

**FINAL REPORT OF THE
JOINT SUBCOMMITTEE STUDYING**

**The NAIC Long-Term Model
Act and Regulation and
the Designation of Family
Resources for the Long-Term
Care of the Disabled**

**TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA**



HOUSE DOCUMENT NO. 76

**COMMONWEALTH OF VIRGINIA
RICHMOND
1990**

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**REPORT OF THE JOINT SUBCOMMITTEE
STUDYING THE NAIC LONG-TERM MODEL ACT AND REGULATION &
THE DESIGNATION OF FAMILY RESOURCES FOR THE LONG-TERM CARE
OF THE DISABLED**

to

**The Governor and the General Assembly of Virginia
Richmond, Virginia**

**To: The Honorable L. Douglas Wilder, Governor of Virginia,
and
The General Assembly of Virginia**

I. Executive Summary

A. Study Authority and Scope.

House Joint Resolution 332 (HJR 332) of 1989 (Appendix A) established a joint subcommittee (the Subcommittee) to study two issues. First, the Subcommittee was directed to reexamine the Virginia Long-Term Care Act in the light of recent amendments to the National Association of Insurance Commissioners' (NAIC) model long-term care act. A review of the NAIC's model long-term care regulations was also part of the Subcommittee's work. To date, long-term care insurance regulations have not been adopted in Virginia.

The Subcommittee also considered a related issue: supplementary trusts for disabled individuals. Virginia code §55-19.1 reputedly prevents some parents from establishing trusts intended to supplement (but not supplant) the public benefits their disabled children receive such as Medicaid, Supplementary Security Income (SSI), and custodial care in public institutions. This statute enables the Commonwealth to invade virtually any trust to recover public funds expended on behalf of a trust's beneficiary -- regardless of the trust's purpose or structure. Advocates for disabled children and their families suggest that this law compels parents to disinherit their disabled children rather than give them financial resources that can be seized by the Commonwealth.

The Subcommittee consisted of seven members appointed as follows: One member from each of the following House Committees was appointed by the Speaker of the House: Health, Welfare and Institutions; Courts of Justice; and Corporations, Insurance and Banking. One member at-large from the House of Delegates was also appointed. The Senate committee on Privileges and Elections appointed one member from each of the following Senate Committees: Education and Health; Courts of Justice; and Commerce and Labor.

Delegate Bernard S. Cohen served as the Subcommittee's Chairman. Delegate Stephen H. Martin served as its Vice-Chairman. Other members appointed to serve from the House of Delegates were Franklin P. Hall and Joan H. Munford.

Members appointed to serve from the Senate were W. Onico Barker, John H. Chichester, and Johnny S. Joannou.

Arlen Kent Bolstad, Esq., Mary P. Devine, Esq., and Mark C. Pratt, Research Analyst, all of the Division of Legislative Services, served as legal and research staff to the Subcommittee. Barbara Hanback and Anne Howard from the House Committee Operation's office provided administrative assistance to the Subcommittee.

The Subcommittee held its first meeting in Richmond on June 22, 1989. Subsequently, the Subcommittee convened a work session and a public hearing. The Subcommittee held its final meeting in Richmond on December 4, 1989, to discuss its findings and recommendations, and to finalize legislative proposals for the 1990 session of the General Assembly.

B. Subcommittee Recommendations and Findings: NAIC Amendments to the model long-term care act.

1. Findings. The Subcommittee found that most of the NAIC's amendments to its model long-term care act were consistent with the policies embraced in the Virginia Long-Term Care Act (the Virginia Act). Moreover, the Subcommittee found that incorporating these amendments into the Virginia Act would be beneficial to elderly consumers purchasing long-term care insurance. Additionally, it was generally agreed that some of the amendments would assist long-term care insurers, as well, by providing some clarification about the Commonwealth's requirements where long-term care benefits are offered through annuities and life insurance policy riders.

2. Recommendations. The Subcommittee recommended legislation incorporating most of these NAIC amendments into the Virginia Act. The proposed legislation is annexed as Appendix B. The amendments, if adopted, would:

a) Expand the definition of "long-term care insurance" in §38.2-5200 to include annuities and life insurance policies or riders that provide long-term care benefits. The amendments also mandate certain disclosures in conjunction with the sale of these hybrid products;

b) Reduce existing 12-month preexisting condition exclusions permitted in §38.2-5204 to 6 months;

c) Eliminate all prior hospitalization and higher level of institutional care preconditions presently permitted under §38.2-5205;

d) Provide a uniform 30-day period following policy delivery in which a purchaser of long-term care insurance can return the policy for a full refund of premium;

e) Prohibit policies providing skilled nursing care benefits only, or disproportionately greater coverage for skilled care than for lower levels of care in a facility. Note: This NAIC amendment did not receive the Subcommittee's full endorsement, but its purpose was deemed worthy of further consideration by the General Assembly; and

f) Direct the State Corporation Commission to prescribe a standard long-term care insurance policy outline.

C. Subcommittee Findings and Recommendations: Supplemental Trusts for Disabled Individuals.

1. Findings. The Subcommittee reviewed this issue at length. It heard testimony from parents of disabled children, groups such as the Planned Lifetime Assistance Network (PLAN) of Charlottesville, Virginia that assist parents and others in caring for disabled persons, agencies of the Commonwealth that served the disabled, and legal experts in the areas of estates and trusts.

The Subcommittee found that §55-19.1 of the Code of Virginia was enacted to promote the use of private resources to cover individual health care and living expenses, whenever possible, thus reserving public benefit programs for those who are genuinely needy. The Subcommittee learned of two elderly trust beneficiaries who were forced to seek public assistance through Medicaid, and other programs, when the trustee refused to expend money for their support and maintenance. Apparently, this specific case was the catalyst for the enactment of §55-19.1.

However, the Subcommittee also found that §55-19.1 has had the unintended effect of inhibiting the creation of trusts intended to supplement public benefits received by disabled individuals. Consequently, the Subcommittee concluded that the interests of the Commonwealth, and the interests of the disabled and their families would be best served by repealing §55-19.1 and amending §55-19 to (i) articulate the Commonwealth's right to be reimbursed from a spendthrift trust where its beneficiary has received public benefits, and (ii) exempt disabled individuals' supplemental trusts from invasion by the Commonwealth.

2. Recommendations. Accordingly, the Subcommittee recommended that the General Assembly adopt a legislative proposal accomplishing these objectives. The proposal is annexed as Appendix E to this report.

II. Subcommittee Deliberations.

A. Overview.

1. Summary of the issue and the Subcommittee's work: NAIC model act amendments.

a. Background: long-term care insurance. Dramatic improvements in nutrition and health care have resulted in equally dramatic increases in the nation's elderly population. Ironically, however, increased life expectancies resulting from a superior health care system are frequently attended by poor health and dependence on others. Consequently, nursing homes, adult retirement homes, senior citizens communities, and similar facilities provide care and shelter to many in this burgeoning group.

The Virginia State Corporation Commission's (the Commission) guide to long-term care insurance reports that one in four individuals will spend some time in a nursing home. Of that number, one-third will stay longer than three months. The annual cost of nursing home care in Virginia is not inexpensive. The Commission's guide notes that costs average from \$15,000 to \$26,000 annually, or from \$1200+ to \$2100+ per month.

Nursing home residents typically meet the cost of their care through (i) private resources, or (ii) Medicaid, if they are without private resources. Long-term care insurance is a third alternative, serving as a specialized form of health care insurance that frequently covers nursing home care. For some, it may preclude the necessity of exhausting personal resources and becoming totally dependent on Medicaid funding for nursing home care.

Long-term care insurance policies, however, vary to the same degree as ordinary health insurance products. The types of services, facilities and care covered will vary widely, as will the duration of these coverages. Many policies distinguish between "skilled," "intermediate," "custodial" and "home" levels of care and link coverages and duration of benefits to those terms. Coverage limitations tied to specified coverage exclusions (e.g., Alzheimer's disease) and preexisting conditions add further intricacies to many policies.

b. Background: the Virginia Long-Term Care Act. The Virginia Long-Term Care Insurance Act of 1987 (Virginia Code §38.2-5200, et seq.) requires long-term care policies issued or issued for delivery in the Commonwealth to conform to a number of requirements. The law was patterned after the National Association of Insurance Commissioners' (NAIC) model long-term care act. It was intended to establish certain minimum standards for long-term care policies, and help older consumers find policies best suited to their needs by requiring insurers to disclose critical policy features such as principal coverages, exclusions, and renewal provisions. The law also provides long-term care insurance purchasers the right to return these policies for a full refund of premium, if returned within a stipulated number of days following delivery.

The NAIC's model act has been amended several times since the Virginia Act's 1987 adoption. The amendments addressed the following issues: a) coverage exclusions linked to preexisting conditions; b) coverage preconditions tied to prior hospitalization; c) long-term care insurance marketed as riders to life insurance policies; and d) uniform "free look" periods in which policies can be returned and premiums fully refunded.

c. Subcommittee study focus. The Subcommittee was directed by the study resolution to examine the NAIC amendments and advise the General Assembly and Governor whether the amendments should be incorporated into the Virginia Long-Term Care Act. Additionally, the Subcommittee was directed to look at the NAIC's long-term care model regulations. These regulations have been adopted in a number of states. However, Virginia has no long-term care insurance regulations in place at this time.

d. The NAIC amendments discussed. The Subcommittee discussed the following proposals expressed in the NAIC model act amendments:

1) Regulating long-term care insurance offered through annuities and life insurance policy riders. The Subcommittee learned that a number of insurance companies have blended long-term care benefits into life insurance and annuity products. These hybrid policies permit, in some instances, the insured to "spend" some variant of the policy's cash value on long-term care benefits. Typically, however, electing to use the long-term care benefits will result in coordinate reductions of death benefits payable under the policy.

The NAIC model act amendments suggest language stating unambiguously that these hybrid policies are subject to the provisions of the Long-Term Care Act. Moreover, such policies are subject to specific disclosure provisions which, among other things, require the insurer to provide the insured a detailed policy summary. The insurer must also furnish monthly statements once the insured elects to utilize the long-term care component of a life insurance policy. The statement must inform the insured of (i) benefits paid during the previous month, (ii) any changes of cash value or death benefits as a consequence of long-term care benefit payments, and (iii) the amount of remaining long-term care benefits.

2) Modifying preexisting conditions exclusions. If incorporated into the Virginia Act, the NAIC amendments would reduce the length of time an insurer can exclude coverage for the expense of those conditions that existed before the policy went into effect. Such preexisting conditions can be excluded for up to 12 months under current law. The amendment would reduce the maximum exclusion period to six months.

3) Eliminating prior institutionalization and higher level of care requirements. §38.2-5205 of the Virginia Act permits an insurer to write policies that make the receipt of long-term care benefits, such as nursing home benefits,

contingent upon the insured's discharge from an institution (such as a hospital) within the previous sixty days before applying for benefits. The Subcommittee was advised that this requirement often results in hospital admissions intended solely to qualify an elderly patient for his long-term care insurance benefits.

The NAIC model act amendments considered and ultimately approved by the Subcommittee generally prohibit these requirements and expressly bar their use as preconditions to payment of home care and home health care benefits. A narrow exception for other noninstitutional benefits is made provided, however, that the prior institutional stay required not exceed thirty days. The NAIC amendments considered and approved in a closely related area prohibit coverage preconditions tied to a policyholder's prior receipt of higher levels of institutional care. Within this prohibition fall contracts that require, for example, the policyholder's prior receipt of skilled care as a precondition to coverage for intermediate care.

Subsequent to the Subcommittee's final meeting on December 4, 1989, the NAIC revised its proposed Model Act amendments to permit insurers to condition waiver of premium as well as post-confinement, post-acute care and recuperative benefits on prior institutionalization. The details of this revision were communicated to the Subcommittee chairman by the Bureau of Insurance when the General Assembly convened in January 1990.

However, the Subcommittee's chairman felt that the sense of the Subcommittee was not to permit such preconditions and, therefore, this NAIC revision was not incorporated into House Bill 595 before its introduction, nor was it offered as an amendment to that bill prior to its passage in the 1990 session. Consequently, the amendments to Section 38.2-5205 approved by this Subcommittee (Appendix B) and subsequently by the General Assembly in House Bill 595 (p/o Appendix F), incorporate the NAIC's prior policy position on this issue: long-term care insurers are not permitted to use prior institutionalization as a prerequisite to providing policy benefits, with the exception of noninstitutional care noted above.

4) Unifying "Free look" periods. §38.2-5208 presently permits an insured to return a long-term care policy for a full refund of premium if (i) returned within 10 days of its delivery, or (ii) returned within 30 days of delivery if the policy was solicited through "direct response" solicitation (e.g., television advertising encouraging application via "800" telephone numbers). The NAIC model act amendments eliminate the separate return periods and create one unitary 30-day return period. Some suggested that the change was not grounded purely in symmetry because elderly individuals may need more than 10 days under any circumstances to discuss a policy purchase with family members or trusted advisors.

5) Prohibiting policies weighted toward skilled care. The amendments further prohibit the sale of policies that provide coverage for "skilled care" only, or provide coverage that is disproportionately weighted toward "skilled

care" coverage. The Subcommittee learned that "skilled care" coverage encompasses care requiring the attention of medical professionals due to an acute medical condition. "Intermediate care" describes the care required by elderly individuals who need assistance in many aspects of daily living, but do not require sustained medical attention. Apparently, "intermediate care" is the type of care most long-term care insurance purchasers expect from long-term care policies.

Most of the Subcommittee members agreed that this model act amendment was probably designed to prevent the sale of "skilled care" policies that may be of little practical value to many. However, the Subcommittee withheld its full endorsement of the amendment because several members believed its implementation would present practical difficulties. For example, some noted, the coverages provided by many long-term care policies are "tiered" with the highest daily benefit paid for skilled care, the next highest for intermediate care, and the lowest for custodial care. This structure, some said, reflects the relative cost of care, i.e., skilled care simply costs more than intermediate care, etc.

Thus, while endorsing the prohibition of policies offering coverage for skilled care, alone, the Subcommittee believed that the tiered structure of long-term care policies would render insurer conformance to the "weighting" prohibition problematic, at best. However, the Subcommittee also believed that this amendment merited discussion by the members of the General Assembly.

6) Requiring long-term care policy outlines. Finally, the model act amendments authorize the State Corporation Commission's Bureau of Insurance to develop a policy outline for long-term care insurance policies. This, in effect, permits the Bureau of Insurance to prescribe a standardized long-term care policy format for all offering this coverage in the Commonwealth.

7) Miscellaneous amendments. The Subcommittee also endorsed amendments suggested by the NAIC that would amend §§38.2-5201 and 38.2-5202 of the Virginia Act. The former brings all policies that offer long-term care benefits within the Act's purview. The current law excludes from the Act's coverage those policies that are not "primarily" long-term care policies. The amendment to §38.2-5202 enables the State Corporation Commission to adopt long-term care policy standards, in addition to those prescribed, that are deemed appropriate by the Commission.

e. Subcommittee Recommendations: NAIC Model Act Amendments. The Subcommittee endorsed the NAIC long-term care model act amendments summarized in subparagraphs 1), 2), 3), 4), 6) and 7), as discussed above. While endorsing the NAIC's intent in the amendment discussed in subparagraph 5), the Subcommittee declined to endorse the express language contained in the amendment. The Subcommittee's legislative proposal is Appendix B.

f. Subcommittee Recommendation: The NAIC Model Regulations. At the suggestion of Insurance Commissioner Stephen Foster, the Subcommittee devoted only a limited amount of time to the NAIC model regulations. The Commissioner said that the content of Virginia-specific long-term care regulations will depend, in large part, on the General Assembly's action on the NAIC model act amendments.

The Long-Term Care Advisory Council, an advisory group comprised of representatives from the health insurance industry, the Department of Medical Assistance Services, the Bureau of Insurance, and others interested groups, assisted the Subcommittee in reviewing the model regulations. They prepared a report for the Subcommittee detailing their recommendations on long-term care insurance regulations for Virginia policies. A copy of that report is Appendix C.

2. Summary of the issue and the Subcommittee's work: Supplementary trusts for disabled individuals.

a. Background: family resources and disabled individuals. A substantial number of individuals in the Commonwealth are physically or mentally disabled and must depend on others for their care and well-being. The cost of food, shelter, clothing, medical treatment and, in many cases, institutionalization, for these disabled individuals is borne by private resources, insurance, and public funding -- separately, or in combination.

In many cases, however, the expense of caring for disabled individuals exceeds private resources. Consequently, many families depend on public programs -- principally Medicaid and Supplemental Security Income (SSI) -- to cover the expense of medical care and maintenance needs.

Medicaid covers the cost of an individual's medical care, including physician services, diagnostic tests, hospitalization expenses, and other related services. SSI provides monthly cash payments to eligible disabled individuals who may receive up to \$368 per month. Significantly, both Medicaid and SSI are funded by state and federal governments; both are subject to federal regulations and program guidelines. SSI is administered through local Social Security Administration offices; Medicaid is administered in the Commonwealth by the Department of Medical Assistance Services (DMAS).

Disabled individuals are categorically eligible for SSI and Medicaid. However, they must also satisfy income and resource eligibility standards to qualify for these programs. Generally, an individual with resources less than \$2,000 and an annual income of less than \$4,250 is eligible for both programs.

A number of assets, including an individual's home (entire value), automobile (up to \$4,500 in value) and other enumerated items, are not counted as resources in determining SSI benefit eligibility. The Department of Medical Assistance Services advised the Subcommittee, however, that the \$4,000+ resource

level is applicable only to those receiving both SSI and Medicaid. Virginia residents eligible for Medicaid, only, must satisfy stricter resource requirements: a maximum of \$2600 - \$3900 of non-excluded resources are permitted, depending on where the applicant resides in the Commonwealth.

The income and resources of a disabled child's parents are deemed that of the child for SSI and Medicaid eligibility purposes. However, when the disabled child reaches age 18, only the child's income and resources can, as a matter of law, be taken into consideration when determining economic need. One final note on financial eligibility: if a disabled person's income or resources exceed the thresholds discussed above, the excess must be "spent down" in order to establish, or reestablish eligibility for full benefits.

Medicaid and SSI benefits cover a disabled individual's most basic needs, only. Life-enhancing items and services, such as special education classes, must be funded by other sources. Parents or guardians of the disabled frequently provide these extra services, while they are alive. However, many parents and guardians want to ensure that these "extras" will be provided in the event they are unable, due to death or disability, to provide them directly.

b. Supplemental trusts. Some address this problem by creating trusts that fund the "extras." Since the trust principal and income could render a disabled person ineligible for SSI and Medicaid (until "spent down" to maximum income and resource levels), the trust instrument must be drafted with care.

The Subcommittee was advised that some attorneys recommend that supplemental trusts employ express language prohibiting payments from the trust for support and maintenance of the disabled child. Others advise the use of trusts with so-called "spendthrift" clauses to immunize such trusts from the claims of creditors. Still others advocate "discretionary" trusts in which the disabled beneficiary has no enforceable interest; the amount and timing of payments rest solely within the trustee's discretion.

c. Virginia Code §55-19.1. Advocates for the disabled, however, contend that current Virginia trust law inhibits the creation of supplementary trusts -- even discretionary trusts -- regardless of drafting technique. Virginia Code §55-19.1 (Appendix D) permits the Commonwealth to seek "reformation" of any trust whose beneficiary has received public benefits "from any state and federal program of assistance." The statute authorizes a "reformation" order directing the trust's trustee to compensate the Commonwealth for benefits previously received. Furthermore, the statute says that a discretionary trust's trustee may be directed to "exercise...such discretion." Even the income from a spendthrift trust is not exempt from such an order.

Thus, the statute expressly permits trusts -- including supplementary trusts -- to be invaded for the purpose of reimbursing the Commonwealth for Medicaid, SSI and other benefits received by their disabled beneficiaries. Accordingly, a trust may be "reformed" to accomplish a purpose inconsistent with the parent-grantor's intent. The

net effect, advocates for the disabled argue, is that parents of disabled children are forced to disinherit such children rather than create trusts of little practical value, whose principal and income could be seized under the authority of §55-19.1.

d. Practical and policy considerations. Nearly all study participants agreed that the statute may operate unfairly when applied to the specific case of supplementary trusts for disabled children and other disabled individuals. Some suggested that the obvious solution lie in repealing it. Representatives from Department of Medical Assistance Services (DMAS), Virginia's Medicaid coordinator, cautioned the Subcommittee that the statute may perform the salutary function of discouraging the creation of trusts intended to circumvent Medicaid and SSI financial eligibility criteria. They advised the Subcommittee's that the law addressed a problem can arises when a trust's trustee is also its remainderman. In one case, they said, two elderly trust beneficiaries were forced to seek public assistance when the trustee refused to expend money for their support. DMAS representatives conceded, however, that no reformation actions for Medicaid reimbursement have been brought by the Attorney General under the authority of this statute, since its 1981 enactment.

Professor John Donaldson of the Marshall-Wythe School of law at the College of William and Mary observed that a simple repeal would provide immediate relief to parents and guardians of disabled children while leaving, however, many important questions unanswered. Concurring in this observation was Professor Rodney Johnson of the T.C. Williams School of Law at the University of Richmond. Professors Donaldson and Johnson are professors of trusts and estates law.

Professors Donaldson and Johnson pointed out that eliminating the statute would leave unresolved the posture of the Commonwealth toward spendthrift trusts. Most state supreme courts addressing this issue have held that unless a statute provides otherwise, they noted, a trust's spendthrift provision does not bar a state's creditor claims.

Thus, repealing §55-19.1, alone, they suggested, would create an ambiguity in the law requiring a subsequent judicial determination of whether a spendthrift trust clause, in a trust subject to Virginia law, bars creditor claims of the Commonwealth. Moreover, they added, until such a determination, the law would be unsettled and attorneys drafting supplemental trusts for the benefit of the disabled would be without essential guidance on this key issue. Moreover, if the Virginia Supreme Court eventually ruled on this issue and, thereupon, adopted the rule followed in sister-states, such supplementary trusts would be as vulnerable to Commonwealth invasion as they presently are under §55-19.1.

Professors Donaldson and Johnson suggested that Virginia adopt the approach taken by Wisconsin and other states in declaring that spendthrift trusts are not exempt from a state's creditor claims unless established for the benefit of disabled individuals. A legislative proposal along this line was drafted by Professor Donaldson and presented to the Subcommittee for consideration.

The draft proposal, annexed as Appendix E, repeals §55-19.1 and amends §55-19 -- the statute authorizing spendthrift trusts not exceeding \$500,000 in value. The amendment provides that the Commonwealth's creditor claims are not generally barred by a trust's spendthrift provision (subsection B). Second, it states that where a trust's creator is also its beneficiary, a spendthrift provision is no bar to any creditor of the creator, including the Commonwealth (subsection C). Additionally, it authorizes the Commonwealth to utilize an accelerated proceeding in circuit court to obtain reimbursement for public assistance benefits (such as Medicaid) provided to a trust's beneficiary (subsection D).

However, subdivision two of subsection D prohibits the circuit court from compelling reimbursement payments to the Commonwealth where the trust beneficiary is an individual "who has a medically determined physical or mental disability that substantially impairs his ability to provide for his care or custody and constitutes a substantial handicap."

The proposal also amends §37.1-110 of the Virginia Code to provide that the Department of Mental Health, et al, may not proceed against a trust for a disabled person meeting the criteria of §55-19 when seeking reimbursement for the cost of a trust beneficiary's institutionalization in a state hospital. This amendment was deemed essential to the implementation of §55-19 since §§37.1-105 - 37.1-119 expressly address Department procedures for obtaining reimbursement for the cost of institutionalization from the assets and income of state hospital patients.

Some members of the Subcommittee expressed concern that these amendments would encourage the creation of large spendthrift trusts for disabled persons (a \$500,000 ceiling is authorized by §55-19) while, concurrently, permitting their beneficiaries to receive public benefits under Medicaid, SSI and other public programs. It was generally agreed, however, that financial eligibility for these programs is an issue that must be distinguished from the question of Commonwealth reimbursement.

If the terms of a trust valued at \$500,000, for example, gave its disabled beneficiary complete access to all of the trust's principal and income, full disclosure of the availability of this financial resource would, in all likelihood, result in the denial of SSI and Medicaid benefits under current resource/income criteria. If such a trust was created and became operative after its disabled beneficiary had begun to receive Medicaid or SSI benefits, the beneficiary would probably be disqualified from receiving further benefits under these programs.

Thus, it proponents noted, this legislative proposal would not give the financially able a "free ride" on the public benefits system, nor would it compromise the need-based eligibility standards that govern these programs. Instead, §55-19, as amended, would simply provide that a trust's spendthrift provision is not a bar to the Commonwealth's enforcement of creditor rights against such a trust, except in the case of trusts established for disabled persons.

The General Assembly, of course, cannot mandate federal policy on the question of federal reimbursement from trusts for that portion of public benefits funded by the federal government. The Subcommittee was advised by Professor Donaldson, however, that federal legislative history in the Medicaid and SSI areas suggests that the federal government is unlikely to seek reimbursement for SSI or Medicaid from disabled persons' trusts. Moreover, the federal government has no law or regulation similar to §55-19.1. Consequently, some suggested, the current Virginia law is the greatest barrier to the creation of supplementary trusts for disabled persons.

e. Findings and Recommendations.

1) Findings. The Subcommittee reviewed this issue at length. It heard testimony from parents of disabled children, groups such as the Planned Lifetime Assistance Network (PLAN) of Charlottesville, Virginia that assist parents and others in caring for disabled persons, agencies of the Commonwealth that served the disabled, and legal experts in the areas of estates and trusts.

The Subcommittee found that §55-19.1 of the Code of Virginia was enacted to promote the use of private resources to cover individual health care and living expenses, whenever possible, thus reserving public benefit programs for those who are genuinely needy. The Subcommittee learned of two elderly trust beneficiaries who were forced to seek public assistance through Medicaid, and other programs, when the trustee refused to expend money for their support and maintenance. Apparently, this specific case was the catalyst for the enactment of §55-19.1.

However, the Subcommittee also found that §55-19.1 has had the unintended effect of inhibiting the creation of trusts intended to supplement public benefits received by disabled individuals. Consequently, the Subcommittee concluded that the interests of the Commonwealth, and the interests of the disabled and their families would be best served by repealing §55-19.1 and amending §55-19 to (i) articulate the Commonwealth's right to be reimbursed from a spendthrift trust where its beneficiary has received public benefits, and (ii) exempt disabled individuals' supplemental trusts from invasion by the Commonwealth.

2) Recommendations. Accordingly, the Subcommittee recommended that the General Assembly adopt a legislative proposal accomplishing these objectives. The proposal is annexed as Appendix E to this report.

B. Study Participants.

1. NAIC model act amendments. The Subcommittee was assisted on this issue by Ms. Anne Colley of the State Corporation Commission's Bureau of Insurance; Ms. Joan Gardner, Government Affairs Counsel to Blue Cross and Blue Shield of Virginia; and The Long Term Care Advisory Committee. Other individuals who provided testimony and comment on this issue included Peter Clendenin

representing the Virginia Health Care Association; Mr. Harley Tabak, President of the Health Care Association; and Ms. Roberta Meyer, counsel to the American Council of Life Insurers. The Subcommittee also heard from Dr. Arthur Fleming, former Secretary of the U.S. Department of Health, Education and Welfare.

2. Supplementary trusts for the disabled. Key testimony and significant drafting assistance on this issue was furnished by Professors John E. Donaldson of the Marshall-Wythe Law School at the College of William and Mary, and Rodney Johnson of the T. C. Williams School of Law at the University of Richmond. Other individuals who provided testimony or information to the Subcommittee included Ms. Jennifer Fidura, Deputy Commissioner of the Department of Mental Health; Ms. Carolyn White Hodgins, Director of the Department for the Rights of the Disabled; Commissioner Bruce Kozlowski of the Department of Medical Assistance Services; Ms. Ann Cook of the Department of Medical Assistance Services; Ms. Judy Kirkendall, Executive Director for the Planned Lifetime Assistance Network (PLAN); Ronnie Shorestein, Esq., of Arlington; Mr. Phillip Dresser from the Virginia Alliance of Mentally Ill; Mr. Arthur Jones, Member, Alexandria Community Services board.

III. Legislative Action

The Subcommittee's recommendation to incorporate the NAIC amendments into the Virginia Long-Term Care Act were formally proposed to the 1990 General Assembly as House Bill 595. House Bill 183 served as the vehicle for the proposed repeal of §55-19.1 and the amendments to §55-19 recommended by the Subcommittee. Both bills were approved by the General Assembly and are annexed as Appendix F.

IV. Conclusion

The Subcommittee welcomed this opportunity to examine two issues that are of vital interest to all Virginians: care of our elderly and protection of our disabled. The Subcommittee's legislative proposals reflect these concerns as well as invaluable input provided by concerned individuals, groups, professionals, business organizations and state agency representatives. Both issues require continual monitoring. To that end, individuals and groups who assisted the Subcommittee are encouraged to advise the General Assembly of all future developments affecting elderly and disabled where the legislative process should be invoked to assist them.

Respectfully submitted,

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V. Appendices

Appendix A -- House Joint Resolution 332 of 1989.

Appendix B -- HJR-332 Subcommittee Proposal re: NAIC Model Act Amendments.

Appendix C -- Long-Term Advisory Council recommendations re: long-term care insurance regulations for Virginia policies.

Appendix D -- Code of Virginia §55-19.1

Appendix E -- HJR-332 Subcommittee Proposal re: supplemental trusts for disabled individuals.

Appendix F -- House Bills 188 and 595.

HOUSE JOINT RESOLUTION NO. 332

Requesting a joint subcommittee to study the Long-term Care Insurance Model Regulation and the revisions to the Model Long-term Care Insurance Act adopted by the National Association of Insurance Commissioners, and to study the feasibility of allowing the designation of family resources for the long-term care of disabled persons.

Agreed to by the House of Delegates, February 24, 1989

Agreed to by the Senate, February 23, 1989

WHEREAS, long-term care insurance is a relatively new private financing mechanism for long-term care services, those services required due to a chronic illness or a condition lasting over a prolonged period of time, designed to assist the elderly in paying for such services without having to deplete all of their assets; and

WHEREAS, the elderly population, the primary users of such insurance, will increase in the future with the estimated number of persons over age eighty-five in the year 2000 being 129 percent higher than the same age group in 1980; and

WHEREAS, in 1987, the General Assembly enacted legislation to regulate the standards of long-term health care insurance policies, the terms of which are twelve months or longer, in order to protect the purchasers of such insurance; and

WHEREAS, the National Association of Insurance Commissioners (NAIC) has developed a model regulation for long-term care insurance which is designed to promote the availability of such insurance, protect applicants from unfair or deceptive sales or enrollment practices, facilitate public understanding of such insurance, and promote flexibility and innovation in the development of long-term care insurance; and

WHEREAS, at this time, insurance companies in Virginia may cancel long-term care policies with appropriate notice, but the Model Regulation would prohibit such practices by explicitly requiring that such policies be "guaranteed renewable" or "noncancellable"; and

WHEREAS, although definitions of terms such as "reasonable and customary" and "usual and customary" are not required to be defined in long-term care policies in Virginia now, the Model Regulation would require definitions of these terms within the policies; and

WHEREAS, since the enactment of the Virginia Long-term Care Insurance Act, the Model Long-term Care Insurance Act has been revised by the National Association of Insurance Commissioners and several of these revisions interact with the disclosure provisions of the Model Regulation; and

WHEREAS, the Commonwealth and affected families currently expend significant resources to meet the needs of the disabled; and

WHEREAS, many families wish to ensure the continuation of services to disabled family members after the nondisabled family members are deceased, but the current laws of the Commonwealth do not presently permit the establishment of specific mechanisms designed to address this problem thus limiting the ability of families to utilize their own resources to assist the Commonwealth in providing services; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That a joint subcommittee is hereby established to study the Long-term Care Insurance Model Regulation, the revisions to the Model Long-term Care Insurance Act adopted by the National Association of Insurance Commissioners, and the feasibility of allowing the designation of family resources for the long-term care of disabled persons. The joint subcommittee shall consist of seven members to be appointed as follows: one member each of the House Committees on Health, Welfare and Institutions, for Courts of Justice and on Corporations, Insurance and Banking, and one member at-large from the House of Delegates to be appointed by the Speaker of the House; one member each from the Senate Committees on Education and Health, for Courts of Justice and on Commerce and Labor to be appointed by the Senate Committee on Privileges and Elections.

The State Corporation Commission and all agencies of the Commonwealth shall provide assistance to the joint subcommittee upon request.

The joint subcommittee shall complete its work in time to submit its findings and recommendations to the Governor and the 1990 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for processing legislative documents.

LD017244

1 D 10/17/89 Bclstad C 12/11/89 jds

2 SENATE BILL NO. HOUSE BILL NO.

3 A BILL to amend and reenact §§ 38.2-5200, 38.2-5201, 38.2-5202,
4 38.2-5203, 38.2-5204, 38.2-5205, 38.2-5207, and 38.2-5208 of the
5 Code of Virginia and to amend the Code of Virginia by adding
6 sections numbered 38.2-5207.1 and 38.2-5207.2, all relating to
7 long-term care insurance.

8

9 Be it enacted by the General Assembly of Virginia:

10 1. That §§ 38.2-5200, 38.2-5201, 38.2-5202, 38.2-5203, 38.2-5204,
11 38.2-5205, 38.2-5207, and 38.2-5208 of the Code of Virginia are
12 amended and reenacted and that the Code of Virginia is amended by
13 adding sections numbered 38.2-5207.1 and 38.2-5207.2 as follows:

14 § 38.2-5200. Definitions.--As used in this chapter:

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

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

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

25 "Long-term care insurance" means any insurance policy ~~primarily-~~
26 or rider advertised, marketed, offered or designed to provide coverage
27 for not less than twelve consecutive months for each covered person

1 an expense incurred, indemnity, prepaid, or other basis, for one or
 2 or more necessary or medically necessary diagnostic, preventive,
 3 therapeutic, rehabilitative, maintenance, personal care, mental health
 4 or substance abuse services, provided in a setting other than an acute
 5 care unit of a hospital. Such term includes group and individual
 6 ~~policies-whether-annuities and life insurance policies or riders that~~
 7 ~~provide directly or that supplement long-term care insurance.~~
 8 Long-term care insurance may be issued by insurers, fraternal benefit
 9 societies, health services plans, health maintenance organizations,
 10 cooperative nonprofit life benefit companies or mutual assessment
 11 life, accident and sickness insurers to the extent they are otherwise
 12 authorized to issue life or accident and sickness insurance. Health
 13 maintenance organizations, cooperative nonprofit life benefit
 14 companies and mutual assessment life, accident and sickness insurers
 15 may apply to the Commission for approval to provide long-term care
 16 insurance.

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

22 § 38.2-5201. What laws applicable.--All policies and
 23 certificates shall comply with all of the provisions of this title
 24 relating to insurance policies and certificates generally, except
 25 Article 2 (§ 38.2-3408 et seq.) of Chapter 34 and Chapter 36 of this
 26 title. In the event of conflict between the provisions of this chapter
 27 and other provisions of this title, the provisions of this chapter
 28 shall be controlling. ~~A policy or certificate that is not primarily~~

~~1 advertised, marketed or offered as long-term care insurance is not
2 required to meet the provisions of this chapter.~~

3 § 38.2-5202. Standards for policy provisions.--A. The Commission
4 may adopt regulations to establish specific standards for policy
5 provisions of long-term care insurance policies. These standards
6 shall be in addition to and in accordance with applicable laws of this
7 Commonwealth ~~and~~. The standards shall address terms of
8 renewability, nonforfeiture provisions if applicable, initial and
9 subsequent conditions of eligibility, continuation or conversion from
10 ~~group long-term care to individual long-term care coverage,~~
11 nonduplication of coverage provisions, coverage of dependents,
12 preexisting conditions, termination of insurance, probationary
13 periods, limitations, exceptions, reductions, elimination periods,
14 requirements for replacement, recurrent conditions, and definitions of
15 terms and may address any other standards considered appropriate by.
16 the Commission .

17 B. Regulations issued by the Commission shall:

- 18 1. Recognize the unique, developing and experimental nature of
19 long-term care insurance;
- 20 2. Recognize the appropriate distinctions necessary between group
21 and individual long-term care insurance policies; and
- 22 3. Recognize the unique needs of both those individuals who have
23 reached retirement age and those preretirement individuals interested
24 in purchasing long-term care insurance products.
- 25 4. Recognize the appropriate distinctions necessary between
26 long-term care insurance and accident and sickness insurance policies,
27 prepaid health plans, and other health service plans.

28 § 38.2-5203. Prohibited provisions.--No long-term care insurance

1 policy may:

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

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

10 3. Provide coverage for skilled nursing care only or provide
11 significantly more coverage for skilled care in a facility than
12 coverage for lower levels of care .

13 § 38.2-5204. Preexisting conditions.--A. No long-term care
14 insurance policy or certificate shall use a definition of "preexisting
15 condition" which is more restrictive than the following: "preexisting
16 condition" means the existence of symptoms which would cause an
17 ordinary prudent person to seek diagnosis, care or treatment, or a
18 condition for which medical advice or treatment was recommended by, or
19 received from a provider of health care services, within ~~twelve-six~~
20 months preceding the effective date of coverage of an insured person.

21 B. No long-term care insurance policy may exclude coverage for a
22 loss or confinement which is the result of a preexisting condition for
23 a period of confinement longer than ~~twelve-six~~ months following the
24 effective date of coverage of an insured person.

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

1 D. The definition of "preexisting condition" does not prohibit an
 2 insurer from using an application form designed to elicit the complete
 3 health history of an applicant, and, on the basis of the answers on
 4 that application, underwriting in accordance with that insurer's
 5 established underwriting standards for long-term care insurance
 6 policies. Unless otherwise provided in the policy or certificate, a
 7 preexisting condition, regardless of whether it is disclosed on the
 8 application, need not be covered until the waiting period described in
 9 subsection A or B expires. No long-term care insurance policy or
 10 certificate may exclude or use waivers or riders of any kind to
 11 exclude, limit, or reduce coverage or benefits for specifically named
 12 or described preexisting diseases or physical conditions beyond the
 13 waiting period described in subsection A or B.

14 § 38.2-5205. Prior institutionalization.-- A-A. No long-term
 15 care insurance policy which provides benefits only following
 16 institutionalization shall provide benefits to an insured if the
 17 insured has been discharged from a facility within the previous sixty
 18 days for the same or related conditions may be delivered or issued
 19 for delivery in this Commonwealth if such policy conditions
 20 eligibility (i) for any benefits provided in an institutional care
 21 setting on the receipt of a higher level of institutional care or (ii)
 22 for any benefits on a prior hospitalization requirement.

23 B. A long-term care insurance policy containing any limitations
 24 or conditions for eligibility other than those prohibited in subsection
 25 A shall clearly label such limitations or conditions, including any
 26 required number of days of confinement, in a separate paragraph of the
 27 policy or certificate entitled "Limitations or Conditions on
 28 Eligibility for Benefits."

1 ~~C. A long-term care insurance policy containing a benefit~~
 2 ~~advertised, marketed or offered as a home health care or home care~~
 3 ~~benefit may not condition receipt of benefits on a prior~~
 4 ~~institutionalization requirement.~~

5 ~~D. A long-term care insurance policy which conditions~~
 6 ~~eligibility of noninstitutional benefits on the prior receipt of~~
 7 ~~institutional care shall not require a prior institutional stay of~~
 8 ~~more than thirty days for which benefits are paid.~~

9 § 38.2-5207. Disclosure.--In order to provide for fair
 10 disclosure in the sale of long-term care insurance policies:

11 1. An outline of coverage shall be delivered to an applicant for
 12 an individual long-term care insurance policy at the time of
 13 application for an individual policy. In the case of direct response
 14 solicitation, the insurer shall deliver the outline of coverage upon
 15 the applicant's request, but regardless of request shall make such
 16 delivery no later than at the time of policy delivery. The Commission
 17 shall prescribe a standard format, including style, arrangement, and
 18 overall appearance, and the content of an outline of coverage. In the
 19 case of agent solicitations, an agent shall deliver the outline of
 20 coverage prior to the presentation of an application or enrollment
 21 form. In the case of direct response solicitations, the outline of
 22 coverage shall be presented in conjunction with any application or
 23 enrollment form.

24 Such outline of coverage shall include:

25 a. A description of the principal benefits and coverage provided
 26 in the policy;

27 b. A statement of the exclusions, reductions and limitations
 28 contained in the policy;

1 c. A statement of the renewal provisions, including any
2 reservation in the policy of a right to change premiums —
3 Continuation or conversion provisions of group coverage shall be
4 specifically described ; and-

5 d. A statement that the outline of coverage is a summary of the
6 policy issued or applied for and that the policy should be consulted
7 to determine governing contractual provisions ;

8 e. A description of the terms under which the policy may be
9 returned and premium refunded; and

10 f. A brief description of the relationship of cost of care and
11 benefits .

12 2. A certificate delivered or issued for delivery in this
13 Commonwealth shall include:

14 a. A description of the principal benefits and coverage provided
15 in the policy;

16 b. A statement of the exclusions, reductions and limitations
17 contained in the policy; and

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

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

24 § 38.2-5207.1 Disclosure: life insurance policies.--Whenever an
25 individual life insurance policy which provides long-term care
26 benefits within the policy or by rider is delivered, it shall be
27 accompanied by a policy summary. In the case of direct response
28 solicitations, the insurer shall deliver the policy summary upon the

1 applicant's request, but regardless of request shall make such
 2 delivery no later than at the time of policy delivery. In addition to
 3 complying with all applicable requirements, the summary shall also
 4 include:

5 1. An explanation of how the long-term care benefit interacts
 6 with other components of the policy, including deductions from death
 7 benefits:

8 2. An illustration of the amount of benefits, the length of
 9 benefit, and the guaranteed lifetime benefits, if any, for each
 10 covered person; and

11 3. Any exclusions, reductions, and limitations on benefits of
 12 long-term care.

13 If applicable to the policy type, the summary shall also include
 14 (i) a disclosure of the effects of exercising other rights under the
 15 policy, (ii) a disclosure of guarantees related to long-term care
 16 costs of insurance charges, and (iii) current and projected maximum
 17 lifetime benefits.

18 § 38.2-5207.2. Long-term care benefits; monthly
 19 report.--Whenever long-term care benefits being paid are funded
 20 through a life insurance policy by acceleration of the death benefit,
 21 a monthly report shall be provided to the policyholder. Such report
 22 shall include:

23 1. Any long-term care benefits paid out during the month.

24 2. An explanation of any changes in the policy, e.g., death
 25 benefits or cash values, due to long-term care benefits being paid
 26 out; and

27 3. The amount of long-term care benefits existing or remaining.

28 § 38.2-5208. Right to return; free look provision.-- A---

1 ~~Individual-long-term~~ Long-term care insurance policies and
 2 certificates shall have a notice prominently printed on the first page
 3 ~~of-the-policy-or~~ attached thereto stating in substance that the
 4 policyholder ~~shall-have-or~~ insured person has the right to return the
 5 policy or certificate within ~~ten-thirty~~ days of its delivery and to
 6 have the premium refunded if, after examination of the policy or
 7 certificate, the policyholder or insured person is not satisfied for
 8 any reason. A policy or certificate returned pursuant to the notice
 9 shall be void from its inception upon the mailing or delivery of the
 10 policy or certificate to the insurer or its agent.

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

20

#

**Blue Cross
Blue Shield**
of Virginia



Joan M. Gardner
Government Affairs Counsel

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February 28, 1990

The Honorable Steven T. Foster
Commissioner of Insurance
State Corporation Commission
Bureau of Insurance
P O. Box 1157
Richmond, Virginia 23209

Re: Long-Term Care Insurance Regulation -
Recommendation of Long-Term Care Advisory Committee

Dear Commissioner Foster:


Enclosed for consideration by the State Corporation Commission and its Bureau of Insurance is the recommendation of the Long-Term Care Regulation Advisory Committee regarding a regulation for use in Virginia. The Advisory Committee was established slightly less than three years ago to assist the Bureau with analyzing the Long-Term Care Model Regulation of the National Association of Insurance Commissioners (NAIC) to determine its appropriateness for use in Virginia. A memorandum is enclosed also which compares the Advisory Committee's recommended regulation with the NAIC Model.

This recommended regulation represents the consensus of the Advisory Committee, the membership list of which is attached. If you or members of your staff have any questions or concerns regarding this recommendation, do not hesitate to contact me or other members of the Advisory Committee. While change at the NAIC on long-term care models will be constant, the Advisory Committee believes that the provisions incorporated in the attached recommendation are appropriate and responsive to the Long-Term Care Act in Virginia, including the statutory revisions to be effective July 1, 1990.

The Honorable Steven T. Foster
February 28, 1990
Page Two

Thank you for providing us with this opportunity to participate in the initial development process. We look forward to the State Corporation Commission's promulgation of this regulation so that carriers interested in providing long-term care insurance to Virginians will have the best guidance for working with the Bureau in getting quality products approved for use in Virginia.

Respectfully submitted,



Joan M. Gardner
Acting Chairman

JMG:bb
Enclosures

cc: Members of the Long-Term Care Regulation Advisory Committee

Members of HJR 332 Joint Legislative Subcommittee

The Honorable Bernard S. Cohen
The Honorable Franklin P. Hall
The Honorable Stephen H. Martin
The Honorable Joan H. Munford
The Honorable John H. Chichester
The Honorable Johnny S. Joannou
The Honorable W. Onico Barker

✓Arlen K. Bolstad, Staff Attorney

2/23/90

VIRGINIA

RULES GOVERNING LONG-TERM CARE INSURANCE

Section 1. Authority.

This Regulation is issued pursuant to the authority vested in the Commission under §§38.2-5200 through 38.2-5208.

Section 2. Purpose.

This Regulation is designed to:

1. promote the public interest;
2. promote the availability of long-term care insurance coverage;
3. promote public understanding and comparison of long-term care insurance coverages; and
4. promote flexibility and innovation in the development of long-term care insurance.

Section 3. Effective Date.

- A. This Regulation shall be effective on _____ (date)_____.
- B. No new policy form shall be approved on or after _____ (date)_____, unless it complies with this Regulation.
- C. No policy form shall be delivered or issued for delivery in this Commonwealth on or after _____ (date)_____, unless it complies with this Regulation.

Section 4. Applicability and Scope.

Except as otherwise specifically provided, this Regulation applies to all long-term care insurance policies delivered or issued for delivery in this Commonwealth on or after the effective date hereof, by insurers, fraternal benefit societies, health services plans, health maintenance organizations, cooperative non-profit life benefit companies or mutual assessment life, accident and sickness insurers.

Section 5. Definitions.

For purposes of this Regulation:

- A. "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 certificate holder.

- B. "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.
- C. "Expected Loss Ratio" is the ratio of the present value of future premiums to the present value of future benefits over the entire period of the contract.
- D. "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.
- E. "Long-term care insurance" means any insurance policy primarily advertised, marketed, offered or designed to provide coverage for not less than twelve 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, personal care, mental health or substance abuse 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 non-profit 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 care insurance.
- F. "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.

Section 6. Policy Definitions.

No long-term care insurance policy delivered or issued for delivery in this Commonwealth shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

- A. "Medicaid" shall be defined as the program administered in accordance with Title 32 of the Code of Virginia.
- B. "Medicare" shall be defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of

1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

- C. "Skilled nursing care", "intermediate care", "personal care", "home health care", and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.
- D. All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal care facility," "home for adults," and "home health care agency" shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

Section 7. Policy Practices and Provisions.

- A. Renewability. The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 8 of this regulation.
 - 1. No such policy issued to an individual shall contain renewal provisions less favorable to the insured than "guaranteed renewable"; however, the Commission may authorize nonrenewal on a statewide basis, on terms and conditions deemed necessary by the Commission, to best protect the interest of the insureds, if the insurer demonstrates:
 - a. That renewal will jeopardize the insurer's solvency; or
 - b. That:
 - (1) the actual paid claims and expenses have substantially exceeded the premium and investment income associated with the policies; and
 - (11) the policies will continue to experience substantial and unexpected losses over their lifetime; and
 - (111) the projected loss experience of the policies

cannot be significantly improved or mitigated through reasonable rate adjustments or other reasonable methods; and

(iv) the insurer has made repeated and good faith attempts to stabilize loss experience of the policies, including the timely filing for rate adjustments.

2. The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.
3. The term "noncancellable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

B. Limitations and Exclusions. No policy may be delivered or issued for delivery in this state as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

1. Preexisting conditions or diseases;
2. Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease, senile dementia, organic brain disorder or other similar diagnoses;
3. Alcoholism and drug addiction;
4. Illness, treatment or medical condition arising out of:
 - a. war or act of war (whether declared or undeclared);
 - b. participation in a felony, riot or insurrection;
 - c. service in the armed forces or units auxiliary thereto;
 - d. suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or
 - e. aviation (this exclusion applies only to non-fare-paying passengers).

5. Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.
 6. This Subsection B is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.
- C. Extension of Benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to one year, or the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.
- D. Continuation or Conversion.
1. Group long-term care insurance issued in this state on or after the effective date of this section shall provide covered individuals with a basis for continuation or conversion of coverage.
 2. For the purposes of this section, "a basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies which restrict provision of benefits and services to, or contain incentives to use certain providers and/or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The Commission shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.
 3. For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual

whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

4. For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the Commission to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers and/or facilities, the Commission, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.
5. Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy.
6. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.
7. Continuation of coverage or issuance of a converted policy shall be mandatory, except where:
 - a. Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or
 - b. The termination coverage is replaced not later than

thirty-one days after termination, by group coverage effective on the day following the termination of coverage:

- (i) Providing benefits identical to or benefits determined by the Commission to be substantially equivalent to or in excess of those provided by the terminating coverage; and
 - (ii) The premium for which is calculated in a manner consistent with the requirements of Paragraph 6. of this section.
8. Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.
9. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.
10. Notwithstanding any other provision of this section, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.
11. For the purposes of this section: a "Managed-Care Plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

Section 8. Required Disclosure Provisions.

- A. **Renewability.** Individual long-term care insurance policies shall contain a renewability provision. Such provision shall

be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. This provision shall not apply to policies which do not contain a renewability provision, and under which the right to nonrenewal is reserved solely to the policyholder.

- B. Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.
- C. Payment of Benefits. A long-term care insurance policy which provides for the payment of benefits based on standards described as "usual and customary", "reasonable and customary" or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.
- D. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations".
- E. Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in Section 38.2-5205 shall set forth a description of such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

Section 9. Requirements for Replacement.

- A. Questions Concerning Replacement. Individual and direct response solicited long-term care insurance application forms shall include a question designed to elicit information as to whether the proposed insurance policy is intended to replace any other accident and sickness or long-term care insurance

policy presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

- B. **Solicitations Other than Direct Response.** Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its agent, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF
INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE**

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by (Company Name) Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all

information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

- C. Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

**"NOTICE TO APPLICANT REGARDING REPLACEMENT OF
ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE**

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by (Company Name) Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. (To be included only if the application is attached to the policy.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are

answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (Company Name and Address) within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

Section 10. Discretionary Powers of Commission.

The Commission may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this regulation with respect to a specific long-term care insurance policy or certificate upon a written finding that:

- A. The modification or suspension would be in the best interest of the insureds; and
- B. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and
- C. (1) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or
(2) The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or
(3) The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

Section 11. Reserve Standards.

- A. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for such benefits shall be determined in accordance with Section 38.2-1311(A). Claim reserves must also be established in the case when such policy or rider is in claim status.

Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

- (1) Definition of insured events;
- (2) Covered long-term care facilities;
- (3) Existence of home convalescence care coverage;
- (4) Definition of facilities;
- (5) Existence or absence of barriers to eligibility;
- (6) Premium waiver provision;
- (7) Renewability;
- (8) Ability to raise premiums;
- (9) Marketing method;
- (10) Underwriting procedures;
- (11) Claims adjustment procedures;
- (12) Waiting period;
- (13) Maximum benefit;
- (14) Availability of eligible facilities;
- (15) Margins in claim costs;

- (16) Optional nature of benefit;
- (17) Delay in eligibility for benefit;
- (18) Inflation protection provisions; and
- (19) Guaranteed insurability option.

Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

- B. When long-term care benefits are provided other than as in Subsection A above, reserves shall be determined in accordance with Section 38.2-1311(B).

Section 12. Loss Ratio.

Benefits under individual long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

- A. Statistical credibility of incurred claims experience and earned premiums;
- B. The period for which rates are computed to provide coverage;
- C. Experienced and projected trends;
- D. Concentration of experience within early policy duration;
- E. Expected claim fluctuation;
- F. Experience refunds, adjustments or dividends;
- G. Renewability features;
- H. All appropriate expense factors;
- I. Interest;
- J. Experimental nature of the coverage;
- K. Policy reserves;
- L. Mix of business by risk classification; and
- M. Product features such as long elimination periods, high deductibles and high maximum limits.

Section 13. Standard Format Outline of Coverage.

This section of the regulation implements, interprets and makes specific, the provisions of Section 38.2-5207 in prescribing a standard format and the content of an outline of coverage.

- A. The outline of coverage shall be a free-standing document, using no smaller than ten point type.
- B. The outline of coverage shall contain no material of an advertising nature.
- C. Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.
- D. Use of the text and sequence of text of the standard format outline coverage is mandatory, unless otherwise specifically indicated.
- E. Format for outline of coverage:

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

1. This policy is [an individual policy of insurance]([a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).
2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

- (a) [Provide a brief description of the right to return -- "free look" provision of the policy.]
- (b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

- (a) [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.
- (b) [For direct response] [insert company name] is not representing Medicare, federal government or any state government.

5. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provide in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

6. BENEFITS PROVIDED BY THIS POLICY.

- (a) [Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.]
- (b) [Institutional benefits, by skill level.]
- (c) [Non-institutional benefits, by skill level.]

[Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible

for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.]

7. LIMITATIONS AND EXCLUSIONS.

[Describe:

- (a) Preexisting conditions;
- (b) Non-eligible facilities/provider;
- (c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);
- (d) Exclusions/exceptions;
- (e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in (6) above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

8. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

- (a) That the benefit level will not increase over time;
- (b) Any automatic benefit adjustment provisions;
- (c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;
- (d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;
- (e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

9. TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.

- [(a) Describe the policy renewability provisions;
- (b) For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;
- (c) Describe waiver of premium provisions or state that there are not such provisions;
- (d) State whether or not the company has a right to change premium, and if such a right exists, describe clearly and concisely each circumstance under which premium may change.]

10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

11. PREMIUM.

- [(a) State the total annual premium for the policy;
- (b) if the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

12. ADDITIONAL FEATURES.

- [(a) Indicate if medical underwriting is used;
- (b) Describe other important features.]

Section 14. Severability.

If any provision of this Regulation or the application thereof to any person or circumstance is for any reason to be held invalid, the remainder of this Regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

RGJ/kt

VIRGINIA LONG-TERM CARE REGULATION
AS RECOMMENDED TO
THE BUREAU OF INSURANCE
OF THE
VIRGINIA STATE CORPORATION COMMISSION
BY
THE LONG-TERM CARE REGULATION ADVISORY COMMITTEE
COMPARISON WITH THE NATIONAL ASSOCIATION OF INSURANCE
COMMISSIONERS (NAIC) MODEL REGULATION

Section 1. Authority

Same as NAIC Model Section 2, referring specifically to the Virginia Long-Term Care Insurance Act, §38.2-5200 through §38.2-5208, as amended by HB 595.

Section 2. Purpose

Same as NAIC Model Section 1.

Section 3. Effective Date

No similar provision in the NAIC Model, but is consistent with the format of other Virginia insurance regulations.

Section 4. Applicability and Scope

Same as NAIC Model Section 3.

Section 5. Definitions

Same as NAIC Model Section 4, except rather than merely referring to definitions in the Long-Term Care Statute, the Advisory Committee recommends re-stating in the Regulation definitions used in the Statute for "applicant," "certificate," "group long-term care insurance," "long-term care insurance" and "policy," in addition to a definition for "expected loss ratio."

Section 6. Policy Definitions

Same as NAIC Model Section 5, with the exception of including the definition for mental or nervous disorder, desiring to leave more flexibility in the definition than that of the NAIC Model.

Section 7. Policy Practices and Provisions

Same as the NAIC Model Section 6 concerning explanations for renewability terms such as "guaranteed renewable" and "noncancellable." Also, similarly lists the permissible limitations and exclusions as indicated in the NAIC Model, including the prohibition of an exclusion for Alzheimer's disease, including senile dementia, organic brain disorder or other similar diagnoses.

The Draft Regulation also tracks the NAIC Model language for paragraphs on extension of benefits in the case of termination, and provisions for the continuation or conversion of group to individual long-term care insurance. Paragraph 5 of the "conversion" provision deleted one phrase from the Model in order to avoid any confusion over the fact that the converted policy could be anything other than guaranteed renewable.

Section 8. Required Disclosure Provisions

Same as NAIC Model Section 7, tracking paragraphs explaining disclosure requirements for "renewability," "riders and endorsements," "payment of benefits," and various other limitations, including those for pre-existing conditions.

Section 9. Requirements for Replacement

Same as NAIC Model Section 11 concerning notice requirements for direct response solicitations as well as solicitations using other means. The recommended regulation includes the December NAIC change from 10 to 30 days for the free-look period for replacement coverage which is solicited other than by direct response. This also is consistent with the HB 595 revision.

Section 10. Discretionary Powers of Commission

Section 11. Reserve Standards

Section 12. Loss Ratio

At its final meeting, the Advisory Committee voted to drop its suggested rate filing requirement in lieu of the NAIC Model Sections 12, 13 and 14 concerning the powers of the commission, reserve standards and loss ratio. Former Advisory Committee concerns with the appropriateness of those NAIC Model provisions were considered to be addressed by the intent of the section on the Powers of the Commission which provide the commission with limited discretion and flexibility to accommodate innovative long-term care insurance products shown to be in the public's best interest. Consequently, Section 10, 11 and 12 track the NAIC Model Sections 12, 13 and 14.

Section 13. Standard Format Outline of Coverage

Same as NAIC Model Section 16.

Section 14. Severability

While this section does not appear in the NAIC Model, it is consistent with the format of other Virginia insurance regulations.

Just as the HJR 332 Joint Legislative Subcommittee determined not to take up changes contemplated in the Model Act by the NAIC at its December meeting, the Advisory Committee determined, with limited exception, not to include December amendments to the Model Regulation in its recommendation. In a dramatic move, the NAIC adopted three controversial Model Regulation provisions in December: Section 8. Prohibition Against Post Claims Underwriting; Section 9. Minimum Standards for Home Health Care Benefits in Long-Term Care Insurance Policies; and Section 10. Requirement to Offer Inflation Protection. As we have seen over the past three years, the Advisory Committee anticipates much continued discussion and change particularly concerning these three long-term care provisions in future NAIC meetings. At the time when the impact of these new sections become better known and understood, Virginia may want to consider them as appropriate for use in Virginia. At this point in time, the Advisory Committee considers it most prudent to act on the Regulation as currently recommended, which is consistent with the HB 595 revisions to the Virginia Long-Term Act as recommended by the HJR 332 Joint Legislative Subcommittee.

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§ 55-19.1. Petition for reformation of trusts in certain cases. — A. In the event that the beneficiary of any trust subject to the laws of this Commonwealth is found eligible for and has received benefits from any state or from any state and federal program of public assistance, including medical assistance, the State Health Commissioner, the State Welfare Commissioner, or any head of an agency of state government having responsibility for the program of public assistance may petition an appropriate circuit court for a reformation of the trust for the purpose of reaching income or principal which is vested in or may be payable to the recipient of welfare benefits. The circuit court, upon finding that the beneficiary has been found eligible for a program of public assistance, that the beneficiary has received benefits from that program, and that the trust has income, or that the trust has res which can reasonably be disposed of, shall enter an order reforming the trust and requiring the trustees, to the extent necessary, to expend all income from the trust and to dispose of any or all parts of the trust res in order to compensate the Commonwealth for any benefits received and any subsequent benefits as they are received by the beneficiary from the program of public assistance.

B. In the event that the trust referred to in paragraph A benefits more than one person, the circuit court's order of reformation shall require the trustees to expend only so much of the income of the trust and to dispose of only so much of the trust res to which the beneficiary, who has received the public assistance, would be entitled in accordance with the provisions of the trust. In the case of a trustee having discretionary powers with regard to the disposal of trust income or trust res, the court may direct exercise of such discretion, having due regard for the public's interest and for the basic needs of the other beneficiaries of the trust and their relationship to the settlor. Nothing in this section, however, shall permit the disposal of any trust res unless it is proven by clear and convincing evidence that disposal of the res is economically feasible and would not irreparably harm the additional persons, and nothing in this section shall permit the circuit court to affect any income or trust res to which the beneficiary receiving public assistance has no legal or equitable entitlement whatsoever. Nothing herein shall permit the invasion of a trust res created under § 55-19 of the Code. (1981, c. 545.)

LD0142440

JDS

1 D 10/16/89 Devine C 12/5/89 jds

2 SENATE BILL NO. HOUSE BILL NO.

3 A BILL to amend and reenact §§ 37.1-110 and 55-19 of the Code of
4 Virginia and to repeal § 55-19.1 of the Code of Virginia,
5 relating to liability of trust to debts of beneficiary;
6 exceptions.

7

8 Be it enacted by the General Assembly of Virginia:

9 1. That §§ 37.1-110 and 55-19 of the Code of Virginia are amended and
10 reenacted as follows:

11 § 37.1-110. Application for order to compel payment of
12 expenses.--When any patient or his guardian, committee, trustee or the
13 person or persons legally liable for his expenses fails to pay such
14 expenses, and it appears from investigation that such patient, his
15 guardian, committee, trustee or the person or persons legally liable
16 for the support of the patient is able or has sufficient estate to pay
17 such expenses, the Department shall petition the appropriate court
18 having jurisdiction over the estate of the patient or the court for
19 the county or city of which the patient is a legal resident or from
20 which he was admitted to a state hospital for an order to compel
21 payment of such expenses by persons liable therefor. In any case in
22 which a person or persons legally liable for the support of the
23 patient is being proceeded against, the petition shall be directed to
24 the appropriate court of the county or city in which such person or
25 persons legally liable for the support of the patient reside.

The patient and his estate shall first be liable for the payment

1 of his expenses and thereafter, the person or persons legally liable
 2 for the support of the patient. Such person or persons shall be the
 3 father, mother, husband, wife and child or children of the patient,
 4 who have attained the age of majority. Such persons shall be jointly
 5 and severally liable. The Department shall collect such part or all of
 6 such expenses from the several sources as appears proper under the
 7 circumstances and may proceed against all of such sources , except
 8 that principal or income or both from a trust created for the benefit
 9 of the patient shall be liable for payment only as provided in § 55-19
 10 . In evaluating the circumstances, the Department may consider any
 11 events related to the admission of the patient for treatment which
 12 have affected the person or persons legally liable, such as the
 13 infliction of serious injury by the patient on any person who is
 14 legally liable. The proceedings for the collection of such expenses
 15 shall conform to the procedure for collection of debts due the
 16 Commonwealth.

17 § 55-19. Estates in trust subject to debts of beneficiaries;
 18 exception for certain trusts.-- All-A. Except as otherwise provided
 19 in this section, all trust estates shall be subject to the debts and
 20 charges of the persons who are beneficiaries of such trusts as if
 21 those persons owned a similar interest in the trust estate.

22 However,--any such-B. Any trust estate --not exceeding \$500,000
 23 in actual value --may be held in trust upon condition that the trust
 24 corpus and income, or either of them, shall in the case of a simple
 25 trust or, in the case of a complex trust, may in the discretion of the
 26 fiduciary be paid to or applied by the trustee for the benefit of the
 27 beneficiaries without being subject to their liabilities or to
 28 alienation by them --but--. However, no such trust shall operate to

1 the prejudice of any existing creditor of the creator of such trust.
2 In addition, as to any claim first accruing on or after July 1, 1990,
3 and subject to the limitations of subsections C and D, no such trust
4 condition shall operate to the prejudice of the United States or this
5 Commonwealth or any county, city or town.

6 C. If the creator of a trust is also a beneficiary of the trust
7 and the creator's interest is held upon condition that it is not
8 subject to the creator's liabilities or to alienation by the creator,
9 such condition is invalid against creditors and transferees of the
10 creator, but shall not otherwise affect the validity of the trust. A
11 transferee or creditor of the creator, including the Commonwealth, may
12 reach the maximum amount that the trustee could pay to or for the
13 benefit of the creator under the trust instrument, which shall not
14 exceed the amount of the creator's proportionate contribution to the
15 trust. When a trust is funded by amounts attributable to any claim
16 possessed by a beneficiary, whether paid pursuant to a structured
17 settlement or otherwise, the beneficiary shall be considered a creator
18 of the trust to the extent so funded.

19 D. Notwithstanding any contrary condition in the trust
20 instrument, if a statute or regulation of the United States or the
21 Commonwealth makes a beneficiary liable for reimbursement to the
22 Commonwealth or any agency or instrumentality thereof, for public
23 assistance, including medical assistance, furnished or to be furnished
24 to the beneficiary, the Attorney General or the head of the state
25 agency having responsibility for the program may file a petition in
26 chancery in an appropriate circuit court having jurisdiction over the
27 trustee seeking reimbursement without first obtaining a judgment. The
8 beneficiary, or his guardian or committee, if any, shall be made a

1 party. Following its review of the circumstances of the case, the
2 court may:

3 1. Order the trustee to satisfy all or part of the liability out
4 of all or part of the amounts to which the beneficiary is entitled,
5 whether presently or in the future, to the extent the beneficiary has
6 the right under the trust to compel the trustee to pay income or
7 principal or both to or for the benefit of the beneficiary. A duty in
8 the trustee under the instrument to make disbursements in a manner or
9 in amounts that do not cause the beneficiary to suffer a loss of
10 eligibility for public assistance to which the beneficiary might
11 otherwise be entitled shall not be considered a right possessed by the
12 beneficiary to compel such payments.

13 2. Whether or not the beneficiary has the right to compel the
14 trustee to pay income or principal or both to or for the benefit of
15 the beneficiary, order the trustee to satisfy all or part of the
16 liability out of all or part of the future payments, if any, that the
17 trustee chooses to make to or for the benefit of the beneficiary in
18 the exercise of discretion granted under the trust.

19 No order shall be made pursuant to this subsection D if the
20 beneficiary is an individual who has a medically determined physical
21 or mental disability that substantially impairs his ability to provide
22 for his care or custody and constitutes a substantial handicap.

23 2. That § 55-19.1 of the Code of Virginia is repealed.

24

#

1990 SESSION
ENGROSSED

HP0142440

HOUSE BILL NO. 188

House Amendments in [] - January 30, 1990

A BILL to amend and reenact §§ 37.1-110 and 55-19 of the Code of Virginia and to repeal § 55-19.1 of the Code of Virginia, relating to liability of trust to debts of beneficiary; exceptions.

Patrons—Hall, Moss, Cohen, Martin, Munford, Almand, Marshall, Plum, Van Landingham, Copeland, Byrne, Brickley, Robinson, Ealey, Eck, Cunningham, J.W., Higginbotham, Cox and Rollins; Senator: Joannou

Referred to the Committee for Courts of Justice

Be it enacted by the General Assembly of Virginia:

1. That §§ 37.1-110 and 55-19 of the Code of Virginia are amended and reenacted as follows:

§ 37.1-110. Application for order to compel payment of expenses.—When any patient or his guardian, committee, trustee or the person or persons legally liable for his expenses fails to pay such expenses, and it appears from investigation that such patient, his guardian, committee, trustee or the person or persons legally liable for the support of the patient is able or has sufficient estate to pay such expenses, the Department shall petition the appropriate court having jurisdiction over the estate of the patient or the court for the county or city of which the patient is a legal resident or from which he was admitted to a state hospital for an order to compel payment of such expenses by persons liable therefor. In any case in which a person or persons legally liable for the support of the patient is being proceeded against, the petition shall be directed to the appropriate court of the county or city in which such person or persons legally liable for the support of the patient reside.

The patient and his estate shall first be liable for the payment of his expenses and thereafter, the person or persons legally liable for the support of the patient. Such person or persons shall be the father, mother, husband, wife and child or children of the patient, who have attained the age of majority. Such persons shall be jointly and severally liable. The Department shall collect such part or all of such expenses from the several sources as appears proper under the circumstances and may proceed against all of such sources, except that principal or income or both from a trust created for the benefit of the patient shall be liable for payment only as provided in § 55-19. In evaluating the circumstances, the Department may consider any events related to the admission of the patient for treatment which have affected the person or persons legally liable, such as the infliction of serious injury by the patient on any person who is legally liable. The proceedings for the collection of such expenses shall conform to the procedure for collection of debts due the Commonwealth.

§ 55-19. Estates in trust subject to debts of beneficiaries; exception for certain trusts.—
A. Except as otherwise provided in this section, all trust estates shall be subject to the debts and charges of the persons who are beneficiaries of such trusts as if those persons owned a similar interest in the trust estate.

However, any such B. Any trust estate, not exceeding \$500,000 in actual value, may be held in trust upon condition that the trust corpus and income, or either of them, shall in the case of a simple trust or, in the case of a complex trust, may in the discretion of the fiduciary be paid to or applied by the trustee for the benefit of the beneficiaries without being subject to their liabilities or to alienation by them; but. However, no such trust shall operate to the prejudice of any existing creditor of the creator of such trust. In addition, as to any claim first accruing on or after July 1, 1990, and subject to the [limitations of subsections C and limitation of subsection] D, no such trust condition shall operate to the prejudice of the United States or this Commonwealth or any county, city or town.

1 C. If the creator of a trust is also a beneficiary of the trust and the creator's interest
 2 is held upon condition that it is not subject to the creator's liabilities or to alienation by
 3 the creator, such condition is invalid against creditors and transferees of the creator, but
 4 shall not otherwise affect the validity of the trust. A transferee or creditor of the creator [
 5 ; ~~including the Commonwealth,~~ may, in addition to amounts required to be paid to or for
 6 the benefit of the creator, also] reach the maximum amount that the trustee [, in the
 7 exercise of discretion,] could pay to or for the benefit of the creator under the trust
 8 instrument, which shall not exceed the amount of the creator's proportionate contribution
 9 to the trust. When a trust is funded by amounts attributable to any claim possessed by a
 10 beneficiary, whether paid pursuant to a structured settlement or otherwise, the beneficiary
 11 shall be considered a creator of the trust to the extent so funded.

12 D. Notwithstanding any contrary condition in the trust instrument, if a statute or
 13 regulation of the United States or the Commonwealth makes a beneficiary liable for
 14 reimbursement to the Commonwealth or any agency or instrumentality thereof, for public
 15 assistance, including medical assistance, furnished or to be furnished to the beneficiary, the
 16 Attorney General or the head of the state agency having responsibility for the program
 17 may file a petition in chancery in an appropriate circuit court having jurisdiction over the
 18 trustee seeking reimbursement without first obtaining a judgment. The beneficiary, or his
 19 guardian or committee, if any, shall be made a party. Following its review of the
 20 circumstances of the case, the court may:

21 1. Order the trustee to satisfy all or part of the liability out of all or part of the
 22 amounts to which the beneficiary is entitled, whether presently or in the future, to the
 23 extent the beneficiary has the right under the trust to compel the trustee to pay income
 24 or principal or both to or for the benefit of the beneficiary. A duty in the trustee under
 25 the instrument to make disbursements in a manner or in amounts that do not cause the
 26 beneficiary to suffer a loss of eligibility for public assistance to which the beneficiary
 27 might otherwise be entitled shall not be considered a right possessed by the beneficiary to
 28 compel such payments.

29 2. Whether or not the beneficiary has the right to compel the trustee to pay income or
 30 principal or both to or for the benefit of the beneficiary, order the trustee to satisfy all or
 31 part of the liability out of all or part of the future payments, if any, that the trustee
 32 chooses to make to or for the benefit of the beneficiary in the exercise of discretion
 33 granted under the trust.

34 No order shall be made pursuant to this subsection D if the beneficiary is an
 35 individual who has a medically determined physical or mental disability that substantially
 36 impairs his ability to provide for his care or custody and constitutes a substantial
 37 handicap.

38 2. That § 55-19.1 of the Code of Virginia is repealed.
 39 [3. That an emergency exists and this act is in force from its passage.]
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Official Use By Clerks	
<p style="text-align: center;">Passed By The House of Delegates</p> <p>without amendment <input type="checkbox"/></p> <p>with amendment <input type="checkbox"/></p> <p>substitute <input type="checkbox"/></p> <p>substitute w/amdt <input type="checkbox"/></p>	<p style="text-align: center;">Passed By The Senate</p> <p>without amendment <input type="checkbox"/></p> <p>with amendment <input type="checkbox"/></p> <p>substitute <input type="checkbox"/></p> <p>substitute w/amdt <input type="checkbox"/></p>
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Clerk of the House of Delegates	Clerk of the Senate

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1990 SESSION

LD0172440

HOUSE BILL NO. 595

Offered January 23, 1990

A BILL to amend and reenact §§ 38.2-5200, 38.2-5201, 38.2-5202, 38.2-5203, 38.2-5204, 38.2-5205, 38.2-5207, and 38.2-5208 of the Code of Virginia and to amend the Code of Virginia by adding sections numbered 38.2-5207.1 and 38.2-5207.2, all relating to long-term care insurance.

Patrons—Cohen, Hall, Glasscock, Copeland, Van Landingham, Plum, Almand, Marshall, Munford and Martin; Senator Chichester

Referred to the Committee on Corporations, Insurance and Banking

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-5200, 38.2-5201, 38.2-5202, 38.2-5203, 38.2-5204, 38.2-5205, 38.2-5207, and 38.2-5208 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding sections numbered 38.2-5207.1 and 38.2-5207.2 as follows:

§ 38.2-5200. 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.

“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.

“Long-term care insurance” means any insurance policy ~~primarily~~ or rider advertised, marketed, offered or designed to provide coverage for not less than twelve consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one ~~of~~ or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, personal care, mental health or substance abuse services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual ~~policies whether annuities and life insurance policies or riders that provide directly or that supplement long-term care insurance.~~ Long-term care insurance may be 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 to the extent they are otherwise authorized to issue life or accident and sickness insurance. 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 care insurance.

“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.

§ 38.2-5201. 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 (§ 38.2-3408 et seq.) of Chapter 34 and Chapter 36 of this title. 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.~~

§ 38.2-5202. 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

1 Commonwealth ~~and~~ *The standards* shall address terms of renewability, nonforfeiture
2 provisions if applicable, initial and subsequent conditions of eligibility, *continuation or*
3 ~~conversion from group long-term care to individual long-term care coverage~~ ,
4 nonduplication of coverage provisions, coverage of dependents, preexisting conditions,
5 termination of insurance, probationary periods, limitations, exceptions, reductions,
6 elimination periods, requirements for replacement, recurrent conditions, and definitions of
7 terms *and may address any other standards considered appropriate by the Commission* .

8 B. Regulations issued by the Commission shall:

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

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

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

16 4. Recognize the appropriate distinctions necessary between long-term care insurance
17 and accident and sickness insurance policies, prepaid health plans, and other health service
18 plans.

19 § 38.2-5203. Prohibited provisions.—No long-term care insurance policy may:

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

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

27 3. *Provide coverage for skilled nursing care only or provide significantly more coverage*
28 *for skilled care in a facility than coverage for lower levels of care* .

29 § 38.2-5204. Preexisting conditions.—A. No long-term care insurance policy or certificate
30 shall use a definition of “preexisting condition” which is more restrictive than the
31 following: “preexisting condition” means the existence of symptoms which would cause an
32 ordinary prudent person to seek diagnosis, care or treatment, or a condition for which
33 medical advice or treatment was recommended by, or received from a provider of health
34 care services, within ~~twelve~~ *six* months preceding the effective date of coverage of an
35 insured person.

36 B. No long-term care insurance policy may exclude coverage for a loss or confinement
37 which is the result of a preexisting condition for a period of confinement longer than
38 ~~twelve~~ *six* months following the effective date of coverage of an insured person.

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

42 D. The definition of “preexisting condition” does not prohibit an insurer from using an
43 application form designed to elicit the complete health history of an applicant, and, on the
44 basis of the answers on that application, underwriting in accordance with that insurer’s
45 established underwriting standards for long-term care insurance policies. *Unless otherwise*
46 *provided in the policy or certificate, a preexisting condition, regardless of whether it is*
47 *disclosed on the application, need not be covered until the waiting period described in*
48 *subsection A or B expires. No long-term care insurance policy or certificate may exclude*
49 *or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for*
50 *specifically named or described preexisting diseases or physical conditions beyond the*
51 *waiting period described in subsection A or B.*

52 § 38.2-5205. Prior institutionalization.— ~~A A. No long-term care insurance policy which~~
53 ~~provides benefits only following institutionalization shall provide benefits to an insured if~~
54 ~~the insured has been discharged from a facility within the previous sixty days for the same~~

1 ~~or related conditions~~ may be delivered or issued for delivery in this Commonwealth if such
 2 policy conditions eligibility (i) for any benefits provided in an institutional care setting on
 3 the receipt of a higher level of institutional care or (ii) for any benefits on a prior
 4 hospitalization requirement .

5 B. A long-term care insurance policy containing any limitations or conditions for
 6 eligibility other than those prohibited in subsection A shall clearly label such limitations or
 7 conditions, including any required number of days of confinement, in a separate paragraph
 8 of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits."

9 C. A long-term care insurance policy containing a benefit advertised, marketed or
 10 offered as a home health care or home care benefit may not condition receipt of benefits
 11 on a prior institutionalization requirement.

12 D. A long-term care insurance policy which conditions eligibility of noninstitutional
 13 benefits on the prior receipt of institutional care shall not require a prior institutional stay
 14 of more than thirty days for which benefits are paid.

15 § 38.2-5207. Disclosure.—In order to provide for fair disclosure in the sale of long-term
 16 care insurance policies:

17 1. An outline of coverage shall be delivered to an applicant for an individual long-term
 18 care insurance policy at the time of application for an individual policy. In the case of
 19 direct response solicitation, the insurer shall deliver the outline of coverage upon the
 20 applicant's request, but regardless of request shall make such delivery no later than at the
 21 time of policy delivery. *The Commission shall prescribe a standard format, including style,*
 22 *arrangement, and overall appearance, and the content of an outline of coverage. In the*
 23 *case of agent solicitations, an agent shall deliver the outline of coverage prior to the*
 24 *presentation of an application or enrollment form. In the case of direct response*
 25 *solicitations, the outline of coverage shall be presented in conjunction with any application*
 26 *or enrollment form.*

27 Such outline of coverage shall include:

- 28 a. A description of the principal benefits and coverage provided in the policy;
- 29 b. A statement of the exclusions, reductions and limitations contained in the policy;
- 30 c. A statement of the renewal provisions, including any reservation in the policy of a
 31 right to change premiums . *Continuation or conversion provisions of group coverage shall*
 32 *be specifically described ; and*
- 33 d. A statement that the outline of coverage is a summary of the policy issued or
 34 applied for and that the policy should be consulted to determine governing contractual
 35 provisions ;
- 36 e. *A description of the terms under which the policy may be returned and premium*
 37 *refunded; and*
- 38 f. *A brief description of the relationship of cost of care and benefits .*

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

- 40 a. A description of the principal benefits and coverage provided in the policy;
- 41 b. A statement of the exclusions, reductions and limitations contained in the policy; and
- 42 c. A statement that the group master policy should be consulted to determine governing
 43 contractual provisions.

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

47 § 38.2-5207.1. Disclosure; life insurance policies.—Whenever an individual life insurance
 48 policy which provides long-term care benefits within the policy or by rider is delivered, it
 49 shall be accompanied by a policy summary *In the case of direct response solicitations, the*
 50 *insurer shall deliver the policy summary upon the applicant's request, but regardless of*
 51 *request shall make such delivery no later than at the time of policy delivery. In addition*
 52 *to complying with all applicable requirements, the summary shall also include:*

- 53 1. An explanation of how the long-term care benefit interacts with other components of
 54 the policy, including deductions from death benefits;

1 2. An illustration of the amount of benefits, the length of benefit, and the guaranteed
2 lifetime benefits, if any, for each covered person; and

3 3. Any exclusions, reductions, and limitations on benefits of long-term care.

4 If applicable to the policy type, the summary shall also include (i) a disclosure of the
5 effects of exercising other rights under the policy, (ii) a disclosure of guarantees related to
6 long-term care costs of insurance charges, and (iii) current and projected maximum
7 lifetime benefits.

8 § 38.2-5207.2. Long-term care benefits; monthly report.—Whenever long-term care
9 benefits being paid are funded through a life insurance policy by acceleration of the death
10 benefit, a monthly report shall be provided to the policyholder. Such report shall include:

11 1. Any long-term care benefits paid out during the month;

12 2. An explanation of any changes in the policy, e.g., death benefits or cash values, due
13 to long-term care benefits being paid out; and

14 3. The amount of long-term care benefits existing or remaining.

15 § 38.2-5208. Right to return; free look provision.— ~~A. Individual long-term~~ Long-term
16 care insurance policies and certificates shall have a notice prominently printed on the first
17 page of the policy or attached thereto stating in substance that the policyholder shall have
18 or insured person has the right to return the policy or certificate within ~~ten~~ thirty days of
19 its delivery and to have the premium refunded if, after examination of the policy or
20 certificate, the policyholder or insured person is not satisfied for any reason. A policy or
21 certificate returned pursuant to the notice shall be void from its inception upon the mailing
22 or delivery of the policy or certificate to the insurer or its agent.

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

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Official Use By Clerks	
Passed By	Passed By The Senate
The House of Delegates	
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