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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2624 Session of 1992

INTRODUCED BY REINARD, CLARK, JOHNSON, DEMPSEY, FARGO, TRELLO, MICOZZIE, STEELMAN, BELFANTI, CARLSON, M. N. WRIGHT, HECKLER, HERMAN, NAHILL, HARLEY, SAURMAN, GANNON, CLYMER, WOGAN, JOSEPHS, MAIALE, McCALL, STABACK, SEMMEL, BUTKOVITZ, KENNEY, D. W. SNYDER, KING, McHUGH, E. Z. TAYLOR, PETRONE AND MARSICO, MAY 4, 1992

REFERRED TO COMMITTEE ON AGING AND YOUTH, MAY 4, 1992

AN ACT

Establishing the Partnership for Long-Term Care Program to be administered by the Department of Public Welfare; providing for long-term care insurance and for the protection of certain assets; providing for coordination with the Medicaid program; providing for additional duties of the Insurance Department in relation to the precertification of certain policies offered by private insurers; and providing for additional duties of the Department of Aging.

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The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

CHAPTER 1

PRELIMINARY PROVISIONS

Section 101. Short title.

This act shall be known and may be cited as the Long-Term Care Act.

Section 102. Definitions.

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Activities of daily living (ADL's)." Includes each of the following items: dressing, bathing, eating, feeding, toileting and transferring from bed to chair. In each instance, an ADL

deficiency is determined by reference to the need for human assistance in performing that activity.

"Asset protection." The right extended by this act to persons purchasing precertified long-term care insurance policies to retain amounts of assets equal to the sum of qualifying insurance payments made on their behalf in determining eligibility for the Medicaid program.

"Authorized agent." Includes a guardian, conservator or any other person designated in writing to the insurance company.

"Coordination, assessment and monitoring agency" or "CAM agency." An agency approved as such by the Department of Public Welfare.

"Family member." A person's husband, wife, natural parent, child or sibling, adopted child or parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent or grandchild.

"Folstein mini-mental state examination." A method for clinicians to grade the cognitive state of patients.

"Insured event." For the purposes of determining asset protection for a privately insured individual, any one of the following criteria must be satisfied:

(1) the individual has a documented need for substantial human assistance or supervision with two or more of the following activities of daily living: dressing, bathing, eating, feeding, toileting and transferring;

(2) the individual has been assessed using the mental status questionnaire and has failed to answer correctly at least seven of the ten questions on the test; or

(3) the individual exhibits specific behavior problems

requiring daily supervision, including, but not limited to, wandering, abusive or assaultive behavior, poor judgment or uncooperativeness which poses a danger to self or others and extreme or bizarre personal hygiene habits, and has either taken the MSQ and failed to answer correctly at least four questions or has taken the Folstein mini-mental state examination and achieved a score of 23 or lower.

"Long-term care insurance policy." An insurance policy authorized for sale by the Insurance Department under this act and the regulations promulgated hereunder.

"Mental status questionnaire (MSQ)." The short portable questionnaire comprised of ten questions.

"Plan of care." A written individualized plan of community services, including, but not limited to, community-based services, which specifies the type and frequency of all services required to maintain the individual in the community, the service providers and the cost of services, regardless of whether or not there is an actual charge for the service.

"Policyholder." The certificateholder of a group long-term care insurance policy or a precertified group long-term care insurance policy as well as the owner of an individual long-term care insurance policy or a precertified individual long-term care insurance policy.

"Precertified long-term care insurance policy" or "precertified policy." A long-term care insurance policy issued for delivery to any resident of this Commonwealth which is designed to provide, within the terms and conditions of the policy, contract or certificate, benefits on an expense-incurred, indemnity or prepaid basis for necessary care or treatment of an injury, illness or loss of functional capacity

provided by a certified or licensed health care provider in a setting other than an acute care hospital, for at least one year and is precertified for sale to Commonwealth residents by the Insurance Department under this act.

"Service summary." A written summary prepared by an insurer for an individual policyholder which identifies the specific precertified policy, the total benefits paid for services rendered to date and the amount qualifying for asset protection.

CHAPTER 3

LONG-TERM CARE PROGRAM

Section 301. Definitions.

The following words and phrases when used in this chapter shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Department." The Department of Public Welfare of the Commonwealth.

Section 302. Establishment.

There is hereby established the Long-Term Care Program to be administered by the Department of Public Welfare with the assistance of the Insurance Department.

Section 303. General description of program.

Under the program, private insurance and Medicaid funds shall be combined to finance long-term care. Under this program, an individual may purchase a precertified long-term care insurance policy in an amount commensurate with his assets. Notwithstanding any provision of law, the resources of an individual, to the extent those resources are equal to the amount of long-term care insurance benefit payments as provided in section 304, shall not be considered by the department in a determination of any of the following:

(1) His eligibility for Medicaid.

(2) The amount of any Medicaid payment.

(3) Any subsequent recovery by the Commonwealth of a payment for medical services.

Section 304. Protection of resources and income.

The department shall appropriate amendments to its Medicaid regulations and Commonwealth plan to allow protection of resources and income pursuant to section 303. This protection shall be provided, to the extent approved by the Federal Health Care Financing Administration, for any purchaser of a precertified long-term care policy delivered, issued for delivery or renewed on or after January 1, 1993. The department shall count insurance benefit payments toward resource exclusion to the extent the payments are for any of the following:

(1) Services Medicaid approves or covers for its recipients.

(2) The lower of the actual charge and the amount paid by the insurance company.

(3) Nursing home care or formal services delivered to insureds in the community.

(4) Services provided after the individual meets the coverage requirements for long-term care benefits established by the department.

Section 305. Regulations.

(a) General rule.--The department shall, in the manner provided by law, promulgate the regulations necessary to carry out this chapter. These shall include all of the following:

(1) Regulations amending existing Medicaid regulations and the State Plan to accomplish the resource protection purposes of this chapter.

(2) Regulations relating to determining eligibility of applicants for Medicaid and the coverage requirements for long-term care benefits.

(3) Any other regulations necessary to carry out this chapter.

(b) Inapplicability of certain laws.--The act of June 25, 1982 (P.L.633, No.181), known as the Regulatory Review Act, shall not apply to the promulgation of any regulations of the department as described in this section.

Section 306. Department of Aging.

The Department of Aging shall establish an outreach program to educate consumers as to the following:

(1) The need for long-term care.

(2) Mechanisms for financing this care.

(3) The availability of long-term care insurance.

(4) The asset protection provided under this act.

The Department of Aging shall provide public information to assist individuals in choosing appropriate insurance coverage.

Section 307. Acceptance of funding.

The department shall seek and may accept the foundation and other private source funding and such Federal approvals necessary to carry out the purposes of this act. Each year, on January 1, the department shall report to the General Assembly on the progress of the program. This report shall include the following:

(1) The success in implementing the public and private partnership.

(2) The number of policies precertified.

(3) The number, age and financial circumstances of individuals purchasing precertified policies.

(4) The number of individuals seeking consumer information services.

(5) The extent and type of benefits paid under precertified policies that could count toward Medicaid resource protection.

(6) Estimates of impact on present and future Medicaid expenditures.

(7) Cost-effectiveness of the program.

(8) A determination regarding the appropriateness of continuing the program.

CHAPTER 5

INSURANCE PROVISIONS

Section 501. Definitions.

The following words and phrases when used in this chapter shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Department." The Insurance Department of the Commonwealth.

Section 502. Criteria for precertification in general.

The department shall only precertify long-term care insurance policies which:

(1) alert the purchaser to the availability of consumer information and public education provided by the Department of Aging under section 306;

(2) offer the option of home-based and community-based services in lieu of nursing home care;

(3) in all home care plans, offer case management services approved by the Department of Public Welfare;

(4) offer automatic inflation protection or optional

periodic per diem upgrades until the insured begins to receive long-term care benefits;

(5) provide for the keeping of records and an explanation of benefit reports on insurance payments which count toward Medicaid resource exclusion; and

(6) provide the management information and reports necessary to document the extent of Medicaid resource protection offered and to evaluate the Long-Term Care Program.

No policy shall be precertified if it requires prior hospitalization or a prior stay in a nursing home as a condition of providing benefits.

Section 503. Specific conditions for precertification.

(a) Conditions enumerated.--No long-term care insurance policy may be advertised, solicited or issued for delivery in this Commonwealth as a precertified long-term care policy which does not meet the minimum standards set forth in this section. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards. The following standards apply to precertified long-term care policies as defined in this act and are in addition to all other requirements of this act. Each company seeking precertification for its long-term care insurance product must:

(1) Notify the department in writing as to the method it will use to alert the consumer, prior to any purchase, of the availability of consumer information and public education which is provided by the Department of Aging.

(2) Offer the option of or include a provision for home-based and community-based services with a minimum benefit of

one year at issue, in addition to nursing home care. Home-based and community-based services shall include, but not be limited to, medical services provided in the home such as skilled nursing care, physical, occupational, respiratory and speech therapy, other therapeutic services, home health aide services and support services which shall include, but not be limited to, homemaker and adult day-care health services. All home care plans shall include case management services delivered by a coordination, assessment and monitoring agency, approved by the Department of Public Welfare or by a home health care agency approved by the Department of Public Welfare. Case management service shall include, but not be 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 those services.

(3) Provide a provision for inflation protection which satisfies at least one of the following criteria:

(i) The policy covers at least 70% of actual or reasonable charges, where reasonable is defined as not less than 90% of the average private pay rate for that service based on a listing of actual or allowable rates that will be inflated or updated annually by the Department of Public Welfare, and does not include a maximum specified daily indemnity amount or daily limit.

(ii) The policy provides for automatic increases in the per diem dollar level, with or without related increases in premiums, in accordance with the Consumer Price Index or at a rate not less than 5% each year over the previous year for each year that the contract is in

force. Premiums shall be based on the age of the policyholder at the time of the issuance of the precertified policy.

(iii) The policy provides, on a guaranteed issue basis at premiums based on the age of the policyholder at the time of the issuance of the precertified policy, periodic per diem upgrades which, unless the insured takes positive action to decline them, automatically increase the level of daily coverage to meet or exceed the minimum inflation-adjusted daily benefit, defined as the amount or amounts derived by taking the minimum daily benefits for nursing home care and, where applicable, home-based and community-based services at the time of purchase as specified in paragraph (4) and inflating them by the Consumer Price Index of 5% each year over the previous year for each year that the contract is in force. The schedule of minimum per diem dollar amounts shall be updated and maintained at the department. A precertified policy containing this inflation protection provision will remain precertified as long as the insured's daily benefit amount automatically equals or exceeds the minimum inflation-adjusted daily benefit. The insurer will notify those policyholders choosing the upgrade option when the upgrades automatically are taking effect and what the increased premium, if any, will be. The insurer will also provide to the policyholder at the time of the upgrade the opportunity to decline the upgrade. In addition, the insurer shall notify the policyholder that his insurance policy will lose its precertification at the time the insured's daily benefit

amount is less than the minimum inflation-adjusted daily benefit.

(4) At a minimum, issue a product which provides a nursing home benefit of at least $80 a day if issued in 1993 or 1994; $84 a day if issued in 1995; $88 a day if issued in 1996; $92.50 a day if issued in 1997; and $97 a day if issued in 1998. No policy need pay for care in excess of the actual charges. In addition, those policies issued with home-based and community-based services must provide a home-based and community-based benefit of at least $40 a day if issued in 1993 or 1994; $42 a day if issued in 1995; $44 a day if issued in 1996; $46.25 a day if issued in 1997; and $48.50 a day if issued in 1999. No policy need pay for care in excess of the actual charges. Policies issued on an expense-incurred basis shall provide benefits which are equal to at least 70% of the actual or reasonable charges incurred by the insured. Expense-incurred policies need not meet the minimum daily benefit levels described in this paragraph.

(5) Use applications to be signed by the applicant which indicate that he:

(i) received a general description of this act and related regulations as prepared by the Department of Aging, including that department's toll-free number; and

(ii) agrees to the release of information by the insurer to the Commonwealth as may be needed to evaluate this act and document a claim for Medicaid resource protection. This release shall be in the following format:

I hereby agree to the release of my insurance records pertaining to this long-term care policy

by the (insert insurance company name) to the Commonwealth of Pennsylvania for the purpose of documenting a claim for asset protection under the State Medicaid program, evaluating the Long-Term Care Act and meeting Medicaid audit requirements.

I understand that my records will be used for no purpose other than those stated above and will be kept strictly confidential by the Commonwealth of Pennsylvania.

.....

(Signature of Applicant(s))

(iii) 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 to remain precertified by the Commonwealth and qualify to provide asset protection for the State Medicaid program, daily coverage benefits must meet or exceed standards established by the Commonwealth. Depending on the option you choose to automatically inflate daily coverage benefits, premiums may rise over the life of the policy contract. The insurance company 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 losing its precertification status and no longer being allowed to provide asset protection. It is the insurance company's responsibility to automatically inflate daily coverage benefit levels in order to maintain precertification; it is your responsibility to make premium payments in order to maintain precertification.

(iv) Received a graphic comparison showing the difference 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.

(6) All sales involving replacement shall be reported to the commissioner by the replacing insurer within 30 days of the effective date of the newly issued policy or certificate. The report shall include the name and address of the insured, the name of the company whose policy is being replaced and the name of the agent replacing the coverage. For sales involving replacement by an insurer other than a direct response insurer, this report shall also include a comparison of the coverage issued with that being replaced, including a comparison of the premiums and an explanation of how the replacement was beneficial to the insured. If a long-term care policy, whether it be precertified or not, replaces a precertified long-term care insurance policy, the replacing insurer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods

and probationary periods in the new long-term care policy to the extent such time was spent under the original policy.

(7) Issue a product which shall 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 insurer or the agent through whom it was effected for a full refund of any premium that was paid. The policy 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 certificateholder shall have the right to return the policy or certificate to the insurer or its agent 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.

(8) Agree to provide to each individual who is denied a precertified long-term care insurance policy, a survey produced by the Commonwealth which the individual would, at his option, complete and return to the department.

(9) Issue a product which does not require prior hospitalization or a prior stay in a nursing home as a condition of providing benefits.

(10) Provide assurances to the department that no agent will be authorized to market, sell, solicit or otherwise contact any person for the purpose of marketing a precertified long-term care insurance policy unless the agent has completed seven hours of training on long-term care insurance in general and this act specifically. These assurances shall be in the form of a document signed by the agent and a representative of the company attesting to the

completion of the required training by the agent and submitted to the department.

(11) Issue a product which, in the event the policy is about to lapse, offers the insured the option to switch their coverage to a shorter period of care. The offering must include an option covering a period of care less than or equal to two years but no less than three months. This option need only be offered one time. Premiums shall be based on the age of the policyholder at the time of the issuance of the original precertified policy.

(12) Issue a product which in the event a policyholder lapses a precertified policy and retains a nonforfeiture benefit, the policy will maintain its precertification status only so long as the minimum inflation-adjusted daily benefits, as defined in paragraph (3) are met or exceeded or the policy pays at least 70% of actual or reasonable charges, and the total period of covered care is no less than three months for the life of the policy. If at any point while in a nonforfeiture benefit the above criteria are not met, the policy will lose its precertification status.

(13) Issue a product which defines the phrase "one period of confinement" as meaning consecutive days of confinement; it shall be deemed to include successive periods of confinement which are due to the same or related cause and are not separated by at least 90 days during which the insured is not confined for either skilled nursing care, custodial, intermediate care or home-based and community-based care.

(b) Additional conditions.--

(1) Long-term care insurance policies that qualify for

precertification will be required to include a statement on the front page of the policy in bold type and in contrasting color to the effect that the policy has been precertified and provides Medicaid asset protection under this act.

(2) Conversely, long-term care insurance policies that do not meet precertification standards must include a statement on the front page of the policy in bold type and in contrasting color to the effect that the policy does not qualify for Medicaid asset protection.

(3) Long-term care insurance policies in force at the effective date of this act may be amended to qualify for precertification by fulfilling all precertification requirements.

(c) Rules and regulations.--The department may, in the manner provided by law, promulgate the rules and regulations it deems desirable to carry out this chapter, consistent with the purposes of this act.

Section 504. Insurer documentation and reporting.

(a) Scope of section.--Unless otherwise noted, the requirements of this section refer to insurer documentation and reporting requirements for precertified policies.

(b) Registering new insureds.--Each insurer shall maintain a registry and submit to the department a report on a quarterly basis that will include the following information on all individuals who purchased a precertified policy during that quarter:

(1) Name, address, date of birth, sex, telephone number and Social Security number.

(2) Date and type of policy purchased, nursing home only or nursing home and home care, and any applicable elimination

period.

(3) Maximum daily benefits for institutional and noninstitutional services covered by the policy.

(4) Maximum length of time and/or maximum dollar amounts for which the policyholder is covered.

(5) Options and riders available on the precertified policy in force.

(6) Method of inflation protection is in force.

(c) Reporting on persons who changed their policies.--Each insurer shall submit to the department a report on an annual basis which includes a list of names, addresses, telephone numbers and Social Security numbers of all persons who changed their coverage during the year, the date the coverage was changed and a description of the new policies as described in subsection (b)(2), (3), (4), (5) and (6).

(d) Reporting on persons who dropped their policies.--Each insurer shall submit to the department a report on an annual basis which includes a list of names, addresses, telephone numbers and Social Security numbers of all persons who dropped their policies during the year, the date the policies were dropped and the reasons they were dropped.

(e) Reporting on persons who were assessed for long-term care.--Each insurer shall submit to the department a report on a quarterly basis which includes a list of names, addresses, telephone numbers and Social Security numbers of all persons who applied for and were assessed for long-term care benefits, the date the assessment took place and the following information regarding the findings of the assessment:

(1) Who performed the assessment and whether the individual was found eligible for long-term care services

according to the terms of the policy and according to the Commonwealth's definition of the insured event.

(2) The following items drawn from the individual's assessment:

(i) the number of activities of daily living items for which the insured needs human assistance;

(ii) the number of incorrect responses made by the insured on the MSQ or insured's score on the Folstein mini-mental test; and

(iii) indication of whether the individual exhibits a behavior problem requiring daily supervision.

(f) Reporting service delivery.--Each insurer shall submit to the department a report on a quarterly basis which includes the names, addresses, telephone numbers and Social Security numbers of all insured persons who received long-term care services during the quarter and, in addition, the following information regarding those services, on a month-by-month basis during the quarter:

(1) The total amount paid by the insurer during the month and a cumulative total.

(2) The portion of those payments made by the insurer that count toward asset protection and a cumulative total.

(3) The expenditures made by the insurer to or in behalf of the insured during the month for the following services:

(i) nursing home;

(ii) home health services; and

(iii) community-based services.

(g) Reporting aggregate information.--Each insurer shall report to the department on a quarterly basis the following aggregate information:

(1) The number of applications received during the quarter.

(2) The number of persons denied a policy by reason for denial. Reasons for denial to be specified include:

(i) application was incomplete;

(ii) age was not in allowable range;

(iii) medical or health reasons; or

(iv) other reasons not included in subparagraphs (i) or (ii).

(3) The number of policies purchased during the quarter that included both nursing home care and home health and community-based services.

(4) The number of policies purchased during the quarter that included nursing home care only.

(5) The number of policyholders who dropped their policies during the quarter by reason.

(6) The number of policies in effect at the end of the quarter.

Section 505. Maintaining auditing information.

(a) General rule.--Each insurer shall maintain information as stipulated in subsection (b) on all policyholders who have ever received any benefit under the policy. This information shall be updated at least quarterly, but this requirement for updating shall not require the conduct of any assessment, reassessment or other evaluation of the policyholder's condition which is not otherwise required by Federal or State law or regulation. When a policyholder who has received any benefit dies or lapses his policy for any other reason, the insurer must retain the stipulated information for at least five years after the time when the policy ceases to be in force. At the time the

policy ceases to be in force, the insurer shall notify the policyholder of his right to request his service records as stipulated in subsection (b). The insurer shall also, upon request, provide the policyholder and the policyholder's authorized agent, if any, with a complete copy of the insurer's service records as required in subsection (b). These records shall be provided to the policyholder and policyholder's authorized agent, if any, within 60 days of the request. The insurer shall enclose with the records a statement advising the former policyholder that it is in his interests to retain the records if he may ever wish to establish eligibility for Medicaid.

(b) Description of records.--The records required to be maintained, as described in subsection (a), shall include the following:

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

(i) By CAM agency staff, as part of the initial assessment of the client or as part of a subsequent reassessment.

(ii) By an assessment conducted by the Department of Public Welfare.

(iii) By an assessment of a resident of a skilled nursing facility (SNF) or intermediate care facility (ICF) as required by section 1919(b)(3) of the Social Security Act (Public Law 74-271, 42 U.S.C. § 301 et seq.).

(iv) For persons for whom subparagraphs (i) through (iii) 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 (i) through (iii). 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 the assessment shall sign and certify as to the accuracy of that portion of the assessment.

(2) Description of services provided under the policy as follows:

(i) The name, address, phone number and license number, if applicable, of providers.

(ii) The amount, date and nature, indicating whether and under which category the service qualifies for asset protection, of services provided.

(iii) The dollar amounts paid by the insurer, whether on an indemnity, expense-incurred or other basis.

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

(v) Identification of the CAM agency, if applicable, and copies of all assessments and reassessments.

(3) In order for home health or community-based services to qualify for asset protection, they must be in accord with a plan of care drawn up by a CAM agency. If the policyholder has received any benefits delivered as part of a plan of care, the insurer must retain all of the following:

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

(ii) Copies of the reviews of the plan of care required by the Department of Public Welfare.

(iii) Copies 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. The services shall count toward asset protection after the CAM 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. Insurers must maintain initial assessments and subsequent reassessments as part of insured event documentation.

Section 506. Reporting on asset protection.

(a) General rule.--Each insurer shall send an asset protection report at least quarterly to each policyholder who has received any benefits since the last asset protection report sent to the policyholder. Each asset protection report shall include the following information:

(1) The amount of asset protection for which the policyholder had qualified prior to the quarter covered by the report.

(2) The total benefits paid by the insurer for services rendered during the quarter.

(3) A statement of the amount of benefits paid by the insurer for services rendered during the quarter which

qualify for asset protection.

(4) A summary total of the amount paid to date under the policy which qualifies for asset protection.

(b) Audit.--Asset protection reports shall be subject to audit by the Department of Public Welfare under the same requirements as specified in section 508(a)(2), which covers the records in section 505.

Section 507. Service summary.

Each insurer shall prepare a service summary at the client's request specifically for the purpose of the policyholder applying for Medicaid. Also the insurer shall prepare a service summary when the policyholder has exhausted his benefits under the policy or when the policy ceases to be in force for a reason other than the death of the policyholder, whichever occurs first. The service summary shall identify the specific precertified policy, the total benefits paid for services rendered to date and the amount qualifying for asset protection. This service summary is separate and in addition to the information requirement described in section 505.

Section 508. Plan of action.

(a) Contents of plan.--Each insurer shall, prior to precertification by the Insurance Department, submit to the Department of Public Welfare a plan for complying with the information maintenance and documentation requirements set forth in this chapter. No policy shall be precertified until the Department of Public Welfare has approved the insurer's documentation plan for the policy. The documentation plan shall include the following:

(1) The location where records will be kept. Records required for purposes of this act must be available at one

location, which shall be easily available to staff of the Department of Public Welfare and the Insurance Department.

(2) The insurer shall agree to give the Department of Public Welfare access to all information described in section 505 on an aggregate basis for all policyholders and on an individual basis for all policyholders who have ever received any benefits. Access to information on persons who have not applied for Medicaid is required in order for the Department of Public Welfare to determine if an insurer's system for documenting asset protection is functioning correctly. The Department of Public Welfare shall have the final decision concerning the frequency of access to the data and the size of samples for auditing or other purposes.

(3) The name, job title, address and telephone number of the person primarily responsible for the maintenance of the information required and acting as liaison with the Department of Public Welfare concerning the information.

(4) Methods for determining when insurance benefits qualify for asset protection, including documentation of the insured event, description of services, documentation of charges and benefits paid and documentation of plans of care when required.

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

(6) Information which will be retained which is needed to comply with these regulations.

(7) Copies of forms and descriptions of standard procedures for maintaining and reporting the information required. In the event that all or part of the data will be provided in computer-readable form, the specific medium such

as tape, diskette, etc., will be specified in addition to a description of the relevant file.

(b) Action by agencies.--When the Department of Public Welfare determines that a plan of action is adequate, it shall advise the Insurance Department and the insurer of that fact in writing. If the Department of Public Welfare determines that there are shortcomings in a plan of action, it shall advise the Insurance Department and the insurer of those shortcomings in writing and shall cooperate with the insurer in efforts to resolve the matter.

Section 509. Auditing and correcting deficiencies in insurer recordkeeping.

The following represent instances of insurer deficiency, procedures for resolution, asset protection determinations and required penalties:

(1) Within one year of the first time that any policyholder of a particular company's policy has met the criteria for the insured event, and as often as the Department of Public Welfare deems necessary thereafter, the Department of Public Welfare shall conduct a systems audit of that company's records. The insurer shall be responsible for advising the Department of Public Welfare when this one-year period has begun. The Department of Public Welfare shall promptly inform each insurer of inaccuracies and other potential problems discovered in its systems audits and shall cooperate with insurers in efforts to correct any problems in the insurer's methods of operation.

(2) The Department of Public Welfare shall periodically audit a sample of individual applications to Medicaid of persons who have qualified for asset protection. The

Department of Public Welfare shall have the final decision concerning sample sizes and other auditing methods. The Department of Public Welfare shall promptly advise insurers of any problems discovered and shall cooperate with insurers in efforts to correct any problems in the insurer's methods of operation. The Department of Public Welfare shall also notify the insurer of any obligations described in this subsection to hold clients harmless.

(i) The Department of Public Welfare may enter into voluntary arrangements with offerors of precertified long-term care insurance policies under which the Department of Public Welfare would issue binding determinations as to whether or not services qualify for asset protection.

(ii) Policyholders may submit requests for information and advice through their insurer or CAM agency. When the procedures described below are followed in all material respects, the written determinations of the Department of Public Welfare's designee concerning whether services qualify for asset protection shall be binding upon the Department of Public Welfare in all subsequent actions, and the Department of Public Welfare shall not make any assertion contradicting these determinations in any action arising in this paragraph.

(A) All requests for determinations as to whether or not services qualify for asset protection shall be submitted to the Secretary of Public Welfare's designee in writing. These requests may include but are not limited to requests for determinations in the following areas:

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

(II) Whether a care plan is required.

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

(IV) Whether a service or services is in accord with the care plan.

(V) Whether a service is of such a nature as to qualify for asset protection as defined by the department.

(VI) Whether the applicable amount is the amount paid by the insurer or the amount charged for the service.

(VII) Whether a provider or proposed provider of service is a family member as defined by the department.

(B) The Secretary of Public Welfare's designee may require insurers and CAM agencies submitting requests for determinations to provide all records and other information necessary for making a determination. These may include, but not necessarily be limited to, assessments, care plans and invoices for services rendered. The party providing the records and other information shall be responsible for their accuracy. If any records or other information are later determined to be materially inaccurate, the determination based on the inaccurate information shall not be binding on the Department of Public Welfare in subsequent actions. In the case of a policyholder for whom a determination has been

invalidated because information provided was determined to be inaccurate, the provisions of this subsection will apply in the same manner as for any other policyholder.

(C) The Secretary of Public Welfare's designee shall render a determination on each request in writing. Each determination of the designee shall state the reasons for the determination, including the relevant facts, documentation of facts, statutes, regulations and policies.

(D) A copy of all determinations of the designee shall be kept on file at the Department of Public Welfare, together with the related records and information. The original of the determination shall be sent to the insurer or the CAM agency who originally requested it. The recipient of the original determination shall be responsible for notifying the policyholder or the policyholder's authorized agent.

(3) When an audit or other review by the Department of Public Welfare reveals deficiencies in the recordkeeping procedures of an insurer, the Department of Public Welfare shall so notify that insurer and establish a reasonable deadline for correction. If an insurer fails to correct deficiencies within a reasonable period of time, the Department of Public Welfare will notify the Insurance Department of the deficiencies.

(4) The commissioner shall reserve the right to remove precertification status of long-term care insurance policies when deemed necessary. If the Insurance Department removes

precertification status from a long-term care insurance policy, policyholders who purchased their policies while the policy was precertified will retain their right to asset protection. Policyholders who purchase their policies after the removal of precertification status will have no right to asset protection.

(5) If an insurer prepares a service summary which is used in a Medicaid application for a policyholder and the policyholder is found eligible for Medicaid, but after receiving Medicaid services, the policyholder is found to be ineligible for Medicaid solely by reason of errors in the insurer's service summary or documentation of services, the Department of Public Welfare may require the insurer to pay for services counting toward asset protection required by the policyholder until the insurer has paid an amount equal to the amount of the insurer's errors; after which, the policyholder, if otherwise eligible, shall qualify for Medicaid coverage.

(6) If the Department of Public Welfare determines that an insurer's records pertaining to a policyholder who has received Medicaid benefits are in such condition that the Department of Public Welfare cannot determine whether the policyholder qualifies for asset protection, the Department of Public Welfare may require the insurer to pay for services counting toward asset protection required by the policyholder until the insurer has paid an amount equal to the amount of the insurer's errors; after which, the policyholder, if otherwise eligible, shall qualify for Medicaid coverage.

(7) Compliance with paragraphs (5) and (6) is a requirement for a policy to retain precertification.

CHAPTER 11

MISCELLANEOUS PROVISIONS

Section 1101. Severability.

The provisions of this act are severable. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this act which can be given effect without the invalid provision or application.

Section 1102. Repeals.

All acts and parts of acts are repealed insofar as they are inconsistent with this act.

Section 1103. Effective date.

This act shall take effect in 60 days.