REPORT OF THE
STATE CORPORATION COMMISSION'S
BUREAU OF INSURANCE AND THE
DEPARTMENT OF MEDICAL ASSISTANCE
SERVICES TO STUDY AND REPORT ON

Changes Needed to Implement Private Insurance Coverage for Patients in Nursing Homes

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

House Document No. 35

COMMONWEALTH OF VIRGINIA
RICHMOND
1987

THOMAS P. HARWOOD, JR.
CHAIRMAN

ELIZABETH B. LACY
COMMISSIONER

PRESTON C. SHANNON
COMMISSIONER

COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

MARY LYNNE BAILEY
DIRECTOR

DIVISION OF INFORMATION RE
BOX 1197
RICHMOND, VIRGINIA 23.
(804) 786-7141

January 16, 1987

TO: The Honorable Gerald L. Baliles
Governor of Virginia
and
The General Assembly of Virginia

The report contained herein is pursuant to House Joint Resolution No. 87 of the 1986 Session of the General Assembly of Virginia.

This report represents the response of the State Corporation Commission's Bureau of Insurance and the Department of Medical Assistance Services to the legislative directive to study and report on changes needed in order to implement private insurance coverage for patients residing in nursing homes.

Respectfully submitted,

Thomas P. Harwood, Jr., Chairman

Elizabeth B. Lacy, Commissioner

Preston C. Shannon, Commissioner

COMMONWEALTH of VIRGINIA

RAY T. SORRELL
DIRECTOR

BRUCE U. KOZLOWSKI
DEPUTY DIRECTOR

Department of Medical Assistance Services

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219

January 23, 1987

MEMORANDUM

TO: The Honorable Members of the General Assembly

FROM: Ray T. Sorrell Ray Sorrell

SUBJECT: Report on Encouraging the Development of Private Long-Term Care Insurance

It is with pleasure that I present to you the study report prepared in response to House Joint Resolution No. 81 approved by the 1986 session of the General Assembly.

This report, which was prepared jointly by the Department of Medical Assistance Services and the State Corporation Commission, recommends legislation that promotes the availability of long-term care insurance. The study further recommends the continued study of tax-incentives, the use of reinsurance and the monitoring of legislation enacted by other states.

The availability of long-term care insurance has the potential after several years of reducing some of the costs to the Medicaid program for these services.

RTS/ml

Enclosure

Table of Contents

I. EXECUTIVE SUMMARY

The State Corporation Commission's (SCC) Bureau of Insurance and the Department of Medical Assistance Services (DMAS) were requested by the 1986 General Assembly in House Joint Resolution No. 87, introduced by Delegate Bernard S. Cohen, to review the need for and feasibility of enacting legislation that would encourage private insurance coverage for long-term care. This request was made because of the high cost of nursing home care, the large expenditures for nursing home care by the Commonwealth, and the projected continued increase in the elderly population of Virginia.

An advisory committee consisting of representatives of consumer groups, long-term care providers, insurers, and other interested parties was formed to assist the SCC and DMAS. The advisory committee has recommended the adoption of legislation that is similar to the newly adopted National Association of Insurance Commissioners (NAIC) Model Act. Section IX contains the advisory committee's recommendations.

The SCC and DMAS support legislation similar to the recommendation of the advisory committee. However, modifications are suggested to provide additional and, what is believed by the SCC and DMAS, necessary protection for the consumer.

The advisory committee, the SCC, and DMAS also recommend investigation of areas related to the development of private long-term care insurance, as well as monitoring the initial effects of the proposed legislation, if enacted. The additional areas of concern include further study of tax incentives for insurers and consumers. The SCC and DMAS will report the need for any further legislation to the General Assembly, as appropriate.

All participants in the study support the development and circulation of a consumer guide for long-term care insurance, in addition to other types of educational aids to improve the awareness of the public about the need for protection for long-term care. One of the surveys conducted as part of the study confirmed the lack of awareness by Virginians of the cost of nursing home care and how it is paid. The average cost for nursing home care in Virginia varies from $15,000 to $26,000 per year.

This report also contains information about the activities of other states as they attempt to deal with the area of long-term care. National activity in this area is also included to provide a complete picture of the scope of the problem.

At the present time there is not a great deal of long-term care coverage available in either Virginia or the United States. The adoption of the legislation as proposed by the advisory committee, and modified to include SCC and DMAS recommendations, will be helpful in encouraging insurers to develop long-term care insurance products.

GENERAL ASSEMBLY OF VIRGINIA -- 1986 SESSION

HOUSE JOINT RESOLUTION NO. 87

Requesting the Bureau of Insurance, with the Department of Medical Assistance Servic to conduct a study concerning changes needed in order to implement private insura coverage for patients residing in nursing homes.

Agreed to by the House of Delegates, February 10, 1986
Agreed to by the Senate, March 6, 1986

WHEREAS, in the United States, an estimated one-half of all nursing home patients who enter as private paying patients become indigent within a two-year peri_, and

WHEREAS, nursing home reimbursement is the largest line item in the Commonwealth's Medicaid budget; and

WHEREAS, most elderly people are unaware that Medicare will only reimburse a maximum of 100 days of skilled nursing care; and

WHEREAS, the growth of the elderly population in Virginia is increasing at a rate higher than the national average; and

WHEREAS, the high cost of nursing home services can be traumatic and devastating to not only the patient but also the family, who are usually in the position of caring for the patient, and, in some cases, causes the deterioration of familial relationships; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Bureau of Insurance, with the Department of Medical Assistance Services, with the assistance of other individuals, groups and agencies as it deems appropriate, conduct a study, to review the need for and feasibility of enacting legislation which would specifically encourage private insurance coverage for long-term-care coverage. The study should include, but not be limited to, the identification of barriers in the current state statute to the provision for such insurance, as well as potential tax incentives, educational requirements, public awareness programs and consumer guides that would be needed in order to make this type of insurance feasible.

The Bureau of Insurance and the Department of Medical Assistance Services sh report their findings and recommendations to the General Assembly prior to the 19 Session; and be it

RESOLVED FURTHER, That the Clerk of the House of Delegates transmit copies of this resolution to the Directors of the Bureau of Insurance and the Department of Medical Assistance Services.

III. INTRODUCTION

The State Corporation Commission's Bureau of Insurance and the Department of Medical Assistance Services were directed by House Joint Resolution No. 87, introduced by Delegate Bernard S. Cohen, to review the need for and feasibility of enacting legislation that would encourage the development of insurance for long-term care.

An advisory committee to the State Corporation Commission's Bureau of Insurance and the Department of Medical Assistance Services was formed and met four times over the course of the study. The advisory committee was composed of representatives of interested consumers, long-term care providers, insurers, and other state agencies, labor, and business. State Corporation Commission and Department of Medical Assistance Services personnel also attended the advisory committee meetings. Additional meetings were held by individual components of the committee.

The term "long-term care" includes a variety of services that are provided to individuals who have a need for services that are vital to the well-being of the individual for an extended period of time. Long-term care for the purposes of this report includes any nursing home stay, whether in a skilled, intermediate, or custodial care facility. Long-term care also includes health care that is given to people in their own homes and care given those individuals who choose to live in facilities that provide housing and medical care in a community setting for a fixed monthly charge. Although long-term care is often viewed as a service that is rendered to the elderly, the elderly are not the exclusive users. Long-term care is used by many individuals who are handicapped, or need rehabilitative services, or who may need constant care as a result of accidental injury or incapacitating sickness. While this segment of long-term care users is considerably smaller, it is important to recognize that those individuals also need care for extended periods of time.

The current number of Virginians over age 80 is approximately 95,000. By the year 2000 that number will almost double to 179,000. At the same time, the role of the family in the care of individuals needing care has undergone considerable change in the past decades. Many of the individuals who are presently nursing home residents, in the past would have been cared for by family members in a home environment. Today, with many more women in the work force, the traditional home care giver is not available to provide care on a round-the-clock basis. Additionally, the increase in single parent families, multiple marriages, and siblings with different parents may further reduce traditional reliance on the family to provide care for its elderly members.

The increasing need for institutional long-term care is easily recognized. What is not widely recognized by the general population however, is how costly this care is, ranging from $15,000 to $26,000 on the average per year in Virginia. Additionally, there is a general lack of awareness on the part of the public concerning the potential sources of payment of these costs. Erroneously, our citizens believe that this care is covered either by Medicare or private insurance policies that are sold as supplements to Medicare coverage. The Medicare program does not cover the long-term needs of those over 65, nor was it ever intended to cover those needs. It is a program designed to cover the acute health care needs of the elderly.

The need for private coverage for long-term care has been studied extensively on the national level. The financial impact of long-term care on individuals is usually devastating. According to national studies, the life savings of the majority of individuals are depleted within two years of entering a nursing home. This problem is projected to increase in the coming years as the population of the United States continues to "grow grey." We are living longer and healthier lives, but the longer life span results in an increasing need for long-term care services.

The financial impact of long-term care is also potentially devastating to the budgets of the individual states, and as a result general research on long-term care is being conducted on the state level. Most states, including Virginia, revised the coverage of their medical assistance programs (Medicaid) during the 1970's to include coverage for intermediate care, along with skilled care and home health services. The increasing reliance on Medicaid for long-term care is straining the budgets of many states, including Virginia.

There are numerous needs that must be addressed if we are to solve the dilemma of long-term care. There is the need to protect the public from the financial consequences of long-term care and a need to stimulate the development of affordable insurance to cover long-term care. The stimulation of the market should not be detrimental to those individuals who purchase long-term care insurance. A balanced approach must be used to resolve this problem.

IV. ADVISORY COMMITTEE

The advisory committee that was formed to assist the State Corporation Commission (SCC) and the Department of Medical Assistance Services (DMAS) provided invaluable assistance. The SCC and DMAS gratefully acknowledge their assistance.

Dr. Robert T.C. Cone, Chairman	Consolidated Health Care, Inc.
John G. Barrie	Virginia Power
Jack Boritas	Metropolitan Life
Peter C. Clendenin	Virginia Health Care Association
William Egelhoff	Virginia Center on Aging
Wilda M. Ferguson	Department for the Aging
Ronald Hagan	American Association of Retired Persons
Regenia G. Jamerson	Health Insurance Association of America
D. Patrick Lacy, Jr.	Group Hospitalization Inc.
Brenda Larsen	Blue Cross/Blue Shield Association
David H. Laws	AFL-CIO
Dr. James McAuley	Center for Gerontology, Virginia Polytechnic Institute and State University
Roberta B. Meyer Robert J. Demichelis	American Council of Life Insurance
Margaret M. Parker Althelia Battle	The Life Insurance Company of Virginia
Edna Paylor	Virginia Association for Non-Profit Homes for the Aging
Dr. Brian Rasmussen	Blue Cross/Blue Shield Association
Dr. Louis Rossiter	Virginia Commonwealth University
Charles H. Wilson III	Blue Cross/Blue Shield of Virginia

V. STATEMENT OF PROBLEM

Increasing the availability of private insurance coverage for long-term care is being recognized as a crucial concern as the growth of the population over 65 continues to increase. The financial cost of caring for those individuals needing long-term care frequently exceeds the budgets of families, the state and federal governments. The statistics included in the National Association of Insurance Commissioners (NAIC) Advisory Committee Report on long-term care show the 1984 national long-term health expenditures of the elderly to have been financed primarily through out-of-pocket payments.

Total 1984 Long-Term Care	$25.1 billion
Out-of-pocket	50.1%
Medicaid	41.5
Medicare	2.1
Other Govt. Programs	4.4
Private Insurance	1.1
Other	.8

Given the tightening of the federal budget for all spending and the increasing financial responsibility of states for social programs, the need to develop private insurance is apparent.

The area of long-term care insurance development has been characterized as having three major problems:

- Lack of awareness by consumers, and the resultant low demand for insurance.
- Low availability of insurance because of insufficient data and great potential for adverse selection.
- Limited coverage provided by products currently marketed.

Consumer Awareness

There is a lack of awareness of the need for private insurance by the public. The majority of individuals surveyed nationally, as well as in Virginia, are not aware that Medicare does not cover nursing home stays for other than 100 days of skilled care. The national poll done for the American Association of Retired Persons (AARP) indicates that 79% of the public believe that Medicare would pay for all or part of their stay in a nursing home. The survey conducted of Virginians for this study indicates that 75% of the individuals surveyed thought that Medicare would pay for custodial nursing home stay. The public is also unaware of the likelihood that they will need long-term care. Estimates are that one out of every two Americans will need professional long-term care after age 65.

A major educational effort is necessary to correct the misconceptions of the public about their own probable need for long-term care and to inform them of the reality of how the costs of that care are likely to be paid.

Limited Availability of Insurance

As the Bureau of Insurance and the Department of Medical Assistance Services began this study it was necessary to determine the availability of long-term care products. Currently, there are at least 14 companies who have policies approved in Virginia that cover nursing home care. The policies vary as to the type of coverage that is offered; skilled, intermediate and/or custodial care, home health benefits; the length of time that they provide coverage, and the cost of the coverage. However, insurers are expressing increased interest in this segment of the insurance market. Information from a mail survey of accident and sickness insurers that write a substantial amount of the health coverage sold in Virginia indicates that another 11 insurers plan to test market or market a long-term care product in the next 12 months. Eight of the 14 companies that have policies available here have been approved in the last two years. The test of an indemnity long-term care product by a major insurer to AARP members in six states was conducted in the fourth quarter of 1985. A second test of AARP members in eight states was scheduled for the end of 1986. Although much of the data from the AARP test is not public, it has generated a great deal of interest and the preliminary indications are that the market is a viable one.

Insurers have been reluctant to enter the long-term care market for a number of reasons. They perceive a low demand for this product based on the lack of awareness by the public of the need for coverage, as well as a great potential for adverse selection, and a lack of actuarial data for effective product pricing. The policies now available have primarily been sold to people as they near age 80. For insurance to work properly a large pool of individuals is needed to share the losses of some of those individuals. There is a need for younger segments of the population to purchase this insurance, but there is an apparent reluctance by individuals in their 20's and 30's to purchase what is viewed as "nursing home insurance". Many young people with limited funds focus on their immediate insurance needs, such as basic health coverage, automobile, homeowners, life, and disability insurance. Many of these individuals feel that they cannot afford to spend additional money to cover a need that they will not face until they reach age 70 or 80.

The majority of the policies available at this time are indemnity products. They pay a predetermined amount for each day's stay in a nursing home irrespective of the actual cost of the stay. Indemnity products allow companies to project their losses with much more certainty than other types of products; products that would pay the entire cost of care or a certain percentage of the cost of care. General economic theory predicts that a consumer will tend to increase his consumption of a given good or service if he believes the price of that good or service understates the cost of providing the good or service. In the case of an insurance product, once the consumer pays the policy premium, he considers the cost of the service to be zero (free). As a result, the insured consumer has an incentive to use more of the service that the uninsured consumer does not have. On the other hand, others believe that the costs of nursing home care in the absence of an insurance product are indicative of the cost of care if long-term care insurance were more readily available. Supporters of this position state that the use of these services will not change with the introduction of a long-term care insurance product. Many insurers do not feel that the existing data is sufficient to support the sound actuarial pricing and underwriting of long-term care products but feel that a combination of the existing data and additional research are necessary before products, other than the indemnity type, can be properly developed.

Some insurers also believe that the regulatory requirements of states do not recognize the need for a different approach to long-term care product development and are too restrictive to allow creation of the type of products that might be best suited to long-term care needs. One example cited is a product combining cash values and other non-forfeiture options with long-term care. The majority of respondents to the survey of insurers indicated that they feel that Virginia's current insurance requirements do not contain any unnecessary barriers to developing long-term care products. However, some of the respondents did comment on the lack of flexibility that exists to permit the combination of investment type vehicles with long-term care coverage.

Limited Coverage by Present Products

The majority of policies currently sold are indemnity products, as previously mentioned. These products have restrictions on the number of days coverage that they will provide, as well as the type of services that they will pay for (skilled, intermediate, custodial, home health). The types of coverages that are provided are not always consistent with the care the individual actually needs and receives, and policy definitions also may vary from company to company.

Currently, there is disagreement on the most effective way to address this problem. Some individuals believe that the answer to this problem is strictly requiring or "mandating" exactly what coverages should be included in any long-term care policy. Others feel that, at this stage of product development, mandates will be extremely discouraging to companies considering entering the market.

The solutions to these problems must consider the perspectives of all those involved including the public, insurers, long-term care providers, and the regulators charged to oversee this area. Consumers must be better educated about the need for long-term care coverage. Individuals need to be made aware of the likelihood that they or a family member will need long-term care services as well as the actual cost of that care and that long-term care is not covered by Medicare or Medicare Supplement policies.

From an insurance company perspective, an attractive potential market must be developed, and actuarially sound data must be available to effectively design and price a product. Many feel that companies should be allowed a great deal of flexibility in the long-term care market so that there can be innovative attempts to develop products that will be attractive to consumers, affordably priced, and actuarially sound.

Long-term care providers generally favor the availability of products that will cover all or most of the types of long-term care that are usually required, for the length of time the services are utilized. Some long-term care providers have voiced a preference for legislation or regulation that requires specific provisions and coverages to be included in any long-term care policies. Opponents of this type of approach believe that a policy that would cover all of the types of care that could be needed for the maximum duration of time that care would be provided would not be affordable for the majority of individuals.

Whatever the solution, the interests of the public must be protected without unnecessarily impeding the development of the market.

VI. IMPACT OF LONG-TERM CARE ON THE MEDICAL ASSISTANCE PROGRAM

The Medical Assistance Program, commonly referred to as Medicaid, is a federal/state health care financing program which makes available a comprehensive continuum of medical and health services to Virginia's poor citizens. Two groups of indigent citizens are eligible for Medicaid. The first group - the categorically needy - includes the aged, blind, disabled, foster children and families with dependent children who may receive public assistance payments under Aid to Families with Dependent Children (AFDC) or the Supplemental Security Income program (SSI). The second group - medically needy - includes those persons who, with the exception of income and resources, would be eligible for the AFDC and SSI public assistance payment programs; persons in this group are able to provide for their food, clothing and shelter, but do not have sufficient funds to pay for medical care.

Eligibility for Medicaid is determined by local Departments of Social Services. All Medicaid recipients must be United States citizens or lawfully admitted aliens, and must be residents of Virginia. All eligible persons can receive any service provided by the state Medicaid program unless an age or service restriction exists. In addition to category-related criteria (aged, disabled, blind or a dependent child), there are also financial eligibility requirements for income and resources.

The state is divided into three locality groups (see Appendix II). Income standards for each group are determined by the cost of shelter for the area and are based on the flat grant system of payments for Aid to Families with Dependent Children. Financial resources are also considered in determining eligibility. Persons with income in excess of the established guidelines may be eligible for medical assistance if the excess is insufficient to meet the total cost of needed medical care.

INCOME LIMITS FOR ELIGIBILITY UNDER MEDICAID
FY 1986

Number of Persons in Family Unit	Group I Annual Income	Group II Annual Income	Group III Annual Income
1	$2600	$3000	$3900
2	3400	3700	4800
3	3900	4300	5300
4	4400	4800	5800
5	4900	5300	6300
6	5400	5800	6800
7	5900	6300	7300
8	6500	6900	7800
9	7100	7500	8500
10	7800	8200	9100
Each Additional Person	600	600	600

For categorically-needy and certain medically-needy persons, eligibility continues as long as need exists and other eligibility requirements are met. For some medically-needy persons with excess income, eligibility exists for a maximum of six months. They must reapply at the end of that period.

The resource standard for Medicaid is currently $1700 for one person, $2500 for a couple and $100 for each additional person in the family unit. Certain resources such as the home and $5000 worth of contiguous property, one automobile, etc. are exempted in determining eligibility for Medicaid. Skilled and intermediate nursing home services represented $198.5 million or 31% of all Medicaid expenditures in 1986. 21,102 Medicaid clients received nursing home services at some time during that year.

Approximately 33% of all nursing home patients in Virginia are private pay. Medicaid pays some or all of the costs for the remainder. 78% of the Medicaid recipients in nursing homes are medically needy and therefore have excess income or insurance which is used to offset the total cost of their care. Therefore, most Medicaid nursing home patients are paying some portion of their nursing home costs.

Many individuals who enter a nursing home, do so as a private pay patient using their income and (or) savings to pay for their care. However, the high cost of care ($15,000 - $26,000 per year) soon consumes whatever savings they have, making it impossible for them to continue paying the full cost of their care.

A recent study of the 1985 Medicaid nursing home admissions data indicates that within two years, 77.4% of patients who originally entered as private pay began receiving assistance from Medicaid.

DURATION OF PRIVATE PAY STATUS BEFORE CONVERSION TO MEDICAID

TIME FRAME	PERCENT
0-3 months	21.0%
4-6 months	14.3%
7-9 months	14.4%
10-12 months	7.6%
13-24 months	20.1%
25-36 months	11.1%
over 36 months	11.5%
	100.%

Based on recent demographic information and the high cost of nursing home care, Virginia is faced with a tremendous challenge to meet the needs of her citizens for the next 15 years. Between 1980 and the year 2000, Virginia's population of citizens 60 years and older is projected to increase 24%. The population of citizens 80 and over is projected to increase 87%. This is especially important because this group represents 58% of the current Medicaid nursing home cohort. The following table shows the current demographics of Medicaid elderly in nursing homes.

AGE	% OF POPULATION
60	7%
60-64	4%
65-69	6%
70-74	10%
75-79	15%
80-84	18%
85+	40%
	100%

SEX (Approx.)

Males	Females
27%	73%

Medicaid was created as a program to serve the poor. Because of the high cost of nursing home care, it has quickly become a program serving the middle class, at least after they have exhausted their personal resources. No one wants to spend a lifetime accumulating a home and savings only to lose it to pay for needed nursing home care. Conversely, as a program for the poor, the Medicaid standards for allowable income and resources will remain low. The cost impact of changing the Medicaid financial eligibility criteria would necessitate additional expenditures of Federal and State funds at a time when Federal participation is declining. Additionally, adjustments in Medicaid eligibility criteria would be counterproductive to the desire to increase public interest in purchasing long term-care insurance by making more people eligible for and, therefore, dependent on Medicaid to pay the cost of nursing home care. With increased access to Medicaid, middle income people will find it less desirable to expend income on long-term care insurance. It is the desire to avoid expending all income and resources in order to access Medicaid which will motivate middle income citizens to use a portion of spendable income in the present to provide an insurance resource to meet future long term-care needs.

Low income individuals will never provide a viable market for long-term care insurance because they do not have income sufficient to meet present needs of food, shelter, and clothing. They rarely can set aside savings and would not easily be persuaded to use their meager resources for future needs. The best markets for long-term care insurance exist among middle and upper income persons who wish to protect future accumulated resources by purchasing long-term care insurance.

LTC insurance could be a very effective vehicle for meeting the needs of our elderly, especially if it were affordable by the middle class and paid a sizeable portion of the daily rate for nursing home or home care which could be supplemented by personal income and savings. Since the average patient only spends 24 months in a

nursing home, it is possible that the availability and purchase of a comprehensive plan of LTC insurance could feasibly protect the resources of citizens requiring nursing home or home care, thereby reducing Medicaid's liability.

It is not possible to project the potential impact at this time, as the few existing policies available are quite restrictive in amount, duration, and scope of services provided. Once comprehensive long-term care insurance plans are developed in Virginia and the cost, benefit limits, and scope of services of the basic policies are defined, it will be possible to do some projection on the future potential impact on Medicaid. It may also be appropriate to reexamine the income, resource, and spend-down requirements at that time.

In the interim, Medicaid's greatest contribution can be the provision to the insurance industry of the comprehensive demographic information it has on nursing home patients to facilitate the industry's actuarial needs.

We support the development and expansion of long-term care insurance as a vehicle to offset the high cost of nursing home and home care.

VII. NATIONAL ACTIVITY

There has been considerable activity in the area of long-term care on the national level. A federal task force is currently studying long-term care as the result of legislation that was proposed by Congressman Ron Wyden. Congressman Wyden expressed the desire that the task force prepare an action plan that will result in making more private insurance available for long-term care. The task force began meeting in September, 1986 and will make its report in July, 1987. The task force is planning to make recommendations to states to assist them as they wrestle with the economic and social problems of long-term care, and not to mandat tion that the states must institute. The task force plans to develop recommendations to assure access to information by consumers that will permit them to make informed purchase decisions, to assure that policy benefits are reasonable in relationship to premiums, to promote the development and marketing of long-term care insurance, and to limit market abuses. The Department of Health and Human Services will report to Congress on state action on the task force's recommendations 18 months after the report is distributed to the states.

Another federal task force under the direction of Secretary of Health and Human Services Otis Bowen studied the need for insurance for catastrophic illness. The Secretary made his report in November, 1986. The report recommends the expansion of Medicare to limit a beneficiary's out-of-pocket expenses for all covered services to $2,000. Bowen also recommended that people under age 65 begin saving more money to pay for long-term medical care. He proposed that people under age 65 should be allowed the option of opening tax-favored individual medical accounts that could only be used to pay for long-term medical care. He also suggests that tax incentives may be a way to encourage the insurance industry to offer more long-term care policies. Reaction to the Bowen proposals has been mixed. Many observers doubt the success of these recommendations when, over the past six years, the participation of the federal government in the funding of social programs has been reduced.

Several bills were introduced in the 99th Congress that would have either offered federal tax benefits to taxpayers who pay for the care of an elderly dependent, or would have expanded the role of the federal government in the financing of long-term care. None of the bills were successful, but the activity in this area (at least 18 such bills were introduced) is indicative of the recognition of the long-term care dilemma on the federal level.

The National Association of Insurance Commissioners (NAIC) is the organization of state regulators of insurance that work together to provide a forum for the exchange of ideas and to assist in the formulation of uniform policy. The NAIC assists regulators in maintaining and improving state regulation of insurance. The NAIC began studying long-term care in 1985. The industry advisory committee to the NAIC produced a very extensive and detailed report that was released for review in June, 1986 and finalized in December, 1986. The industry advisory committee recommended the adoption of model legislation to encourage companies to enter the long-term care market. The NAIC made some revisions to the industry model at its December, 1986 meeting and adopted the revised model.

Studies are also being conducted, or have been completed, by nationally recognized independent organizations such as the Brookings Institute, the Stanford Research Institute, and Harvard University, as the impact of long-term care is felt across the country.

VIII. STATE ACTIVITY

Fourteen other states are either currently studying or have recently completed studies in the area of long-term care and insurance coverage. Another fourteen states have, in the past five years, passed some type of legislation that covers long-term care insurance issues. This past year legislation was proposed or is still pending in yet another six states. The fact that a majority of states are currently active in this area is further evidence of both the importance and magnitude of the problem.

The legislation that has been passed recently has largely focused on increasing the availability of private long-term care insurance, which is part of the charge of this study. The methods that six other states have implemented, or are strongly considering, are detailed below along with information about the actual or anticipated results of their changes. The approaches of these states vary considerably and the results of their actions will be very useful in future decision-making.

New York

The state of New York enacted legislation, effective on July 1, 1986, that allows the New York Insurance Department some flexibility in approving experimental plans. Authority is specifically given to the Superintendent of Insurance to waive or limit statutes and regulations that would be applicable to long-term care policies without the legislative changes.

As of December 1, 1986, there were only three long-term care policies approved for sale in New York. There are currently forms awaiting approval, but they are the indemnity type policy that is presently available throughout the country. However, the New York Insurance Department reports that it has received a number of inquiries from insurers and feels that some companies may be filing innovative policies in the future. The New York law requires that insurers report their experience data to the insurance department. The department may then use that information for research and to prepare reports on long-term care.

Colorado

Legislation effective July 1, 1986, was passed in Colorado that provides tax incentives for consumers who purchase long-term care policies and insurers who offer long-term care policies. The law provides that on or after January 1, 1987, the tax on premiums for long-term care policies be reduced by one percent. The law also provides that any person paying premiums for a long-term care policy that is certified by the commissioner may receive a deduction on their income taxes for an amount equal to the total premiums paid for the long-term care policy. A regulation has been drafted that was effective December 31, 1986, which provides basic requirements that long-term care policies must meet to receive certification from the commissioner.

The Colorado Department reported that a number of previously approved policies have been resubmitted to receive approval for a premium tax reduction. Currently, approximately twenty policies have requested certification. At this point it is too early to gauge the success of the legislative changes but insurance department personnel are optimistic.

Arizona

The Governor's task force on long-term care made its report in January, 1986. The task force was charged to review the state of long-term care financing with regard to the insurance industry and to evaluate the desirability, feasibility, and barriers to the development of private long-term care products. After completing the study, the task force found that no new legislation or revisions to current laws or regulations were necessary in Arizona. The task force did recommend that the Arizona Department of Insurance continue to be flexible in its regulatory approach to long-term care policies. The task force also recommended that the Arizona Department of Insurance develop a prototype or model policy covering home or community based care and encourage health insurers to offer this type of coverage. A recommendation was also made for the study of the establishment of a long-term care risk pool in the state.

Kentucky

A law passed in Kentucky that becomes effective July 1, 1987, is expected to create considerable change in the health insurance market in that state. The Kentucky law requires all insurers that issue individual health policies providing coverage on an "expense incurred" basis develop a policy to provide long-term health care in a long-term health care facility licensed by the Commonwealth of Kentucky. Insurers issuing group or blanket policies and certificates on an expense incurred basis, as well as non-profit hospital, medical-surgical, dental, and health service corporations and health maintenance organizations shall "make available" to the master policyholder, enrollee or subscriber the option for the long-term health care benefits that are required to be offered to individual expense incurred policyholders. The law contains a minimum loss ratio requirement of 75% of the total cost of covered care and requires that coverage be included for skilled, intermediate, and custodial care.

There are currently 23 companies offering long-term care policies in Kentucky. No policies have been filed since this legislation was passed. A regulation is now being developed and will probably not be finalized until February. At the December, 1986 hearing on the proposed regulation, alternatives were proposed by at least two other groups. Some support was expressed for use of the recently adopted NAIC model as an alternative approach.

There has been speculation that some companies may be forced to withdraw from writing health coverage in Kentucky because of the difficulty in complying with the law. Some insurers feel that the products developed to meet the Kentucky requirements will be so expensive that there will be no market for them. The NAIC advisory committee agreed with the assessment that policies may be unaffordable.

Massachusetts

The Massachusetts Division of Insurance requested an evaluation of the existing insurance regulation in the state with regard to the appropriateness of the use of accident and health insurance regulations for long-term care insurance, and the protection afforded long-term care policy purchasers under current regulations. The report to the Insurance Commissioner from the independent group that assisted the department with the study made several recommendations for implementation. None

of the recommendations have been adopted as of December, 1986, but final decisions are expected to be made in the Spring of 1987. The report recommended, in part, that standard definitions be set by the Insurance Division for "skilled, intermediate, and rest home/convalescent levels of care and home health benefits" to standardize and simplify policy terminology and definitions. The report also recommends that the Insurance Division consider adopting one of two alternatives providing for minimum benefits. Both alternatives incorporate minimum standards for elimination periods, preexisting conditions, and mental and nervous disorder coverage. The alternatives differ in that one requires that all policies offer skilled and intermediate care coverage that meet a minimum level of coverage. Insurers would then be allowed to offer other coverages as options. The second alternative does not prescribe specific requirements in terms of the minimum range of benefits to be provided. Companies would be able to offer any combination of coverages as long as the benefits included meet the minimum standards for that benefit. The report also recommends that the Division reserve the right to approve innovative policies that do not meet all of the requirements of the regulation and that legislation might be considered to facilitate new types of long-term care products.

Wisconsin

Wisconsin promulgated a regulation in 1981 that defined the type of nursing home insurance that could be sold in that state. The regulation was intended to reduce abuses and confusion in the sale of nursing home coverage by providing minimum levels of coverage. These standards required policies to cover at least one year of coverage, prohibited a prior hospitalization requirement, set minimum daily indemnity payments, and provided that coverage could not be limited to skilled nursing care. After Wisconsin instituted this regulation, only one insurer continued to offer any long-term care insurance in the state. The remaining insurer stopped advertising its product.

In 1985, a study was completed on the feasibility and advisability of promoting private insurance coverage of long-term care. The report discussed several options for the state to consider to increase long-term care insurance, including allowing insurers to limit use of skilled nursing or home health care coverage, and subsidizing group insurance premiums for the elderly who are low income and at risk of needing Medicaid coverage after institutionalization. Last year, the insurance department proposed changes to Wisconsin's laws and regulations that would allow a prior hospitalization requirement under some conditions and would allow insurers to limit coverage to skilled and intermediate care, and to exclude benefits for custodial care. The proposed changes are currently being considered.

IX. ADVISORY COMMITTEE RECOMMENDATIONS

A total of four committee meetings were held at which members with varying perspectives were given an opportunity to address the committee with specific problems and recommendations associated with long-term care. In addition, representatives from the NAIC's advisory committee made presentations regarding long-term care products.

The Advisory Committee Report to the NAIC was read by all committee members. Presentations were also made to committee members concerning the present status of regulation in other states, and federal activity in this area. After studying the NAIC report and being briefed on other general studies and legislative activity, the committee was also informed of the present impact of long-term care services on the Medicaid program, and the current availability of long-term care insurance in Virginia and existing regulatory requirements. The advisory committee to the SCC and DMAS then decided to recommend legislation similar to the NAIC model law.

Numerous sub-committee meetings were held in order to incorporate the views of the committee after public testimony into revisions of the NAIC model act. The committee strived to be objective, analytical, and thorough in its analysis of the charges of HJR 87. It would be fair to state that all parties recognized the need to compromise in order to reconcile differences between the various perspectives. Those who participated in this effort showed a high degree of commitment to the ultimate public interest.

HJR 87 specifically requests that a study be done regarding "the need for and feasibility of enacting legislation which would specifically encourage private insurance coverage for long-term care coverage". The objective of encouraging private insurance coverage in the long-term care market was constantly at the forefront of the committee's deliberations and considerations. Conscientious consideration was given to the development of minimum standards for long-term care policies as being a desirable public interest goal. Offsetting that desire was the reality that requiring excessive benefits in long-term care policies could create a severe affordability problem which ultimately would lead to having no suppliers in the market, a condition which obviously would not serve the public interest. The committee was also sensitive to the fact that no regulation may allow a proliferation of inferior products, a condition which would not be in the public interest. Many hours were spent debating the various sides of this issue. The conclusion of the committee was that the consumer must be the one to make the ultimate decision regarding the purchase of this type of coverage. The consumer however, must be given the information required to analyze this purchase decision. Members of the committee believe that the recommendation regarding a consumer guide is vital and essential to the proper development of this market. This guide must be succinct in nature and have such an impact on the consumer that it will literally shock him or her into evaluating the policy being purchased. The development of this guide, which could in fact be partially based on the NAIC's model guide, should be the responsibility of the SCC with the assistance of an advisory committee comprised of representatives of all of the various areas interested in this product.

Additional recommendations were also made. The recommendations cover a wide variety of concerns which the committee believes merit additional research. It is the committee's recommendation that the SCC and other appropriate agencies continue to study the area of long-term care insurance. Public policy formed from this research should stimulate demand for a long-term care product, as well as increase the supply of this product.

Recommended Legislation

Chapter 50
Long Term Care Insurance

§ 38.2-5000. Definitions. - As used in this chapter:

"Applicant" means in the case of an individual long-term care insurance policy, the person who seeks to contract for such benefits, and applicant shall also mean in the case of a group long-term care insurance policy, the proposed certificate-holder.

"Certificate" means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this Commonwealth.

"Long-Term Care Insurance" means any insurance policy primarily advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual policies whether issued by insurers, fraternal benefit societies, health services plans, health maintenance organizations, or any similar organization.

"Group long-term care insurance" means a long-term care insurance policy delivered or issued for delivery in this Commonwealth and issued to any group which complies with §38.2-3523.

"Policy" means, any individual or group policy of insurance, contract, subscriber agreement, certificate, rider or endorsement delivered or issued for delivery in this Commonwealth by an insurer, fraternal benefit society, health services plan, health maintenance organization or any similar organization.

§ 38.2-5001. What Laws Applicable.

All policies shall comply with all of the provisions of this title relating to accident and sickness insurance policies generally, except Article 2 of Chapter 34 and Chapter 36. In the event of conflict between the provisions of this chapter and other provisions of this title, the provisions of this chapter shall be controlling. A policy that is not primarily advertised, marketed or offered as long-term care insurance is not required to meet the provisions of this chapter.

§ 38.2-5002. Standards for Policy Provisions.

A. The Commission may issue regulations to establish specific standards for policy provisions of long-term care insurance policies. These standards shall be in addition to and in accordance with applicable laws of this Commonwealth, and shall address terms of renewability, non-forfeiture provisions if applicable, initial and subsequent conditions of eligibility, non-duplication of coverage provisions, coverage of dependents, pre-existing conditions, termination of insurance, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definitions of terms.

B. Regulations issued by the Commission shall:

1. Recognize the unique, developing, and experimental nature of long-term care insurance;

2. Recognize the appropriate distinctions necessary between group and individual long-term care insurance policies; and

3. Recognize the unique needs of those individuals who have reached retirement age and the needs of those pre-retirement individuals interested in purchasing long-term care insurance products.

§ 38.2-5003. Prohibited Provisions. No long-term care insurance policy may:

A. Be cancelled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificateholder; or,

B. Contain a provision establishing any new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder.

§ 38.2-5004. Preexisting Conditions.

A. No long-term care insurance policy or certificate shall use a definition of "Preexisting condition" which is more restrictive than the following: Pre-existing condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment, or a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within twelve (12) months preceding the effective date of coverage of an insured person.

B. No long-term care insurance policy may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins twelve (12) months following the effective date of coverage of an insured person.

C. The Commission may extend the limitation periods set forth in subsections A and B above as to specific age group categories or specific policy forms upon findings that the extension is in the best interest of the public.

D. The definition of "preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards for long-term care insurance policies.

§ 38.2-5005. Prior Institutionalization.

A long-term care insurance policy which provides benefits only following institutionalization shall provide benefits to an insured if the insured has been discharged from the facility within the previous thirty days for the same or related conditions.

§ 38.2-5006. Rates.

A. No regulation shall establish loss ratio standards for long-term care insurance policies unless a specific reference to long-term care insurance policies is contained in the regulation. However, any individual long term care policies which, in the opinion of the Commission, could be classified as limited benefit policies shall be subject to limited benefit loss ratio standards.

B. The regulation promulgated under this section shall recognize the unique, developing and experimental nature of long-term care insurance and shall recognize the unique needs of those individuals who have reached retirement age and the needs of those pre-retirement individuals interested in purchasing long-term care insurance policies.

§ 38.2-5007. Disclosure.

In order to provide for fair disclosure in the sale of long-term care insurance policies:

A. An outline of coverage shall be delivered to an applicant for an individual long-term care insurance policy at the time of application for an individual policy. In the case of direct response solicitation, the insurer shall deliver the outline of coverage upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. Such outline of coverage shall include:

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

2. A statement of the exclusions, reductions, and limitations contained in the policy;

3. A statement of the renewal provisions, including any reservation in the policy of a right to change premiums; and

4. A statement that the outline of coverage is a summary of the policy issued or applied for, and that the policy should be consulted to determine governing contractual provisions.

B. A certificate delivered or issued for delivery in this Commonwealth shall include:

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

2. A statement of the exclusions, reductions and limitations contained in the policy; and

3. A statement that the group master policy should be consulted to determine governing contractual provisions.

C. The Commission shall adopt and publish a Long-Term Care Consumer Guide. After adoption and publication by the Commission, a copy of the Consumer Guide shall be provided at the time of delivery of the policy or certificate.

§ 38.2-5008. Right to Return - Free Look Provision

A. Individual long-term care insurance policies shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within ten (10) days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. A policy returned pursuant to the notice shall be void from its inception upon the mailing or delivery of the policy to the insurer or its agent.

B. Long-term care insurance policies or certificates issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page or attached thereto stating in substance that the insured person shall have the right to return the policy within thirty (30) days of its delivery and to have the premium refunded if after examination the insured person is not satisfied for any reason. A policy returned pursuant to the notice shall be void from its inception upon the mailing or delivery of the policy or certificate to the insurer or its agent.

Additional Recommendations

The advisory committee also recommends further study of the following issues:

- The value of public education by the Bureau of Insurance, the Department for the Aging, and others to inform consumers of the risk of long-term care expenses, the lack of long-term care coverage under Medicare and Medigap, and the availability of long-term care insurance.

- The estimated extent to which the Commonwealth's Medicaid spending would be reduced by purchase of long-term care insurance, and whether Medicaid "spend down" requirements should be reduced for persons purchasing long-term care insurance policies.

- The probable effect of tax incentives, including state income tax deductions or credits for individual and corporate purchasers of long-term care insurance, tax-favored Individual Retirement Accounts earmarked for long-term care coverage, and reduction of premium taxes and favorable treatment of insurers' reserve accounts for long-term care insurance.

- The availability of re-insurance for insurers and employers who offer long-term care coverage, and whether increased availability of re-insurance would improve consumer access to long-term care coverage.

Rationale for Additional Recommendations

The advisory committee concludes that issues relating to public education, Medicaid, tax incentives, and re-insurance deserve legislative consideration, but that the deadline for the advisory committee's report does not permit thorough study of these issues. However, specific points suggested for further consideration including the following:

1. Public Education. Nearly 80 percent of the elderly incorrectly believe that Medicare or Medigap will cover long-term care, according to the American Association of Retired Persons. This misperception substantially limits consumer demand for long-term care insurance, thereby increasing Medicaid spending and the elderly's out-of-pocket expenses for nursing home care.

   Consumers could benefit from a multi-media campaign describing long-term care insurance, similar to that now distributed by the Bureau of Insurance for Medicare Supplement Insurance. Several states also operate programs that compare coverage and other features of long-term care policies. Comparative information could be particularly important because state-of-the art policies vary widely on specific provisions, a situation consistent with the advisory committee's legislative recommendation broadly defining long-term care insurance.

2. Medicaid. Currently the Medical Assistance (Medicaid) program will cover persons needing skilled and intermediate levels of nursing home care once those persons meet state and federal eligibility requirements regarding their level of income and assets. Persons exceeding required income and assets must "spend down" their own funds for nursing home care prior to Medicaid coverage.

Persons who expect to need nursing home care in the future may decide to transfer their assets to family members to avoid the need to "spend down." Such action precludes Medicaid eligibility if done less than two years prior to nursing home admission or if evidence is clear that the transfer was for purposes of future Medicaid eligibility. But some persons still may be able to transfer assets more than two years prior to the time of institutionalization and achieve Medicaid coverage at admission to the nursing home.

Therefore, purchase of long-term care insurance could reduce Medicaid spending. A 1985 report prepared for the U.S. Department of Health and Human Services concluded that national Medicaid spending would decline 23 percent for persons aged 67 to 69 if half of all such persons bought long-term care policies that paid $40 per day for up to four years. If only one of five persons bought these policies, Medicaid spending for that age group would drop about 8 percent. Because persons over age 69 have a greater probability of being admitted to a nursing home, corresponding Medicaid savings probably would be even greater for those 70 or older who bought such policies.

However, this level of Medicaid savings might not occur in Virginia because the Commonwealth's eligibility criteria for Medical Assistance are more stringent than those of the "average" state. In addition, the extent to which Virginians would purchase long-term care insurance would depend in part on cost and coverage, which has not been established.

Nevertheless, if the net cost were reduced through tax incentives or lessened Medicaid spend down requirements after private coverage was exhausted, consumers would be more likely to buy the insurance. Additional study could estimate the Commonwealth's Medicaid savings based on various levels of consumer demand, as influenced by availability of a comprehensive affordable product, tax, and Medicaid incentives.

3. Tax Incentives. A variety of tax incentives could be used to reduce the net cost of long-term care insurance, thereby increasing its purchase. Because private long-term care insurance would reduce Medicaid spending, tax incentives might result in a net fiscal surplus to the Commonwealth. In addition, tax incentives could help educate the public about the need for long-term care coverage.

A key issue is the effect that tax incentives would have on purchase of insurance. Incentives would be ineffective and costly if consumers would purchase insurance even in their absence. But less than one-half percent of Americans are covered by long-term care policies. Consideration also could be given to encouraging employers to provide the alternative of a long-term care insurance benefit as a part of employee benefit packages. Thus, tax incentives might be helpful in promoting long-term care coverage.

The extent to which incentives would be helpful depends on the size and type of incentive. For instance, a tax-favored IRA earmarked for long-term care coverage and a state income tax deduction for long-term care insurance premiums might have very limited impact because of Virginia's low income tax rates. An income tax credit might be more effective and would equally benefit taxpayers at all income levels. Reduction of the insurance premium tax could lower the price for all Virginians, including the low-income who would not

benefit from income tax deductions. Favorable tax treatment of insurer reserves for long-term care coverage might also lower prices of some long-term care insurance products. But this would not improve affordability of coverage offered by tax-exempt hospital and medical service corporations, and would rely on the uncertainty that other insurers would pass on their tax savings to consumers.

Yet tax incentives are perhaps the most direct and visible way for the Commonwealth to encourage private long-term care insurance. Regulating the scope of long-term care policies will have little benefit if Virginians do not buy those policies. Therefore, tax incentives deserve serious consideration. Of course, any future federal tax incentives also will be important, both because such incentives would add to any existing under state law, and because Virginia's income tax deductions are "coupled" to those of the federal tax code.

4. Re-insurance. Protection for insurers and self-insuring employers against possible long-term care underwriting losses might improve availability of long-term care coverage. Some insurers and employers may be reluctant to offer this coverage because of a lack of claims experience. However, others are proceeding cautiously without re-insurance.

   Though less pressing than issues relating to public education, Medicaid, and tax incentives, a study of insurer and employer interest in re-insurance might be helpful in persuading private re-insurance companies to offer this protection.

X. ANALYSIS OF ADVISORY COMMITTEE RECOMMENDATIONS

Recommended Legislation

The committee recommends legislation that specifically applies to long-term care insurance. The legislation recommended applies to both group and individual contracts. Long-term care policies will be subject to all provisions of the title relating to accident and sickness insurance generally except Article 2 of Chapter 34 and Chapter 36, which deal with medicare supplement insurance and mandated benefits respectively. The authority of the State Corporation Commission to issue regulations to establish specific standards for policies is set out. The regulations are to recognize the experimental nature of long-term care insurance.

The definition of "long-term care insurance" includes policies or riders that offer coverage for at least 12 consecutive months for necessary "diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services provided in a setting other than an acute care unit of a hospital." This definition is sufficiently broad to include nearly all types of long-term care presently being offered, and to also cover types of care that could possibly be offered in the future. The definition includes the contracts issued by traditional insurers, health service plans (Blue Cross/Blue Shield plans), fraternal benefit societies, health maintenance organizations, or similar organizations. This approach allows the company to decide what coverages to offer. The company can use market research and other tools to assist it in the decision.

Long-term care policies are prohibited from having provisions allowing them to terminate a policy based on the age, or mental or physical condition of the insured. The policies are also prohibited from having an additional waiting period if a policy is replaced by another policy with the same company.

A preexisting condition may not be excluded from coverage for more than 12 months. The authority of the SCC to extend the limitation period is specifically included. Companies are allowed to underwrite policies according to their established standards for long-term care policies and to request a complete health history.

Insurers must allow insureds at least 30 days to enter a long-term care facility after leaving a hospital if hospitalization is required by the contract.

Any individual long-term care policies that, in the Commission's opinion, could be considered limited benefit policies must meet the loss ratio standards that apply to all limited benefit policies. However, existing loss ratio standards that do not specifically include long-term care policies cannot be used to evaluate any other long-term care policy. This means the SCC must develop new loss ratio standards for long-term care policies.

A full and complete outline of coverage is required to be delivered to an applicant for individual long-term care insurance when the insured applies. Direct response policies must provide the outline no later than when the applicant receives the policy. Certificates issued under group policies must also include an outline of coverage. In addition, a copy of a long-term care consumer's guide published by the SCC must be provided to the insured at the time of delivery. This provides for complete disclosure to applicants and insureds so that they can make informed purchase decisions.

"Free-Look" provisions are also included in the proposed legislation. These provisions give individuals purchasing long-term care insurance policies an opportunity to review the policies and return them within a designated period if the policies are not in accordance with their needs. Individual policies must provide at least a 10 day period. Direct response solicitations require a thirty day free look period for individual and group policies. The existence of this provision must be prominently displayed on each policy or certificate.

Suggested Changes

The recommendation of the advisory committee to adopt a modified version of the NAIC model is viewed by the SCC and DMAS as a positive step in encouraging companies to develop long-term care policies. The following changes are suggested by the SCC:

- § 38.2-5000

  The definition of long-term care insurance should be modified to provide that health maintenance organizations, cooperative nonprofit life benefit companies, and mutual assessment life, accident and sickness insurers can apply to the Commission for approval to offer long-term care policies.

- § 38.2-5001

  The requirement of the life insurance chapters and the general insurance laws should also be applicable to long-term care products.

- § 38.2-5006

  Language should be added to this section to specifically state that the Commission may require that certification from an actuary or other qualified professional as to the adequacy of rates and reserves be filed, along with adequate supporting information.

The change in § 38.2-5000 will provide additional regulatory protection to those individuals who purchase contracts from health maintenance organizations, cooperative nonprofit life benefit companies, and mutual assessment life, accident and sickness insurers. These organizations do not have to meet the financial requirements that apply to traditional insurers. It is felt that additional authority should be given to the Commission in considering the issuance of long-term care contracts offered by these types of organizations.

The change to § 38.2-5001 is suggested to further clarify that the general insurance laws apply to these policies and that the laws regulating life insurance contracts also apply if they are applicable.

The change to § 38.2-5006 is suggested to provide additional protection because of the great need to assure financial solvency of the companies issuing contracts for which they may not be called upon to provide benefits for up to 40 years in the future.

Education Recommendation

The SCC and DMAS agree that education of the public to improve consumer awareness is one of the keys to solving the long-term care problem. The SCC's Bureau of Insurance is already involved in consumer education, and has planned to increase its efforts in this area. The Department for the Aging (DA) is also active in consumer education and, as a member of the advisory committee to this study and the federal task force on long-term care, is particularly aware of current efforts in this area. We believe that working together the SCC, DMAS, and DA can develop a plan for education of the public.

Medicaid Expansion

As discussed in Section VI, at this point it is difficult to determine the effect of changes in the current Medicaid system on long-term care insurance. If this study is continued informally by the SCC and DMAS, these agencies can monitor the effects of the proposed legislation on the long-term market as well as any changes instituted by the federal government with regard to the Medicaid program. It would be extremely difficult at this time to estimate the potential for cost savings of the Medicaid program without knowledge of exactly what services policies developed in the future will cover, or at what cost.

Tax Incentives

The use of tax incentives has been considered in a number of states and was recently enacted in Colorado. Response to the Colorado approach will be valuable in gauging the effect of this type of legislation in Virginia. When consumers were asked in the Survey Research Laboratory survey if they would buy a policy to cover long-term care if the premiums could be deducted for their state income taxes, 34% of those who had previously said they would not buy such a policy said they would then do so. The full report of the consumer survey is contained in Appendix I of this report. Responding to the company survey question asking if a reduction in the premium tax would encourage them to test or market a long-term care product in Virginia, only five companies that currently have no plans in this area said they would change their position. Eighteen respondents said it would not encourage them to enter the long-term care market. The remaining respondents were not sure or are already involved in testing or marketing long-term care products.

The responses to the above surveys indicate that tax incentives could be useful to some degree here in Virginia, but the responses were not positive in the majority of cases. Further consideration of this area can be continued by appropriate state agencies. The effects of the proposed legislation, if it is enacted, and the Colorado experience can be monitored, in addition to national activity affecting long-term care.

Reinsurance Recommendation

The use of reinsurance in the development of long-term care coverage is not wide spread.

The SCC will further investigate this area to determine if the existing state regulatory environment restricts the use of reinsurance in this area.

Summary

The enactment of the revised advisory committee recommendation is viewed as the best alternative at the present time. If no legislation is enacted, there will be no additional stimulation to the market and the development of long-term care insurance is likely to continue very slowly. The enactment of legislation similar to the NAIC Model will be helpful in encouraging the widespread development of long-term care insurance by assisting companies who market policies in more than one state.

XI. CONCLUSION

The State Corporation Commission and the Department of Medical Assistance Services recommend that the legislation proposed by the advisory committee be enacted, with the incorporation of the changes that are suggested in Section X. We believe that this legislation will be helpful in encouraging insurance companies to enter the long-term care market and, at the same time, will provide the mechanisms to protect the consumer. We further recommend that the effects of this legislation be monitored by the State Corporation Commission and the Department of Medical Assistance Services along with continued study by the State Corporation Commission in the areas of tax-incentives and the use of reinsurance.

The State Corporation Commission, Department of Medical Assistance Services, and the Department for the Aging will increase their efforts in the area of consumer education. The Bureau of Insurance of the State Corporation Commission will begin work on a consumer's guide to long-term care insurance for distribution to the public.

The State Corporation Commission and the Department of Medical Assistance Services further recommend that these agencies monitor the effects of future activities in this area, including the results of legislation enacted by other states, and report any need for additional legislative action to the General Assembly.

Given supporting legislation, we believe there is great potential to increase the availability of long-term care insurance in the Commonwealth.

APPENDIX I

CONSUMER SURVEY

NURSING HOME COSTS AND INSURANCE: KNOWLEDGE AND ATTITUDES OF THE VIRGINIA PUBLIC

Prepared for The State Corporation Commission
Commonwealth of Virginia

by

Survey Research Laboratory
Virginia Commonwealth University

Scott Keeter
Principal Investigator

Norman Westerberg
Project Management

Joan Baker
Field Supervision

SUMMARY OF FINDINGS

Most of the Virginia public knows little about cost of nursing home care and the extent to which government health insurance will pay for nursing home stays, according to a statewide telephone survey of 1219 adult heads-of-household. Over half of those interviewed indicated a willingness to buy nursing home insurance under some conditions.

The survey was conducted during September and October 1986 by the Survey Research Laboratory at Virginia Commonwealth University in Richmond. Half of the interviews were conducted with a randomly selected sample of households, while the other half used a targeted sample designed to increase the proportion of low-income households. Results from the two samples on the nursing home questions were nearly identical.

Sixty percent of the respondents said they didn't know that a custodial nursing home stay would cost between $15,000 and $26,000 annually; only a fourth knew that Medicare would not pay any of this cost. One-fourth of the public correctly indicated that Medicare would pay part of the cost of a stay in a skilled nursing facility, but very few knew the maximum length of a stay covered by Medicare.

Over two-thirds of those surveyed said they would not be willing to reduce their assets in order to become eligible for Medicaid assistance with nursing home costs. Even among respondents with incomes below $15,000 annually, a majority said they would not spend down to become eligible.

Over half of the respondents indicated that they would buy some type of nursing home insurance under certain conditions, while 31 percent said they definitely would not buy a policy. The remainder were unsure. Not surprisingly, willingness to buy was a function of the size of the monthly premium posed in the questions: among those who initially indicated a willingness to consider a policy, only 8 percent said they would pay $150 per month, while 36 percent who were unwilling to pay $150 or $100 per month said they would buy a policy at $50 per month. Among those who were otherwise unwilling, the prospect of tax deductible premiums led 34 percent to say they would buy a policy.

METHODOLOGY

This report is based upon data collected from a telephone survey of the Virginia public during September and October 1986. Heads of household in a total of 1219 households were interviewed.

All interviewing was conducted from the facilities of the Survey Research Laboratory by interviewers who had undergone special training on health insurance coverage. Interviewing was continuously supervised by staff members, who also reviewed each completed questionnaire for clarity and consistency. On occasion, interviewers were directed to make call-backs to clarify or supplement the information they had obtained.

Each telephone number in the samples was called up to four times on different interviewing shifts in an attempt to reach households

where residents were rarely at home. Respondents who could not be interviewed when first called were called back at another time. Completed interviews were obtained with 62 percent of all households reached.

The type of information sought by the health insurance portion of this survey (results reported elsewhere) required that interviews be conducted with a knowledgeable informant who could provide information about the personal characteristics, health status, and health insurance coverage of each family member. Specifically, interviewers asked for "the head of the household or that person's spouse."

Knowledge of nursing home costs and insurance coverage, and willingness to purchase nursing home insurance were measured using a series of questions developed jointly by the Bureau of Insurance and the Survey Research Laboratory. A copy of the nursing home portion of the questionnaire may be found in the appendix to this report.

The samples.

Two separate samples were employed: one was a random digit (RDD) sample to obtain a representative cross-section of the state's telephone households, while the other was targeted so as to increase the proportion of low-income households obtained. Answers to the nursing home questions were nearly identical in the two samples. Consequently, most of the findings reported below are based on the RDD sample alone, but a table showing the results in the targeted sample is included.

The samples were created by Survey Sampling Incorporated of Westport, Connecticut, one of the nation's leading specialists in

survey samples. The RDD sample was generated through a multi-stage process that selected telephone exchanges in proportion to the number of households served by each exchange. Working blocks within each exchange were identified and a sample of telephone numbers was generated randomly, so that the final sample correctly reflected the size of the population in different geographic areas of the state. The random generation of numbers ensured that unlisted and new numbers were represented in their proper proportions.

The targeted sample used a multiple regression analysis of U.S. Census data in Virginia to identify telephone exchanges in Census tracts with below-average household income. The sample was then generated using those exchanges. Because a given telephone exchange usually serves many kinds of neighborhoods, the targeting process does not yield only low-income households, but the proportion of such households is increased.

Representativeness of the samples.

The representativeness of the RDD sample was assessed through a comparison of key variables with national and statewide data from the Current Population Survey (CPS), which is a regular, large survey of households conducted by the Census Bureau, and from the U.S. Census.

Overall, the sample of households appears quite representative with respect to important population characteristics. The sample matched U.S. data remarkably well with respect to family size and age distribution. The racial composition of the sample was very close to Census figures for Virginia (18 percent non-white in the sample compared with 21 percent in the Census estimate for Virginia).

A direct comparison of sample data with an independent statewide measure of family income was not possible; no recent statewide data were available. Instead, the sample data (based on 1985 family income) were compared with national CPS family income data for 1985 to determine the relationship between our state data and CPS national data. A similar relationship was calculated between the most recent state and national CPS data available (1981). Finally, these two relationships were compared as a means of assessing the representativeness of the sample data. The ratio of the sample proportion in each income category to the corresponding 1985 national data was very similar to the ratios calculated with 1981 CPS state and national data. Thus we conclude that the distribution of income in our sample closely matches the actual distribution in the Virginia population.

Sampling error.

Surveys of the type reported here are subject to many types of error. Fortunately, the likely magnitude of one kind of error -- that of sampling error -- can be estimated so that we may quantify the degree of confidence in our findings.

Since it would not be feasible to interview every adult in Virginia, we rely upon a carefully selected but very small fraction of the public -- a random sample. The extent to which any sample is different from the population is sampling error. For random samples, probability theory can be used to predict the likely range of error. The amount of error in random samples is mostly dependent upon the

size of the sample; large samples are, generally speaking, better samples.

Sampling error is usually expressed as an interval around the finding in the sample, and the interval is associated with a "level of confidence." An example will help to clarify this. Consider the finding that 40 percent of our respondents claimed to know the annual cost of staying in a custodial nursing home. This is based upon a sample size of 597. The sampling error for 597 cases is plus or minus four percentage points at the 95 percent level of confidence. To create the interval we simply subtract 4 percentage points from 40 (the finding in the sample) to find the lower limit (36 percent) and add 4 points to find the higher limit (44 percent); thus the interval is between 36 and 44 percent.

The proper interpretation of the confidence interval is as follows: in 95 out of 100 samples like the one we used here, an interval created by adding and subtracting four percentage points to the finding in the sample will include the true population value (which is the percentage we would find if we could interview all adult Virginians about the cost of a nursing home stay).

Readers should bear in mind that not all of the analyses presented here will be based upon 600 cases. For example, the RDD sample included fewer than 125 elderly respondents; thus when the opinions or knowledge of this group are described, the findings are subject to a larger sampling error (125 elderly respondents are representing all of state's elderly citizens). Here is a table showing the sampling errors for groups of different sizes (95 percent level of confidence:

NUMBER OF CASES	PLUS OR MINUS...
50	14.0%
100	9.9
150	8.0
200	7.0
250	6.2
300	5.7
400	4.9
500	4.4
600	4.0

KNOWLEDGE REGARDING NURSING HOMES COSTS AND INSURANCE

Much of the Virginia public is uninformed about the costs of using nursing homes and the nature and extent of assistance provided by government health insurance programs. Table 1 shows the results for all respondents in the RDD sample, with a breakdown by age and family income. Table 2 shows the same data for the targeted sample.

Most respondents -- 60 percent -- said they did not know that staying in a custodial nursing home is estimated to cost between $15,000 and $26,000 per year. Some who said they didn't know may have actually thought the cost was higher, though these would likely be offset by individuals who claimed to know when they in fact did not. Older individuals were more likely than young ones to say they knew the cost; 57 percent of those aged 65 or older said they knew,

compared with only 19 percent of those under 30 years of age. Graph 1 shows the relationship between age and knowledge.

The difference between custodial and skilled nursing homes was explained to respondents, on the assumption that even this basic information would not be known by most people. Respondents were asked whether or not Medicare (identified as the health insurance program for the elderly) would pay any of the cost of staying in a custodial nursing home. About one-fourth (24 percent) said Medicare would not pay, while another 18 percent said incorrectly that Medicare would pay. Most (58 percent) said they didn't know.

Somewhat surprisingly, there was little association between knowledge on this item and the age of the respondent. Elderly respondents were not clearly more knowledgeable than the rest. Family income was also not associated with knowledge.

Next, respondents were asked if Medicare would pay any of the cost of staying in a skilled nursing facility. Those who answered "yes" were asked: "For how long a stay will Medicare pay?" About two-thirds (64 percent) said they didn't know whether or not Medicare would pay (Graph 2). Fifteen percent said, incorrectly, that Medicare would not pay. Most of those who said Medicare would pay didn't know the length of stay for which Medicare would pay, or gave an answer that was incorrect (e.g., more than 100 days or "indefinitely"). In the RDD sample, only 2 percent correctly said that Medicare would pay for 100 or fewer days.

Again, the youngest respondents were a little less likely than others to know the correct answer, but there was otherwise little relationship between knowledge and age.

WILLINGNESS TO REDUCE ASSETS TO OBTAIN MEDICAID ASSISTANCE

In order to determine whether individuals would be willing to reduce their assets in order to become eligible for Medicaid assistance in paying custodial nursing home costs, respondents were read the following statement and question:

> The state wants you to know that Medicare will pay only 100 days in a skilled nursing facility and nothing for a custodial nursing home. In order for the government to pay for a stay in a custodial nursing home, a person would have to get rid of almost all of their personal property and money except their home, down to a total of $1700. Would you personally be willing to do this in order to be eligible for government help in paying for nursing home care?

Relatively few individuals (13 percent) said they would be willing to spend down. Another 20 percent said they didn't know or weren't sure, while 67 percent said they definitely would not. Respondents aged 65 and older were somewhat more likely than others to indicate a willingness to spend down, or at least to consider it. Only about one-half of this group rejected the idea completely.

Willingness to spend down was also associated with income (Graph 3). Nearly half of the poorest respondents (incomes below $15,000) were uncertain or said they would, compared with only one-fifth of those with incomes over $35,000.

POTENTIAL MARKET FOR NURSING HOME INSURANCE

All respondents were asked if they presently had some kind of insurance policy that would cover nursing home care. Ten percent said

they did; these individuals were not asked the subsequent series of questions about their willingness to purchase nursing home coverage.

Overall, a majority of those questioned said they would be willing to purchase insurance that would cover nursing home care. In order to determine the conditions under which a purchase might be made, all respondents who indicated in an initial question that they would consider such a purchase (or were uncertain) were asked if they would pay $150 per month for a policy. If not, they were asked if they would pay $100 per month, and then $50 per month. Those who said "no" initially, as well as those who said no to each of the monthly premium amounts, were asked if they would be willing to buy "if you could deduct the premiums on your state income tax."

In response to the initial question, 41 percent said they would not buy nursing home insurance. Those who said yes to the initial question, or were unsure, were taken through the series of questions on premium costs. Of these, only 8 percent said they would pay $150 per month, while another 21 percent were not sure or didn't know.

Asked about a $100 premium, 14 percent said they would buy, with 23 percent unsure (please recall that these percentages are based upon respondents who said "no" or were unsure about $150 per month). Asked about a policy for $50 per month, a much larger group expressed a willingness to buy: 36 percent said yes, and 35 percent were unsure (only 28 percent said no).

Finally, all who had said "no" initially, and those who said "no" to each of the premium cost questions, were asked if deductibility of premiums would lead them to buy. One-third of this group (34 percent) said yes, and 26 percent were unsure (40 percent said no).

Reconfiguring the results to show the ultimate decisions of all respondents, 52 percent indicated a willingness to buy a policy under some condition. Another 18 percent were unsure (but did not say no), while 31 percent said they wouldn't buy such a policy.

The age and family income of respondents had relatively little impact on their answers to this series of questions, except among the (somewhat overlapping) poorest and oldest individuals. Elderly individuals were 14 percentage points less likely than the average to say they would buy a nursing home insurance policy. Deductibility of premiums appears relatively unattractive to this group. Individuals in the lowest income group were also less likely than the rest to express interest in a policy, and deductibility persuaded a smaller portion of this group as well.

All respondents were asked if a family member were currently staying in a nursing home. Overall, 8 percent said yes. Interestingly, respondents with a family member in a home were not clearly more knowledgeable than others about the costs and insurance coverage of nursing home stays. Those with a family member in a home were six percentage points more likely to say they knew a stay in a custodial home could cost $15,000 to $26,000 annually, but 31 percent said incorrectly that Medicare would help pay these costs (compared with 17 percent of those with no family member in a home). Respondents with a member in a nursing home were also more likely than others to say (correctly in this case) that Medicare would help with skilled nursing home costs (33 percent to 21 percent).

Having the direct experience of a family member in a nursing home appears to have some impact on an individual's willingness to prepare

for such an eventuality. Those with a family member in a home were 9 percentage points more likely to say they would buy an insurance policy, and to say they would reduce their assets in order to obtain government assistance with custodial care costs.

TABLE 1
RDD SAMPLE

TYPE OF SAMPLE
STATEWIDE

	TOTAL	FAMILY INCOME				AGE				
		UNDER $15K	$15-25K	$25-35K	OVER $35K	UNDER 30	30-39	40-49	50-64	65 AND OLDER
ANY FAMILY MEMBER IN A NURSING HOME?										
NO	551 92%	137 94%	121 95%	92 85%	134 92%	101 91%	137 94%	96 90%	111 93%	104 91%
YES	48 8%	8 6%	6 5%	16 15%	12 8%	10 9%	9 6%	11 10%	8 7%	10 9%
KNOW THAT NURSING HOME WILL COST $15-26K?										
YES	239 40%	62 43%	43 34%	44 41%	59 41%	21 19%	59 40%	38 36%	57 48%	64 57%
NO	358 60%	83 57%	85 66%	63 59%	86 59%	91 81%	87 60%	69 64%	61 52%	48 43%
MEDICARE PAY FOR CUSTODIAL NURSING CARE?										
NO	141 24%	34 24%	25 20%	30 28%	35 24%	18 16%	46 32%	21 20%	28 24%	27 24%
YES	107 18%	26 18%	27 21%	12 11%	31 21%	22 20%	25 17%	17 16%	22 19%	21 19%
DK	349 58%	83 58%	76 59%	65 61%	80 55%	71 64%	75 51%	69 64%	68 58%	65 58%
MEDICARE PAY FOR SKILLED NURSING FACILITY?										
NO	91 15%	21 15%	19 15%	16 15%	23 16%	14 13%	26 18%	14 13%	22 19%	15 13%
YES	132 22%	33 23%	27 21%	21 19%	39 27%	17 15%	38 26%	25 23%	25 21%	27 24%
DK	373 63%	87 62%	82 64%	71 66%	84 58%	81 72%	82 56%	68 64%	70 60%	70 63%
WILL MEDICARE PAY FOR SKILLED CARE... AND FOR HOW LONG?										
DON T KNOW	387 64%	94 65%	83 65%	73 68%	87 60%	81 72%	87 60%	68 64%	74 62%	75 66%
NO, WON T PAY	91 15%	21 14%	19 15%	16 15%	23 16%	14 13%	26 18%	14 13%	22 18%	15 13%
YES:100 OR FEWER DAYS	13 2%	4 3%	3 2%	2 2%	4 3%	1 1%	3 2%	2 2%	3 3%	4 4%
YES:MORE THAN 100 DAYS	8 1%	1 1%	1 1%	4 4%	2 1%	1 1%	3 2%	2 2%	1 1%	1 1%
YES:INDEFINITE	13 2%	4 3%	1 1%	1 1%	3 2%	4 4%	1 1%	2 2%	3 3%	3 3%
YES:DON T KNOW HOW LONG	88 15%	21 14%	21 16%	12 11%	27 18%	11 10%	26 18%	19 18%	16 13%	16 14%

(CONTINUED)

OF SAMPLE
STATEWIDE

	TOTAL	FAMILY INCOME				AGE				
		UNDER $15K	$15-25K	$25-35K	OVER $35K	UNDER 30	30-39	40-49	50-64	65 AND OLDER
WILLING TO SPEND DOWN?										
NO	395 67%	77 54%	89 70%	72 67%	115 79%	94 84%	105 73%	68 65%	67 57%	59 52%
YES	78 13%	31 22%	19 15%	9 8%	11 8%	8 7%	15 10%	12 11%	17 15%	26 23%
DEPENDS	55 9%	17 12%	10 8%	13 12%	9 6%	7 6%	12 8%	10 10%	13 11%	13 12%
DK	65 11%	18 13%	9 7%	13 12%	10 7%	3 3%	12 8%	15 14%	20 17%	15 13%
HAVE NURSING HOME INSURANCE COVERAGE?										
NO	441 74%	119 83%	100 78%	72 67%	98 68%	88 79%	103 71%	80 75%	89 75%	79 70%
YES	61 10%	13 9%	13 10%	15 14%	12 8%	6 5%	11 8%	8 8%	14 12%	22 19%
DK	95 16%	12 8%	15 12%	21 19%	34 24%	18 16%	32 22%	18 17%	15 13%	12 11%
WOULD YOU BUY A NURSING HOME POLICY										
NO	226 41%	50 38%	45 38%	43 45%	51 38%	54 52%	69 51%	36 35%	28 27%	37 38%
YES	146 27%	36 27%	32 27%	28 29%	43 32%	27 26%	35 26%	30 29%	34 32%	20 21%
DEPENDS	123 23%	31 23%	32 27%	19 20%	32 24%	15 14%	27 20%	28 27%	25 24%	28 29%
DK	51 9%	15 11%	8 7%	6 6%	10 7%	8 8%	5 4%	8 8%	18 17%	12 12%
WOULD YOU PAY $150.00 A MONTH?										
NO	221 70%	65 80%	50 70%	36 69%	53 64%	36 73%	39 58%	45 69%	56 76%	45 76%
YES	26 8%		7 10%	6 12%	11 13%	4 8%	13 19%	6 9%	2 3%	1 2%
NOT SURE	41 13%	10 12%	10 14%	5 10%	13 16%	7 14%	9 13%	8 12%	11 15%	6 10%
DK	26 8%	6 7%	4 6%	5 10%	6 7%	2 4%	6 9%	6 9%	5 7%	7 12%
WOULD YOU PAY $100.00 PER MONTH?										
NO	180 63%	57 71%	36 57%	27 57%	45 63%	27 63%	35 65%	39 65%	45 62%	34 60%
YES	41 14%	7 9%	13 21%	11 23%	9 13%	9 21%	7 13%	10 17%	9 12%	6 11%
NOT SURE	44 15%	10 13%	11 17%	5 11%	14 19%	7 16%	7 13%	5 8%	15 21%	10 18%
DK	22 8%	6 7%	3 5%	4 9%	4 6%		5 9%	6 10%	4 5%	7 12%
WOULD YOU PAY $50.00 PER MONTH?										
NO	74 28%	26 35%	12 22%	13 29%	17 26%	14 35%	14 29%	16 28%	17 25%	13 25%
YES	96 36%	22 30%	23 42%	17 38%	28 43%	15 38%	18 38%	26 46%	22 32%	15 29%
NOT SURE	69 26%	19 26%	16 29%	10 22%	15 23%	9 22%	10 21%	11 19%	23 34%	16 31%
DK	25 9%	7 9%	4 7%	5 11%	5 8%	2 5%	6 13%	4 7%	6 9%	7 14%

TABLE 1 CONTINUED

(CONTINUED)

TYPE OF SAMPLE
STATEWIDE

	TOTAL	FAMILY INCOME				AGE				
		UNDER $15K	$15-25K	$25-35K	OVER $35K	UNDER 30	30-39	40-49	50-64	65 AND OLDER
IF YOU COULD DEDUCT FROM STATE INCOME TAX?										
NO.....	181 40%	64 55%	25 28%	29 35%	34 33%	31 35%	38 36%	32 38%	34 38%	45 55%
YES.....	154 34%	28 24%	38 42%	34 41%	40 39%	37 42%	43 41%	28 33%	32 36%	14 17%
DEPENDS.....	78 17%	8 7%	21 23%	17 20%	23 23%	14 16%	21 20%	18 21%	15 17%	9 11%
DK.....	39 9%	16 14%	6 7%	3 4%	5 5%	6 7%	4 4%	6 7%	9 10%	14 17%
OVERALL WILLINGNESS TO BUY NURSING HOME INSURANCE										
NO.....	168 31%	59 45%	23 20%	25 26%	33 25%	30 29%	37 28%	27 27%	32 31%	41 43%
YES, WOULD BUY.	281 52%	56 42%	71 61%	54 57%	79 59%	58 55%	75 56%	58 57%	54 52%	36 38%
DEPENDS.....	63 12%	5 4%	19 16%	13 14%	18 13%	13 12%	19 14%	11 11%	11 11%	8 8%
DONT KNOW.....	30 6%	12 9%	4 3%	3 3%	4 3%	4 4%	3 2%	5 5%	7 7%	11 11%

TABLE 1 CONTINUED

TABLE 2
TARGETED SAMPLE

OF SAMPLE
Special

	TOTAL	FAMILY INCOME				AGE				
		UNDER $15K	$15-25K	$25-35K	OVER $35K	UNDER 30	30-39	40-49	50-64	65 AND OLDER
ANY FAMILY MEMBER IN A NURSING HOME?										
NO.....	570 93%	235 92%	102 97%	74 94%	57 92%	84 98%	101 90%	71 97%	122 90%	187 93%
YES.....	43 7%	20 8%	3 3%	5 6%	5 8%	2 2%	11 10%	2 3%	13 10%	15 7%
KNOW THAT NURSING HOME WILL COST $15-26K?										
YES.....	241 39%	101 39%	40 38%	32 41%	26 42%	18 21%	32 29%	30 41%	62 46%	97 48%
NO.....	374 61%	156 61%	64 62%	47 59%	36 58%	67 79%	80 71%	43 59%	74 54%	107 52%
MEDICARE PAY FOR CUSTODIAL NURSING CARE?										
NO.....	150 24%	55 21%	32 30%	22 28%	18 30%	17 20%	35 32%	24 33%	20 15%	52 25%
YES.....	118 19%	51 20%	17 16%	12 15%	14 23%	12 14%	20 18%	14 19%	36 27%	36 18%
DK.....	346 56%	150 59%	56 53%	45 57%	29 48%	57 66%	56 50%	35 48%	79 59%	116 57%
MEDICARE PAY FOR SKILLED NURSING FACILITY?										
NO.....	91 15%	35 14%	16 15%	13 17%	11 18%	12 14%	20 18%	15 21%	13 10%	30 15%
YES.....	126 21%	54 21%	23 22%	19 24%	17 28%	13 15%	25 23%	15 21%	36 26%	37 18%
DK.....	396 65%	168 65%	65 63%	46 59%	33 54%	60 71%	65 59%	42 58%	87 64%	138 67%
WILL MEDICARE PAY FOR SKILLED CARE... AND FOR HOW LONG?										
DON T KNOW.....	409 66%	172 67%	67 64%	49 62%	36 57%	61 71%	70 63%	43 59%	91 66%	140 68%
NO, WON T PAY..	91 15%	35 14%	16 15%	13 16%	11 17%	12 14%	20 18%	15 21%	13 9%	30 15%
YES:100 OR FEWER DAYS..	11 2%	3 1%	3 3%	2 3%	2 3%	2 2%	1 1%	2 3%	3 2%	3 1%
YES:MORE THAN 100 DAYS....	8 1%	1 0%	3 3%	2 3%	2 3%	3 3%	3 3%	1 1%		1 0%
YES:INDEFINITE.	7 1%	4 2%	1 1%		2 3%		4 4%		3 2%	
YES:DON T KNOW HOW LONG....	92 15%	43 17%	15 14%	13 16%	10 16%	8 9%	14 13%	12 16%	27 20%	31 15%

(CONTINUED)

TYPE OF SAMPLE
SPECIAL

	TOTAL	FAMILY INCOME				AGE				
		UNDER $15K	$15-25K	$25-35K	OVER $35K	UNDER 30	30-39	40-49	50-64	65 AND OLDER
WILLING TO SPEND DOWN?										
NO	388 64%	149 59%	69 67%	62 79%	49 79%	67 80%	77 70%	49 67%	87 64%	104 53%
YES	66 11%	33 13%	12 12%	3 4%	6 10%	3 4%	10 9%	9 12%	18 13%	26 13%
DEPENDS	59 10%	26 10%	9 9%	6 8%	3 5%	5 6%	11 10%	7 10%	12 9%	23 12%
DK	93 15%	45 18%	13 13%	7 9%	4 6%	9 11%	12 11%	8 11%	19 14%	45 23%
HAVE NURSING HOME INSURANCE COVERAGE?										
NO	465 76%	207 80%	79 76%	54 70%	41 67%	59 69%	80 73%	56 77%	109 80%	156 76%
YES	63 10%	24 9%	12 12%	9 12%	9 15%	9 11%	14 13%	5 7%	10 7%	25 12%
DK	85 14%	27 10%	13 13%	14 18%	11 18%	17 20%	16 15%	12 16%	17 13%	23 11%
WOULD YOU BUY A NURSING HOME POLICY										
NO	259 47%	121 52%	38 40%	30 45%	20 37%	48 61%	34 35%	32 47%	49 40%	94 52%
YES	113 20%	33 14%	21 22%	18 27%	23 43%	13 16%	35 36%	11 16%	31 25%	21 12%
DEPENDS	119 22%	60 26%	24 26%	11 16%	9 17%	13 16%	18 19%	18 26%	29 24%	40 22%
DK	62 11%	20 9%	11 12%	8 12%	2 4%	5 6%	10 10%	7 10%	13 11%	27 15%
WOULD YOU PAY $150.00 A MONTH?										
NO	216 72%	89 77%	37 66%	28 74%	21 62%	22 71%	51 78%	24 69%	55 73%	62 68%
YES	22 7%	6 5%	4 7%	5 13%	3 9%	3 10%	4 6%	2 6%	7 9%	6 7%
NOT SURE	37 12%	12 10%	10 18%	5 13%	6 18%	5 16%	5 8%	7 20%	7 9%	13 14%
DK	25 8%	8 7%	5 9%		4 12%	1 3%	5 8%	2 6%	6 8%	10 11%
WOULD YOU PAY $100.00 PER MONTH?										
NO	179 64%	81 74%	30 58%	20 61%	14 45%	21 75%	41 67%	22 67%	42 64%	51 59%
YES	22 8%	2 2%	3 6%	7 21%	7 23%	4 14%	7 11%	2 6%	3 5%	6 7%
NOT SURE	44 16%	13 12%	12 23%	5 15%	7 23%	2 7%	8 13%	6 18%	13 20%	14 16%
DK	33 12%	14 13%	7 13%	1 3%	3 10%	1 4%	5 8%	3 9%	8 12%	16 18%
WOULD YOU PAY $50.00 PER MONTH?										
NO	75 28%	42 39%	7 14%	4 14%	5 17%	4 15%	16 29%	9 28%	18 28%	28 33%
YES	88 33%	22 20%	23 46%	14 50%	19 66%	14 52%	25 45%	13 41%	18 28%	17 20%
NOT SURE	67 25%	33 30%	11 22%	8 29%	2 7%	8 30%	10 18%	9 28%	18 28%	21 25%
DK	36 14%	12 11%	9 18%	2 7%	3 10%	1 4%	5 9%	1 3%	10 16%	18 21%

TABLE 2 CONTINUED

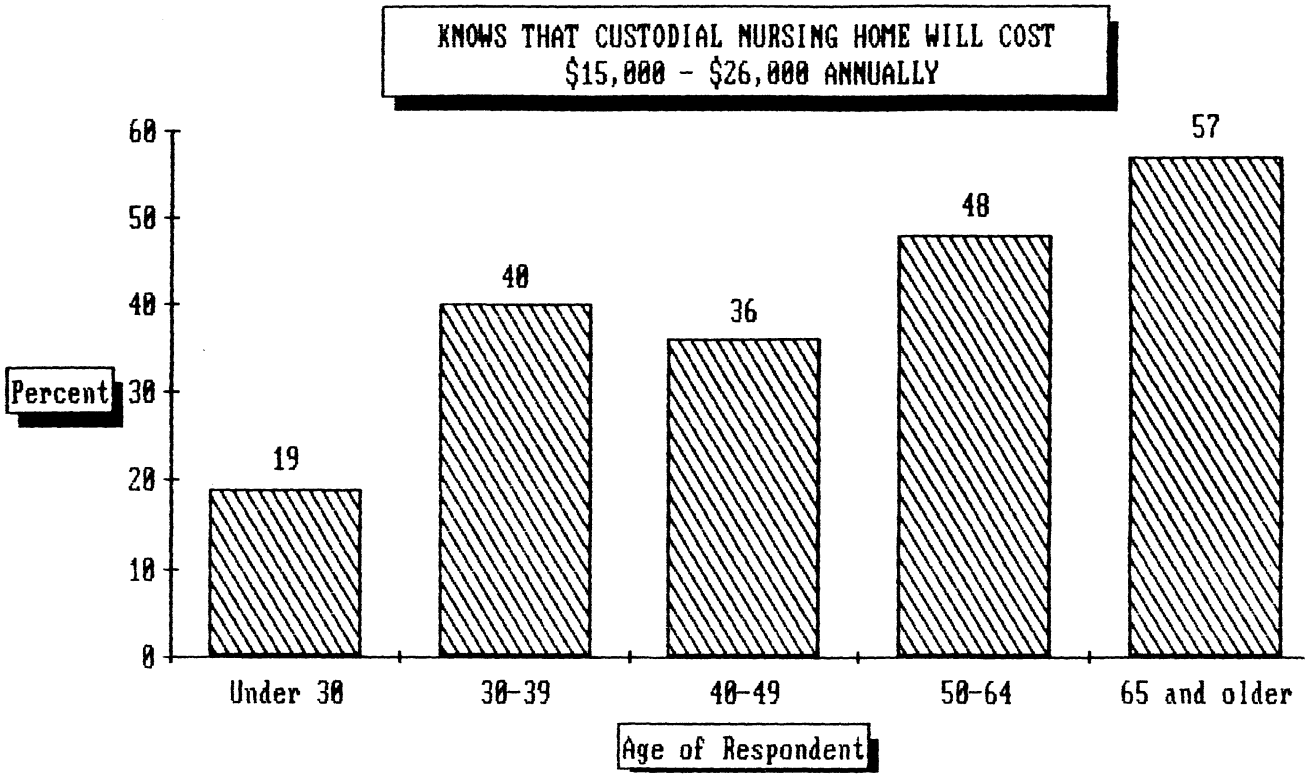
(CONTINUED)

TABLE 2 CONTINUED

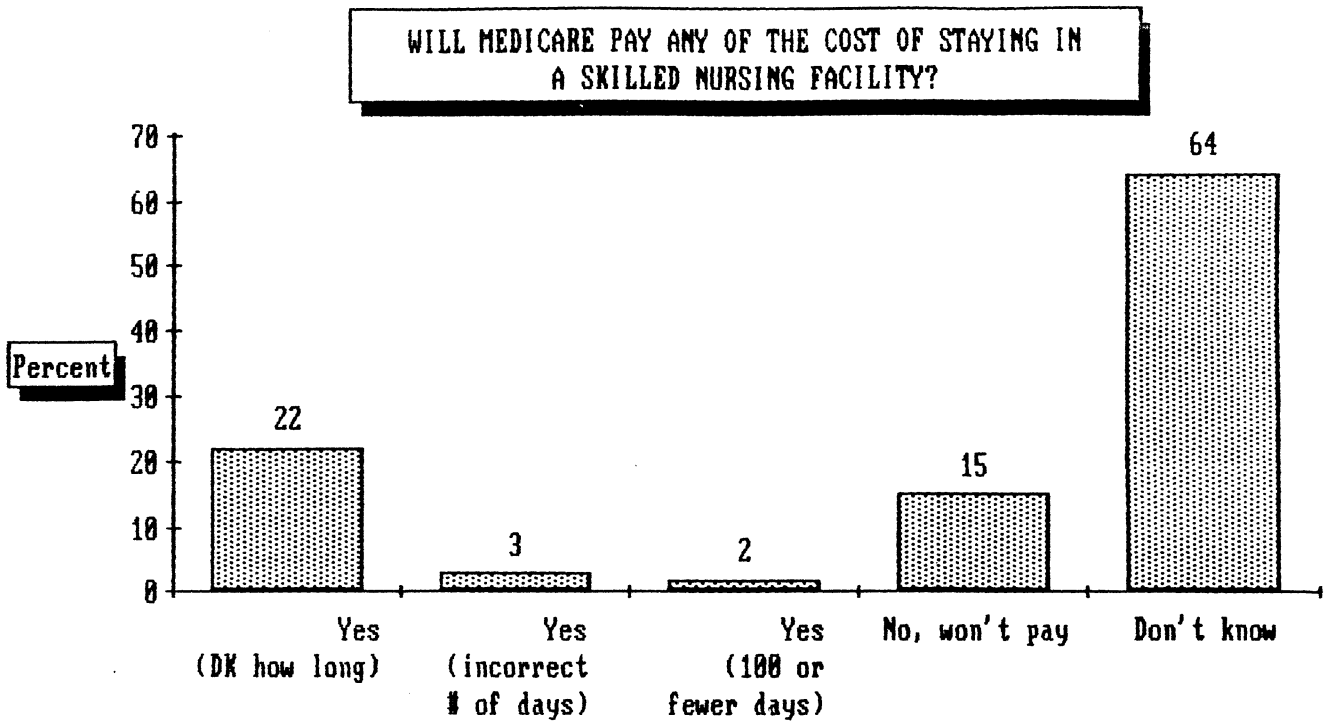
TYPE OF SAMPLE
SPECIAL

	TOTAL	FAMILY INCOME				AGE				
		UNDER $15K	$15-25K	$25-35K	OVER $35K	UNDER 30	30-39	40-49	50-64	65 AND OLDER
IF YOU COULD DEDUCT FROM STATE INCOME TAX?										
NO.....	205 44%	116 53%	22 31%	13 29%	12 29%	18 28%	25 35%	26 43%	42 43%	92 55%
YES.....	115 25%	36 17%	25 36%	19 42%	24 57%	26 41%	32 45%	17 28%	17 17%	21 13%
DEPENDS.....	69 15%	31 14%	13 19%	8 18%	3 7%	13 20%	10 14%	8 13%	20 20%	18 11%
DK.....	74 16%	34 16%	10 14%	5 11%	3 7%	7 11%	4 6%	9 15%	19 19%	35 21%
OVERALL WILLINGNESS TO BUY NURSING HOME INSURANCE										
NO.....	190 35%	108 46%	20 22%	12 18%	11 21%	18 23%	23 24%	24 35%	38 31%	85 47%
YES, WOULD BUY.	233 43%	71 30%	51 56%	42 63%	37 70%	41 53%	61 63%	30 44%	50 41%	48 27%
DEPENDS.....	60 11%	27 12%	11 12%	8 12%	2 4%	12 16%	10 10%	6 9%	15 12%	17 9%
DONT KNOW.....	64 12%	28 12%	9 10%	5 7%	3 6%	6 8%	3 3%	8 12%	18 15%	29 16%

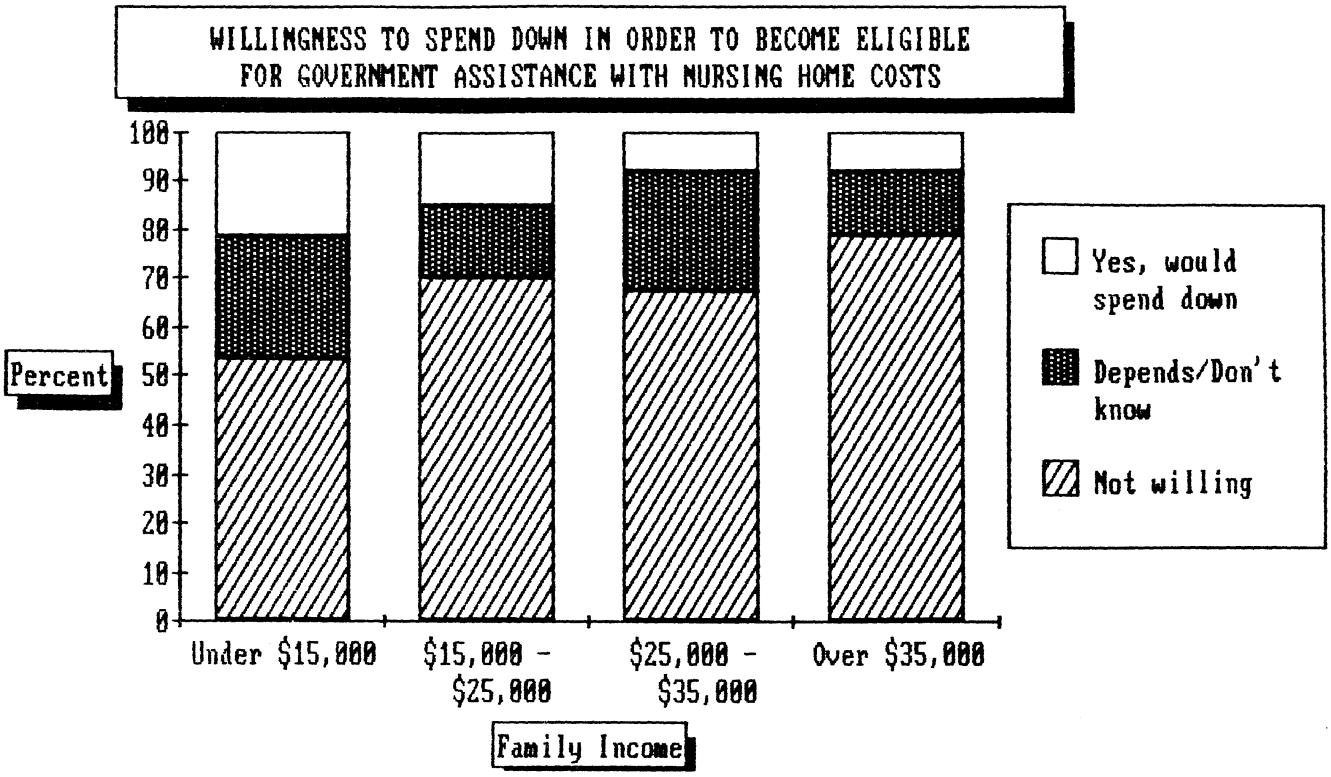
Graph 1


KNOWS THAT CUSTODIAL NURSING HOME WILL COST
$15,000 - $26,000 ANNUALLY
Percent
60
50
40
30
20
10
0
19
40
36
48
57
Under 30
30-39
40-49
50-64
65 and older
Age of Respondent

Graph 2


WILL MEDICARE PAY ANY OF THE COST OF STAYING IN A SKILLED NURSING FACILITY?
Percent
70
60
50
40
30
20
10
0
22
3
2
15
64
Yes (DK how long)
Yes (incorrect # of days)
Yes (100 or fewer days)
No, won't pay
Don't know

Graph 3


WILLINGNESS TO SPEND DOWN IN ORDER TO BECOME ELIGIBLE FOR GOVERNMENT ASSISTANCE WITH NURSING HOME COSTS
Percent
100
90
80
70
60
50
40
30
20
10
0
Under $15,000
$15,000 - $25,000
$25,000 - $35,000
Over $35,000
Family Income
Yes, would spend down
Depends/Don't know
Not willing

APPENDIX

THE QUESTIONNAIRE

21. Is anyone in your family -- such as parents, grandparents, sisters, brothers -- currently living in a nursing home?

NO.....1
YES.....2
DON'T KNOW.....8
NO ANSWER.....9

22. There are different kinds of nursing homes for elderly and disabled persons. Skilled nursing homes are specially qualified to provide medical care and rehabilitation services. Custodial nursing homes provide little medical care but assist people with things like dressing, bathing, or eating.

The state of Virginia estimates that staying in a custodial nursing home will cost between $15,000 and $26,000 per year. Did you know this?

YES, KNEW THIS.....1
NO, DIDN'T KNOW.....2
NO ANSWER.....9

23. As far as you know, will Medicare, the health insurance program for the elderly, pay any of the cost of staying in a custodial nursing home?

NO, WON'T PAY.....1
YES, WILL PAY.....2
DON'T KNOW.....8
NO ANSWER.....9

24. And will Medicare pay any of the cost of staying in a skilled nursing facility?

NO, WON'T PAY.....1
YES, WILL PAY (ASK 24B).....2
DON'T KNOW.....8
NO ANSWER.....9

24B. IF "YES WILL PAY" ASK:
For how long a stay will Medicare pay?

_____DAYS/MONTHS/YEARS
WILL PAY INDEFINITELY; AS LONG AS NEEDED...2
DON'T KNOW.....8
NO ANSWER.....9

25. The state wants you to know that Medicare will pay only 100 days in a skilled nursing facility and nothing for a custodial nursing home. In order for the government to pay for a stay in a custodial nursing home, a person would have to get rid of almost all of their personal property and money except their home, down to a total of $1700. Would you personally be willing to do this in order to be eligible for government help in paying for nursing home care?

NO.....1
YES, WOULD SPEND DOWN TO $1700.....2
DEPENDS.....3
DON'T KNOW.....8
NO ANSWER.....9

26. Do you have any kind of insurance policy that would cover nursing home care?

NO.....1
YES....(SKIP TO 28).....2
DON'T KNOW.....8
NO ANSWER.....9

27. The state of Virginia wants to find out if people like yourself would purchase insurance that would cover nursing home care. Would you consider buying such a policy if it were available?

NO....(GO TO 27E).....1
YES.....2
DEPENDS.....3
DON'T KNOW.....8
NO ANSWER.....9

27B. Would you pay $150 per month for such a policy?

NO, [GO TO 27C].....1
YES, WOULD BUY (GO TO 28).....2
NOT SURE.....3
DON'T KNOW.....8

27C. Would you pay $100 per month?

NO [GO TO 27D].....1
YES, WOULD BUY.(GO TO 28).....2
NOT SURE.....3
DON'T KNOW.....8

27D. How about $50 per month?

NO, (GO TO 27E).....1
YES, WOULD BUY..(GO TO 28).....2
NOT SURE.....3
DON'T KNOW.....8

27E. Would you be willing to buy such a policy if you could deduct the premiums on your state income tax?

NO, WOULDN'T BUY.(GO TO 28).....1
YES, WOULD BUY.....2
DEPENDS.....3
DON'T KNOW.....8

APPENDIX II

MEDICALLY NEEDY FINANCIAL ELIGIBILITY

LOCALITY GROUPINGS

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Group I

Counties

Accomack	Dickenson	King and Queen	Prince Edward
Alleghany	Dinwiddie	King William	Prince George
Amelia	Essex	Lancaster	Pulaski
Amherst	Fauquier	Lee	Rappahannock
Appomattox	Floyd	Loudoun	Richmond
Bath	Fluvanna	Louisa	Rockbridge
Bedford	Franklin	Lunenburg	Russell
Bland	Frederick	Madison	Scott
Botetourt	Giles	Mathews	Shenandoah
Brunswick	Gloucester	Mecklenburg	Smyth
Buchanan	Goochland	Middlesex	Southampton
Buckingham	Grayson	Nelson	Spotsylvania
Campbell	Greene	New Kent	Stafford
Caroline	Greensville	Northampton	Surry
Carroll	Halifax	Northumberland	Sussex
Charles City	Hanover	Nottoway	Tazewell
Charlotte	Henry	Orange	Washington
Clarke	Highland	Page	Westmoreland
Craig	Isle of Wight	Patrick	Wise
Culpeper	James City	Pittsylvania	Wythe
Cumberland	King George	Powhatan	York

Cities

Bedford	Clifton Forge	Franklin	South Boston
Bristol	Danville	Galax	Suffolk
Buena Vista	Emporia	Norton	

Group II

Counties		Cities	
Albemarle	Chesapeake	Newport News	Roanoke
Augusta	Covington	Norfolk	Salem
Chesterfield	Harrisonburg	Petersburg	Staunton
Henrico	Hopewell	Portsmouth	Virginia Beach
Roanoke	Lexington	Radford	Williamsburg
Rockingham	Lynchburg	Richmond	Winchester
Warren	Martinsville		

Group III

Counties		Cities	
Arlington		Alexandria	Falls Church
Fairfax		Charlottesville	Fredericksburg
Montgomery		Colonial Heights	Hampton
Prince William		Fairfax	Waynesboro

APPENDIX III

CHAPTER 50
LONG TERM CARE INSURANCE

§ 38.2-5000. Definitions. - As used in this chapter:

"Applicant" means in the case of an individual long-term care insurance policy, the person who seeks to contract for such benefits, or in the case of a group long-term care insurance policy, the proposed certificateholder.

"Certificate" means any certificate or evidence of coverage issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this Commonwealth.

"Long-Term Care Insurance" means any insurance policy primarily advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual policies whether issued by insurers, fraternal benefit societies, health services plans, health maintenance organizations, cooperative nonprofit life benefit companies or mutual assessment life, accident and sickness insurers. Health maintenance organizations, cooperative nonprofit life benefit companies and mutual assessment life, accident and sickness insurers may apply to the Commission for approval to provide long-term insurance.

"Group long-term care insurance" means a long-term care insurance policy delivered or issued for delivery in this Commonwealth to any group which complies with §38.2-3523.

"Policy" means, any individual or group policy of insurance, contract, subscriber agreement, certificate, rider or endorsement delivered or issued for delivery in this Commonwealth by an insurer, fraternal benefit society, health services plan, health maintenance organization or any similar organization.

§ 38.2-5001. What Laws Applicable.

All policies and certificates shall comply with all of the provisions of this title relating to insurance policies and certificates generally, except Article 2 of Chapter 34 and Chapter 36. In the event of conflict between the provisions of this chapter and other provisions of this title, the provisions of this chapter shall be controlling. A policy or certificate that is not primarily advertised, marketed or offered as long-term care insurance is not required to meet the provisions of this chapter.

§ 38.2-5002. Standards for Policy Provisions.

A. The Commission may adopt regulations to establish specific standards for policy provisions of long-term care insurance policies. These standards shall be in addition to and in accordance with applicable laws of this Commonwealth, and shall address terms of renewability, non-forfeiture provisions if applicable, initial and subsequent conditions of eligibility, non-duplication of coverage provisions, coverage of dependents, pre-existing conditions, termination of insurance, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definitions of terms.

B. Regulations issued by the Commission shall:

1. Recognize the unique, developing and experimental nature of long-term care insurance;

2. Recognize the appropriate distinctions necessary between group and individual long-term care insurance policies; and

3. Recognize the unique needs of both those individuals who have reached retirement age and those pre-retirement individuals interested in purchasing long-term care insurance products.

§ 38.2-5003. Prohibited Provisions. No long-term care insurance policy may:

A. Be cancelled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificateholder; or,

B. Contain a provision establishing any new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder.

§ 38.2-5004. Preexisting Conditions.

A. No long-term care insurance policy or certificate shall use a definition of "Preexisting condition" which is more restrictive than the following: Pre-existing condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment, or a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within twelve (12) months preceding the effective date of coverage of an insured person.

B. No long-term care insurance policy may exclude coverage for a loss or confinement which is the result of a preexisting condition for a period of confinement longer than twelve (12) months following the effective date of coverage of an insured person.

C. The Commission may extend the limitation periods set forth in subsections A and B above as to specific age group categories or specific policy forms upon findings that the extension is in the best interest of the public.

D. The definition of "preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application underwriting in accordance with that insurer's established underwriting standards for long-term care insurance policies.

§ 38.2-5005. Prior Institutionalization.

A long-term care insurance policy which provides benefits only following institutionalization shall provide benefits to an insured if the insured has been discharged from the facility within the previous thirty days for the same or related conditions.

§ 38.2-5006. Rates.

A. No regulation shall establish loss ratio standards for long-term care insurance policies unless a specific reference to long-term care insurance policies is contained in the regulation. However, any individual long term care policies which, in the opinion of the Commission, could be classified as limited benefit health policies shall be subject to limited benefit loss ratio standards.

B. The regulation promulgated under this section shall recognize the unique, developing and experimental nature of long-term care insurance and shall recognize the unique needs of those individuals who have reached retirement age and the needs of those pre-retirement individuals interested in purchasing long-term care insurance policies.

C. A certificate by a qualified actuary or other qualified professional approved by the Commission, as to the adequacy of the rates and reserves shall be filed with the Commission along with adequate supporting information.

§ 38.2-5007. Disclosure.

In order to provide for fair disclosure in the sale of long-term care insurance policies:

A. An outline of coverage shall be delivered to an applicant for an individual long-term care insurance policy at the time of application for an individual policy. In the case of direct response solicitation, the insurer shall deliver the outline of coverage upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. Such outline of coverage shall include:

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

2. A statement of the exclusions, reductions and limitations contained in the policy;

3. A statement of the renewal provisions, including any reservation in the policy of a right to change premiums; and

4. A statement that the outline of coverage is a summary of the policy issued or applied for, and that the policy should be consulted to determine governing contractual provisions.

B. A certificate delivered or issued for delivery in this Commonwealth shall include:

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

2. A statement of the exclusions, reductions and limitations contained in the policy; and

3. A statement that the group master policy should be consulted to determine governing contractual provisions.

C. The Commission shall adopt and publish a Long-Term Care Insurance Consumer Guide. After adoption and publication by the Commission, a copy of the Consumer Guide shall be provided at the time of delivery of the policy or certificate.

§ 38.2-5008. Right to Return - Free Look Provision

A. Individual long-term care insurance policies shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within ten (10) days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. A policy returned pursuant to the notice shall be void from its inception upon the mailing or delivery of the policy to the insurer or its agent.

B. Long-term care insurance policies or certificates issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page or attached thereto stating in substance that the insured person shall have the right to return the policy within thirty (30) days of its delivery and to have the premium refunded if after examination the insured person is not satisfied for any reason. A policy returned pursuant to the notice shall be void from its inception upon the mailing or delivery of the policy or certificate to the insurer or its agent.