and end date for the service.

f. Number of units of service and amount billed.

g. Amount paid by the policy or certificate and the amount paid which counts toward the asset protection.

72.9(7) Maintain a registry and submit on a quarterly basis and in a format specified by the state of Iowa a report to the department of human services that will include the following information on the following aggregate information for the reporting period:

a. The number of applications for qualified long-term care insurance policies and certificates received during the quarter.

b. The number of persons denied a qualified policy or certificate and the reason for denial. Reasons for denial to be specified include the following:

(1) Application was incomplete.

(2) Age was not in allowable range.

(3) Eligibility for Medicaid.

(4) Medical or health reasons.

(5) Other.

c. The number of qualified policies and certificates purchased during the quarter.

d. The number of qualified policyholders and certificate holders who dropped their qualified policy or certificate during the quarter for any of the following reasons:

(1) Death of insured.

(2) Converted policy or certificate.

(3) Maximum benefits expended.

(4) Recision.

(5) Voluntarily.

(6) Qualification of the policy or certificate lost.

(7) Other.

(8) Unknown.

e. The number of beneficiaries of qualified policies and certificates in force at the end of the quarter.

191—72.10(249G) Maintaining auditing information.

72.10(1) Each issuer shall maintain information as stipulated in 72.10(6) on all policyholders or certificate holders who have ever received any benefit under the policy or certificate. Such information shall be updated at least quarterly. This requirement for updating shall not require the conduct of any assessment, reassessment, or other evaluation of the policyholder's or certificate holder's condition which is not otherwise required by federal or state statute or regulation.

72.10(2) When a policyholder or certificate holder who has received any benefit dies or lapses the policy or certificate for any reason, the issuer must retain the stipulated information for a period of at least five years after the time when the policy was in force. Unless notified by the division of insurance to the contrary during this period, after the five years, the service summary provided by the issuer will be deemed to comply with all asset protection reporting, record keeping, and auditing requirements of this rule. The issuer may use microfiche, microfilm, optical storage media, or any other cost-effective method of record storage as alternatives to storage of paper copies of stipulated information.

72.10(3) At the time the policy or certificate ceases to be in force, the issuer shall notify the policyholder or certificate holder of the right to request service records as stipulated in 72.10(6).

72.10(4) The issuer shall also, upon request in writing, provide such policyholder or certificate holder or the policyholder's or certificate holder's authorized designee, if any, with a copy of the issuer's service records as required in 72.10(6) which are necessary to establish the asset disregard. These records shall be provided to the policyholder or certificate holder or the policyholder's or certificate holder's authorized designee, if requested, within 60 days of the request. The issuer may charge a reasonable fee to cover the costs of providing each set of requested service record copies.

72.10(5) The issuer shall enclose with the records a statement advising the former policyholder or certificate holder that it is in the best interest of the former policyholder or certificate holder to retain the records to establish eligibility for Medicaid.

72.10(6) The information to be maintained includes the following:

a. Evidence that the insured event has taken place. The occurrence of the insured event may be documented in any of the following ways:

(1) By case management agency staff, as part of the initial assessment of the client or as part of a subsequent reassessment.

(2) By an assessment conducted as part of the preadmission screening program of the Iowa Foundation of Medical Care.

(3) By an assessment of a resident of a nursing facility as required by Section 1919(b)(3) of the Social Security Act.

(4) For persons for whom subparagraphs (1) through (3) are not available or do not provide the required information, by an assessment, carried out by or under the supervision of a physician or a registered nurse, which is substantially comparable to any of the methods in subparagraphs (1) through (3). These assessments must be based on direct observations and interviews in conjunction with a medical record review. The physician or registered nurse carrying out or supervising the assessment must sign and certify the completion of the assessment. Each individual who completes a portion of such assessment shall sign and certify as to the accuracy of that portion of the assessment.

b. Description of services provided under the policy or certificate, including the following:

(1) Name, address, telephone number, and license number, if applicable, of provider.

(2) Amount, date, and type of services provided, and whether the services qualify for asset protection.

(3) Dollar amounts paid by the issuer, whether on an indemnity, expense incurred, or other basis.

(4) The charges of the service providers, including copies of invoices for all services counting toward asset protection.

(5) Identification of the case management agency, if applicable, and copies of all assessments and reassessments.

(6) Determination of whether the policyholder or certificate holder was a qualified insured at the time of benefit payment. The issuer may rely on written representation by the policyholder or certificate holder as to whether the required coverages were held.

c. In order for home- and community-based services to qualify for asset protection, these services must be in accord with a plan of care developed by a case management agency. If the policyholder or certificate holder has received any benefits delivered as part of a plan of care, the issuer must retain the following:

(1) A copy of the original plan of care.

(2) A copy of any changes made in the plan of care. The plan of care must document that the changes are required by changes in the client's medical situation, cognitive abilities, behavioral abilities, or the availability of social supports. Such services shall count toward asset protection after the case management agency adds the documented need for and description of the new services to the plan of care. In cases when the service must begin before the revisions to the plan of care are made, the new services will only count toward asset protection if the revisions to the plan of care are made within ten business days of the commencement of the new services. Issuers must maintain initial assessments and subsequent reassessments as part of insured event documentation.

191—72.11(249G) Reporting on asset protection.

72.11(1) Each issuer shall send an asset protection report at least quarterly to each policyholder or certificate holder who has received any benefits since the last asset protection report sent to the policyholder or certificate holder. Each asset protection report shall include the following information:

a. The amount of asset protection for which the policyholder or certificate holder had qualified prior to the quarter covered by the report.

b. The total benefits paid by the issuer for services rendered during the quarter.

c. A statement of the amount of benefits paid by the issuer for services rendered during the quarter which qualify for asset protection.

d. A summary total of the amount paid to date under the policy or certificate which qualifies for asset protection.

72.11(2) Asset protection reports shall be subject to audit by the division of insurance under the same requirements as specified in 72.13(1)*"b."*

191—72.12(249G) Preparing a service summary.

72.12(1) Each issuer shall prepare a service summary at the client's request specifically for the policyholder or certificate holder applying for Medicaid. The issuer shall also prepare a service summary when the policyholder or certificate holder has exhausted benefits under the policy or certificate or when the policy or certificate ceases to be in force for a reason other than the death of the policyholder or certificate holder, whichever occurs first.

72.12(2) The service summary shall identify the following:

a. The specific qualified policy or certificate.

b. The total benefits paid for services rendered to date.

c. The amount qualifying for asset protection.

This service summary is separate and in addition to any other information requirement in this chapter.

191—72.13(249G) Plan of action.

72.13(1) Each issuer shall, prior to qualification by the division of insurance, submit to the department of human services a plan for complying with the information maintenance and documentation requirements set forth in rules 72.9(249G) and 72.10(249G). No policy or certificate shall be qualified until the department of human services has approved the issuer's documentation plan for the policy or certificate. The documentation plan will include the following:

a. The location where records will be kept. Records required for purposes of the Iowa long-term care asset preservation program must be available at no more than three locations, each of which shall be easily accessible to the division of insurance.

b. The issuer shall agree to give the commissioner access to all information described in rule 72.10(249G) on an aggregate basis for all policyholders or certificate holders and on an individual basis for all policyholders or certificate holders who have ever received any benefits. Access to information on persons who have not applied for Medicaid is required in order for the commissioner to determine if an issuer's system for documenting asset protection is functioning correctly. The commissioner shall have the final decision concerning the frequency of access to the data and the size of samples for auditing or other purposes.

c. The name, job title, address, and telephone number of the person primarily responsible for the maintenance of the information required and for acting as liaison with the department of human services and the division of insurance concerning the information.

d. Methods for determining when insurance benefits or prepaid benefits qualify for asset protection, including the following:

(1) Documentation of the insured event.

(2) Description of services.

(3) Documentation of charges and benefits paid.

(4) Documentation of plans of care, when required.

e. Description of electronic and manual systems which will be used in maintaining the required information.

f. Information that will be retained which is needed to comply with this rule.

g. Copies of forms and descriptions of standard procedures for maintaining and reporting the information required, including the specific electronic medium which will be used to report required information and a description of the relevant files.

72.13(2) After the department of human services reviews a plan of action, that department shall advise the division of insurance and the issuer in writing whether the department of human services approves the plan of action. If the department of human services disapproves a plan of action, that

department shall advise the division of insurance and the issuer of the shortcomings in the plan of action and shall instruct the issuer of the methods necessary to resolve them.

191—72.14(249G) Auditing and correcting deficiencies in issuer record keeping.

72.14(1) Within one year of the first date that any policyholder or certificate holder of a particular issuer's policy or certificate has met the criteria for the insured event, and as often as the commissioner of insurance or department of human services deems necessary thereafter, the commissioner of insurance or department of human services shall conduct a systems audit of that company's records. The issuer shall be responsible for advising the department of human services and the division of insurance when this one-year period has begun. The commissioner or department of human services shall promptly inform each issuer of inaccuracies and other potential problems discovered in its systems audits and shall instruct the issuer of the methods necessary to correct any problems in the issuer's methods of operation.

72.14(2) The department of human services shall periodically reconcile a sample of individual applications to Medicaid of persons who have submitted documentation for qualification for asset protection with the reports submitted by issuers. The department of human services shall have the final decision concerning sample sizes and other auditing methods. The department of human services shall promptly advise issuers of any problems discovered and shall instruct the issuer of the methods necessary to correct any problems in the issuer's method of operation. The department of human services shall also notify the issuer of any obligations described in this subrule to hold clients harmless.

72.14(3) The department of human services may enter into voluntary arrangements with issuers of qualified long-term care insurance policies and certificates under which the department of human services would issue binding determinations as to whether or not services qualify for asset protection. Policyholders or certificate holders may submit requests for information and advice through their issuer or case management agency. When the following procedures are followed in all material respects, the written determinations of the department of human services concerning whether services qualify for asset protection shall be binding upon the department of human services in all subsequent actions, and the department of human services shall not make any assertion contradicting these determinations in any action arising in this subrule:

a. All requests for determinations as to whether or not services qualify for asset protection shall be submitted to the department of human services in writing. These requests may include, but are not limited to, requests for determinations in the following areas:

(1) Whether the insured event has occurred and has been adequately documented.

(2) Whether a care plan is required.

(3) Whether a revision of a care plan is required.

(4) Whether a service or services are in accord with the care plan.

(5) Whether a service is of such a nature as to qualify for asset protection.

(6) Whether the applicable amount is the amount paid by the issuer or the amount charged for the service.

b. The department of human services or one of its other authorized individuals may require issuers and case management agencies submitting requests for determination to provide all records and other information necessary for making a determination. The records and other information may include, but are not limited to, the following:

(1) Assessments.

(2) Care plans.

(3) Invoices for services rendered.

The party providing the records and other information shall be responsible for their accuracy. If any records or other information is later determined to be materially inaccurate, the determination based on the inaccurate information shall be void and not be binding on the department of human services or any other person or entity in subsequent actions. In the case of a policyholder or certificate holder for whom a determination has been invalidated because information provided was determined to be inaccurate, the provisions of 72.14(6) and 72.14(7) will apply in the same manner as for any other policyholder or certificate holder.

c. The department of human services or its authorized individual shall render a determination on each request in writing. Each determination of the department of human services or its other authorized individual shall state the reason for the determination, including the following:

(1) Relevant facts.

(2) Documentation of facts.

(3) Statutes.

(4) Regulations.

(5) Policies.

d. A copy of all determinations of the department of human services or its authorized individual shall be kept on file at the department of human services, together with the related records and information. The original of the determination shall be sent to the issuer or the case management agency who originally requested it. The recipient of the original determination shall be responsible for notifying the policyholder or certificate holder or the policyholder's or certificate holder's authorized producer.

72.14(4) When an audit or other review by the department of human services or the division of insurance reveals deficiencies in the record-keeping procedures of an issuer, the department of human services or the division of insurance will notify the issuer of the deficiencies and establish a reasonable deadline for correction. If an issuer fails to correct deficiencies discovered by the department of human services within a reasonable period of time, the department of human services will notify the division of insurance of the deficiencies. If an issuer fails to correct deficiencies discovered by the division of insurance within a reasonable period of time, the division will notify the department of human services of the deficiencies.

72.14(5) The commissioner of insurance shall reserve the right to remove qualification status of long-term care insurance policies and certificates when deemed necessary. If the division of insurance removes qualification status from a long-term care insurance policy or certificate, a policyholder or certificate holder who purchased a policy or certificate while the policy or certificate was qualified will retain the right to asset protection. A policyholder or certificate holder who purchases a policy or certificate after the removal of qualification status will have no right to asset protection.

72.14(6) If an issuer prepares a service summary which is used in a Medicaid application for a policyholder or certificate holder and the client is found eligible for Medicaid, and the policyholder or certificate holder after receiving Medicaid services is found to be ineligible for Medicaid solely by reason of errors in the issuer's service summary or documentation of services, the department of human services may require the issuer to pay for services counting toward asset protection required by the policyholder or certificate holder until the issuer has paid an amount equal to the amount of the issuer's errors after which the policyholder or certificate holder, if otherwise eligible, could qualify for Medicaid coverage.

72.14(7) If the department of human services determines that an issuer's records pertaining to a policyholder or certificate holder who has received Medicaid benefits are in such condition that the department of human services cannot determine whether the policyholder or certificate holder qualifies for asset protection, the department of human services may require the issuer to pay for services counting toward asset protection required by the policyholder or certificate holder until the issuer has paid an amount equal to the amount of the issuer's error; after which the policyholder or certificate holder, if otherwise eligible, could qualify for Medicaid coverage.

72.14(8) The commissioner of insurance and the department of human services shall consult on all audits and examinations that may be required to determine compliance with this rule.

72.14(9) Compliance with 72.14(6) and 72.14(7) is a requirement for a policy or certificate to retain qualification.

191—72.15(249G) Separability. If any provision of this chapter or the application thereof to any person or circumstance is for any reason held to be invalid or unenforceable, the remainder of the chapter and the application of such provision to other persons or circumstances shall not be affected thereby.

These rules are intended to implement Iowa Code Supplement chapter 249G.

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