

**VERMONT DEPARTMENT OF BANKING, INSURANCE, SECURITIES  
AND HEALTH CARE ADMINISTRATION**

**RULE H-2009-01**

**LONG-TERM CARE INSURANCE REGULATION**

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## **Section 1. Purpose**

The purpose of this regulation is to implement Title 8, Chapter 154, to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverage, to facilitate flexibility and innovation in the development of long-term care insurance and to support consumers of long-term care insurance in attaining and maintaining their highest level of functioning in the most independent and least restrictive setting.

## **Section 2. Authority**

This regulation is issued pursuant to the authority vested in the Commissioner under Title 8, Chapters 1, 101, 107, 129, 131 and 154 and other applicable law.

## **Section 3. Applicability and Scope**

Except as otherwise specifically provided, this regulation applies to any insurance policy or rider advertised, marketed, offered or designed to provide coverage for long-term care services, including qualified long-term care policies, long-term care partnership policies and life insurance policies that accelerate benefits to pay for long-term care, delivered, issued for delivery, or renewed in this state, by insurers, fraternal benefit societies, hospital and medical service corporations, prepaid health plans, health maintenance organizations and all similar

organizations. Certain provisions of this regulation apply only to qualified long-term care insurance contracts or long-term care partnership policies as noted.

#### **Section 4. Definitions**

For the purpose of this regulation, the terms “long-term care insurance,” “group long-term care insurance,” “Commissioner,” “applicant,” “policy” and “certificate” shall have the meanings set forth in 8 V.S.A. § 8082. The term “qualified long-term care insurance” shall have the meaning set forth in Section 7702B of the Internal Revenue Code of 1986 as amended. In addition, the following definitions apply.

- A. “Benefit trigger” means a contractual provision in a policy of long-term care insurance conditioning the payment of benefits on a determination of the insured’s ability to perform activities of daily living, or on a cognitive impairment. For purposes of a qualified long-term care insurance contract, “Benefit trigger” shall include a determination by a licensed health care practitioner that an insured is a chronically ill individual.
- B. “Compound annual inflation protection” means automatic annual compounded inflation increases at a rate not less than three percent (3%); or automatic annual compounded inflation increases at a rate based on changes in the consumer price index. “Consumer price index” means consumer price index for all urban consumers, U.S. city average, all items, as determined by the Bureau of Labor Statistics of the United States Department of Labor
- C. “Department” shall refer to the Vermont Department of Banking, Insurance, Securities and Health Care Administration.
- D. (1) “Exceptional increase” means only those increases filed by an insurer as exceptional for which the Commissioner determines the need for the premium rate increase is justified:
  - (a) Due to changes in laws or regulations applicable to long-term care coverage in this state; or
  - (b) Due to increased and unexpected utilization that affects the majority of insurers of similar products.
- (2) Except as provided in Section 20, Exceptional increases are subject to the same requirements as other premium rate schedule increases.
- (3) As with other filings, the Commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an Exceptional increase.

- (4) The Commissioner, in determining that the necessary basis for an Exceptional increase exists, shall also determine any potential offsets to higher claims costs.
- E. “Incidental,” as used in Section 20J, means that the value of the long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.
- F. “Qualified actuary” means a member in good standing of the American Academy of Actuaries.
- G. “Similar policy forms” means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in 8 V.S.A. §8082(4)(A) are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications.
- H. “Simple inflation protection” means an automatic inflation feature that provides annual simple inflation increases (not compounded) at a rate not less than three percent (3%), or at a rate based on changes in the consumer price index. “Consumer price index” means consumer price index for all urban consumers, U.S. city average, all items, as determined by the Bureau of Labor Statistics of the United States Department of Labor.
- I. “Some level of inflation protection” means an inflation feature that meets the definition of Simple inflation protection or compound inflation protection as defined in this Section.
- J. "Qualified state long-term care insurance partnership policy" or "Partnership policy " means an insurance policy that meets the following requirements:
- (1) The policy covers an insured who was a resident of Vermont (or a Partnership State) when coverage first became effective under the policy.
  - (2) The policy is a qualified long-term care insurance contract as defined in Section 7702B(b) of the Internal Revenue Code of 1986, as amended, and was issued no earlier than the effective date of Vermont’s plan amendment required by section 6021 of the Deficit Reduction Act of 2005 (Pub.L. 109-171).
  - (3) The policy meets all of the applicable requirements of the National Association of Insurance Commissioners long-term care insurance model act and model regulation as those requirements are set forth in Section 1917(b)(5)(A) of the Social Security Act (42 USC Section 1396p(b)(5)(A)).
  - (4) The policy provides the level of inflation protection set forth in Section 36 of this Regulation.

## **Section 5. Policy Definitions**

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

- A. “Activities of daily living” means at least bathing, continence, dressing, eating, toileting and transferring.
- B. “Acute condition” means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.
- C. “Adult day care services” means medical or nonmedical care on a less than 24-hour basis provided in a licensed facility outside the residence, for persons in need of personal services, supervision, protection, or assistance in sustaining daily needs, including eating, bathing, dressing, ambulating, transferring, toileting, and taking medications..
- D. “Assisted Living Residence” means a licensed program or facility that combines housing, health and supportive services to support resident independence and aging in place.
- E. “Bathing” means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- F. “Cognitive impairment” means a deficiency in a person’s short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.
- G. “Continence” means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- H. “Dressing” means putting on and taking off all items of clothing, including items such as any necessary braces, fasteners, or artificial limbs.
- I. “Eating” means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- J. “Elimination period” means the specified number of days of out of pocket expenses paid by the insured for long-term care services after the insurance benefits are triggered, but before the benefits are paid under the policy.
- K. “Hands-on assistance” means physical assistance (minimal, moderate or maximal)

without which the individual would not be able to perform one or more activities of daily living.

- L. “Home health care services” means skilled nursing or other professional services in the residence, including, but not limited to, part-time and intermittent skilled nursing services, home health aid services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.
- M. “Long-term care services” means necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a covered setting.
- N. “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.
- O. “Mental health condition ” means any condition or disorder involving mental illness or alcohol or substance abuse that falls under any of the diagnostic categories listed in the mental disorders section of the international classification of disease, as periodically revised.
- P. “Nursing facility care” means care and services provided in a nursing home licensed pursuant to Title 33 V.S.A., Chapter 71.
- Q. “Residential care” means care rendered in a facility licensed as a residential care home pursuant to Title 33 V.S.A., Chapter 71.
- R. “Personal care” means skilled nursing or other professional services to aid with the activities of daily living and cognitive impairments, including the instrumental activities of daily living, under a plan of care developed by a licensed or certified professional such as a physician, nurse or social worker. “Instrumental activities of daily living” include using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry, and light housekeeping.
- S. "Pre-existing condition" means a condition for which medical advice or treatment was recommended by or received from a provider of health care services within six months preceding the effective date of coverage of an insured person.
- T. “Toileting” means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- U. “Transferring” means moving into or out of a bed, chair or wheelchair.

## **Section 6. 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 this regulation.
- (1) A policy issued to an individual shall not contain renewal provisions other than “guaranteed renewable” or “noncancellable.”
  - (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. The term “class basis” shall be defined in the policy.
  - (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.
  - (4) The term “level premium,” “fixed premium” and similar words may only be used when the insurer does not have the right to change the premium.
  - (5) In addition to the other requirements of this subsection, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.
- B. **Limitations and Exclusions.** No policy may be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:
- (1) Pre-existing conditions or diseases, provided that the exclusion complies with 8 V.S.A. § 8086 and the definition is no more restrictive than the following:  
"Preexisting condition" means a condition for which medical advice or treatment was recommended by or received from a provider of health care services within six months preceding the effective date of coverage of an insured person.
  - (2) 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) The insured's attempted suicide (while sane), or intentionally self-inflicted injury (while sane); or
  - (e) Aviation (this exclusion applies only to non-fare-paying passengers).
- (3) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are payable 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 except as required by Section 6(H)(3), and services for which no charge is normally made in the absence of insurance.
- (4) Expenses for services or items paid under another long-term care insurance or health insurance policy;
- (5) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.
- (6) (a) This subsection is not intended to prohibit, exclude, or limit by type of provider. However, no long-term care issuer may deny a claim because services are provided in a state other than the state of policy issued under the following conditions:
- (i) When the state other than the state of policy issue does not have the provider licensing, certification or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or regulation; or
  - (ii) When the state other than the state of policy issue licenses, certifies or registers the provider under another name.
- (b) For purposes of this paragraph, "state of policy issue" means the state in which the individual policy or certificate was originally issued.
- (7) This subsection is not intended to prohibit 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 benefit beyond the period the long-term care insurance

was in force may be limited to 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 or renewed on or after the effective date of this regulation 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 that are substantially equivalent to the benefits of the existing group policy. The Commissioner 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 Commissioner to be substantially equivalent to or in excess of those provided under the group 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 Commissioner, 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 (31) 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, and shall be renewable annually.

- (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 terminating coverage is replaced not later than thirty-one (31) 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 Commissioner 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 that provides benefits on the basis of incurred expenses, may contain a provision that 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, an 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 or civil union.

- (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.

E. Discontinuance and Replacement

If a group long-term care policy is replaced by another group long-term care policy purchased by the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

- (1) Shall not result in an exclusion for pre-existing conditions that would have been covered under the group policy being replaced; and
- (2) Shall not vary or otherwise depend on the individual’s health or disability status, claim experience or use of long-term care services.

F. (1) The premium charged to an insured shall not increase due to either:

- (a) The increasing age of the insured at ages beyond sixty-five (65); or
- (b) The duration the insured has been covered under the policy.

- (2) The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under Section 27, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

- (3) A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under Section 27, the initial annual premium shall be based on the reduced benefits.

G. Electronic Enrollment for Group Policies

- (1) In the case of group long-term care insurance as defined in 8 V.S.A. § 8082(4)(A), any requirement that a signature of an insured be obtained by a producer or insurer shall be deemed satisfied if:

- (a) The group policyholder or the insurer obtains the policyholder’s consent by telephonic or electronic enrollment. A verification of enrollment information shall be provided to the enrollee;

- (b) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records;
  - (c) The telephonic or electronic enrollment provides necessary and reasonable safeguards to ensure that the confidentiality of individually identifiable information and privileged information as defined by state and federal law is maintained; and
  - (d) In the case of telephonic enrollment, the carrier records the entire telephone call and retains a copy of this recording.
- (2) The insurer shall make available, upon request of the Commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

#### H. Required Coverage

- (1) No policy may provide coverage for Nursing facility care only or provide significantly more coverage for skilled care.
- (2) Policies shall not define an eligible provider or facility in a manner that is more restrictive than that used to license that provider or facility by the state where the service is provided.
- (3) Family Caregivers
  - (a) Policies must cover services delivered by a member of the individual's family if:
    - (1) the family member is a regular employee of an organization which is providing the services;
    - (2) the organization receives the payment for the services; and
    - (3) the family member receives no compensation other than the normal compensation for employees in his or her job category.
  - (b) Insurers selling long-term care insurance in Vermont shall offer an optional insurance rider that covers Long-term care services provided by a family member licensed to provide the necessary or medically necessary services.

- (4) Every long-term care policy or certificate shall provide at least the following:
  - (a) Home health care services;
  - (b) Personal care;
  - (c) Adult day care services; and
  - (d) Hospice services.
- (5) For the purposes of this section, policy definitions of these benefits may be no more restrictive than the following:
  - (a) “Home health care” is skilled nursing or other professional services in the residence, including, but not limited to, part-time and intermittent skilled nursing services, home health aid services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.
  - (b) “Personal care” means skilled nursing or other professional services to aid with the activities of daily living and cognitive impairments, including the instrumental activities of daily living, under a plan of care developed by a licensed or certified professional such as a physician, nurse or social worker. “Instrumental activities of daily living” include using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry, and light housekeeping.
  - (c) “Adult day care” is medical or nonmedical care on a less than 24-hour basis provided in a licensed facility outside the residence, for persons in need of personal services, supervision, protection, or assistance in sustaining daily needs, including eating, bathing, dressing, ambulating, transferring, toileting, and taking medications.
  - (d) “Hospice services” are services that are designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease.
- (6) Nothing in this subsection shall be interpreted to prohibit insurers from offering additional long-term care services.

I. Elimination Periods:

- (1) The definition of “elimination period” may be no more restrictive than the definition set forth in Section 5 of this Regulation;

- (2) The elimination period may not exceed 100 days for any covered benefit; and
- (3) Policies may not require a deductible or elimination period to be satisfied between levels of care and/or benefit types (any waiver of a deductible or elimination period for a particular benefit shall be deemed to be a waiver of the deductible or elimination period for all benefits). This requirement does not prohibit an insurer from offering a zero-day elimination period for one or more levels of care.

J. No long-term care insurance policy may:

- (1) Require payment of premiums more frequently than monthly;
- (2) Impose a preexisting condition exclusion inconsistent with the requirements of 8 V.S.A. § 8086;
- (3) Deny benefits or coverage on the basis that the need for long-term care services arises from a mental health condition, including Alzheimer's disease, dementia and other related disorders;
- (4) Deny benefits or rescind a policy upon a showing of fraud or misrepresentation except as provided otherwise by 8 V.S.A. § 8094; or
- (5) Provide benefits for less than 365 benefit days or provide a minimum daily benefit of less than \$75. The minimum daily benefit amount may be adjusted to reflect, at the Commissioner's discretion, appropriate inflation factors. Insurers may issue a policy with a daily benefit of less than \$75 only if the combined total of the new coverage and any existing long-term care coverage for daily benefits equals or exceeds \$75.

K. Required Benefit Configurations.

- (1) Insurers selling long-term care insurance in Vermont shall provide a price quote and offer all Vermont applicants the opportunity to elect the following benefit configurations:
  - (a) A policy that includes a 90 or 100-day elimination period, a 5-year benefit period and a \$200 maximum daily benefit;
  - (b) A policy that includes a 90 or 100-day elimination period, a 3-year benefit period and a \$150 maximum daily benefit; and
  - (c) A policy that includes a 90 or 100-day elimination period, a \$100 maximum daily benefit and a 2-year benefit period.

- (2) Insurers shall provide price quotes for the benefit configurations described in subsection K(1) of this section that include price variations for the following benefit options:
  - (a) Compound inflation protection at a rate of 5%;
  - (b) Simple inflation protection at a rate of 5%;
  - (c) No inflation protection.
- (3) Insurers shall submit the annual premium for a currently marketed long-term care policy required by subsections (K)(1) and (K)(2) of this section. Insurers shall complete Appendix M and submit this form to the Department annually on or before June 30<sup>th</sup>. In addition, insurers shall notify the Department of any changes to the information submitted in Appendix M.
- (4) The Commissioner may waive one or more requirements of this section for good cause, or approve alternative benefit configurations so long as the alternative benefit configuration meets the intent of this subsection and the benefit configuration is filed with and approved by the Commissioner.
- (5) Where the policy is issued to a group, the required offer shall be made to the group policyholder.
- (6) This offer shall not be required of life or annuity policies containing long-term care benefits.
- (7) Nothing shall prohibit the insurer from offering additional options provided that the insurer provides a price quote for each of the required benefit configurations. Any modifications to these benefit configurations shall be priced and quoted separately.

L. Right to Return

Individual long-term care insurance policyholders and persons insured under a long-term care insurance policy issued pursuant to a direct response solicitation shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. Insurers shall prominently print a notice on the first page of these policies stating in substance that the policyholder shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

- M. Denial of claims: If a claim under a long-term care insurance contract is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificate holder, or a representative thereof:

- (1) Provide a written explanation of the reasons for the denial;
- (2) Describe any additional material or information necessary for the member to perfect the request and an explanation of why such material or information is necessary;
- (3) Explain the insured's right to internal appeal, the time limits applicable to such procedures, and the right to submit new or additional information relating to the claim;
- (4) If the insurer relied upon an internal rule, guideline, protocol, or other similar criterion, state the specific rule, guideline, protocol, or other similar criterion and provide a copy upon request;
- (5) Provide an explanation of the scientific or clinical judgment or other reason for the determination, if applicable; and
- (6) Make available all information directly related to the denial.

## **Section 7. Unintentional Lapse**

Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

- A. (1) Notice before lapse or termination. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured.
  - (a) Designation shall not constitute acceptance of any liability on the third party for services provided to the insured.
  - (b) The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address.
  - (c) In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care

insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice.”

- (d) The insurer shall notify the insured of the right to change this written designation, no less often than once every two (2) years.
  - (2) When the policyholder or certificateholder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in subsection A(1) need not be met until sixty (60) days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.
  - (3) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to subsection A(1), at the address provided by the insured for the purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing. The notice shall state that the insured has the right to reduce the maximum benefit or reduce the daily, weekly or monthly benefit amount, consistent with Section 27 of this Regulation.
- B. Reinstatement. In addition to the requirement in subsection A, a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage in the event of lapse if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five (5) months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

## **Section 8. Required Disclosure Provisions**

- A. Renewability. Individual long-term care insurance policies shall contain a renewability provision.
  - (1) Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the coverage is guaranteed renewable or

noncancellable. This provision shall not apply to long-term care policies which are part of, or combined with, life insurance policies which do not contain a renewability provision and under which the right to nonrenew is reserved solely to the policyholder.

- (2) A long-term care policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change.
- 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 a concomitant increase in premium during the policy term must be agreed to in writing and 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. **Facilities Coverage.** A long-term care insurance policy that provides for the payment of benefits for services received in specific types of facilities, such as assisted living residences, shall set forth a clear description of the types of facilities wherein such payment of benefits is provided and any limitations or conditions for eligibility of coverage.
- E. **Pre-existing Condition Limitations.** If a long-term care insurance policy or certificate contains any limitations with respect to pre-existing conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as “Pre-existing Condition Limitations.” Any pre-existing condition limitation must comply with 8 V.S.A. § 8086 or other applicable law.
- F. **Disclosure of Tax Consequences.** With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This subsection shall not apply to qualified long-term care insurance contracts.

- G. **Benefit Triggers.** Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional Benefit triggers shall also be explained in this section. If these triggers differ for different benefits, explanation of the trigger shall 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 shall be specified.
- H. **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 8 V.S.A. § 8085 shall set forth a description of such limitations or conditions, including satisfaction of the elimination period, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."
- I. A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in Section 32E(3) that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

## **Section 9. Required Disclosure of Rating Practices to Consumers**

- A. This section shall apply as follows:
  - (1) Except as provided in Paragraph (2), this section applies to any long-term care policy or certificate issued in this state on or after January 1, 2010.
  - (2) For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in 8 V.S.A §8082(4)(A), which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following January 1, 2010.
- B. Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subsection to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this section to the applicant no later than at the time of delivery of the policy or certificate.
  - (1) A statement in a conspicuous manner that the policy may be subject to rate increases in the future;

- (2) An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision;
- (3) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase and the Department approves the proposed rate increase;
- (4) A general explanation for applying premium rate or rate schedule adjustments that shall include:
  - (a) A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and
  - (b) The right to a revised premium rate or rate schedule as provided in subsection(B)(2), above, if the premium rate or rate schedule is changed;
- (5)
  - (a) Information regarding each premium rate increase on this policy form or Similar policy forms over the past ten (10) years for this state or any other state that, at a minimum, identifies:
    - (i) The policy forms for which premium rates have been increased;
    - (ii) The calendar years when the form was available for purchase; and
    - (iii) The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.
  - (b) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.
  - (c) Upon approval of the Commissioner, an insurer may waive the disclosure requirements for premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.
  - (d) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this section or the end of a twenty-four-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with Subparagraph (a) of this paragraph.

- (e) If the acquiring insurer in Subparagraph (d) above files for a subsequent rate increase, even within the twenty-four-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in Subparagraph (d), the acquiring insurer shall make all disclosures required by Paragraph (5), including disclosure of the earlier rate increase referenced in Subparagraph (d).
- C. An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under subsection B(1) and (5). If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.
- D. An insurer shall use the forms in Appendices B and F to comply with the requirements of subsections A and B of this section.
- E. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least forty-five (45) days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by subsection B when the rate increase is implemented.

## **Section 10. Initial Filing Requirements**

- A. This section applies to any long-term care policy issued in this state on or after January 1, 2010.
- B. Pursuant to 8 V.S.A. § 4062, no policy form shall be sold or marketed in this state prior to approval by the Commissioner. Product forms, including but not limited to policy forms, member handbooks, certificates, endorsements, riders, and applications, shall not be approved if the forms contain any provision which is unjust, unfair, inequitable, misleading, or contrary to the law of this state.
- C. Pursuant to 8 V.S.A. § 4062, insurers shall file premium rates for approval by the Commissioner prior to implementation. No rate shall be approved if it is excessive, inadequate or unfairly discriminatory. An insurer shall provide the information listed in this subsection to the Commissioner:
  - (1) A copy of the disclosure documents required in Section 9; and

- (2) An actuarial certification consisting of at least the following:
- (a) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;
  - (b) A statement that the policy design and coverage provided have been reviewed and taken into consideration;
  - (c) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;
  - (d) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:
    - (i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;
    - (ii) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;
    - (iii) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and
    - (iv) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur;
      - (I) An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;
      - (II) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the Commissioner may request a demonstration under Subsection C based on a standard age distribution; and
  - (e)
    - (i) A statement that the premium rate schedule is not less than the premium rate schedule for existing Similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or
    - (ii) A comparison of the premium schedules for Similar policy forms that are currently available from the insurer with an explanation of the differences.

- D. The Commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums and any other information he or she deems necessary for review of the rates. The actuarial demonstration shall include either premium and claim experience on Similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

## **Section 11. Requirements for Applications, Underwriting and Prohibition Against Post-Claims Underwriting**

- A. Requirements for applications and health questions:
1. All applications for long-term care insurance except that which is guaranteed issue, shall contain clear, unambiguous, short, simple questions designed to ascertain the health condition of the applicant.
  2. Questions Concerning Medications:
    - (a) If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.
    - (b) If the medications listed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.
  3. Except for policies or certificates which are guaranteed issue:
    - (a) The following warning shall be printed conspicuously and in close conjunction with the applicant's signature block:

***“Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your coverage.”***
    - (b) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

**Caution: The issuance of this long-term care insurance [policy][certificate] is based upon your responses to the questions on your application. A copy of your [application][enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are misstated or untrue, the company has the right**

**to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]**

- (c) Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the insurer shall obtain one of the following:
  - (i) A report of a physical examination;
  - (ii) An assessment of functional capacity;
  - (iii) An attending physician's statement; or
  - (iv) Copies of medical records.

- 4. A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

#### B. Contestability Periods

- 1. For a policy or certificate that has been in force for less than six months, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.
- 2. For a policy or certificate that has been in force for at least six months but less than two years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.
- 3. After a policy or certificate has been in force for two years, it is not contestable upon the grounds of misrepresentation alone, but may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health that are both material to the acceptance for coverage and which pertain to the condition for which benefits are sought.
- 4. If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.
- 5. In the event of the death of the insured, this section shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for

long-term care. In this situation, the remaining death benefits under these policies shall be governed by sections 3731 and 4065 of Title 8.

- C. Underwriting procedures must comply with applicable sections of Chapter 129 of Title 8.
- D. Prohibition Against Post-Claims Underwriting:
  - 1. An insurer may not place an elimination rider, deny a claim or rescind coverage for an otherwise valid long-term care claim except as provided in Subsection B of this section.
  - 2. Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated, and shall annually furnish this information to the Commissioner in the format prescribed by the National Association of Insurance Commissioners in Appendix A.

**Section 12. Minimum Standards for Home Health Care and Community Care Benefits in Long-Term Care Insurance Policies**

- A. A long-term care insurance policy or certificate shall not limit or exclude benefits for home health care services or community services. In addition, a long-term care policy or certificate shall not limit or exclude benefits for home health care or community services:
  - (1) By requiring that the insured/claimant would need skilled care in a skilled nursing facility if home health care services were not provided;
  - (2) By requiring that the insured/claimant first or simultaneously receive nursing and/or therapeutic services in a home, or community or institutional setting before home health care services are covered;
  - (3) By limiting eligible services to services provided by registered nurses or licensed practical nurses;
  - (4) By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;
  - (5) By excluding coverage for personal care services provided by a home health aide;
  - (6) By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;
  - (7) By requiring that the insured/claimant have an acute condition before home health care services are covered;

- (8) By limiting benefits to services provided by Medicare-certified agencies or providers;
  - (9) By excluding coverage for adult day care services; or
  - (10) By requiring prior confinement in any type of medical or health facility.
- B. A long-term care insurance policy or certificate shall provide total home health or community care coverage equal to the coverage available for nursing home benefits under the policy or certificate. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.
- C. Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

**Section 13. Requirement to Offer Inflation Protection**

- A. No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with inflation protection that increases benefit levels annually in a manner so that the increases are compounded annually at a rate no less than five percent (5%). A policyholder must affirmatively decline this offer in writing before an insurer can offer a policy that does not include 5% compound inflation. Insurers may also offer the option to purchase a policy that:
- (1) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or
  - (2) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.
- B. Where the policy is issued to a group, the required offer in Subsection A shall be made to the group policyholder; except, if the policy is issued to a group defined in 8 V.S.A. §

8082 (4)(D), other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

- C. The offer in Subsection A shall not be required for life insurance policies or riders containing accelerated long-term care benefits.
- D. Insurers shall include the following information in or with the outline of coverage:
  - (1) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period; and
  - (2) A hypothetical or graphic demonstration of any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases.
- E. Inflation protection benefit increases under a policy that contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.
- F. An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.
- G.
  - (1) Inflation protection as provided in subsection A(1) of this section shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection. The rejection may be either in the application or in a separate form.
  - (2) The rejection shall be considered a part of the application and shall state: "I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without 5% compound inflation protection. Specifically, I have reviewed this feature, and I reject 5% compound inflation protection. I understand that I may elect other inflation protection options if available."

#### **Section 14. Requirements for Application Forms and Replacement Coverage**

- A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care

insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer, except where the coverage is sold without a producer, containing such questions may be used. With regard to a replacement policy issued to a group defined in 8 V.S.A. § 8082(4)(A), the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement.

- (1) Do you have another long-term care insurance policy or certificate in force (including a health care service contract or a health maintenance organization contract)?
  - (2) Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months?
    - (a) If so, with which company?
    - (b) If that policy lapsed, when did it lapse?
  - (3) Are you covered by Medicaid? Note: Medicaid is not the same as Medicare. You are covered by Medicaid if you receive Supplemental Security Income (SSI) or if you have applied and been found eligible by the appropriate state agency.
  - (4) Do you intend to replace any of your medical or health insurance coverage with this policy or certificate?
- B. Producers shall list on the application (or other form referred to in Section 14(A) above) any other health insurance policies they have sold to the applicant, including policies still in force and policies sold within the past five (5) years which are no longer in force.
- C. 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 producer, 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**

[Insurance company's name and address]

**SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.**

According to [your application] [information you have furnished], you intend to let 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]. 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.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

**STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]:**

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

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. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy or coverage for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage you may wish to secure the advice of your present insurer, its agent or producer, a family member or other advisor 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.
4. 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 the

application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has 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.

\_\_\_\_\_  
(Signature of Agent, Broker or Other Representative)

[Typed Name and Address of Agent or Broker]

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

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Applicant's Signature)

D. 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  
ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE**

**[Insurance company's name and address]**

**SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.**

According to [your application] [information you have furnished], you intend to let 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]. 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.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

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. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy or coverage for similar benefits to the extent such time was spent or depleted under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer, its producer or agent, a family member, or other advisor 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.
4. [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.

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(Company Name)

- E. Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Notice shall be made within five (5) working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.
- F. Life insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of Regulation I-2001-03. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing

insurer shall comply with both the long-term care and the life insurance replacement requirements.

## **Section 15. Reporting Requirements**

- A. Every insurer shall maintain records for each producer of that producer's amount of replacement sales as a percent of the producer's total annual long-term care insurance policy sales. Each insurer shall also maintain record for each producer of that producer's amount of lapses of long-term care insurance policies sold by the producer as a percent of the producer's total sales of long-term care insurance policies.
- B. Every insurer shall report annually by June 30 the top ten percent (10%) of its producers with the greatest percentages of lapses and replacements as measured by subsection 15(A) above. (Appendix G)
- C. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely producer activities regarding the sale of long-term care insurance.
- D. Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year. (Appendix G)
- E. Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual long-term care insurance policy sales and as a percent of its total number of policies in force as of the preceding calendar year. (Appendix G)
- F. Every insurer shall report annually by June 30, for qualified long-term care insurance contracts and non-qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. (Appendix E)
- G. Every insurer shall report annually by June 30, for qualified long-term care insurance contracts and non-qualified long-term care insurance contracts, the number of claims denied or not paid because the insured did not meet the benefit trigger under the policy.
- H. Every insurer shall report annually by June 30 the number of policies returned within the 30-day free look period.
- I. Every insurer shall report annually by June 30 the number of internal appeals requested and the outcome of each internal appeal.
- J. Every insurer shall report annually by June 30 the number of independent reviews requested and the outcome of each independent review.

- K. Every insurer shall report annually by June 30 the number of policy or certificate rescissions, both state and countrywide. (Appendix A)
- L. For purposes of this section:
  - (1) “Policy” means only long-term care insurance;
  - (2) Subject to Paragraph (3), “claim” means a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;
  - (3) “Denied” means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to satisfy the elimination period or because of an applicable preexisting condition; and
  - (4) “Report” means on a statewide basis unless specified to the contrary.
- M. Reports required under this section shall be filed with the Commissioner.

#### **Section 16. Licensing**

A producer is not authorized to sell, solicit or negotiate with respect to long-term care insurance except as authorized under Title 8, Chapter 131.

#### **Section 17. Discretionary Powers of Commissioner**

- A. The Commissioner 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:
  - (1). The modification or suspension would be in the best interest of insureds;
  - (2) The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and
  - (3)
    - (a) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or
    - (b) 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

- (c) 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.

- B. Consistent with the standards and procedures established in subdivision A, the Commissioner may issue a temporary order modifying or suspending a specific provision or provisions of this regulation provided that the Commissioner provides notice of the temporary order and holds an administrative hearing within 20 days of the date that the Commissioner issues the temporary order.

### **Section 18. 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 reserve for such benefits shall be determined in accordance in accordance Vermont's standard valuation law, Title 8, Subchapter 4, 8 V.S.A. § 3781, *et seq.* 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 methods;
- (10) Underwriting procedures;
- (11) Claims adjustment procedures;
- (12) Waiting periods;
- (13) Maximum benefits;
- (14) Availability of eligible facilities;
- (15) Margins in claim costs;
- (16) Optional nature of benefits;
- (17) Delay in eligibility;
- (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, reserves shall be as directed by the Commissioner.

### **Section 19. Loss Ratios**

- A. This section shall apply to all long-term care insurance policies or certificates, except where application conflicts with specific portions of Sections 10 (initial filing requirements) and 20 (premium rate schedule increases).
- B. 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, and benefits under group long-term policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least seventy percent. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:
  - (1) Statistical credibility of incurred claims experience and earned premiums;

- (2) The period for which rates are computed to provide coverage;
- (3) Experienced and projected trends;
- (4) Concentration of experience within early policy duration;
- (5) Expected claim fluctuation;
- (6) Experience refunds, adjustments or dividends;
- (7) Renewability features;
- (8) All appropriate expense factors;
- (9) Interest;
- (10) Experimental nature of the coverage;
- (11) Policy reserves;
- (12) Mix of business by risk classification; and
- (13) Product features such as long elimination periods, high deductibles and high maximum limits.

C. Subsection B shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

- (1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
- (2) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of the Standard Nonforfeiture Law for Life Insurance, Title 8, Chapter 103, and any other applicable provisions of Vermont law;
- (3) The policy meets the disclosure requirements of 8 V.S.A. §§ 8091 and 8092, and this regulation;
- (4) Any policy illustration that meets the applicable requirements of Vermont Insurance Regulation 98-1 Life Insurance Illustrations and any later amendments; and

- (5) An actuarial memorandum prepared and signed by an actuary who is a member in good standing of the American Academy of Actuaries is filed with the Department that includes:
- (a) A description of the basis on which the long-term care rates were determined;
  - (b) A description of the basis for the reserves;
  - (c) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
  - (d) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;
  - (e) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
  - (f) The estimated average annual premium per policy and the average issue age;
  - (g) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
  - (h) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

## **Section 20. Premium Rate Schedule Increases**

A. This section shall apply as follows:

- (1) Except as provided in Paragraph (2), this section applies to any long-term care policy or certificate issued in this state on or after July 1, 2010.
- (2) For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in 8 V.S.A. §

8082(4)(A), which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following January 1, 2011.

- B. An insurer shall request approval of a premium rate schedule increase, including an Exceptional increase, as required by 8 V.S.A. §4062, at least 60 days prior to the anticipated notice to the policyholders. Such rate request filing shall include:
- (1) Information required by Section 9;
  - (2) Certification by a Qualified actuary that:
    - (a) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;
    - (b) The premium rate filing is in compliance with the provisions of this section;
  - (3) An actuarial memorandum justifying the rate schedule change request that includes:
    - (a) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase, and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;
      - (i) Annual values for the five (5) years preceding and the three (3) years following the valuation date shall be provided separately;
      - (ii) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an Exceptional increase;
      - (iii) The projections shall demonstrate compliance with subsection C; and
      - (iv) For Exceptional increases,
        - (I) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the Exceptional increase set forth in Section 4(D) of this Regulation; and

- (II) In the event the Commissioner determines as provided in Section 4(D)(4) that offsets may exist, the insurer shall use appropriate net projected experience;
  - (b) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;
  - (c) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;
  - (d) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and
  - (e) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates;
  - (4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the Commissioner; and
  - (5) Any other information deemed necessary for review and approval of the premium rate schedule increase by the Commissioner.
- C. All premium rate schedule increases shall be determined in accordance with the following requirements:
- (1) Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the Exceptional increase will be returned to policyholders in benefits;
  - (2) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:
    - (a) The accumulated value of the initial earned premium times fifty-eight percent (58%);
    - (b) Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;
    - (c) The present value of future projected initial earned premiums times fifty-eight percent (58%); and

- (d) Eighty-five percent (85%) of the present value of future projected premiums not in Subparagraph (c) on an earned basis;
  - (3) In the event that a policy form has both exceptional and other increases, the values in Paragraph (2)(b) and (2)(d) will also include seventy percent (70%) for exceptional rate increase amounts; and
  - (4) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves permitted by law in the valuation of whole life insurance issued on the same date as the contract at issue. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.
- D. For each rate increase that is implemented, the insurer shall file for approval by the Commissioner updated projections, as defined in subsection B(3)(a), annually for the next three (3) years and include a comparison of actual results to projected values. The Commissioner may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the Commissioner.
- E. If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in Subsection (B)(3)(a), shall be filed for approval by the Commissioner every five (5) years following the end of the required period in Subsection D. For group insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the Commissioner.
- F. (1) If the Commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection C, the Commissioner may require the insurer to implement any of the following:
- (a) Premium rate schedule adjustments; or
  - (b) Other measures to reduce the difference between the projected and actual experience.
- (2) In determining whether the actual experience adequately matches the projected experience, consideration should be given to Subsection (B)(3)(e), if appropriate.
- G. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

- (1) A plan, subject to Commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the Commissioner may impose the condition in subsection H of this section; and
  - (2) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection C had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculations described in Subsection (C)(2)(a) and (c).
- H.
- (1) For a rate increase filing that meets the following criteria, the Commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapse rates have occurred or is anticipated:
    - (a) The rate increase is not the first rate increase requested for the specific policy form or forms;
    - (b) The rate increase is not an Exceptional increase; and
    - (c) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.
  - (2) In the event the Commissioner determines significant adverse lapse rates has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the Commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the Commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.
    - (a) The offer shall:
      - (i) Be subject to the approval of the Commissioner;
      - (ii) Be based on actuarially sound principles, but not be based on attained age; and
      - (iii) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

- (b) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:
    - (i) The maximum rate increase determined based on the combined experience; and
    - (ii) The maximum rate increase determined based only on the experience of the insureds to which the form was originally issued plus ten percent (10%).
  
- I. If the Commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the Commissioner may, in addition to the provisions of subsection H of this section and any other provisions of Vermont law, prohibit the insurer from either of the following:
  - (1) Filing and marketing comparable coverage for a period of up to five (5) years; or
  - (2) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.
  
- J. Subsections A through I shall not apply to policies for which the long-term care benefits provided by the policy are Incidental, as defined in Section 4(E), if the policy complies with all of the following provisions:
  - (1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
  - (2) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:
    - (a) 8 V.S.A. §§ 3741 – 3749;
    - (b) 8 V.S.A. § 3750; and
    - (c) 8 V.S.A. § 3859 and related Vermont law.
  - (3) The policy meets the disclosure requirements of 8 V.S.A. Chapter 154 and this Rule.

- (4) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:
  - (a) Policy illustrations as required by Vermont Insurance Regulation 98-1 Life Insurance Illustrations and later amendments;
  - (b) Disclosure requirements in 8 V.S.A. §3856 and other applicable laws.
- (5) An actuarial memorandum is filed with the Commissioner that includes:
  - (a) A description of the basis on which the long-term care rates were determined;
  - (b) A description of the basis for the reserves;
  - (c) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
  - (d) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;
  - (e) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
  - (f) The estimated average annual premium per policy and the average issue age;
  - (g) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
  - (h) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

K. Subsections F and H shall not apply to group insurance policies as defined in 8 V.S.A. §8082(4)(A) where:

- (1) The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

- (2) The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed.

### **Section 21. Filing Requirements**

- A. Pursuant to 8 V.S.A. § 4062, insurers shall file all forms and rates for approval by the Commissioner prior to use of the form or rate. No form or rate shall be approved if it contains any provision which is unjust, unfair, inequitable, misleading, or contrary to the law of this state.
- B. Forms, as used in this Rule, shall include the following: all product forms, including but not limited to, policy forms, member handbooks, certificates, endorsements, riders, and applications.

### **Section 22. Filing Requirements for Advertising**

- A. Every insurer or other entity providing long-term care insurance or benefits in Vermont shall file a copy of any long-term care insurance advertisement intended for use in Vermont whether through written, radio, television, internet, electronic, or other medium to the Commissioner for review and approval. In addition, all advertisements shall be retained by the insurer or other entity for at least three years from the date the advertisement was first used.
- B. The Commissioner may exempt from these requirements any advertising form or material when, in the Commissioner's opinion, this requirement may not be reasonably applied.

### **Section 23. Standards for Marketing**

- A. Every insurer or other entity marketing long-term care insurance coverage in Vermont, directly or through its agents or producers, shall:
  - (1) Establish marketing procedures and training requirements to ensure that any marketing activities, including comparison of policies by its agents or producers, will be fair, accurate and understandable;
  - (2) Establish marketing procedures and training requirements to ensure policies sold are suitable and that excessive insurance is not sold or issued;
  - (3) Display prominently by type, stamp or other appropriate means on the first page of the outline of coverage and policy the following:

“Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.”

- (4) Provide copies of the disclosure forms required in Section 9(D) (Appendices B and F) to the applicant.
- (5) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance.
  - (i) An agent or producer who initiates an application shall submit to the insurer, with or as part of the application, a statement signed by both the applicant and the agent or producer as to whether the applicant has existing policies or contracts. If the answer is “no,” the agent or producer’s duties with respect to replacement are complete.
  - (ii) If the applicant answered “yes” to the question regarding existing coverage referred to in Subsection A, the agent or producer shall present and read to the applicant, not later than at the time of taking the application, the following notice regarding replacements: “A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract. Make sure you know the facts and carefully consider whether a replacement is in your best interests. Contact your existing company or its agent or producer for information about the old policy or contract. Ask for and retain all sales material used by the agent or producer in the sales presentation. Be sure that you are making an informed decision.”
  - (iii) In connection with a replacement transaction the agent or producer shall leave with the applicant at the time an application for a new policy or contract is completed the original or a copy of all sales material. With respect to electronically presented sales material, it shall be provided to the policy or contract owner in printed form no later than at the time of policy or contract delivery.
  - (iv) In connection with a replacement transaction the agent or producer shall submit to the insurer to which an application for a policy or contract is presented, a copy of each document required by this Section, a statement identifying any preprinted or electronically presented company approved sales materials used, and copies of any individualized sales materials, including any illustrations related to the specific policy or contract purchased.

- (v) In connection with a replacement transaction, the insurer shall notify any other existing insurer that may be affected by the proposed replacement within five (5) business days of receipt of a completed application indicating replacement or when the replacement is identified if not indicated on the application, and mail a copy of the available illustration or policy summary for the proposed policy or available disclosure document for the proposed contract within five (5) business days of a request from an existing insurer.
  - (6) Establish auditable procedures for verifying compliance with this section.
  - (7) If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the Commissioner, the insurer and agent or producer shall, at solicitation, provide written notice to the prospective policyholder and certificateholder that the program is available and the name, address and telephone number of the program.
  - (8) Use the terms “noncancellable” or “level premium” only when the policy or certificate conforms to Section 6(A)(3) and Section 6(A)(4) of this regulation.
  - (9) Provide an explanation of contingent benefit upon lapse rights provided for in Section 28(C)(2).
- B. In addition to the practices prohibited in Title 8, Chapter 129, and other applicable Vermont law, the following acts and practices are prohibited:
- (1) **Twisting.** Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to forfeit, surrender, let lapse, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.
  - (2) **High pressure tactics.** Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
  - (3) **Cold lead advertising.** Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or producer or insurance company.
  - (4) **Misrepresentation.** Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

- (5) Replacement of Long-Term Care Insurance Benefits Unnecessarily. No insurer, broker, agent, producer or other person shall cause a policyholder to replace a long-term care insurance policy unnecessarily. Nothing in this section shall be construed to allow an insurer, broker, agent, producer or other person to cause a policyholder to replace a long-term care insurance policy that will result in a decrease in benefits and an increase in premium.
- C. (1) With respect to the obligations set forth in this subsection, the primary responsibility of an association or trust, as defined by 8 V.S.A. § 8082(4), when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Such groups shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such groups to ensure that members receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.
- (2) The insurer shall file for approval with the Commissioner, in accordance with 8 V.S.A. § 4062 and any other applicable law, the following material:
- (a) The policy and certificate,
  - (b) A corresponding outline of coverage, and
  - (c) All advertisements.
- (3) The association or trust shall disclose in any long-term care insurance solicitation:
- (a) The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association or trust receives from endorsement or sale of the policy or certificate to its members; and
  - (b) A brief description of the process under which the policies and the insurer issuing the policies were selected.
- (4) If the association or trust and the insurer have interlocking directorates or trustee arrangements, this fact shall be disclosed to its members.
- (5) The board of directors (or other responsible party if no board of directors exists) of any group under 8 V.S.A. §§ 8082(4)(B) or (C) selling or endorsing long-term policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.
- (6) The association or trust shall also:

- (a) At the time of the group’s decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features and rates and update the examinations thereafter in the event of material changes;
  - (b) Actively monitor the marketing efforts of the insurer and its agents or producers; and
  - (c) Review and approve all marketing materials and other insurance communications used to promote sales or sent to members regarding the policies or certificates.
- (7) No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the Department the information required in this subsection.
- (8) The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this section.
- (9) Nothing in this subsection should be construed to mean that other applicable long-term care laws and regulation do not apply to policies issued through associations or trusts.
- D. Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of Title 8, Chapter 129.

**Section 24. Suitability**

- A. This section shall not apply to life insurance policies that accelerate benefits for long-term care.
- B. Every insurer or other entity marketing long-term care insurance (the “issuer”) shall:
- (1) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;
  - (2) Train its agents or producers in the use of its suitability standards; and
  - (3) Maintain a copy of its suitability standards and make them available for inspection upon request by the Commissioner.

- C. (1) To determine whether the applicant meets the standards developed by the issuer, the agent or producer and issuer shall develop procedures that take the following into consideration:
- (a) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage, including but not limited to the applicant's age, income, assets, expenses and financial eligibility for Medicaid;
  - (b) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs, including but not limited to asset protection; and
  - (c) The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.
- (2) The issuer, and where a agent or producer is involved, the agent or producer shall obtain the information set out in Paragraph (1) above, and shall present to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix B, in not less than twelve (12) point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the Commissioner for approval. Issuers must refile the personal worksheet with the Commissioner for approval if the issuer changes the personal worksheet.
- (3) A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance coverage to employees and their spouses.
- (4) The sale or dissemination outside the insurer or agency by the issuer or its agent or producer of information obtained through the personal worksheet in Appendix B is prohibited.
- D. The issuer, and where an agent or producer is involved, the agent or producer, shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate. The issuer shall file a copy of the suitability standards with the Department on or before June 30, 2010. Thereafter, the issuer shall file the standards annually only if the issuer revises the suitability standards.
- E. At the same time as the personal worksheet is provided to the applicant, the insurer and where an agent or producer is involved, the agent or producer, shall provide the

disclosure form entitled “Things You Should Know Before You Buy Long-Term Care Insurance.” The form shall be in the format contained in Appendix C, in readable font that is not less than twelve (12) point type.

- F. (1) The issuer, and where an agent or producer is involved, the agent or producer, shall not issue a long-term care insurance policy to a consumer unless the policy is suitable based on the suitability information provided by the applicant at the time of sale.
- (2) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide financial information requested in the personal worksheet, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant’s intent. Either the applicant’s returned letter or a record of the alternative method of verification shall be made part of the applicant’s file and retained by the issuer.
- G. The issuer shall report annually, by June 30, to the Commissioner the total number of applications received from Vermont residents, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

**Section 25. Prohibition Against Pre-existing Conditions, Elimination Periods and Probationary Periods in Replacement Policies or Certificates**

- A. If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions, elimination periods and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions and elimination periods have been satisfied under the original policy or certificate.

**Section 26. Availability of New Services or Providers**

- A. An insurer shall notify policyholders of the availability of a new long-term policy series that provides coverage for new long-term care services or providers that are material in nature and not previously available through the insurer to the general public. The notice shall be provided within twelve (12) months of the date that the new policy series is made available for sale in this state.
- B. Notwithstanding subsection A above, notification is not required for any policy issued prior to the effective date of this section or to any policyholder or certificateholder who is currently eligible for benefits, within an elimination period or on a claim, or who

previously had been in claim status, or who would not be eligible to apply for coverage due to issue age limitation under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

- C. The insurer shall make the new coverage available in one of the following ways:
- (1) By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age;
  - (2) By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits shall be based on premiums paid or reserves held for the prior policy or certificate;
  - (3) By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or
  - (4) By an alternative program developed by the insurer that meets the intent of this section if the program is filed with and approved by the Commissioner.
- D. An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of this subsection, "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders that purchased such a new proprietary policy shall be notified when a new long-term care policy series that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel.
- E. Policies issued pursuant to this section shall be considered exchanges and not replacements. These exchanges shall not be subject to Sections 14 and 24, and the reporting requirements of Section 15A to E of this Regulation.
- F. Where the policy is offered through an employer, labor organization, professional, trade or occupational association, the required notification in subsection A above shall be made to the offering entity. However, if the policy is issued to a group defined in 8 V.S.A. § 4079(4), the notification shall be made to each certificateholder.
- G. Nothing in this section shall prohibit an insurer from offering any policy, rider, certificate or coverage change to any policyholder or certificateholder. However, upon request any

policyholder may apply for currently available coverage that includes the new services or providers. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

- H. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

**Section 27. Right to Reduce Coverage and Lower Premiums**

- A. (1) Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in the following ways:
  - (a) Reducing the maximum benefit; and
  - (b) Reducing the daily, weekly or monthly benefit amount.
- (2) The insurer may also offer other reduction options that are consistent with the policy or certificate design or the insurer's administrative processes.
- (3) Upon a showing that the insurer is unable to offer one or more methods to reduce coverage pursuant to Section 27.A(1), the Department may, in its discretion, waive the requirement that the insurer offer the option to reduce coverage by maximum benefit and by reducing the daily, weekly or monthly benefit amount.
- B. The provision shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.
- C. The age to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force.
- D. The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.
- E. If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by Section 7(A)(3) of this regulation.
- F. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.
- G. The requirement of this section shall apply to any long-term care policy issued in this state on or after the January 1, 2010.

**Section 28. Nonforfeiture Benefit Requirement**

- A. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits. A long-term care insurance policy may not be delivered or issued for delivery in Vermont unless the policyholder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. If a nonforfeiture benefit is declined, the insurer shall provide a contingent benefit upon lapse. To comply with these requirements:
  - (1) Nonforfeiture benefits offered shall have coverage elements, eligibility, Benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection D; and
  - (2) The offer shall be in writing. If the nonforfeiture benefit is described in the Outline of Coverage or other materials given to the prospective policyholder this shall be sufficient.
- B. If the offer of a nonforfeiture benefit required by 8 V.S.A. § 8095 is rejected, the insurer shall provide the contingent benefit upon lapse described in this section.
- C.
  - (1) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.
  - (2) The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over
Initial Premium	
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%

50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

- (3) On or before the effective date of a substantial premium increase as defined in Paragraph (2) above, the insurer shall:
- (a) Provide a written offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;
  - (b) Provide a written offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection D. This option may be elected at any time during the 120-day period referenced in subsection (C)(2); and

- (c) Notify the policyholder in writing that a default or lapse at any time during the 120-day period referenced in subsection (C)(2) shall be deemed to be the election of the offer to convert in Subparagraph (b) above.

D. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in this subsection:

- (1) For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one percent per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (50).
- (2) For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in Paragraph (3).
- (3) The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Subsection E.
- (4)
  - (a) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three (3) years as well as thereafter.
  - (b) Notwithstanding Subparagraph (a), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:
    - (i) The end of the tenth year following the policy or certificate issue date; or
    - (ii) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.
- (5) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

- E. All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.
- F. There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.
- G. The requirements set forth in this section shall become effective twelve (12) months after adoption of this provision and shall apply as follows:
  - (1) Except as provided in Paragraph (2), the provisions of this section apply to any long-term care policy issued in this state on or after the effective date of this amended regulation.
  - (2) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in 8 V.S.A. § 8082(4)(A), which policy was in force at the time this amended regulation became effective, the provisions of this section shall not apply.
- H. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of Section 19 treating the policy as a whole.
- I. To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection (C)(2), a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.
- J. A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:
  - (1) The nonforfeiture provision shall be appropriately captioned;
  - (2) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying contracts approved by the Commissioner for the same contract form; and
  - (3) The nonforfeiture provision shall provide at least one of the following:
    - (a) Reduced paid-up insurance;
    - (b) Shortened benefit period; or

- (c) Other similar offerings approved by the Commissioner.

**Section 29. Standards for Benefit Triggers**

- A. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living or on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than two (2) of the activities of daily living or the presence of cognitive impairment.
- B. (1) Activities of daily living shall include at least the following as defined in Section 5 of this regulation:
  - (a) Bathing;
  - (b) Continence;
  - (c) Dressing;
  - (d) Eating;
  - (e) Toileting; and
  - (f) Transferring.(2) Insurers may use activities of daily living in addition to those contained in Paragraph (1) to trigger covered benefits as long as they are clearly defined in the policy.
- C. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate. However the provisions shall not be more restrictive, and shall not be in lieu of, the requirements contained in subsections A and B.
- D. For purposes of this section the determination of a deficiency shall not be more restrictive than:
  - (1) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or
  - (2) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.
- E. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

- F. A long-term care insurance policy shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations. These standards shall be consistent with Section 31.

**Section 30. Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts**

- A. For purposes of this section, the following definitions apply:

- (1) “Qualified long-term care services” means services that meet the requirements of Section 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.
- (2) (a) “Chronically ill individual” has the meaning prescribed for this term by Section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:
  - (i) Being unable to perform (without substantial assistance from another individual) at least two (2) activities of daily living for a period of at least ninety (90) days due to a loss of functional capacity; or
  - (ii) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.
- (b) The term “chronically ill individual” shall not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner has certified that the individual meets these requirements.
- (3) “Licensed health care practitioner” means a physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the Secretary of the Treasury.
- (4) “Maintenance or personal care services” means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

- B. A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.
- C. A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity or to severe cognitive impairment.
- D. Certifications regarding activities of daily living and cognitive impairment required pursuant to subsection C shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury.
- E. Certifications required pursuant to subsection C may be performed by a licensed health care professional at the direction of the insurer as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety-day period.
- F. Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations. These standards shall be consistent with Section 31.

**Section 31. Appealing an Insurer's Determination That The Benefit Trigger Is Not Met**

- A. If an insurer determines that the Benefit trigger of a long-term care insurance policy has not been met, it shall provide a clear, written notice to the insured of all of the following:
  - (1) The specific reason that the insurer determined that the insured's Benefit trigger has not been met.
  - (2) A description of any additional material or information necessary for the member to perfect the request and an explanation of why such material or information is necessary;
  - (3) The insured's right to internal appeal in accordance with Subsections B and C, the time limits applicable to such procedures, and the right to submit new or additional information relating to the Benefit trigger denial with the appeal request.

- (4) The insured's right, after exhaustion of the insurer's internal appeal process, to have the Benefit trigger determination reviewed under the independent review process in accordance with Subsection C, and the affect of such an election.
- (5) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the member upon request.
- (6) An explanation of the scientific or clinical judgment or other reason for the determination, if applicable.

B. Internal Appeal. The internal appeal procedures shall provide at least the following:

- (1) An insured may request an appeal of the insurer's determination that the Benefit trigger was not met, by sending a written request to the insurer, along with any additional supporting information, within one-hundred and eighty (180) calendar days after the insured receives the insurer's benefit determination notice.
- (2) The internal appeal shall provide the insured with the opportunity to submit written comments, documents, records, and other information relating to the internal appeal.
- (3) The internal appeal shall provide, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the member's internal appeal.
- (4) The internal appeal shall provide for a review that takes into account all comments, documents, records and other information submitted by the member relating to the internal appeal, without regard to whether such information was submitted or considered in the initial benefit determination.
- (5) The internal appeal shall provide for a review that does not afford deference to the initial adverse benefit determination and ensures that the person or persons reviewing the grievance on behalf of insurer shall not have been involved with the adverse benefit determination or other issue that is the subject of the internal appeal, nor shall such person or persons be the subordinate(s) of any individual who was involved with the initial determination or other issue that is the subject of the grievance.
- (6) The internal appeal shall consider any information provided by the insured's treating providers.

- (7) The internal appeal rights shall not exceed two levels of internal appeals, and the second level shall be voluntary. The insurer shall waive any right to assert that a member has failed to exhaust administrative remedies because the member did not elect to submit a grievance to the voluntary second level of grievances.
  - (8) The internal appeal shall provide members for whom English is not a primary language with information in their primary language, if requested, about how to file an internal appeal and how to participate in the internal appeal process. This information may be provided telephonically or in written form.
- C. The internal appeal shall be completed and written notice of the internal appeal decision shall be sent to the insured within thirty (30) calendar days of the insurer's receipt of all necessary information upon which a final determination can be made.
- (1) If the determination that the Benefit trigger was not met is upheld upon internal appeal, the notice of the internal appeal decision shall describe any additional internal appeal rights offered by the insurer.
  - (2) If the determination that the Benefit trigger was not met is upheld after the internal appeal process has been exhausted, and new or additional information has not been provided to the insurer for consideration, the insurer shall provide a written description of the insured's right to request an independent review of the benefit determination as described in Subsection D.
  - (3) If the determination that the Benefit trigger was not met is upheld after the internal appeal process has been exhausted, the insurer shall provide the following information in the written notice of the internal appeal decision:
    - (a) the titles and credentials of the reviewer(s) responsible for the internal appeal decision;
    - (b) the reviewer(s) decision, drafted in sufficient detail for the insured to understand the review(s) decision; and
    - (c) reference to evidence or documentation that the reviewer(s) considered, including any internal rule, guideline, protocol or other criterion that the reviewer(s) relied upon.
- D. Independent Review of Benefit Trigger Determination.
- (1) Request.
    - (a) An insured who is not satisfied with the insurer's Benefit trigger determination may request an independent review of the determination. A written request for an independent review shall be made by the insured or insured's

representative to the insurer within ninety (90) calendar days after the insurer's written notice of the final internal appeal decision is received by the insured.

- (b) The insured may request the opportunity for the insured or his or her representative to participate in person or by telephone.

(2) Independent Review Process.

- (a) The insurer shall refer the appeal on a rotating basis to the next independent review organization on the Department's list of contracted independent review organizations. If the organization has a conflict of interest, then the insurer shall assign the appeal to the next independent review organization on the Department's list of independent review organizations without a conflict.
- (b) The insurer shall acknowledge the insured's request for independent review in writing, to the insured and to the Commissioner, within fifteen (15) business days of receipt of the request. Such acknowledgment shall include: (1) a copy of the insured's request for an internal appeal; (2) a copy of the insurer's determination on internal appeal; (3) a copy of the insured's request for an independent review; and (4) the name of the independent review organization selected to review the insured's request for independent review. The Department may request additional information and documentation about the internal appeal or the independent review at any time.
- (c) If the insured or the insured's representative requested the opportunity to participate in person or by telephone, the independent review organization shall meet by teleconference with the insured, his or her treating provider, and a clinical representative of the health insurer, to review and discuss the evidence in the appeal.
- (d) The insured may submit new or additional information not previously provided to the insurer. When submitting new information, the insured may request that the health insurer reconsider the decision being appealed based on the additional information being provided. In addition, if the independent review organization to whom the appeal is assigned determines at any time that information it has received as part of the appeal was not available or not made available to the health insurer during its internal review process, the independent review organization shall request the health insurer to reconsider the decision based on the new information. Any such request shall stay the review by the independent review organization for no more than fifteen (15) days.
- (e) The independent review organization shall provide the insurer and insured written notice of its decision regarding the insurer's determination within

thirty (30) calendar days from the date the insurer received the request for an independent review of the benefit trigger determination. If the independent review organization overturns the insurer's decision, it shall:

- (i) Establish the date that the Benefit trigger was deemed to have been met;
  - (ii) Establish the specific period of time under review for which the insurer declined eligibility but during which the independent review organization deemed the Benefit trigger to have been met.
  - (iii) For qualified long-term care insurance contracts, the independent review organization shall make a determination that the insured is a chronically ill individual.
- (f) The decision of the independent review organization with respect to whether the insured met the Benefit trigger will be final and binding on the insurer.
- (g) Nothing in this section shall restrict the insured's right to submit a new claim after the independent review decision, should the independent review organization uphold the insurer's decision, if the insured's condition changes.
- (h) At any time before or after the request for independent review has been received and referred to the independent review organization, the insured may submit new or additional information not previously provided to the insurer but pertinent to the Benefit trigger denial. The insurer shall consider such information and affirm or overturn its Benefit trigger determination. If the insurer affirms its Benefit trigger determination, the insurer shall promptly provide such new or additional information to the independent review organization for its review. If the insurer overturns its Benefit trigger determination:
- (i) The insurer shall provide notice to the independent review organization, the insured and the Department of its decision; and
  - (ii) The independent review process shall immediately cease.

E. Qualifications of an Independent Review Organization. The Department shall from time to time enter into contracts with as many independent review organizations as it deems necessary to conduct the review provided for in this regulation. The contracts shall set forth all terms that the Department deems necessary to ensure a full, fair and timely review of appeals. Selection of the independent review organizations shall include review of proposals with regard to at least the following:

- (1) Proposed scope of services;
  - (2) Fee structure and total estimated costs of reviews;
  - (3) Number and qualifications of reviewers, who shall include licensed health care professionals in appropriate disciplines and specialties for determining functional or cognitive impairment (e.g. physical therapy, occupational therapy, neurology, physical medicine and rehabilitation);
  - (4) Accreditation;
  - (5) Procedures to ensure the confidentiality of the appeals, including identifiable health care information used in reviewing the appeals;
  - (6) Procedures to ensure the neutrality of reviewers;
  - (7) Administrative and operational policies and procedures; and
  - (8) Procedures to ensure that no conflict of interest exists among the organization and its reviewers and the health insurer or insured whose case is under review.
- F. Applicability. The requirements of this section apply to Benefit trigger determinations on or after January 1, 2010. However, it shall not apply to long-term care insurance claims made under a group long-term care insurance policy that insures a plan governed by the Employee Retirement Income Security Act of 1974, as amended.

### **Section 32. Standard Format Outline of Coverage**

This section of the regulation implements, interprets and makes specific the provisions of 8 V.S.A. § 8090 in prescribing a standard format and the content of an outline of coverage.

- A. The outline of coverage shall be a free-standing document, and shall use a readable font that is no smaller than twelve 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 of coverage is mandatory, unless otherwise specifically indicated.
- E. The format for the outline of coverage must be:

[COMPANY NAME]

[ADDRESS – CITY & STATE]

[TELEPHONE NUMBER]

## **LONG-TERM CARE INSURANCE**

### **OUTLINE OF COVERAGE**

**[Policy Number or Group Master Policy & Certificate Number]**

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] ([a group policy] which was issued in [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. **PREMIUM.**
  - (a) State the total annual premium for the policy;
  - (b) State the total monthly premium for the policy;
  - (c) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]
4. **LIMITATIONS AND EXCLUSIONS.**

[Describe:

- (a) Preexisting conditions;
- (b) Non-eligible facilities/providers;
- (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, or 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. IF THE POLICY DOES NOT COVER ALL NECESSARY EXPENSES, YOU WILL HAVE TO PAY EXPENSES THAT ARE NOT COVERED.**

**5. FEDERAL TAX CONSEQUENCES.**

This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

OR

Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986 as amended. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

**6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.**

- (a) [For long-term care health insurance policies or certificates, describe one of the following permissible policy renewability provisions:
  - (1) Policies and certificates that are guaranteed renewable shall contain the following statement:] **RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE.** This means you have the right, subject to the terms of your policy, [certificate] to continue

this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(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.]

7. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

8. 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.]

9. 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] [insurance company name] is not representing Medicare, the federal government or any state government.

10. **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, provided in a covered setting, 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.]

11. **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.]
- (d) [Eligibility for Payment of Benefits]

[Activities of daily living, cognitive impairment or the existence of mental health condition shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.]

[Any additional Benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the trigger 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.]

12. **RELATIONSHIP OF COSTS 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; and
- (e) Describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

YOU SHOULD CAREFULLY DETERMINE WHETHER PURCHASING  
COMPOUND INFLATION PROTECTION IS AN APPROPRIATE CHOICE  
FOR YOUR BENEFIT NEEDS.

13. ALZHEIMER’S DISEASE AND MENTAL HEALTH CONDITIONS.

[State that the policy provides coverage for insureds having Alzheimer’s disease and related diseases or mental health conditions. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

14. ADDITIONAL FEATURES.

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

15. IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE, CONTACT THE STATE HEALTH INSURANCE ASSISTANCE PROGRAM (SHIP) AT 1-800-642-5119 OR THE VERMONT DEPARTMENT OF BANKING, INSURANCE, SECURITIES AND HEALTH CARE ADMINISTRATION (BISHCA) AT 1-800-631-7788. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

**Section 33. Requirement to Deliver Shopper’s Guide**

- A. A long-term care insurance shopper’s guide approved by the Commissioner shall be provided to all prospective applicants of a long-term care insurance policy or certificate.
  - (1) In the case of agent solicitations, an agent must deliver the shopper’s guide prior to the presentation of an application or enrollment form.

- (2) In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.
- B. Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-reference guide, but shall furnish the policy summary required by 8 V.S.A. §8091.

### **Section 34. Producer Requirements**

- A. An individual may not sell, solicit or negotiate long-term care insurance unless the individual is licensed as an insurance agent or producer for accident and health or sickness or life and has completed the training requirements set forth in subsection B. For resident licensees, this training can count towards the twenty-four (24) hours of continuing education required in 8 V.S.A. § 4800a and any regulation promulgated thereunder if the training satisfies all requirements for continuing education, including course approval and provider registration. The training requirements of Subsection B must be approved for continuing education under 8 V.S.A. § 4800a.
- B. Training Requirements.
  - (1) An agent or producer selling, soliciting or negotiating the sale of any long-term care insurance policy must complete one, eight (8) hour course specific to long-term care, not less than two hours of which shall contain Vermont-specific information including Vermont Medicaid information. The Vermont-specific information can be part of an eight-hour course or may be provided as a separate course. The initial training requirement shall apply as follows:
    - (a) Insurance agents or producers licensed to sell long-term care insurance policies after March 31, 2010 must complete the one-time eight-hour training before the agent or producer may sell, solicit or negotiate the sale of any long-term care insurance policy.
    - (b) Insurance agents or producers licensed to sell long-term care insurance policies on or before March 31, 2010 must complete the one-time eight-hour training or before March 31, 2011.
  - (2) An agent or producer selling, soliciting or negotiating the sale of any long-term care insurance policy must also complete no less than four (4) hours of ongoing training every 24 months ending March 31<sup>st</sup> of odd-numbered calendar years. The Commissioner may, at his or her discretion, require agents and producers licensed to sell long-term care insurance to complete additional ongoing training if the Commissioner determines that such training is needed due to significant changes in the long-term care statute or the Medicaid program.

- (3) The training required under Subsections (B)(1) and (B)(2) shall consist of topics related to long-term care insurance, long-term care services and, if applicable, qualified state long-term care insurance Partnership programs, including, but not limited to:
  - a. State and federal regulations and requirements and the relationship between qualified state long-term care insurance Partnership programs and other public and private coverage of long-term care services, including Medicaid;
  - b. Available long-term care services and providers;
  - c. Changes or improvements in long-term care services or providers;
  - d. Alternatives to the purchase of private long-term care insurance;
  - e. The effect of inflation on benefits and the importance of inflation protection; and
  - f. Consumer suitability standards and guidelines.
- (4) The training required by this section shall not include training that is insurer or company product specific or that includes any sales or marketing information, materials, or training, other than those required by state or federal law.

C. Insurer's Obligations.

- (1) Insurers subject to this Regulation shall obtain verification that an agent or producer receives training required by this Regulation before an agent or producer is permitted to sell, solicit or negotiate the insurer's long-term care insurance products, maintain records subject to the state's record retention requirements, and make that verification available to the Commissioner upon request.
- (2) Each insurer subject to this Regulation shall maintain the training records that demonstrate that agents and producers have received the training contained in subsection (B)(1) and (B)(2). These records shall be maintained in accordance with the state's record retention requirements and shall be made available to the Department upon request.

D. Satisfaction of the training requirements in any state shall be deemed to satisfy the training requirements in Vermont, except for the Vermont-specific training required as set forth in Subsection (B)(1) of this Section.

E. Agent and Producer Compensation Requirements.

- (1) Agents and producers must obtain a prior written agreement with an applicant, policyholder or other member of the public concerning fees or charges made by that agent or producer directly to the applicant, policyholder or other member of the public for that agent or producer procuring, servicing, or providing advice on insurance contracts.
- (2) Commissions, expense allowances, bonuses, fees or any other compensation received directly by agents or producers from any legal entity engaged in the insurance business is exempt from this requirement.

### **Section 35. Long-Term Care Partnership Policies**

- A. **Applicability.** In accordance with Section 6021 of the Deficit Reduction Act of 2005 (Pub.L. 109-171) and in addition to the requirements of Chapter 154 of Title 8 and other applicable laws, the provisions of this section shall apply to long-term care insurance that is intended to qualify under Vermont's long-term care partnership program as a Partnership policy.
- B. **Policy Certification.**
  - (1) A Partnership policy shall not be issued or issued for delivery in Vermont unless filed with and approved by the Department. Any policy submitted for certification as a Partnership policy shall be accompanied by a Partnership Certification Form (Appendix J).
  - (2) Insurers requesting to make use of a previously approved policy form as a Partnership policy shall submit to the Department a Partnership Certification Form signed by an officer of the company. A Partnership Certification Form shall be required for each policy form submitted for partnership qualification (Appendix J).
- C. **Notice Requirements.**
  - (1) An insurer or its agent, soliciting or offering to sell a policy that is intended to qualify as a Partnership policy, shall provide to each prospective applicant a Partnership Program Notice (Appendix H), outlining the requirements and benefits of a Partnership policy. A similar notice may be used for this purpose if filed and approved by the Department. The Partnership Program Notice shall be provided with the required Outline of Coverage.
  - (2) A Partnership policy issued or issued for delivery in Vermont shall be accompanied by a Partnership Disclosure Notice (Appendix I) explaining the benefits associated with a Partnership policy and indicating that at the time issued, the policy is intended to be a Qualified state long-term care insurance partnership policy. A similar notice may be used if filed and approved by the Department. The Partnership Disclosure Notice shall also include a statement indicating that

by purchasing this Partnership policy, the insured does not automatically qualify for Medicaid.

- (3) Insurers issuing a Partnership policy shall provide a Policyholder Long-Term Care Partnership Program Status Form (Appendix K) upon request of the policyholder or the policyholder's representative. A similar notice may be used if filed and approved by the Department.

D. Inflation Protection. A Partnership policy must provide at least the following levels of inflation protection:

- (1) If a policy is sold to a person who is less than sixty-one (61) years of age as of the date of purchase of the policy, the policy must provide automatic annual compounded inflation increases at a rate not less than three percent (3%); or provide automatic annual compounded inflation increases at a rate based on changes in the consumer price index. "Consumer price index" means consumer price index for all urban consumers, U.S. city average, all items, as determined by the Bureau of Labor Statistics of the United States Department of Labor.
- (2) If a policy is sold to a person who is at least sixty-one (61) years of age but less than seventy-six (76) years of age as of the date of purchase of the policy, the policy must provide Some level of inflation protection. "Some level of inflation protection" means an inflation feature that meets the requirements of Subsection(D)(1) or "Simple inflation protection" as defined by Section 4(H) of this Regulation.
- (3) If a policy is sold to a person aged seventy-six (76) or older, the policy may, but is not required to, provide Some level of inflation protection.
- (4) The Department may also approve an alternative inflation method (including an alternative index) so long as such method is submitted to the Department with an explanation and demonstration as to how the alternative method provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. No alternative method may be used until the Department has approved such method.
- (5) Inflation protection benefit increases shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

E. Exchange.

- (1) A policy received in an exchange after the effective date of Vermont's long-term care partnership program is treated as newly issued and thus is eligible for

Partnership policy status. For purposes of applying the Medicaid rules relating to Vermont's long-term care partnership program, the addition of a rider, endorsement, or change in schedule page for a policy may be treated as giving rise to an exchange.

- (2) An insurer shall offer, on a one time basis, in writing, to all existing policyholders that were issued long-term care coverage of the type certified by the insurer on or after February 8, 2006, the option to exchange their existing long-term care coverage for coverage that is intended to qualify under Vermont's long-term care partnership program. The mandatory offer of an exchange shall only apply to products issued by the insurer that are comparable to the type of policy form (e.g. group policies, individual policies, etc.) and on the policy series that the company has certified as partnership qualified. The following rules shall apply to the offer to exchange:
  - (a) Insurers must send policyholders the written offer of exchange within eighteen months of the date that an insurer begins to advertise, market, offer, sell or issue policies that qualify under Vermont's long-term care partnership program. The written offer of exchange used for this purpose shall be accompanied by The Long-Term Care Partnership Exchange Notification Form (Appendix L). An alternative form may be used for this purpose if filed and approved by the Department. The offer of exchange shall also be accompanied by Partnership Program Notice (Appendix H).
  - (b) The offer shall be made on a nondiscriminatory basis without regard to the age or health status of the insured. However, the insurer may underwrite if the policy is amended to provide additional benefits or inflation protection.
  - (c) If there is no change in coverage material to the risk, the policy shall be calculated on the basis of the insured's age at inception of coverage under the existing policy. Any portion of the policy that was issued prior to the exchange date shall be priced based on the policyholder's age when the policy was originally issued. Any portion of the policy that is added as a result of the exchange may be priced based on the policyholder's age at the time of the exchange.
  - (d) The offer shall remain open for a minimum of forty-five (45) days from the date of mailing by the insurer.
  - (e) If there is no change in coverage material to the risk, policies exchanged under this provision shall not be subject to any medical underwriting or approval process.
  - (f) Any addition to a policy as a result of any exchange shall be subject to the right to return set forth in 8 V.S.A. § 8089 and all applicable regulations.

- (i) In the event of an exchange, the insured shall not lose any rights, benefits or built-up value that has accrued under the original policy with respect to the benefits provided under the original policy, including, but not limited to, rights established because of the lapse of time related to pre-existing condition exclusions, elimination periods, or incontestability clauses.
    - (j) Notwithstanding subsection E(2), an insurer is not required to offer an exchange to an individual who is eligible for benefits or within an elimination period, or who has been in claim status.
  - (3) For those insureds with long-term care policies issued before February 8, 2006, an insurer may offer any insured an option to exchange an existing policy for a policy that qualifies as a Partnership policy under Vermont's long-term care partnership program. The requirements set forth in subsection (E)(2) shall apply to any such exchange.
- F. Policy amendments. Any amendment to the policy that alters the status of a Partnership policy so that it no longer meets the applicable partnership standards must affirmatively disclose that fact and include an amended schedule page that removes the references to the long-term care partnership program.
- G. Reporting Requirements.
  - (1) Each insurer issuing a Partnership policy shall provide regular reports to the United States Secretary of Health and Human Services in accordance with regulations of the Secretary that include notification of the date benefits were paid, the amount paid, the date the policy terminates, and such other information as the Secretary determines may be appropriate to the administration of partnerships. Upon request from the Department, insurers shall provide a copy of these reports to the Department.
  - (2) In addition to the reporting requirements set forth in Subsection (G)(1), each insurer issuing a Partnership policy shall provide annual reports to the Department on or before June 30 that include the following information for the prior calendar year:
    - (a) the total number of certified policies the insurer has issued or issued for delivery in Vermont;
    - (b) the total number of lives covered by Partnership policies certified in Vermont;
    - (c) the total number of claims reported under Partnership policies certified in Vermont;

- (d) the total number of claims paid under Partnership policies certified in Vermont;
- (e) the total number of lapsed Partnership policies certified in Vermont;
- (f) the total number of Partnership policies certified in Vermont that were terminated due to benefit exhaustion; and
- (g) the total amount of premium collected and attributable to Partnership policies certified in Vermont.

**Section 36 Penalties**

- A. No policy may be advertised, marketed or offered as long-term care insurance unless it complies with the provisions of 8 V.S.A. Chapters 129 and 154 and this regulation.
- B. In addition to any other remedy or sanction provided by law, after notice and opportunity for hearing the Commissioner may assess an administrative penalty in an amount not to exceed \$10,000.00 for each violation against any person who violates any provision of 8 V.S.A. Chapter 154 or this regulation.
- C. A person who violates a provision of 8 V.S.A. Chapter 154 or this regulation shall be fined not more than \$10,000.00, or imprisoned for not more than six months, or both.
- D. The Department, or the Attorney General at the request of the Department, may bring an action to enforce the provisions of this chapter in the superior court.

**Section 37 Severability**

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

**Section 38 Effective Date; Repeal**

Sections 1 through 34 and sections 36 through 37 of this regulation shall become effective on April 1, 2010. Section 35 of this regulation shall become effective upon the effective date of Vermont's state plan amendment required by section 6021 of the Deficit Reduction Act of 2005 (Pub.L. 109-171). BISHCA Regulation 91-1 shall be repealed at midnight on March 31, 2010.

**APPENDIX A**

**RESCISSION REPORTING FORM FOR  
LONG-TERM CARE POLICIES  
FOR THE STATE OF VERMONT  
FOR THE REPORTING YEAR 20[ ]**

Company Name: \_\_\_\_\_

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

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

Due: June 30 annually

**Instructions:**

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission: \_\_\_\_\_

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name and Title (please type)

\_\_\_\_\_  
Date

**APPENDIX B**

**Long-Term Care Insurance  
Personal Worksheet**

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

**Drafting Note:** This form includes questions insurers and producers must ask to determine suitability. Insurers and producers are encouraged to ask additional questions beyond what is provided for in this form.

**Existing Long-Term Care Insurance**

Do you currently have a long-term care insurance policy? Yes No (circle one)

If yes, list the carrier, policy number and premium \_\_\_\_\_

Are you considering discontinuing making premium payments under this policy? \_\_\_\_\_

If you intend to replace this policy explain why \_\_\_\_\_

NOTICE: A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract. Make sure you know the facts and carefully consider whether a replacement is in your best interests. Contact your existing company or its agent for information about the old policy or contract. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

**Drafting Note:** If the applicant answered "yes" to the question regarding existing coverage, the producer must read this notice to the applicant.

**Premium Information For New Policy**

Policy Form Numbers \_\_\_\_\_

The premium for the coverage you are considering will be [\$\_\_\_\_\_ per month, or \$\_\_\_\_\_ per year,] [a one-time single premium of \$\_\_\_\_\_.]

**Type of Policy** (noncancellable/guaranteed renewable): \_\_\_\_\_

### The Company's Right to Increase Premiums:

[The company cannot raise your premiums on this policy.] [The company may increase premiums on this policy form in the future as long as the company raises rates for all policies in the same class in this state.] **Drafting note:** Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.

### Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or Similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or Similar policy forms in the last 10 years. Following is a summary of the rate increases.]

**Drafting Note:** A company may use the first bracketed sentence above only if it has never increased rates under any prior policy forms in this state or any other state. The issuer shall list each premium increase it has instituted on this or Similar policy forms in this state or any other state during the last 10 years. The list shall provide the policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.

### Questions Related to Your Income

How will you pay each year's premium?

From my Income       From my Savings/Investments       My Family will Pay

[ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?]

**Drafting Note:** The issuer must use the bracketed sentence unless the policy is fully paid up or is a noncancellable policy.

What is your annual income? (check one)  Under \$10,000       \$10-20,000       \$20-30,000  
 \$30-50,000       \$50-70,000       \$70-100,000       Over \$100,000

How do you expect your income to change over the next 10 years? (check one)

No change       Increase       Decrease

*If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.*

**Will you buy inflation protection?** (check one)  Yes  No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

From my Income

From my Savings/Investments

My Family will Pay

*The national average annual cost of care in [insert year] was [insert \$ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert \$ amount] if costs increase 5% annually.*

**Drafting Note:** The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.

**What elimination period are you considering?** Number of days \_\_\_\_\_ Approximate cost \$ \_\_\_\_\_ for that period of care.

**How are you planning to pay for your care during the elimination period?** (check one)

From my Income

From my Savings/Investments

My Family will Pay

### Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

Under \$20,000

\$20,000-\$30,000

\$30,000-\$50,000

\$50,000-\$80,000

\$80,000-\$120,000

\$120,000-\$150,000

Over \$150,000

How do you expect your assets to change over the next ten years? (check one)

Stay about the same

Increase

Decrease

*If you are buying this policy to protect your assets and your assets are less than \$50,000, you may wish to consider other options for financing your long-term care.*

[Drafting Note: The \$50,000 asset level may be adjusted to reflect, at the Commissioner's discretion, appropriate inflation factors.]

**Disclosure Statement**

<p><input type="checkbox"/> The answers to the questions above describe my financial situation. I understand the company will review this form and notify me if the company determines that this coverage is not appropriate because of my financial situation or existing insurance coverage. I also understand that the company cannot sell or otherwise disseminate the information included on this form, and that the company may not use this form for any purpose other than determining whether this product is suitable for me.</p> <p style="text-align: center;"><b>Or</b></p> <p><input type="checkbox"/> I choose not to complete this information.</p> <p style="text-align: center;">(Check one.)</p>
<p><input type="checkbox"/> I acknowledge that the insurer and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. <b>I understand that the rates for this policy may increase in the future.</b> (This box must be checked).</p>

Signed: \_\_\_\_\_ (Applicant) \_\_\_\_\_ (Date)

I explained to the applicant the importance of completing this information.

Signed: \_\_\_\_\_ (Agent) \_\_\_\_\_ (Date)

Agent's Printed Name: \_\_\_\_\_ ]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.]

Signed: \_\_\_\_\_ ]  
(Applicant) (Date)

**Drafting Note:** Choose the appropriate sentences depending on whether this is a direct mail or agent sale.

*The company may contact you to verify your answers.*

**Drafting Note:** When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading “Disclosure Statement” to the end of the page may be removed. Insurers should remember their reporting obligations in 8 V.S.A. § 8084b(g) and this Regulation.

## APPENDIX C

### Things You Should Know Before You Buy Long-Term Care Insurance

#### Long-Term Care Insurance

- A long-term care insurance policy may not pay all necessary expenses for your care in a nursing home, care at home or other community settings. If the policy does not cover all necessary expenses, you will have to pay expenses that are not covered. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- [You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

**Drafting Note:** For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.

- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

#### Medicare

- Medicare does **not** pay for most long-term care.

#### Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

**Shopper's Guide**

- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy. The Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) also publishes a consumers' publication about long-term care insurance. You can request a copy of this publication by calling 1-800-631-7788 or on BISHCA's website: [http://www.bishca.state.vt.us/HcaDiv/consumerpubs\\_healthcare/index\\_consumerpubs.html](http://www.bishca.state.vt.us/HcaDiv/consumerpubs_healthcare/index_consumerpubs.html).

**Counseling**

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact the State Health Insurance Assistance Program (SHIP) at 1-800-642-5119 or the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) at 1-800-631-7788 for more information about the senior health insurance counseling program in your state.

**Facilities**

- Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

**APPENDIX D Long-Term Care Insurance Suitability Letter**

Dear [Applicant]:

Your recent application for long-term care insurance included a “personal worksheet,” which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage or who cannot afford to purchase long-term care insurance.

[Your answers indicate that you may not be able to afford or you may not need long-term care insurance. We suggest that you review the information provided along with your application, including the booklet “Shopper’s Guide to Long-Term Care Insurance” and the page titled “Things You Should Know Before Buying Long-Term Care Insurance.” If you have questions about long-term care insurance, you can contact the State Health Insurance Assistance Program (SHIP) at 1-800-642-5119 or the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) at 1-800-631-7788.]

[You chose not to provide any financial information for us to review.]

**Drafting Note:** Choose the paragraph that applies.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical and financial standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

*Please check one box and return in the enclosed envelope.*

**Yes,** [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. My insurance agent did not pressure me to make this decision. Please resume review of my application.

**Drafting Note:** Delete the phrase in brackets if the applicant did not answer the questions about income.

**No.**

\_\_\_\_\_  
APPLICANT’S SIGNATURE

\_\_\_\_\_  
DATE

*Please return to [issuer] at [address] by [date].*

**APPENDIX E**

**Claims Denial Reporting Form  
Long-Term Care Insurance  
For the State of Vermont  
For the Reporting Year of \_\_\_\_\_**

Company Name: \_\_\_\_\_ Due: June 30 annually  
Company Address: \_\_\_\_\_

Company NAIC Number: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Line of Business:        Individual                      Group

Instructions

The purpose of this form is to report all long-term care claim denials under in force long-term care insurance policies. “Denied” means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

		<b>State Data</b>	<b>Nationwide Data<sup>1</sup></b>
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Long-Term Care Claim Denied due to:		
8	• Long-Term Care Services Not Covered under the Policy <sup>2</sup>		
9	• Provider/Facility Not Qualified under the Policy <sup>3</sup>		
10	• Benefit Eligibility Criteria Not Met <sup>4</sup>		
11	• Other		

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.
2. Example—home health care claim filed under a nursing home only policy (please note: nursing home only policies are not allowed for issuance in Vermont).
3. Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
4. Examples—a Benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

## APPENDIX F

### Instructions:

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase. Use of this form is mandated by Section 9.

**Insurers shall provide all of the following information to the applicant:**

### **Long-Term Care Insurance Potential Rate Increase Disclosure Form**

1. **[Premium Rate] [Premium Rate Schedules]:** [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and an increase approved by the Vermont Department of Banking, Insurance, Securities and Health Care Administration [is][are] [on the application][(\$\_\_\_\_\_)]
2. **The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.**

3. **Rate Schedule Adjustments:**

The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): \_\_\_\_\_.

4. **Potential Rate Revisions:**

**This policy is Guaranteed Renewable.** This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

**If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:**

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- Exercise your contingent nonforfeiture rights.\* (This option is available if you do not purchase a separate nonforfeiture option.)

*Turn the Page*

### \* **Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

#### **Example:**

- You bought the policy at age 65 and paid the \$1,000 annual premium for 10 years, so you have paid a total of \$10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or \$500 for a new annual premium of \$1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are \$10,000 (provided you have a least \$10,000 of benefits remaining under your policy.)

*Turn the Page*

**Contingent Nonforfeiture**  
**Cumulative Premium Increase over Initial Premium**  
**That qualifies for Contingent Nonforfeiture**

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

**APPENDIX G**

**Long-Term Care Insurance  
Replacement and Lapse Reporting Form**

For the State of \_\_\_\_\_ For the Reporting Year of \_\_\_\_\_

Company Name: \_\_\_\_\_  
 Company Address: \_\_\_\_\_  
 Company Person: \_\_\_\_\_

**Instructions**

The purpose of this form is to report on a statewide basis information regarding long-term care insurance policy replacements and lapses. Specifically, every insurer shall maintain records for each agent on that agent’s amount of long-term care insurance replacement sales as a percent of the agent’s total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent’s total annual sales. The tables below should be used to report the ten percent (10%) of the insurer’s agents with the greatest percentages of replacement and lapses.

**Listing of the 10% of Producers with the Greatest Percentage of Replacements**

Producer’s name	Number of Policies Sold by This Producer	Number of Policies Replaced by This Producer	Number of Replacements As % of Number Sold By This Producer

**Listing of the 10% of Agents with the Greatest Percentage of Lapses**

Producer’s name	Number of Policies Sold by This Producer	Number of Policies Lapsed by This Producer	Number of Lapses As % of Number Sold By This Producer

**Company Tools**

Percentage of Replacement Policies Sold to Total Annual Sales \_\_\_\_%

Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year) \_\_\_\_%

Percentages of Lapsed Policies to Total Annual Sales \_\_\_\_%

Percentages of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) \_\_\_\_%

## Appendix H

### Partnership Program Notice

This Notice explains how the Vermont Long-Term Care Partnership Program works and provides important consumer information regarding the policies that are certified as Partnership Policies.

#### What is the Vermont Long-Term Care Partnership Program?

Some long-term care insurance policies sold in Vermont may qualify for the Vermont Long-Term Care Partnership Program (the Partnership Program). The Partnership Program is a partnership between state government and private insurance companies to assist individuals in planning their long-term care needs. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance policies that qualify as Partnership Policies may protect the policyholder's assets through a feature known as "Asset Disregard" under Vermont's Medicaid program.

#### How Could the Partnership Program Help Protect Assets?

Long-term care insurance helps individuals prepare for future long-term care needs. Qualified Partnership Policies provide an additional level of protection. In particular, such policies may permit individuals to protect resources under Vermont's Medicaid Program if assistance is ever needed under that program and the individual would be otherwise eligible for the Vermont Medicaid Program.

In addition, if these specific protected resources are still in existence when the individual dies and they are part of the decedent's probate estate, they will not be recoverable under state law. The resource, eligibility and estate recovery provisions of the Vermont Medicaid Program permit the disregard of an amount of assets which is equal to the amount of insurance benefits you have received from your qualified Partnership Policy. For example, if you receive \$200,000 of insurance benefits from your qualified Partnership Policy, you would be able to retain \$200,000 of resources and still be eligible for long-term care services provided under the Medicaid Program. This disregard is above and beyond the resources normally permitted to be retained by an individual and still qualify for Medicaid. (Note: special rules may apply to persons whose home equity exceeds \$500,000.) This protection of assets applies to individuals in need of long-term care services both in the community or residing in a long-term care facility.

It is important to understand that all other Medicaid eligibility criteria will apply at the time you apply for Medicaid. ***The purchase of a Partnership Policy does***

***not automatically qualify you for Medicaid.*** In addition, please note that Medicaid eligibility requirements may change over time.

Asset Disregard is not available under a long-term care insurance policy that is not a Partnership Policy. Therefore, you should consider if Asset Disregard is important to you, and whether a Partnership Policy meets your needs.

### **What are the Requirements for a Partnership Policy?**

In order for a policy to qualify as a Partnership Policy, it must, among other requirements:

- be issued to an individual after *{insert effective date of Vermont's long-term care partnership program}*;
- cover an individual who was an Vermont resident when coverage first becomes effective under the policy;
- be a tax-qualified policy under Section 7702(B)(b) of the Internal Revenue Code of 1986;
- meet consumer protection standards required by federal legislation; and
- meet the following inflation protection requirements:
  - For ages 60 or younger, the policy must provide Compound annual inflation protection
  - For ages 61 to 65, the policy must provide some level of inflation protection
  - For ages 76 and older, the policy does not have to provide inflation protection.

If you apply and are approved for long-term care insurance coverage, [carrier name] will provide you with written documentation as to whether or not your policy qualifies as a Partnership Policy.

### **What Could Disqualify a Policy as a Partnership Policy?**

If you make certain types of changes to a Partnership Policy, such changes could affect whether or not the policy continues to qualify as a Partnership Policy. If you purchase a Partnership Policy and later decide to make *any* changes, you should first consult with [carrier name] to determine the effect of a proposed change. In addition, if you move to a state that does not maintain a Partnership Program or does not recognize your policy as a Partnership Policy, you would not receive beneficial treatment of your policy under the Medicaid program of that state. The information contained in this disclosure is based on current Vermont and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your policy under Vermont's Medicaid program.

### **Additional Consumer Protections.**

In addition to providing asset protection, a qualified Partnership Policy has other important features. Partnership Policies must be qualified long-term care insurance contracts under Federal tax law. As such the insurance benefits you receive from the policy generally will be subject to beneficial income tax treatment. (Please note that a policy can be a tax qualified long-term care insurance contract under Federal tax law, with the same beneficial income tax treatment, even if it is not a Partnership Policy.) In addition, if you were under age 76 when you purchased your qualified Partnership Policy, it must provide inflation protection to help protect against potential future increases in the cost of long-term care. (Purchasers over the age of 76 must be offered the option of purchasing a policy with inflation protection).

**Additional Information.** If you have questions regarding the insurance policy please contact [insert name of carrier.] If you have questions regarding current laws governing Medicaid eligibility, you should contact the Vermont Health Access Member Services at 1-800-250-8427.

**Drafting Note:** This form is intended for use with individual long-term care insurance. The insurer may modify these forms for use with group long-term care insurance without filing with the Department so long as no substantive revisions are made. For example, the term “policy” may be replaced with “certificate” or “coverage,” and the term “policyholder” may be replaced with “certificateholder.”

**Appendix I**

**Partnership Status Disclosure Notice**

**Important Information Regarding Your Policy's  
Long-Term Care Partnership Status**

This disclosure notice is issued in conjunction with your long-term care policy:

Some long-term care insurance policies sold in Vermont qualify for the Vermont Long-Term Care Partnership Program. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance policies that qualify as Partnership Policies may be entitled to special treatment, and in particular an "Asset Disregard," under Vermont's Medicaid program.

**Asset Disregard.** Asset disregard means that an amount of the policyholder's assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership Policy without affecting the person's eligibility for Medicaid. In addition, if these specific protected resources are still in existence when the individual dies and they are part of the decedent's probate estate, they will not be recoverable under state law.

The resource, eligibility and estate recovery provisions of the Vermont Medicaid Program permit the disregard of an amount of assets which is equal to the amount of insurance benefits you have received from your qualified Partnership Policy. For example, if you receive \$200,000 of insurance benefits from your qualified Partnership Policy, you would be able to retain \$200,000 of resources and still be eligible for long-term care services provided under the Medicaid Program. This disregard is above and beyond the resources normally permitted to be retained by an individual and still qualify for Medicaid. (Note: special rules may apply to persons whose home equity exceeds \$500,000.) This protection of assets applies to individuals in need of long-term care services both in the community or residing in a long-term care facility.

It is important to understand that all other Medicaid eligibility criteria will apply at the time you apply for Medicaid. ***The purchase of a Partnership Policy does not automatically qualify you for Medicaid.*** In addition, please note that Medicaid eligibility requirements may change over time.

**Partnership Policy Status.** Your long-term care insurance policy is intended to qualify as a Partnership Policy under the *Vermont Long-Term Care Partnership Program* as of your Policy's effective date.

**What Could Disqualify Your Policy as a Partnership Policy.** If you make any changes to your policy, such changes could affect whether your policy continues to be a Partnership Policy. ***Before you make any changes, you should consult with [insert name of carrier] to determine the effect of a proposed change.*** In addition, if you move to a State that does not maintain a Partnership Program or does not recognize your policy as a Partnership Policy, you would not receive beneficial treatment of your policy under the Medicaid program of that State. The information contained in this Notice is based on current State and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your policy under Vermont's Medicaid program.

**Additional Information.** If you have questions regarding your insurance policy please contact [insert name of carrier.] If you have questions regarding current laws governing Medicaid eligibility, you should contact the Vermont Health Access Member Services at 1-800-250-8427.

**Drafting Note:** This form is intended for use with individual long-term care insurance. The insurer may modify these forms for use with group long-term care insurance without filing with the Department so long as no substantive revisions are made. For example, the term "policy" may be replaced with "certificate" or "coverage," and the term "policyholder" may be replaced with "certificateholder."

**Appendix J**

**ISSUER CERTIFICATION FORM**

(relating to Qualified State Long-Term Care Insurance Partnership Policies)

Under section 1917(b)(5)(B)(iii) of the Social Security Act (42 U.S.C. 1396p(b)(5)(B)(iii)), the State insurance commissioner of a State implementing a Qualified State Long-term Care Insurance Partnership (“Qualified Partnership”) may certify that long-term care insurance policies (including certificates issued under a group insurance contract) covered under the Qualified Partnership meet certain consumer protection requirements, and policies so certified are deemed to satisfy such requirements. These consumer protection requirements are set forth in section 1917(b)(5)(A) of the Social Security Act (42 U.S.C. 1396p(b)(5)(A)) and principally include certain specified provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) (referred to herein as the “2000 Model Regulation” and “2000 Model Act” respectively).

To provide the Commissioner with information necessary to provide a certification for policies, this Issuer Certification Form requests information and a certification from issuers of long-term care insurance policies with respect to policy forms that may be covered under the Qualified Partnership of the State.

An insurance company may request certification of policies from time to time and, accordingly, may supplement this issuer certification form, *e.g.*, as it introduces new long-term care insurance policy forms for issuance.

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**I. GENERAL INFORMATION**

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

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

**B. Name, address, telephone number, and email address (if available) of an employee of issuer who will be the contact person for information relating to this form:**

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

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**C. Policy form number(s) (or other identifying information, such as certificate series) for policies covered by this Issuer Certification Form:**

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Specimen copies of each of the above policy forms, including any riders and endorsements, shall be provided upon request.

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**II. QUESTIONS REGARDING APPLICABLE PROVISIONS OF THE 2000 MODEL REGULATION AND 2000 MODEL ACT**

Please answer each of the questions below with respect to the policy forms identified in section I.C above. For purposes of answering the questions below, any provision of the 2000 Model Regulation or 2000 Model Act listed below shall be treated as including any other provision of the 2000 Model Regulation or 2000 Model Act necessary to implement the provision.

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

Yes \_\_\_ No \_\_\_ N/A \_\_\_ A. Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the 2000 Model Act relating to such section 6A.

Yes \_\_\_ No \_\_\_ N/A \_\_\_ B. Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

Yes \_\_\_ No \_\_\_ N/A \_\_\_ C. Section 6C (relating to extension of benefits).

Yes \_\_\_ No \_\_\_ N/A \_\_\_ D. Section 6D (relating to continuation or conversion of coverage).

Yes \_\_\_ No \_\_\_ N/A \_\_\_ E. Section 6E (relating to discontinuance and

replacement of policies).

- Yes \_\_\_ No \_\_\_ N/A \_\_\_ F. Section 7 (relating to unintentional lapse).
- Yes \_\_\_ No \_\_\_ N/A \_\_\_ G. Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.
- Yes \_\_\_ No \_\_\_ N/A \_\_\_ H. Section 9 (relating to required disclosure of rating practices to consumer).
- Yes \_\_\_ No \_\_\_ N/A \_\_\_ I. Section 11 (relating to prohibitions against post-claims underwriting).
- Yes \_\_\_ No \_\_\_ N/A \_\_\_ J. Section 12 (relating to minimum standards).
- Yes \_\_\_ No \_\_\_ N/A \_\_\_ K. Section 14 (relating to application forms and replacement coverage).
- Yes \_\_\_ No \_\_\_ N/A \_\_\_ L. Section 15 (relating to reporting requirements).
- Yes \_\_\_ No \_\_\_ N/A \_\_\_ M. Section 22 (relating to filing requirements for marketing).
- Yes \_\_\_ No \_\_\_ N/A \_\_\_ N. Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.
- Yes \_\_\_ No \_\_\_ N/A \_\_\_ O. Section 24 (relating to suitability).
- Yes \_\_\_ No \_\_\_ N/A \_\_\_ P. Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).
- Yes \_\_\_ No \_\_\_ N/A \_\_\_ Q. The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in section 7702B(g)(4) of the Internal Revenue Code of 1986 (26 U.S.C. 7702B(g)(4)).
- Yes \_\_\_ No \_\_\_ N/A \_\_\_ R. Section 29 (relating to standard format outline of coverage).
- Yes \_\_\_ No \_\_\_ N/A \_\_\_ S. Section 30 (relating to requirement to deliver shopper's guide).

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

Yes \_\_\_ No \_\_\_ N/A \_\_\_ A. Section 6C (relating to preexisting conditions).

Yes \_\_\_ No \_\_\_ N/A \_\_\_ B. Section 6D (relating to prior hospitalization).

Yes \_\_\_ No \_\_\_ N/A \_\_\_ C. The provisions of section 28 relating to contingent nonforfeiture benefits.

Yes \_\_\_ No \_\_\_ N/A \_\_\_ D. Section 6F (relating to right to return).

Yes \_\_\_ No \_\_\_ N/A \_\_\_ E. Section 6G (relating to outline of coverage).

Yes \_\_\_ No \_\_\_ N/A \_\_\_ F. Section 6H (relating to requirements for certificates under group plans).

Yes \_\_\_ No \_\_\_ N/A \_\_\_ G. Section 6J (relating to policy summary).

Yes \_\_\_ No \_\_\_ N/A \_\_\_ H. Section 6K (relating to monthly reports on accelerated death benefits).

Yes \_\_\_ No \_\_\_ N/A \_\_\_ I. Section 7 (relating to incontestability period).

In order for a policy to be covered under the Vermont Partnership Program, the answers to all questions above should be "yes" (or "N/A" where all requirements with respect to a provision above are not applicable). If answers differ between policy forms (e.g., a requirement would be answered "Yes" for one form and "N/A" for another), you should use separate Issuer Certification Forms for such policies.

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_ Certification by company officer that the submitted Qualified LTCP policy will only be sold by producers who have received training and demonstrated evidence of an understanding of Qualified LTCP policies and how they relate to other public and private coverage of long-term care.

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_ Certification by company officer that the appropriate inflation protections will be offered.

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### III. CERTIFICATION

I hereby certify that the answers, accompanying documents, and other information set forth herein are, to the best of my knowledge and belief, true, correct, and complete.

\_\_\_\_\_

Date

\_\_\_\_\_

Name and title of officer of the Issuer

\_\_\_\_\_

Signature of officer of the Issuer

**Appendix K**

**POLICYHOLDER LONG-TERM CARE  
PARTNERSHIP PROGRAM STATUS FORM**

[Issuer Letterhead]

**LONG-TERM CARE PARTNERSHIP PROGRAM POLICY SUMMARY**

1. Name of Insured:

\_\_\_\_\_

2. Policy Number:

\_\_\_\_\_

3. Effective date of Coverage :

\_\_\_\_\_

4. The policy was issued in the state of:

\_\_\_\_\_

5. Issue age of the insured at the time  
the coverage was issued

\_\_\_\_\_

6. The policy/certificate was issued  With  Without inflation coverage

7. The inflation coverage is  Simple Inflation  Compound Inflation  None

8. The inflation coverage is currently in effect on the coverage  Yes  No

If no, the date inflation coverage ceased \_\_\_\_\_

9. The policy meets the standards of a tax qualified long-term care policy  Yes  
 No

10. The cumulative dollar amount of insurance benefits paid \$ \_\_\_\_\_

(Note: The indicated amount does not include any payments for cash surrender, return of premium death benefits, or waiver of premium, and if joint coverage, the amount is for the indicated insured only)

11. The total dollar amount of insurance benefits remaining available under the policy \$ \_\_\_\_\_.

12. Date this form was completed \_\_\_\_\_.

13. The name, phone number and email address of the person completing this form:

\_\_\_\_\_  
Name and Title

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

\_\_\_\_\_  
Email Address

I hereby certify that the above information is true and accurate at the time of this certification.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Appendix L**

**The Long-Term Care Partnership Exchange Notification Form**

**Date:** \_\_\_\_\_

**Company name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Contact information:** \_\_\_\_\_

**Company identifiers:** \_\_\_\_\_

**Insured's name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Policy number:** \_\_\_\_\_

**Policy issue date:** \_\_\_\_\_

Our company participates in Vermont's Long-Term Care Partnership Program by offering long-term care insurance policies that meet certain state and federal requirements. Under the Partnership Program, policies that meet these requirements may allow you to protect a portion of your assets from Medicaid's "spend down" requirements if you should ever need to apply for Medicaid benefits to pay for long-term care expenses in the future.

Partnership policies may allow you to keep a dollar of your own assets for every dollar of benefits paid by the policy for long-term care services should you need to apply for Medicaid. The Partnership Program Notice provides additional information about the Vermont Long-Term Care Partnership Program and how the Partnership Program could help you to protect certain assets.

Although we sell long-term care insurance policies that qualify as Partnership Policies, **the policy you currently have with us does not qualify for the Partnership Program.** Therefore, we are notifying you that you may be able to exchange your current long-term care policy for a new policy that qualifies under the partnership program.

However, before you consider exchanging your current long-term care policy for a policy that qualifies under the partnership program, there are several things you should know. You may be required to update your policy by adding benefits if your current policy does not include required inflation protection. Also, you may be required to add benefits or consumer protections that were not required when your policy was issued.

You should very carefully consider any change in benefits because the changes may increase your premium. Also, if you change your policy, you may be required to answer health questions that will determine whether we will issue you a new policy (medical underwriting).

In addition, if you move to a state that does not maintain a partnership program or does not recognize your policy as a Partnership Policy, you would not receive the asset protection under the Medicaid laws of that state.

If you have questions regarding your insurance policy please contact [insert name of carrier.] If you have questions regarding current laws governing Medicaid eligibility, you should contact the Vermont Health Access Member Services at 1-800-250-8427.

**Drafting Note:** This form is intended for use with individual long-term care insurance. The insurer may modify these forms for use with group long-term care insurance without filing with the Department so long as no substantive revisions are made. For example, the term “policy” may be replaced with “certificate” or “coverage,” and the term “policyholder” may be replaced with “certificateholder.”

## Appendix M

### Long-Term Care Insurance Premium Rate Disclosure For Required Benefit Configurations

Company Name:  
Company Address  
Company NAIC Number:

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Line of Business:     Individual              Group

#### **Instructions**

The purpose of this form is to provide consumers with estimates of the cost of sample long-term care plans that are required by Section (6)(K) of this Regulation. Premium rates disclosed on this form will be posted on the Department’s website. Insurers must complete and submit this form annually on or before June 30<sup>th</sup>. The Department will not approve policy and/or rate filings unless this form has been submitted to the Department.

Please provide for the annual premium for each currently marketed long-term care policy required by Section 6(K). In addition to the benefit parameters described below, assume that the policy does not include a non-forfeiture option, any optional riders, and annual standard rates (excluding all discounts such as preferred or marital). The insurer is responsible for notifying the Department of any changes that will impact the information submitted herein.

#### **Benefit Configurations**

*Benefit Configuration I:* \$200 Daily Benefit; 90 or 100-Day Elimination Period; 5-Year Benefit Period

	With 5% compound inflation protection	With 5% Simple inflation protection	With no inflation protection or GPO at issue	Policy Form Number
Age 45				
Age 50				
Age 55				
Age 60				
Age 65				
Age 70				
Age 75				

**Benefit Configuration II:** \$150 Daily Benefit; 90 or 100-Day Elimination Period; 3-Year Benefit Period

	With 5% compound inflation protection	With 5% Simple inflation protection	With no inflation protection or GPO at issue	Policy Form Number
Age 45				
Age 50				
Age 55				
Age 60				
Age 65				
Age 70				
Age 75				

**Benefit Configuration III:** \$100 Daily Benefit; 90 or 100-Day Elimination Period; 2-Year Benefit Period

	With 5% compound inflation protection	With 5% Simple inflation protection	With no inflation protection or GPO at issue	Policy Form Number
Age 45				
Age 50				
Age 55				
Age 60				
Age 65				
Age 70				
Age 75				