



# Kansas Insurance Department

Sandy Praeger, Commissioner of Insurance

---

## Bulletin 2007-7

**TO:** All Insurers Writing Long-Term Care Insurance Business in Kansas; All Insurance Producers Selling, Soliciting or Negotiating Long-Term Care Insurance in Kansas; and All Approved Continuing Education Providers Offering Long-Term Care Insurance Training

**FROM:** Sandy Praeger  
Commissioner of Insurance

**DATE:** October 12, 2007

**RE:** Establishment of the Long-Term Care Partnership Program; Requirements for Certification of Partnership Policies and Request for Notice to Consumers; Inflation Protection; Producer Training for Sale of Policies Qualifying for the Kansas Long-Term Care Partnership Program; Future Notice of New Developments; and Contact Information.

This bulletin is being issued to provide guidance about the Kansas Long-Term Care Partnership Program.

I. Establishment of the Long-Term Care Partnership Program:

The Kansas Long-Term Care Partnership Program was approved to become effective April 1, 2007. Under the Partnership Program, persons who purchase a qualifying long-term care insurance policy ("Partnership Policy") are subject to special rules relating to eligibility for Medicaid in Kansas. These rules allow assets equal to the amount of benefits received from a Partnership Policy to be disregarded for the purpose of determining Medicaid eligibility. This permits individuals to protect assets from spend-down requirements, if Medicaid assistance is ever needed. This program is authorized by the Deficit Reduction Act of 2005 (the "DRA").

II. Requirements for Certification of Partnership Policies and Request for Notice to Consumers:

Partnership Policies, like all policies, are subject to approval by the Department of Insurance pursuant to K.S.A. 40-2215. The DRA requires that the Commissioner of Insurance certify that policies provide the inflation protection and consumer protection required by the DRA.

To be certified as a Partnership Policy, the policy must:

- (1) Contain the consumer protection provisions required by 42 U.S.C. section 1396p(b)(1)(C)(iii)(III) and 42 U.S.C. section 1396p(b)(5)(A)(see attachment).
- (2) Be a tax-qualified contract under the requirements of 26 U.S.C. section 7702(B)(b)(see attachment).
- (3) Provide compound annual inflation protection, if issued to a person under the age of 61 or provide some level of inflation protection, if issued to a person between the ages of 61 and 76 as required by 42 U.S.C. section 1396p(b)(C)(iii)(V) (see attachment).

In reviewing requests for approval of a long-term care individual or group insurance policy as a Partnership Policy, the Department will rely on a certification of compliance with the consumer protection requirements of the DRA signed by an officer of the insurer. An Issuer Certification Form that meets this requirement is attached hereto. It is essential that the Issuer Certification Form be filled out completely and accurately. False or inaccurate information may result in denial of certification as a Partnership Policy, disapproval of the policy, and/or administrative sanction.

Insurers may want to have some policies or certificate forms that are currently filed and being marketed in Kansas certified as meeting the requirements for Partnership Policies. To do this, the insurer should file an Issuer Certification Form that clearly identifies the previously filed policies and accurately certifies compliance with the required consumer protections. After receipt of an Issuer Certification Form and a determination that a policy meets all applicable consumer protection requirements, the Department will inform the carrier in writing that the policy qualifies as a Partnership Policy.

The Department requests that issuers of Partnership Policies provide notice to consumers in plain language of the current law pertaining to the Partnership Program and asset tests for Medicaid. The notice should appear at the front, or near the front of the policy form. The form of the Asset Disregard Notice for Long-Term Care Partnership Policies attached hereto is suggested. For policy forms that have already been filed for use in Kansas, the Department requests that the carrier file the Notice with the Department as an endorsement to the existing policy, clearly identify the policies to which the filing applies, and explain how the Notice will be incorporated into the policy and where it will appear.

### III. Inflation Protection:

At this time, the Department will apply the language of the DRA literally to require some level of automatic compound annual inflation if a policy is sold to a person under the age of 61 and some level of automatic annual inflation protection if the policy is sold to a person age 61 to 75. No inflation protection will be required, if the policy is sold to a person 76 or older. Inflation protection requirements will not be considered to have been met for purposes of the Kansas Long-Term Care Partnership Program by an option to purchase additional coverage. The Department does not believe that reduction in the level of inflation protection as the consumer

advances in age through the tiers defined by the DRA meets the inflation protection required of Partnership Policies.

IV. Producer Training for Sale of Policies Qualifying for the Kansas Long-Term Care Partnership Program:

The DRA requires the Commissioner of Insurance to provide assurance that any producer who sells, solicits or negotiates a policy under the Kansas Long-Term Care Partnership Program receives appropriate training and demonstrates an understanding of Partnership Policies and their relationship to public and private coverage for long-term care. At this time, producers will be considered to have satisfied the training and licensing requirements for selling Partnership Policies if they are licensed to sell health insurance as required by K.S.A. 2006 Supp. 40-241 and have met the continuing education requirements set forth in K.S.A. 2006 Supp. 40-4903 and K.A.R. 40-7-13.

V. Future Notice of New Developments:

The Department anticipates that additional requirements will be developed for insurers and producers who participate in the Long-Term Care Partnership Program. Statutory and/or regulatory authority is anticipated establishing additional requirements relating to insurer reporting, producer licensing and training, consumer notices, reciprocity, exchange and/or conversion of policies issued before April 1, 2007, and possibly other matters. As the Partnership Program evolves, bulletins will inform insurers and producers of new requirements.

VI. Contact Information:

Questions regarding certification of Long-Term Care Partnership Policies should be directed to the attention of Mark McClafin, Accident and Health Division, Kansas Insurance Department, 420 SW 9<sup>th</sup> Street, Topeka, Kansas 66612, (785) 296-7850.

Questions regarding Long-Term Care Partnership Program producer training requirements should be directed to the attention of the Producers Division, Kansas Insurance Department, 420 SW 9<sup>th</sup> Street, Topeka, Kansas 66612, (785) 296-7862.

Questions regarding Medicaid should be directed to the attention of Tim T. Schroeder, Elderly & Disabled Medical Eligibility Policy Manager, Kansas Health Policy Authority, LSOB-Suite 900, 900 SW Jackson Street, Topeka, Kansas 66612, (785) 296-1144, [Tim.Schroeder@khpa.ks.gov](mailto:Tim.Schroeder@khpa.ks.gov).

## **Deficit Reduction Act of 2005**

### **42 U.S.C. § 1396p. Liens, adjustments and recoveries, and transfers of assets.**

(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan

**(1)** No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except--

**(A)** pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

**(B)** in the case of the real property of an individual--

**(i)** who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and

**(ii)** with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot reasonably be expected to be discharged from the medical institution and to return home,

except as provided in paragraph (2).

**(2)** No lien may be imposed under paragraph (1)(B) on such individual's home if--

**(A)** the spouse of such individual,

**(B)** such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title, or

**(C)** a sibling of such individual (who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution),

is lawfully residing in such home.

**(3)** Any lien imposed with respect to an individual pursuant to paragraph (1)(B) shall dissolve upon that individual's discharge from the medical institution and return home.

(b) Adjustment or recovery of medical assistance correctly paid under a State plan

**(1)** No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:

**(A)** In the case of an individual described in subsection (a)(1)(B) of this section, the State shall seek adjustment or recovery from the individual's estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of the individual.

**(B)** In the case of an individual who was 55 years of age or older when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual's estate, but only for medical assistance consisting of--

**(i)** nursing facility services, home and community-based services, and related hospital and prescription drug services, or

**(ii)** at the option of the State, any items or services under the State plan.

**(C)(i)** In the case of an individual who has received (or is entitled to receive) benefits under a long-term care insurance policy in connection with which assets or resources are disregarded in the manner described in clause (ii), except as provided in such clause, the State shall seek adjustment or recovery from the individual's estate on account of medical assistance paid on behalf of the individual for nursing facility and other long-term care services.

**(ii)** Clause (i) shall not apply in the case of an individual who received medical assistance under a State plan of a State which had a State plan amendment approved as of May 14, 1993, and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii)) which provided for the disregard of any assets or resources--

**(I)** to the extent that payments are made under a long-term care insurance policy; or

**(II)** because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy.

**(iii)** For purposes of this paragraph, the term "qualified State long-term care insurance partnership" means an approved State plan amendment under this subchapter that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy if the following requirements are met:

**(I)** The policy covers an insured who was a resident of such State when coverage first became effective under the policy.

**(II)** The policy is a qualified long-term care insurance policy (as defined in section 7702B(b) of Title 26) issued not earlier than the effective date of the State plan amendment.

**(III)** The policy meets the model regulations and the requirements of the model Act specified in paragraph (5).

**(IV)** If the policy is sold to an individual who--

**(aa)** has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;

**(bb)** has attained age 61 but has not attained age 76 as of such date, the policy provides some level of inflation protection; and

**(cc)** has attained age 76 as of such date, the policy may (but is not required to) provide some level of inflation protection.

**(V)** The State Medicaid agency under section 1396a(a)(5) of this title provides information and technical assistance to the State insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

**(VI)** The issuer of the policy provides regular reports to the Secretary, in accordance with regulations of the Secretary, that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

**(VII)** The State does not impose any requirement affecting the terms or benefits of such a policy unless the

State imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

In the case of a long-term care insurance policy which is exchanged for another such policy, subclause (I) shall be applied based on the coverage of the first such policy that was exchanged. For purposes of this clause and paragraph (5), the term "long-term care insurance policy" includes a certificate issued under a group insurance contract.

(iv) With respect to a State which had a State plan amendment approved as of May 14, 1993, such a State satisfies this clause for purposes of clause (ii) if the Secretary determines that the State plan amendment provides for consumer protection standards which are no less stringent than the consumer protection standards which applied under such State plan amendment as of December 31, 2005.

(v) The regulations of the Secretary required under clause (iii)(VI) shall be promulgated after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, and shall specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. The Secretary, as appropriate, shall provide copies of the reports provided in accordance with that clause to the State involved.

(vi) The Secretary, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, the National Association of Insurance Commissioners, State insurance commissioners, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, shall develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified State long-term care insurance partnerships to a secure, centralized electronic query and report-generating mechanism that the State, the Secretary, and other Federal agencies can access.

(2) Any adjustment or recovery under paragraph (1) may be made only after the death of the individual's surviving spouse, if any, and only at a time--

(A) when he has no surviving child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title; and

(B) in the case of a lien on an individual's home under subsection (a)(1)(B) of this section, when--

(i) no sibling of the individual (who was residing in the individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution), and

(ii) no son or daughter of the individual (who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the medical institution, and who establishes to the satisfaction of the State that he or she provided care to such individual which permitted such individual to reside at home rather than in an institution),

is lawfully residing in such home who has lawfully resided in such home on a continuous basis since the date of the individual's admission to the medical institution.

(3) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency shall waive the application of this subsection (other than paragraph (1)(C)) if such application would work an undue hardship as determined on the basis of criteria established by the Secretary.

(4) For purposes of this subsection, the term "estate", with respect to a deceased individual--

(A) shall include all real and personal property and other assets included within the individual's estate, as defined

for purposes of State probate law; and

**(B)** may include, at the option of the State (and shall include, in the case of an individual to whom paragraph (1)(C)(i) applies), any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

**(5)(A)** For purposes of clause (iii)(III), the model regulations and the requirements of the model Act specified in this paragraph are:

**(i)** In the case of the model regulation, the following requirements:

**(I)** Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the model Act relating to such section 6A.

**(II)** Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

**(III)** Section 6C (relating to extension of benefits).

**(IV)** Section 6D (relating to continuation or conversion of coverage).

**(V)** Section 6E (relating to discontinuance and replacement of policies).

**(VI)** Section 7 (relating to unintentional lapse).

**(VII)** Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.

**(VIII)** Section 9 (relating to required disclosure of rating practices to consumer).

**(IX)** Section 11 (relating to prohibitions against post-claims underwriting).

**(X)** Section 12 (relating to minimum standards).

**(XI)** Section 14 (relating to application forms and replacement coverage).

**(XII)** Section 15 (relating to reporting requirements).

**(XIII)** Section 22 (relating to filing requirements for marketing).

**(XIV)** Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.

**(XV)** Section 24 (relating to suitability).

**(XVI)** Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

**(XVII)** The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).

**(XVIII)** Section 29 (relating to standard format outline of coverage).

**(XIX)** Section 30 (relating to requirement to deliver shopper's guide).

**(ii)** In the case of the model Act, the following:

- (I) Section 6C (relating to preexisting conditions).
- (II) Section 6D (relating to prior hospitalization).
- (III) The provisions of section 8 relating to contingent nonforfeiture benefits.
- (IV) Section 6F (relating to right to return).
- (V) Section 6G (relating to outline of coverage).
- (VI) Section 6H (relating to requirements for certificates under group plans).
- (VII) Section 6J (relating to policy summary).
- (VIII) Section 6K (relating to monthly reports on accelerated death benefits).
- (IX) Section 7 (relating to incontestability period).

(B) For purposes of this paragraph and paragraph (1)(c)--

- (i) the terms "model regulation" and "model Act" mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000);
- (ii) any provision of the model regulation or model Act listed under subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision; and
- (iii) with respect to a long-term care insurance policy issued in a State, the policy shall be deemed to meet applicable requirements of the model regulation or the model Act if the State plan amendment under paragraph (1)(C)(iii) provides that the State insurance commissioner for the State certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements.

(C) Not later than 12 months after the National Association of Insurance Commissioners issues a revision, update, or other modification of a model regulation or model Act provision specified in subparagraph (A), or of any provision of such regulation or Act that is substantively related to a provision specified in such subparagraph, the Secretary shall review the changes made to the provision, determine whether incorporating such changes into the corresponding provision specified in such subparagraph would improve qualified State long-term care insurance partnerships, and if so, shall incorporate the changes into such provision.

(c) Taking into account certain transfers of assets

(1)(A) In order to meet the requirements of this subsection for purposes of section 1396a(a)(18) of this title, the State plan must provide that if an institutionalized individual or the spouse of such an individual (or, at the option of a State, a noninstitutionalized individual or the spouse of such an individual) disposes of assets for less than fair market value on or after the look-back date specified in subparagraph (B)(i), the individual is ineligible for medical assistance for services described in subparagraph (C)(i) (or, in the case of a noninstitutionalized individual, for the services described in subparagraph (C)(ii)) during the period beginning on the date specified in subparagraph (D) and equal to the number of months specified in subparagraph (E).

(B)(i) The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to paragraph (3)(A)(iii) or (3)(B)(ii) of subsection (d) of this section or in the case of any other disposal of assets made on or after February 8, 2006, 60 months) before the date specified in clause (ii).

(ii) The date specified in this clause, with respect to--

**(I)** an institutionalized individual is the first date as of which the individual both is an institutionalized individual and has applied for medical assistance under the State plan, or

**(II)** a noninstitutionalized individual is the date on which the individual applies for medical assistance under the State plan or, if later, the date on which the individual disposes of assets for less than fair market value.

**(C)(i)** The services described in this subparagraph with respect to an institutionalized individual are the following:

**(I)** Nursing facility services.

**(II)** A level of care in any institution equivalent to that of nursing facility services.

**(III)** Home or community-based services furnished under a waiver granted under subsection (c) or (d) of section 1396n of this title.

**(ii)** The services described in this subparagraph with respect to a noninstitutionalized individual are services (not including any services described in clause (i)) that are described in paragraph (7), (22), or (24) of section 1396d(a) of this title, and, at the option of a State, other long-term care services for which medical assistance is otherwise available under the State plan to individuals requiring long-term care.

**(D)(i)** In the case of a transfer of asset made before February 8, 2006, the date specified in this subparagraph is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this subsection.

**(ii)** In the case of a transfer of asset made on or after February 8, 2006, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.

**(E)(i)** With respect to an institutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall be equal to--

**(I)** the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

**(II)** the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

**(ii)** With respect to a noninstitutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall not be greater than a number equal to--

**(I)** the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

**(II)** the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

**(iii)** The number of months of ineligibility otherwise determined under clause (i) or (ii) with respect to the disposal of an asset shall be reduced--

**(I)** in the case of periods of ineligibility determined under clause (i), by the number of months of ineligibility applicable to the individual under clause (ii) as a result of such disposal, and

**(II)** in the case of periods of ineligibility determined under clause (ii), by the number of months of ineligibility applicable to the individual under clause (i) as a result of such disposal.

**(iv)** A State shall not round down, or otherwise disregard any fractional period of ineligibility determined under clause (i) or (ii) with respect to the disposal of assets.

**(F)** For purposes of this paragraph, the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless--

**(i)** the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual under this title; or

**(ii)** the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.

**(G)** For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes an annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services under this title unless--

**(i)** the annuity is--

**(I)** an annuity described in subsection (b) or (q) of section 408 of Title 26; or

**(II)** purchased with proceeds from--

**(aa)** an account or trust described in subsection (a), (c), or (p) of section 408 of such title;

**(bb)** a simplified employee pension (within the meaning of section 408(k) of such title); or

**(cc)** a Roth IRA described in section 408A of such title; or

**(ii)** the annuity--

**(I)** is irrevocable and nonassignable;

**(II)** is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and

**(III)** provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

**(H)** Notwithstanding the preceding provisions of this paragraph, in the case of an individual (or individual's spouse) who makes multiple fractional transfers of assets in more than 1 month for less than fair market value on or after the applicable look-back date specified in subparagraph (b), a State may determine the period of ineligibility applicable to such individual under this paragraph by--

**(i)** treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) during all months on or after the look-back date specified in subparagraph (B) as 1 transfer for purposes of clause (i) or (ii) (as the case may be) of subparagraph (E); and

**(ii)** beginning such period on the earliest date which would apply under subparagraph (D) to any of such transfers.

**(I)** For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage--

**(i)** has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);

**(ii)** provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

**(iii)** prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (i) through (iii), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the individual's application for medical assistance for services described in subparagraph (C).

**(J)** For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least 1 year after the date of the purchase.

**(2)** An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that--

**(A)** the assets transferred were a home and title to the home was transferred to--

**(i)** the spouse of such individual;

**(ii)** a child of such individual who (I) is under age 21, or (II) (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title;

**(iii)** a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or

**(iv)** a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

**(B)** the assets--

**(i)** were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse,

**(ii)** were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,

**(iii)** were transferred to, or to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of, the individual's child described in subparagraph (A)(ii)(II), or

**(iv)** were transferred to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1382c(a)(3) of this title);

**(C)** a satisfactory showing is made to the State (in accordance with regulations promulgated by the Secretary) that

(i) the individual intended to dispose of the assets either at fair market value, or for other valuable consideration,

(ii) the assets were transferred exclusively for a purpose other than to qualify for medical assistance, or (iii) all assets transferred for less than fair market value have been returned to the individual; or

**(D)** the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria

established by the Secretary.

The procedures established under subparagraph (D) shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the personal representative of the individual.

While an application for an undue hardship waiver is pending under subparagraph (D) in the case of an individual who is a resident of a nursing facility, if the application meets such criteria as the Secretary specifies, the State may provide for payments for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of payments for 30 days.

**(3)** For purposes of this subsection, in the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset (or the affected portion of such asset) shall be considered to be transferred by such individual when any action is taken, either by such individual or by any other person, that reduces or eliminates such individual's ownership or control of such asset.

**(4)** A State (including a State which has elected treatment under section 1396a(f) of this title) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with this subsection. In the case of a transfer by the spouse of an individual which results in a period of ineligibility for medical assistance under a State plan for such individual, a State shall, using a reasonable methodology (as specified by the Secretary), apportion such period of ineligibility (or any portion of such period) among the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the State plan.

**(5)** In this subsection, the term "resources" has the meaning given such term in section 1382b of this title, without regard to the exclusion described in subsection (a)(1) thereof.

**(d) Treatment of trust amounts**

**(1)** For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, subject to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such individual.

**(2)(A)** For purposes of this subsection, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:

**(i)** The individual.

**(ii)** The individual's spouse.

**(iii)** A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.

**(iv)** A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

**(B)** In the case of a trust the corpus of which includes assets of an individual (as determined under subparagraph (A)) and assets of any other person or persons, the provisions of this subsection shall apply to the portion of the trust attributable to the assets of the individual.

**(C)** Subject to paragraph (4), this subsection shall apply without regard to--

**(i)** the purposes for which a trust is established,

**(ii)** whether the trustees have or exercise any discretion under the trust,

(iii) any restrictions on when or whether distributions may be made from the trust, or

(iv) any restrictions on the use of distributions from the trust.

**(3)(A)** In the case of a revocable trust--

(i) the corpus of the trust shall be considered resources available to the individual,

(ii) payments from the trust to or for the benefit of the individual shall be considered income of the individual, and

(iii) any other payments from the trust shall be considered assets disposed of by the individual for purposes of subsection (c) of this section.

**(B)** In the case of an irrevocable trust--

(i) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income--

(I) to or for the benefit of the individual, shall be considered income of the individual, and

(II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (c) of this section; and

(ii) any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed of by the individual for purposes of subsection (c) of this section, and the value of the trust shall be determined for purposes of such subsection by including the amount of any payments made from such portion of the trust after such date.

**(4)** This subsection shall not apply to any of the following trusts:

**(A)** A trust containing the assets of an individual under age 65 who is disabled (as defined in section 1382c(a)(3) of this title) and which is established for the benefit of such individual by a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter.

**(B)** A trust established in a State for the benefit of an individual if--

(i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust),

(ii) the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter, and

(iii) the State makes medical assistance available to individuals described in section 1396a(a)(10)(A)(ii)(V) of this title, but does not make such assistance available to individuals for nursing facility services under section 1396a(a)(10)(C) of this title.

**(C)** A trust containing the assets of an individual who is disabled (as defined in section 1382c(a)(3) of this title) that meets the following conditions:

- (i)** The trust is established and managed by a nonprofit association.
  - (ii)** A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.
  - (iii)** Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in section 1382c(a)(3) of this title) by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.
  - (iv)** To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State plan under this subchapter.
- (5)** The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency waives the application of this subsection with respect to an individual if the individual establishes that such application would work an undue hardship on the individual as determined on the basis of criteria established by the Secretary.
- (6)** The term "trust" includes any legal instrument or device that is similar to a trust but includes an annuity only to such extent and in such manner as the Secretary specifies.
- (e)(1)** In order to meet the requirements of this section for purposes of section 1396a(a)(18) of this title, a State shall require, as a condition for the provision of medical assistance for services described in subsection (c)(1)(C)(i) of this section (relating to long-term care services) for an individual, the application of the individual for such assistance (including any recertification of eligibility for such assistance) shall disclose a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as may be specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of such medical assistance.
- (2)(A)** In the case of disclosure concerning an annuity under subsection (c)(1)(F) of this section, the State shall notify the issuer of the annuity of the right of the State under such subsection as a preferred remainder beneficiary in the annuity for medical assistance furnished to the individual. Nothing in this paragraph shall be construed as preventing such an issuer from notifying persons with any other remainder interest of the State's remainder interest under such subsection.
- (B)** In the case of such an issuer receiving notice under subparagraph (A), the State may require the issuer to notify the State when there is a change in the amount of income or principal being withdrawn from the amount that was being withdrawn at the time of the most recent disclosure described in paragraph (1). A State shall take such information into account in determining the amount of the State's obligations for medical assistance or in the individual's eligibility for such assistance.
- (3)** The Secretary may provide guidance to States on categories of transactions that may be treated as a transfer of asset for less than fair market value.
- (4)** Nothing in this subsection shall be construed as preventing a State from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity described in paragraph (1).
- (f)(1)(A)** Notwithstanding any other provision of this subchapter, subject to subparagraphs (B) and (C) of this paragraph and paragraph (2), in determining eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services, the individual shall not be eligible for such assistance if the individual's equity interest in the individual's home exceeds \$500,000.
- (B)** A State may elect, without regard to the requirements of section 1396a(a)(1) of this title (relating to statewideness) and section 1396a(a)(10)(B) of this title (relating to comparability), to apply subparagraph (A) by

substituting for "\$500,000", an amount that exceeds such amount, but does not exceed \$750,000.

**(C)** The dollar amounts specified in this paragraph shall be increased, beginning with 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest \$1,000.

**(2)** Paragraph (1) shall not apply with respect to an individual if--

**(A)** the spouse of such individual, or

**(B)** such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title,

is lawfully residing in the individual's home.

**(3)** Nothing in this subsection shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

**(4)** The Secretary shall establish a process whereby paragraph (1) is waived in the case of a demonstrated hardship.

**(g)** Treatment of entrance fees of individuals residing in continuing care retirement communities

**(1)** In general

For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, the rules specified in paragraph (2) shall apply to individuals residing in continuing care retirement communities or life care communities that collect an entrance fee on admission from such individuals.

**(2)** Treatment of entrance fee

For purposes of this subsection, an individual's entrance fee in a continuing care retirement community or life care community shall be considered a resource available to the individual to the extent that--

**(A)** the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;

**(B)** the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; and

**(C)** the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

**(h)** Definitions

In this section, the following definitions shall apply:

**(1)** The term "assets", with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action--

**(A)** by the individual or such individual's spouse,

**(B)** by a person, including a court or administrative body, with legal authority to act in place of or on behalf of

the individual or such individual's spouse, or

(C) by any person, including any court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse.

(2) The term "income" has the meaning given such term in section 1382a of this title.

(3) The term "institutionalized individual" means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in section 1396a(a)(10)(A)(ii)(VI) of this title.

(4) The term "noninstitutionalized individual" means an individual receiving any of the services specified in subsection (c)(1)(C)(ii) of this section.

(5) The term "resources" has the meaning given such term in section 1382b of this title, without regard (in the case of an institutionalized individual) to the exclusion described in subsection (a)(1) of such section.

Current through P.L. 110-91 (excluding P.L. 110-85 and 110-90)  
approved 09-29-07

## 26 U.S.C. § 7702B. Treatment of qualified long-term care insurance

### **(a) In general.**--For purposes of this title--

- (1) a qualified long-term care insurance contract shall be treated as an accident and health insurance contract,
- (2) amounts (other than policyholder dividends, as defined in section 808, or premium refunds) received under a qualified long-term care insurance contract shall be treated as amounts received for personal injuries and sickness and shall be treated as reimbursement for expenses actually incurred for medical care (as defined in section 213(d)),
- (3) any plan of an employer providing coverage under a qualified long-term care insurance contract shall be treated as an accident and health plan with respect to such coverage,
- (4) except as provided in subsection (e)(3), amounts paid for a qualified long-term care insurance contract providing the benefits described in subsection (b)(2)(A) shall be treated as payments made for insurance for purposes of section 213(d)(1)(D), and
- (5) a qualified long-term care insurance contract shall be treated as a guaranteed renewable contract subject to the rules of section 816(e).

### **(b) Qualified long-term care insurance contract.**--For purposes of this title--

- (1) **In general.**--The term "qualified long-term care insurance contract" means any insurance contract if--
  - (A) the only insurance protection provided under such contract is coverage of qualified long-term care services,
  - (B) such contract does not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount,
  - (C) such contract is guaranteed renewable,
  - (D) such contract does not provide for a cash surrender value or other money that can be--
    - (i) paid, assigned, or pledged as collateral for a loan, or
    - (ii) borrowed,other than as provided in subparagraph (E) or paragraph (2)(C),
  - (E) all refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits, and
  - (F) such contract meets the requirements of subsection (g).

### **(2) Special rules.**--

- (A) **Per diem, etc. payments permitted.**--A contract shall not fail to be described in subparagraph (A) or (B) of paragraph (1) by reason of payments being made on a per diem or other periodic basis without regard to the

expenses incurred during the period to which the payments relate.

**(B) Special rules relating to medicare.--**

(i) Paragraph (1)(B) shall not apply to expenses which are reimbursable under title XVIII of the Social Security Act only as a secondary payor.

(ii) No provision of law shall be construed or applied so as to prohibit the offering of a qualified long-term care insurance contract on the basis that the contract coordinates its benefits with those provided under such title.

**(C) Refunds of premiums.--**Paragraph (1)(E) shall not apply to any refund on the death of the insured, or on a complete surrender or cancellation of the contract, which cannot exceed the aggregate premiums paid under the contract. Any refund on a complete surrender or cancellation of the contract shall be includible in gross income to the extent that any deduction or exclusion was allowable with respect to the premiums.

**(c) Qualified long-term care services.--**For purposes of this section--

**(1) In general.--**The term "qualified long-term care services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which--

(A) are required by a chronically ill individual, and

(B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

**(2) Chronically ill individual.--**

**(A) In general.--**The term "chronically ill individual" means any individual who has been certified by a licensed health care practitioner as--

(i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity,

(ii) having a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in clause (i), or

(iii) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the preceding 12-month period a licensed health care practitioner has certified that such individual meets such requirements.

**(B) Activities of daily living.--**For purposes of subparagraph (A), each of the following is an activity of daily living:

(i) Eating.

(ii) Toileting.

(iii) Transferring.

(iv) Bathing.

(v) Dressing.

(vi) Continence.

A contract shall not be treated as a qualified long-term care insurance contract unless the determination of whether an individual is a chronically ill individual described in subparagraph (A)(i) takes into account at least 5 of such activities.

**(3) Maintenance or personal care services.**--The term "maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

**(4) Licensed health care practitioner.**--The term "licensed health care practitioner" means any physician (as defined in section 1861(r)(1) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

**(d) Aggregate payments in excess of limits.**--

**(1) In general.**--If the aggregate of--

(A) the periodic payments received for any period under all qualified long-term care insurance contracts which are treated as made for qualified long-term care services for an insured, and

(B) the periodic payments received for such period which are treated under section 101(g) as paid by reason of the death of such insured,

exceeds the per diem limitation for such period, such excess shall be includible in gross income without regard to section 72. A payment shall not be taken into account under subparagraph (B) if the insured is a terminally ill individual (as defined in section 101(g)) at the time the payment is received.

**(2) Per diem limitation.**--For purposes of paragraph (1), the per diem limitation for any period is an amount equal to the excess (if any) of--

(A) the greater of--

(i) the dollar amount in effect for such period under paragraph (4), or

(ii) the costs incurred for qualified long-term care services provided for the insured for such period, over

(B) the aggregate payments received as reimbursements (through insurance or otherwise) for qualified long-term care services provided for the insured during such period.

**(3) Aggregation rules.**--For purposes of this subsection--

**(A)** all persons receiving periodic payments described in paragraph (1) with respect to the same insured shall be treated as 1 person, and

**(B)** the per diem limitation determined under paragraph (2) shall be allocated first to the insured and any remaining limitation shall be allocated among the other such persons in such manner as the Secretary shall prescribe.

**(4) Dollar amount.**--The dollar amount in effect under this subsection shall be \$175 per day (or the equivalent amount in the case of payments on another periodic basis).

**(5) Inflation adjustment.**--In the case of a calendar year after 1997, the dollar amount contained in paragraph (4) shall be increased at the same time and in the same manner as amounts are increased pursuant to section 213(d)(10).

**(6) Periodic payments.**--For purposes of this subsection, the term "periodic payment" means any payment (whether on a periodic basis or otherwise) made without regard to the extent of the costs incurred by the payee for qualified long-term care services.

**(e) Treatment of coverage provided as part of a life insurance or annuity contract.**--Except as otherwise provided in regulations prescribed by the Secretary, in the case of any long-term care insurance coverage (whether or not qualified) provided by a rider on or as part of a life insurance contract or an annuity contract--

**(1) In general.**--This title shall apply as if the portion of the contract providing such coverage is a separate contract.

**(2) Denial of deduction under section 213.**--No deduction shall be allowed under section 213(a) for any payment made for coverage under a qualified long-term care insurance contract if such payment is made as a charge against the cash surrender value of a life insurance contract or the cash value of an annuity contract.

**(3) Portion defined.**--For purposes of this subsection, the term "portion" means only the terms and benefits under a life insurance contract or annuity contract that are in addition to the terms and benefits under the contract without regard to long-term care insurance coverage.

**(4) Annuity contracts to which paragraph (1) does not apply.**--For purposes of this subsection, none of the following shall be treated as an annuity contract:

**(A)** A trust described in section 401(a) which is exempt from tax under section 501(a).

**(B)** A contract--

**(i)** purchased by a trust described in subparagraph (A),

**(ii)** purchased as part of a plan described in section 403(a),

**(iii)** described in section 403(b),

**(iv)** provided for employees of a life insurance company under a plan described in section 818(a)(3), or

**(v)** from an individual retirement account or an individual retirement annuity.

(C) A contract purchased by an employer for the benefit of the employee (or the employee's spouse).

Any dividend described in section 404(k) which is received by a participant or beneficiary shall, for purposes of this paragraph, be treated as paid under a separate contract to which subparagraph (B)(i) applies.

**(f) Treatment of certain State-maintained plans.--**

**(1) in general.--If--**

(A) an individual receives coverage for qualified long-term care services under a State long-term care plan, and

(B) the terms of such plan would satisfy the requirements of subsection (b) were such plan an insurance contract,

such plan shall be treated as a qualified long-term care insurance contract for purposes of this title.

**(2) State long-term care plan.--**For purposes of paragraph (1), the term "State long-term care plan" means any plan--

(A) which is established and maintained by a State or an instrumentality of a State,

(B) which provides coverage only for qualified long-term care services, and

(C) under which such coverage is provided only to--

(i) employees and former employees of a State (or any political subdivision or instrumentality of a State),

(ii) the spouses of such employees, and

(iii) individuals bearing a relationship to such employees or spouses which is described in any of subparagraphs (A) through (G) of section 152(d)(2).

**(g) Consumer protection provisions.--**

**(1) In general.--**The requirements of this subsection are met with respect to any contract if the contract meets--

(A) the requirements of the model regulation and model Act described in paragraph (2),

(B) the disclosure requirement of paragraph (3), and

(C) the requirements relating to nonforfeitability under paragraph (4).

**(2) Requirements of model regulation and Act.--**

(A) **In general.--**The requirements of this paragraph are met with respect to any contract if such contract meets--

(i) **Model regulation.--**The following requirements of the model regulation:

**(I)** Section 7A (relating to guaranteed renewal or noncancellability), and the requirements of section 6B of the model Act relating to such section 7A.

**(II)** Section 7B (relating to prohibitions on limitations and exclusions).

**(III)** Section 7C (relating to extension of benefits).

**(IV)** Section 7D (relating to continuation or conversion of coverage).

**(V)** Section 7E (relating to discontinuance and replacement of policies).

**(VI)** Section 8 (relating to unintentional lapse).

**(VII)** Section 9 (relating to disclosure), other than section 9F thereof.

**(VIII)** Section 10 (relating to prohibitions against post-claims underwriting).

**(IX)**Section 11 (relating to minimum standards).

**(X)**Section 12 (relating to requirement to offer inflation protection), except that any requirement for a signature on a rejection of inflation protection shall permit the signature to be on an application or on a separate form.

**(XI)**Section 23 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

**(ii) Model Act.**--The following requirements of the model Act:

**(I)** Section 6C (relating to preexisting conditions).

**(II)** Section 6D (relating to prior hospitalization).

**(B) Definitions.**--For purposes of this paragraph--

**(i) Model provisions.**--The terms "model regulation" and "model Act" mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of January 1993).

**(ii) Coordination.**--Any provision of the model regulation or model Act listed under clause (i) or (ii) of subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.

**(iii) Determination.**--For purposes of this section and section 4980C, the determination of whether any requirement of a model regulation or the model Act has been met shall be made by the Secretary.

**(3) Disclosure requirement.**--The requirement of this paragraph is met with respect to any contract if such contract meets the requirements of section 4980C(d).

**(4) Nonforfeiture requirements.**--

**(A) In general.**--The requirements of this paragraph are met with respect to any level premium contract, if the issuer of such contract offers to the policyholder, including any group policyholder, a nonforfeiture provision meeting the requirements of subparagraph (B).

**(B) Requirements of provision.**--The nonforfeiture provision required under subparagraph (A) shall meet the following requirements:

(i) The nonforfeiture provision shall be appropriately captioned.

(ii) The nonforfeiture provision shall provide for a benefit available in the event of a default in the payment of any premiums and the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the appropriate State regulatory agency for the same contract form.

(iii) The nonforfeiture provision shall provide at least one of the following:

(I) Reduced paid-up insurance.

(II) Extended term insurance.

(III) Shortened benefit period.

(IV) Other similar offerings approved by the appropriate State regulatory agency.

**(5) Cross reference.**--

For coordination of the requirements of this subsection with State requirements, see section 4980C(f).

**STATE OF KANSAS**  
**ISSUER CERTIFICATION FORM FOR THE**  
**LONG-TERM CARE INSURANCE PARTNERSHIP PROGRAM**

Pursuant to Section 1917 of the Social Security Act, the State of Kansas has implemented a Long-Term Care Insurance Partnership Program. Under this program, a person receiving benefits under a qualified Long-Term Care Insurance Partnership Policy ("Partnership Policy") may be entitled to have assets equivalent to the benefits received disregarded for the purpose of determining Medicaid eligibility. The Commissioner of the Department of Insurance may certify that long-term care insurance policies (including certificates issued under a group insurance contract) meet certain consumer protection requirements necessary for a policy to qualify as a Partnership Policy. These consumer protection requirements are set forth in section 1917(b)(5)(A) of the Social Security Act (42 U.S.C. 1396p(b)(5)(A)) and principally include certain specified provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act promulgated by the National Association of Insurance Commissioners.

In determining compliance with the consumer protection requirements applicable to Partnership Policies, the Commissioner will review a certification made on behalf of an insurance carrier that a policy or policies meet all consumer protection requirements necessary to qualify as a Partnership Policy. A carrier wishing to have a long-term care insurance policy certified by the Commissioner as meeting the requirements for treatment as a Partnership Policy must fully and accurately complete this Issuer Certification Form. The certification must be made by an officer of the insurer having the authority to bind the insurer and full contact information for the certifying officer must be provided. A copy of any certification issued by the Commissioner in reliance upon this form can be provided to the person identified as the contact at the end of this form.

**By submitting this form, you are certifying that the information contained on the form is complete and accurate. Any inaccuracies in the information you provide on this form may result in a withdrawal of any certification made by the Commissioner in reliance on this form, retroactive correction of the policy to conform to the information provided in the certification, disapproval of the policy for use in Kansas and administrative sanctions against the insurer on whose behalf the form is submitted. Therefore, it is essential that you carefully review the information set forth on this form for accuracy.**

---

**I. GENERAL INFORMATION**

**A. Name, address and telephone number of issuer of policies:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**B. Policy form(s) covered by this Issuer Certification Form:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Specimen copies of each of the above policy forms, including any riders and endorsements shall be provided with this form if they have not previously been filed with the Department for use in Kansas.

Policy forms that have been previously filed with the Department for use in Kansas shall be provided upon request.

**II. QUESTIONS REGARDING APPLICABLE PROVISIONS OF THE NAIC MODEL REGULATION AND MODEL ACT**

Please answer each of the following questions below with respect to the policy forms identified in section I.B above. Unless otherwise indicated, all section references in part (1) are to sections of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) and incorporated by reference in section 1917(b)(5)(A) of the Social Security Act (42 U.S.C. 1396p(b)(5)(A)).

(1) Do each of the policies identified in section I.B above (including certificates issued under a group insurance contract) comply with the following requirements of the Long-Term Care Insurance Model Regulation and/or the Long-Term Care insurance Model Act?

Yes _____ No _____ N/A _____	A. Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the 2000 Model Act relating to such section 6A.
Yes _____ No _____ N/A _____	B. Section 6B (relating to prohibitions on limitation and exclusions) other than paragraph (7) thereof.
Yes _____ No _____ N/A _____	C. Section 6C (relating to extension of benefits).
Yes _____ No _____ N/A _____	D. Section 6D (relating to continuation or conversion of coverage).
Yes _____ No _____ N/A _____	E. Section 6E (relating to discontinuance and replacement of policies).
Yes _____ No _____ N/A _____	F. Section 7 (relating to unintentional lapse).
Yes _____ No _____ N/A _____	G. Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.
Yes _____ No _____ N/A _____	H. Section 9 (relating to required disclosure of rating practices to consumer).
Yes _____ No _____ N/A _____	I. Section 11 (relating to prohibitions against post-claims underwriting).
Yes _____ No _____ N/A _____	J. Section 12 (relating to minimum standards).
Yes _____ No _____ N/A _____	K. Section 14 (relating to application forms and replacement coverage).
Yes _____ No _____ N/A _____	L. Section 15 (relating to reporting requirements).
Yes _____ No _____ N/A _____	M. Section 22 (relating to filing requirements for marketing).

Yes _____ No _____ N/A _____

- N. Section 23 (relation to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.
- O. Section 24 (relating to suitability).
- P. Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).
- Q. The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in section 7702B(g)(4) of the Internal Revenue Code of 1986 (26 U.S.C. 7702B(g)(4)).
- R. Section 29 (relating to standard format outline of coverage).
- S. Section 30 (relating to requirement to deliver shopper’s guide).

(2) Are the following requirements of the 2000 Model Act met with respect to all policies (including certificates issued under a group insurance contract) intended to be covered under the Partnership that are issued on each of the policy forms identified in section I.B above?

Yes _____ No _____ N/A _____

- A. Section 6C (relating to preexisting conditions).
- B. Section 6D (relating to prior hospitalization).
- C. The provisions of section 8 relating to contingent nonforfeiture benefits.
- D. Section 6F (relating to right to return).
- E. Section 6G (relating to outline of coverage).
- F. Section 6H (relating to requirements for certificates under group plans).
- G. Section 6J (relating to policy summary).
- H. Section 6K (relating to monthly reports on accelerated death benefits).
- I. Section 7 (relating to incontestability period).

In order for a policy to qualify as a Long-Term Care Insurance Partnership Program Policy, the answers to all questions above should be “yes” (or “N/A” where all requirements with respect to a provision above are not applicable). If answers differ between policy forms (e.g., a requirement would be answered “Yes” for one form and “N/A” for another), you should use separate Issuer Certification Forms for such policies.

**III. CERTIFICATION**

I hereby certify that the answers, accompanying documents, and other information set forth herein for certification of the listed policy form or forms are to the best of my knowledge and belief, true, correct, and complete and that the policies identified in this form meet all of the consumer protection requirements pertaining to qualified Long-Term Care Insurance Partnership Policies. I understand that false, inaccurate or incomplete information on this form or accompanying documents may result in disapproval of listed policies for use in Kansas and other administrative sanctions.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**Contact Information:**

Name of Certifying Officer: \_\_\_\_\_

Title of Certifying Officer: \_\_\_\_\_

Name of Company Contact  
(If other than certifying officer) \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

ASSET DISREGARD NOTICE  
FOR LONG TERM CARE PARTNERSHIP POLICIES

At the time of issuance, this long term care insurance policy qualifies as an Kansas Long-Term Care Partnership Program policy. This means that an amount of your assets equal to the dollar amount of long term care insurance benefits paid under this policy will be disregarded for purposes of determining eligibility for Medicaid. As a result, you may qualify for coverage of the cost of your long-term care needs under Medicaid without first being required to substantially exhaust your personal assets. Please note that this policy may lose Partnership Program status if you move to a different state or you modify the coverage after issue. This policy may also lose Partnership Program status due to changes in federal or state laws.

If you have questions regarding long term care insurance and the Kansas Long-Term Care Partnership Program, you may contact the Kansas Department of Insurance. If you have questions regarding the current laws governing Medicaid eligibility and asset disregard, you should contact the Medicaid Division of the Kansas Health Policy Authority.