TEXAS PARTNERSHIP LONG TERM CARE
8 HOUR
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TEXAS LONG TERM CARE PARTNERSHIP PROGRAM

THE HISTORY OF PARTNERSHIP PLANS

The purpose of this course is to first develop a thorough understanding of the Texas Partnership for Long Term Care and then proceed to understand many other arenas within the area of Long Term Care.


These four states are considered the pioneers of the long term care partnership concept. It should also be mentioned that several other states (including Texas) currently are implementing a partnership program. In a 2005 General Accounting Office (GAO) report it is detailed that as of 2003 there were approximately 172,000 partnership long term care policies in force in these four states.

THE CARROT AND THE STICK

These Partnerships for Long-Term Care can be described as agreements between private insurance companies, state governments, and residents of those states whereby individuals purchase private long term care policies and are rewarded (how they are rewarded varies from state to state) should they ever need Medicaid assistance with long term care costs.

The insurance companies are required to structure their partnership long term policies within certain parameters, provide required consumer disclosures, and adhere to market conduct standards.

To receive the reward (some degree of asset protection should they apply for Medicaid assistance) the resident must purchase a partnership long term care policy.
The state government, for their part in the partnership, must reward the resident for having insured their potential long term care needs to the required level by allowing assets to be retained by the insured resident should they apply to Medicaid for assistance.

The concept of the partnership is to provide a mechanism for the Medicaid program to work together with private long-term care insurance companies to help a larger sector of the population solve the long term care equation. There are many individuals who currently can’t afford to pay the costs associated with long term care but possess assets in excess of the Medicaid eligibility limits.

FEDERAL BARRIER TO PARTNERSHIP EXPANSION

The Omnibus Budget Reconciliation Act of 1993 limited most states from adopting partnership programs and thus slowed the spread of the partnership concept beyond the initial four states. With the passage of The Deficit Reduction Act of 2005 (DRA) many of the barriers were removed and more states are now likely to establish a long term care partnership program. DRA was signed by the president in February of 2006.

CHOICE AFFORDED BY A PARTNERSHIP PROGRAM

In the absence of the Texas Partnership, residents have three basis choices to finance the costs of long-term care:

1) Pay for needed care out of assets and income, which can cause significant shrinkage in assets even to the point of financial destitution.

2) Attempt to transfer assets to prior to needing long term care services. The most common method is via gifting to children or a trust. The downside to this approach is that in order to successfully divest yourself of assets you must give up control of your major assets. Many individuals have engaged in this type of planned impoverishment only to never need long term care services. DRA increased the “look back” period during Medicaid the application process and it will soon be 60 months on all transfers which increases the likelihood of a transferee being considered ineligible for Medicaid assistance due to uncompensated transfers.

3) Buy a traditional long-term care insurance policy. This is a sound approach but the policy holder still runs the risk that they will exhaust the policy benefits and still need care or the amount of benefit purchased is not sufficient to cover the cost of the care. This is most likely to occur when someone (due to affordability issues) decides not to buy the inflation rider or buys less daily benefit than is needed to cover the cost of care, or buys a short benefit period.

4) The Texas Partnership adds a fourth alternative.

You purchase a Partnership policy (more on the requirements of a partnership policy later) from an insurance agent. If you need care and the policy pays benefits then for
every dollar of benefits paid by the policy, you are able to exclude one dollar in assets from the “asset test” that is imposed when qualifying for Medicaid assistance. (*It should be noted at this point that only assets are sheltered by the Texas Partnership...the income test is not affected*).

**EXAMPLE**

Assume you purchase a Partnership long term care policy with a three year benefit period and a $140/daily benefit amount (which is considerably less expensive than a lifetime benefit period). If you need long term care services and this policy pays at the end of three years it will have paid $153,300 in benefits. If after the three year period you still need care and apply for Medicaid assistance The Department of Children and Family Services when determining your eligibility will reduce your total countable assets by $153,300. In other word they will disregard one dollar in assets for each dollar you received in benefits from a partnership long term care policy.

**LEGISLATIVE CHANGES**

To begin to understand the approach taken by the Texas partnership we will review the objectives most states have when they implement a long term care partnership program.

1. Partnership Goals:

   - Provide incentives for an individual to obtain or maintain insurance to cover the cost of long term care.
   - Provide a mechanism to qualify for coverage of the cost of long term care needs under Medicaid without first being required to substantially exhaust his or her assets, including a provision for the disregard of any assets in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under the program.
   - Alleviate the financial burden on the state’s medical assistance program by encouraging the pursuit of private initiatives.
   - In determining eligibility for Medicaid long-term care services for an individual who is the beneficiary of an approved long term care partnership program policy, an amount of resources equal to the amount of benefits paid under the long-term care partnership policy shall be excluded from the Department’s calculation of the individual’s resources. The department is authorized to adopt rules to implement this section.

So what we learn about the goals of state long term care partnership programs is that Texas is providing an incentive in the form of asset retention for an individuals to buy long term care coverage (even if they can’t buy enough benefit amount or length to completely cover the risk).
PROGRAM IN A NUTSHELL

There in a nutshell is the heart of all partnership plans. They reward the citizen for taking steps to be financially self sufficient (to the extent that the individual can be self sufficient). The intent is to give more people an incentive to buy private long term care insurance. If the partnership program is successful in getting more people to buy long term care insurance it will help to save Medicaid funds in that some of these policyholders will not ever need Medicaid assistance because their private policies will be sufficient to cover their long term care needs.

The four pioneer states listed above offer one of three partnership program models:

DOLLAR FOR DOLLAR ASSET PROTECTION:

Assets are protected when receiving Medicaid assistance up to the amount of the private insurance benefits paid. This is the model Texas follows.

UNLIMITED ASSET PROTECTION:

The New York Partnership took this approach. All NY partnership policies must provide a minimum of a three year benefit period (inpatient) or six years of home care. If a policy holder exhaust benefit of their private policy then they may qualify for Medicaid assistance regardless of the value of their assets. The key is you must exhaust the benefit of your policy before you are entitled to asset protection. The average daily cost for a nursing home in NY is over $300. A drawback to this approach is that you may not be able to afford a daily benefit sufficient to cover the high local cost for a nursing home. An individual would then be in a position of spending a large portion of their assets making up the difference between their policy benefit and the nursing home cost during the three year period prior to being entitled to asset protection under the partnership program.

HYBRID ASSET PROTECTION:

Indiana provides a combination of the models above. The hybrid plan provides dollar-for-dollar asset protection (like the Texas program model). In addition the policy holder has the option of buying a policy with a four year benefit period in an amount determined to cover the average nursing home cost at the time. The minimum amount of benefit purchased to get the hybrid (or total asset protection) is set by the State and is adjusted periodically for increased long term care costs. In 2005 if an Indiana resident bought a four year benefit with a total dollar benefit amount of $196,994 ($135 daily benefit) or more they were guaranteed total asset protection. According to a 2005 GAO report since the Hybrid model was introduced in 1998 in Indiana 87% of all partnership policies meet the 4 year state minimum in the year they are purchased.
What all of the partnership programs have in common is that your income goes to pay for the cost of care once you qualify for Medicaid. So the Partnership programs protect assets, not income.

**STATE TO STATE RECIPROCITY**

In 2001 Indiana and Connecticut implemented a reciprocity agreement allowing Partnership beneficiaries who have purchased a policy in one state—but move to the other—to receive asset protection if they qualify for Medicaid in their new locale. Although prior to this agreement the insurance benefits of Partnership policies were portable, the asset protection component was state-specific. The asset protection specified in the agreement is limited to dollar-for-dollar, so Indiana residents who purchase total asset protection policies would only receive protection for the amount of LTC services their policy covered if they moved to Connecticut.

Since the Deficit Reduction Act requires all new partnerships to follow the dollar for dollar asset disregard mode the slight wrinkle in the Indiana/Connecticut reciprocity agreements will not be repeated.

Reciprocity is an attractive feature for many consumers, especially those who do not currently know where they will reside in future years. The DRA requires the HHS secretary (in consultation with National Association of Insurance Commissioners, policy issuers, states, and consumers) to develop standards of reciprocal recognition under which benefits paid would be treated the same by all such states. States will be held to such standards unless the state notifies the secretary in writing that it wishes to be exempt.

**INCOME AND SUITABILITY**

Income level is an important part of determining suitability for a partnership policy.

If your income exceeds the costs associated with long term care you will not qualify for Medicaid and thus wouldn’t get the reward offered by the partnership program. Residents in this situation should consider a partnership or non-partnership long term care insurance policy and insure an adequate benefit, with an inflation rider, and consider a lifetime benefit period.

Income level and the cost of nursing home care in the selected area are components to help a consumer decide the amount of benefit to purchase in a long term care policy. For example, if you can afford to pay $60 per day out of income and the local cost for a nursing home averages $150 per day you can consider a $90 to $100 daily benefit amount. It is important to know the daily cost of a nursing home in the area desired by the consumer as cost vary widely with cost generally higher in urban areas and lower in rural areas. All Partnership policies include an inflation benefit for appropriate ages to help keep the benefit in step with actual future costs.

The consumer must be able to afford the premium for the long term care policy now and
have sufficient income levels to continue to afford the policy premiums in the future. Premiums for long term care policies can be increased if the insurer can demonstrate that they have exceeded the required loss ratio. Generally speaking an individual (or couple) with income below the current Medicaid income caps may not be able to afford the coverage. If a consumer has income below these levels and a modest amount of assets they would probably qualify for Medicaid assistance immediately and the purchase of a long term care insurance policy may not be appropriate.

**AFFORDABILITY OF PARTNERSHIP POLICIES**

Since a long term care contract must meet several specific requirements in order to be a partnership policy the costs to afford a partnership policy can be higher than a long term care policy that does not meet these requirements. Most notable of the partnership requirements (from a premium standpoint) is the requirement for inflation protection. Adding an inflation protection component to a long term care policy will increase premiums by between 35% and 50% depending on the type of inflation protection component added. Since an owner of a long term care policy will most likely be paying periods during a period when they are living on a fixed income the ability to initially and continually afford premiums for a long term care policy should be a consideration during product selection. While addressing inflation is vital to a well thought out plan to address the risk of needing and affording the potential costs associated with long term care it is also an expensive risk to insure. Purchasing a long term care policy without an inflation protection device will be much cheaper at issue and will not experience the increased premiums related to increased benefits and therefore will be affordable to a wider range of individuals.

**EFFECT OF INFLATION ON BENEFITS**

If an individual chooses to buy a long term care contract without inflation protection they are taking a gamble. The longer they own the policy the smaller the benefit becomes in relation to services that it will purchase. If they do not need the benefits payable by the long term care policy for 15 years or longer they could well experience costs associated with long term care services that are more than double what they were when the policy was issued. This is such a serious issue that all long term care policies must offer inflation protection and graphically illustrate the impact that inflation can have.

**OTHER HEALTH COSTS**

Other health related coverage such as Medicare Part A & B, a Medicare Supplement (or C Choice or Advantage Plan) and/or a Medicare Part D plan will be necessary to complete the health care package for a senior citizen. The daily costs for a nursing home do not include prescription drugs and/or medical supplies.

As stated earlier the ability of a State to implement a partnership plan was limited prior to the passage of The Deficit reduction Act of 2005 (DRA). Below is a summary of the changes contained in DRA that made the partnership plan more attractive to both the
State and the consumer.

THE EFFECT OF THE DEFICIT REDUCTION ACT OF 2005 ON PARTNERSHIP PLANS

EXPANSION OF STATE LONG-TERM CARE (LTC) PARTNERSHIP PROGRAM

Section 6021(a)(1)(A) of the Deficit Reduction Act of 2005 (DRA), Pub. L. 109-171, expands State LTC Partnership programs, which encourage individuals to purchase LTC insurance. Prior to enactment of the DRA, States could use the authority of section 1902(r)(2) of the Social Security Act (the Act) to disregard benefits paid under an LTC policy when calculating income and resources for purposes of determining Medicaid eligibility.

However, under section 1917(b) of the Act, only States that had State plan amendments approved as of May 14, 1993, could exempt the LTC insurance benefits from estate recovery.

The DRA amends section 1917(b)(1)(C)(ii) of the Act to permit other States to exempt LTC benefits from estate recovery, if the State has a State plan amendment (SPA) that provides for a qualified State LTC insurance partnership (Qualified Partnership). Many states passed a State Plan Amendment in 2005 in anticipation of the president signing the DRA. The DRA then adds section 1917(b)(1)(C)(iii) in order to define a “Qualified Partnership.” States that had State plan amendments as of May 14, 1993, do not have to meet the new definition, but in order to continue to use an estate recovery exemption, those States must maintain consumer protections at least as stringent as those they had in effect as of December 31, 2005. We refer to both types of States as “Partnership States.”

DRA 05 DEFINITION OF “QUALIFIED STATE LTC PARTNERSHIP”

Section 6021(a)(1)(A) of the DRA adds several new clauses to section 1917(b)(1)(C) of the Act. The new clause (iii) defines the term “Qualified State LTC Partnership” to mean an approved SPA that provides for the disregard of resources, when determining estate recovery obligations, in an amount equal to the LTC insurance benefits paid to, or on behalf of, an individual who has received medical assistance.

A policy that meets all of the requirements specified in a Qualified State LTC Partnership SPA is referred to as a “Partnership policy.”
The insurance benefits upon which a disregard may be based include benefits paid as direct reimbursement of LTC expenses, as well as benefits paid on a per diem, or other periodic basis, for periods during which the individual received LTC services.

The DRA does not require that benefits available under a Partnership policy be fully exhausted before the disregard of resources can be applied.

Eligibility may be determined by applying the disregard based on the amount of benefits paid to, or on behalf of, the individual as of the month of application, even if additional benefits remain available under the terms of the policy.

The amount that will be protected during estate recovery is the same amount that was disregarded in the eligibility determination.

It should be noted that while an approved Partnership SPA may enable an individual to become eligible for Medicaid by disregarding assets or resources under the authority of section 1902(r)(2) of the Act, the use of a qualified Partnership policy will not affect an individual’s ineligibility for payment for nursing facility services, or other LTC services, when the individual’s equity interest in home property exceeds the limits set forth in section 1917(f) of the Act, as amended by the DRA.

PARTNERSHIP REQUIREMENTS UNDER THE DEFICIT REDUCTION ACT

The new clause (iii) also sets forth other requirements that must be met in order for a State plan amendment to meet the definition of a Qualified Partnership. These include the following:

- The LTC insurance policy must meet several conditions. These conditions include meeting the requirements of specific portions of the National Association of Insurance Commissioners’ (NAIC) LTC Insurance Model Regulations and Model Act.

  - The Qualified Partnership SPA must provide that the State Insurance Commissioner, or other appropriate State authority, certify to the State Medicaid agency that the policy meets the specified requirements of the NAIC Model Regulations and Model Act.

  - The State Medicaid agency may also accept certification from the same authority that the policy meets the Internal Revenue Code definition of a qualified LTC insurance policy, and that it includes the requisite inflation protections.
If the State Medicaid agency accepts the certification of the Commissioner or other authority, it is not required to independently verify that policies meet these requirements.

Changes in a Partnership policy after it is issued will not affect the applicability of the disregard of resources as long as the policy continues to meet all of the requirements referenced above.

If an individual has an existing LTC insurance policy that does not qualify as a Partnership policy due to the issue date of the policy, and that policy is exchanged for another, the State Insurance Commissioner or other State authority must determine the issue date for the policy that is received in exchange.

To be a qualified Partnership policy, the issue date must not be earlier than the effective date of the Qualified Partnership SPA.

- The State Medicaid agency must provide information and technical assistance to the State insurance department regarding the Partnership and the relationship of LTC insurance policies to Medicaid.

- This information must be incorporated into the training of individuals who will sell LTC insurance policies in the State.

- The State insurance department must provide assurance to the State Medicaid agency that anyone who sells a policy under the Partnership receives training and demonstrates an understanding of Partnership policies and their relationship to public and private coverage of LTC.

- The issuer of the policy must provide reports to the Secretary, in accordance with regulations to be developed by the Secretary, which include notice of when benefits are paid under the policy, the amount of those benefits, notice of termination of the policy, and any other information the Secretary determines is appropriate.

- The State may not impose any requirement affecting the terms or benefits of a Partnership policy unless it imposes the same requirements on all LTC insurance policies.

THE DRA REQUIRES QUALIFIED LTC POLICIES

The Deficit Reduction Act of 2005 requires that all Qualified State Partnership Plans require all partnership policies to be “qualified” so it is necessary for the agent to gain a full understanding of what is required for a long term care policy to be considered as
“qualified” policy.

**DEFINITION OF QUALIFIED LONG TERM CARE POLICIES**

Qualified long-term care insurance is defined as a contract that provides insurance coverage only for qualified long-term care services; does not pay or reimburse for expenses that are covered by Medicare; is guaranteed renewable; does not provide a cash surrender value or that could be assigned or pledged as collateral for a loan; provides that all refunds of premiums and policy holder dividends are to be applied as a reduction of future premiums or to increase future benefits. In addition to the above, a qualified plan must meet certain consumer protections which are set out in the Model Regulations and Long-Term Care Insurance Model Act. Further, the policy must meet disclosure and nonforfeitability requirements.

A qualified long term care policy meets the requirements for favorable tax treatment. The tax advantage of a qualified long term care versus a non-qualified long term care policy is the limited federal income tax deduction of the premiums. The policyholder of a long term care policy will be able to deduct some or all of their long term care premiums depending on their age. Below is a table showing the age thresholds and amount of long term care premiums that may be deducted in tax year 2008. These amounts are adjusted for inflation and will go up periodically.

<table>
<thead>
<tr>
<th>Attained age as of 12/31/2008</th>
<th>Deductible Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 or younger</td>
<td>$310</td>
</tr>
<tr>
<td>Older than 40 but not older than 50</td>
<td>$580</td>
</tr>
<tr>
<td>Older than 50 but not older than 60</td>
<td>$1,150</td>
</tr>
<tr>
<td>Older than 60 but not older than 70</td>
<td>$3,080</td>
</tr>
<tr>
<td>Older than 70</td>
<td>$3,850</td>
</tr>
</tbody>
</table>

In order to deduct the long term care premiums the policyholder must file IRS form 1099-LTC, Long Term Care and Accelerated Benefits with their tax return.

Generally benefits received under qualified or non-qualified long term care policies are not includable in income. Benefits from actual cost (also called reimbursement policies), which pay for the actual services a beneficiary receives, are not included in income. Benefits from per diem or indemnity policies, which pay a predetermined amount each day, are not included in income except amounts that exceed the beneficiary's total qualified long-term care expenses or $260 per day (for 2007…2008 not yet announced), whichever is greater. So the real tax difference between a qualified and non-qualified
long term care policy is the deductibility (subject to the above table) of some or possibly all of the premiums for the federal income tax return of the policyholder.

**CONSUMER PROTECTIONS IN QUALIFIED LTC POLICIES**

A group qualified long-term care policy must provide for continuation of coverage or conversion. In the event that the insured is no longer in the group and is subject to losing coverage. The insured must be able to maintain his/her coverage under the group policy by the payment of premiums. If the benefits or services covered are restricted to certain providers, which the insured can no longer use, the insurance company must provide for a continuation of benefits which are substantially equivalent. Similarly, if a group policy it terminated the insurance company must provide the insured with a converted policy which is substantially equivalent to the policy which was terminated. In order for an insured to benefit from this provision, he or she must have been covered under the terminated plan for at least six month immediately prior to the termination.

All qualified long term care policies must have a provision to protect the insured against unintended lapse. The policy must not be issued until the company has received a written designation from the applicant identifying at least one other person who is to receive notice from the insurance company before the policy may be terminated. The form used to identify the additional person must have a space for the person's full name and address. If for any reason the policy is to lapse, the insurance company is required to provide written notice to the insured and his/her designated agent identified on the form. Further, the insurance company may not terminate a policy for nonpayment of premiums until it has given the insured 30 days notice of the potential termination. Notice must be provided by first class mail, postage paid to the insured and all the persons identified by the insured.

**POST CLAIMS UNDERWRITING**

Another important feature of qualified plans, is that post-claim underwriting is restricted and limited. Post-claim underwriting occurs when after a claim is filed by the policyholder, the insurance company declines the coverage on the ground that it would not have issued to policy if it had know about some medical condition. Under HIPAA, applications for long-term care insurance must contain clear and unambiguous questions designed to elicit information about the healthy status of the applicant. Further, if the application asks whether the applicant takes prescribed medications, it must ask for a list of those medications. The insurance company, if it receives the medication list, may not deny coverage for any condition which was being treated by any of the medications listed, even if that condition would have been grounds for a denial of coverage at the application stage. The application must contain a clear bold caution to applicants that states that if the answers on the application are incorrect or untrue, the company has the right to deny coverage or rescind the contract. Therefore, it is important for applicants to fill out the application fully and correctly and list all the prescribed medications being taken.
HIPAA also established minimum standards for home health and community care benefits in qualified policies. If the policy provides benefits for home health or community care, it may not limit or exclude benefits by requiring that skilled care be required first or that the services be provided by registered or licensed practical nurses or that the provider be Medicare-certified. The policy may not exclude coverage for personal care services provided by a home health aide or adult day care service. The policy may not require that benefits be triggered by an acute illness.

Inflation protection is also included as a required element of a qualified plan. It is intended that meaningful inflation protection be provided. The legislation requires that the insurance company use reasonable hypothetical or graphic demonstrations that disclose how the inflation protection will work.

**PREMIUM DEDUCTIBILITY FOR BUSINESS ENTITIES**

- **Sole Proprietor:** A business owner who files IRS form Schedule C (Profit or Loss from a Business or Profession) is considered an individual for tax purposes and deduct the premiums as noted in the table above. Must be a qualified long term care policy.
- **Sub (s) Corporation:** A sub (s) corporation can deduct the limits described in the table above and the covered employee does not pay income tax on the premiums or benefits (subject to the limits on benefits described above). Must be a qualified long term care policy.
- **C Corporations:** A C corporation is entitled to the deduction of 100% of the premium. The covered employee does not pay income tax on the premiums or benefits (subject to the limits on benefits described above). Must be a qualified long term care policy.
- **L.L.C.:** A limited liability company is allowed to deduct the limits described in the table above and the covered employee does not pay income tax on the premiums or benefits (subject to the limits on benefits described above). Must be a qualified long term care policy.
- **Partnership:** A partnership is allowed to deduct the limits described in the table above and the covered employee does not pay income tax on the premiums or benefits (subject to the limits on benefits described above). Must be a qualified long term care policy.

**BENEFIT TRIGGERS**

HIPAA sets the standard for benefits as needing substantial (either hands on or standby) assistance with two or more activities of daily living

OR

Needing substantial supervision due to cognitive impairment (see below)
The benefit trigger requirement of qualified long-term care insurance is considerably more restrictive than non qualified policies. The services under a qualified plan must be triggered by certification by a licensed health care provider that the beneficiary is chronically ill. Chronic illness is defined as:

- As being unable to perform, without substantial assistance, at least two activities of daily living for at least 90 calendar days due to a loss of functional capacity or
- Requiring substantial supervision in order to be protect from threats to health and safety due to cognitive impairment. The 90 day period may be presumptive, which means that the doctor may certify that in their opinion the impaired performance will last at least 90 days.

FINAL TREASURY REGULATIONS SECTIONS 7702B

As part of the HIPAA process final treasury regulations were implemented in December of 1998 and became internal revenue code (IRC) section 7702(b). Following is a summary of this code section:

Long term care policies issued before January 1, 1997 that meet state requirements in effect at that time are grandfathered as qualified long term care policies (regardless of the new HIPAA sections), however; if a contract has material changes it will lose the grandfathered status.

- Qualified contracts can not accrue cash values
- Qualified contracts must be guaranteed renewable
- Qualified contracts can only use policy dividends to reduce future premiums
- Qualified contracts must be issued within 30 days of approval
- If an insured request information pertaining to a claim denial it must be delivered within 60 days
- Non-qualified policies do not qualify for a premium deduction on the policyholder’s federal tax return

TEXAS PARTNERSHIP IMPLEMENTATION

Texas made numerous changes and additions to existing law to implement the Partnership Program. We will address each of these elements to gain an in-depth understanding of Texas Law as it relates to each of these issues.

We will begin by reviewing general information provided to the public by Texas

TEXAS LTC PARTNERSHIP – EMPOWERING LEGISLATION

TEXAS INSURANCE CODE
SUBTITLE I. SPECIALIZED COVERAGES

CHAPTER 1651. LONG-TERM CARE BENEFIT PLANS

SUBCHAPTER A. GENERAL PROVISIONS

SUBCHAPTER C. PARTNERSHIP FOR LONG-TERM CARE PROGRAM

Text of section effective on March 1, 2008

Sec. 1651.101.

PARTNERSHIP DEFINITIONS:

(1) "Approved plan" means a long-term care benefit plan that is approved by the department under this subchapter.
(2) "Dollar-for-dollar asset disregard" and "asset protection" have the meanings assigned by Section 32.101, Human Resources Code.
(3) "Medical assistance program" means the medical assistance program established under Chapter 32, Human Resources Code.
(4) "Partnership for long-term care program" means the program established under Subchapter C, Chapter 32, Human Resources Code, and this subchapter.

Sec. 1651.103.

ASSISTANCE OF DEPARTMENT.

The department shall assist the Health and Human Services Commission as necessary for the commission to perform its duties and functions with respect to the administration of the partnership for long-term care program.

Sec. 1651.104.

LTC POLICY FOR PARTNERSHIP PROGRAM.

The commissioner, in consultation with the Health and Human Services Commission, shall adopt minimum standards for a long-term care benefit plan that may qualify as an approved plan under the partnership for long-term care program. The standards must be consistent with provisions governing the expansion of a state long-term care partnership program established under the federal Deficit Reduction Act of 2005 (Pub. L. No. 109-171).

Sec. 1651.105.
REQUIRED TRAINING.

(a) Each individual who sells a long-term care benefit plan under the partnership for long-term care program must complete training and demonstrate evidence of an understanding of these plans and how the plans relate to other public and private coverage of long-term care.

(b) Each long-term care benefit plan issuer that offers a plan under the partnership for long-term care program shall certify to the commissioner, in the form required by the commissioner, that each individual who sells the plan on behalf of the issuer complies with the requirements of this section.

Sec. 1651.106.

EFFECT OF DISCONTINUATION OF PROGRAM ON POLICY.

If the partnership for long-term care program is discontinued, an individual who purchased an approved plan before the date the program is discontinued remains eligible to receive dollar-for-dollar asset disregard and asset protection under the medical assistance program.

Sec. 1651.107. RULES.

The commissioner may adopt rules as necessary to implement this subchapter.

TEXAS LONG TERM CARE DEFINITIONS

Texas Administrative Code: Title 28, Part 1, Chapter 3, Subchapter Y: 3.3804

a) Except as otherwise provided by law or this subchapter, no long-term care insurance policy, certificate, group hospital service corporation subscriber contract, rider attached to a life insurance policy or certificate or annuity contract or certificate may be delivered or issued for delivery in this state, unless it complies with, and contains definitions in conformance with, this subchapter.

(b) The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Activities of daily living--Bathing, continence, dressing, eating, toileting and transferring, as those terms are defined in this subsection.
(2) **Acute condition**--The individual's medical condition 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.

(3) **Adult Day Care**--A social and health-related services program provided during the day in a community group setting, for the purpose of supporting frail, impaired elderly, or other disabled adults who can benefit from care in a group setting outside the home.

(4) **Adult Day Care Facility**--Provider of Adult Day Care services, operated pursuant to the provisions of the Human Resources Code, Chapter 103 (concerning licensing and quality of care requirements in the provision of adult day care).

(5) **Applicant**--The person who seeks to contract for benefits or services, in the instance of an individual long-term care insurance policy; or the proposed certificate holder or enrollee, in the instance of a group long-term care insurance policy.

(6) **Attained age rating**--A schedule of premiums starting from the issue date which increases with age at least one percent per year prior to age 50, and at least three percent per year beyond age 50.

(7) **Bathing**--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.

(8) **Care**--Terms referring to care, such as "home health care," "intermediate care," "maintenance or personal care," "skilled nursing care," and other services, shall be defined in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.

(9) **Certificate**--Any certificate issued under a group long-term care insurance policy, which certificate has been delivered or issued for delivery in this state. For purposes of these sections, the term:

   (A) Also includes any evidence of coverage issued pursuant to a group health maintenance organization contract for long-term care health coverage.

   (B) Does not include certificates that are delivered or issued for delivery in this state under a single employer or labor union group policy that is delivered or issued for delivery outside this state.

(10) **Continence**--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).
(11) **Dressing**--Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

(12) **Eating**--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.

(13) **Exceptional premium rate increases**--Increases filed by an insurer as exceptional and for which the department 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 long term care products.

(14) **Group long-term care insurance**--A long-term care insurance policy or certificate of group long-term care insurance which is delivered or issued for delivery in this state, and issued to an eligible group as defined by the Insurance Code Article 3.51-6, §1(a), or a long-term care rider issued to an eligible group as defined by Insurance Code Article 3.50 §1.

(15) **Home health agency**--A business which provides home health service and is licensed by the Texas Department of Health.

(16) **Home health care services**--Medical or nonmedical services provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living, respite care services, case management services, and maintenance or personal care services.

(17) **Level premium long-term care policy**--A non-cancellable long-term care policy.

(18) **Long-term care benefit classifications**--Institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

(19) **Long-term care insurance contract**--Any insurance policy, group certificate, rider to such policy or certificate, or evidence of coverage issued by a health maintenance organization subject to the Texas Health Maintenance Organization Act (Texas Insurance Code, Chapter 20A) which is advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, per diem or other basis, and which provides insurance protection only for one or more necessary or medically necessary services of the following types, administered in a setting other than an acute care unit of a hospital: diagnostic, preventive, therapeutic, curing, treating, mitigating, rehabilitative, maintenance or personal care. The term
"long-term care insurance contract" shall not include any insurance policy, group certificate, subscriber contract, or evidence of coverage which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. The term includes a policy or rider, other than a group or individual annuity or life insurance policy that provides for payment of benefits based on the impairment of cognitive ability or the loss of functional capacity.

(20) **Maintenance or Personal Care Services**—Any care the primary purpose of which is the provision of needed assistance under §3.3818 of this title (relating to Standards for Eligibility for Benefits), including the protection from threats to health and safety due to impairment of cognitive ability.

(21) **Medicare**—"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.

(22) **Mental or Nervous Disorder**—A neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

(23) **Policy**—Any policy, contract, subscriber agreement, rider, or endorsement, delivered or issued for delivery in this state by an insurer, fraternal benefit society, nonprofit group hospital service corporation, or health maintenance organization subject to the Texas Health Maintenance Organization Act (Texas Insurance Code, Chapter 20A).

(24) **Preexisting Condition**—A condition for which medical advice was given or treatment was recommended by, or received from, a physician within six months before the effective date of coverage.

(25) **Qualified actuary**—An actuary who is a member of either the Society of Actuaries or the American Academy of Actuaries.

(26) **Qualified long-term care insurance contract**—A long-term care insurance contract meeting the requirements as contained in Internal Revenue Code of 1986, §7702B(b).

(27) **Qualified long-term care services**—As the term is defined in Internal Revenue Code of 1986, §7702B(c).
(28) **Similar policy forms**--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. Those certificates issued or delivered pursuant to one or more employers or labor union organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations, 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.

(29) **Toileting**--Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(30) **Transferring**--Sufficient mobility to move into or out of a bed, chair or wheelchair or to move from place to place, either via walking, a wheelchair or other means.

**Texas How Providers of Service are Defined in LTC Policy**

Texas Administrative Code: Title 28, Part 1, Chapter 3, Subchapter Y: 3.3812

(a) A provider of services, including, but not limited to, assisted living facility, skilled nursing facility, extended care facility, intermediate care facility, convalescent nursing home, maintenance or personal care facility, and home health care agency, shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. Such definitions may not be more restrictive than definitions for the same or similar facilities contained in the Insurance Code or otherwise in legislative enactments for the State of Texas.

(b) The terms, "assisted living facility," "convalescent nursing home," "extended care facility," "intermediate care facility," or "skilled nursing facility," shall be defined in relation to status, facilities, and available services.

(1) A definition of such home or facility may not be more restrictive than one requiring that it be operated pursuant to state and federal law.

(2) The definition of such home or facility may exclude:
   (A) any home, facility, or part thereof used primarily for rest;
   (B) a home or facility for the aged or for the care of drug addicts or alcoholics; or
   (C) a home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care.
TEXAS REQUIREMENT FOR GUARANTEED RENEWABILITY

Texas Administrative Code: Title 28, Part 1, Chapter 3, Subchapter Y: 3.3822
No long-term care insurance policy or certificate issued in this state shall contain renewal provisions less favorable to the policyholder than guaranteed renewability or noncancellability, as those terms are defined in §3.3807 of this title (relating to Policy or Certificate Standards for Guaranteed Renewability) and §3.3810 of this title (relating to Policy or Certificate Standards for Noncancellability).

TEXAS USE OF TERM GUARANTEED RENEWABLE

Texas Administrative Code: Title 28, Part 1, Chapter 3, Subchapter Y 3.3807

(a) The term "guaranteed renewability" may be used only when the policyholder 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 policyholder retains the right to cancel the long-term care insurance contract with the required notice of cancellation, as outlined in the contract. Upon such cancellation by the policyholder, the insurer must return any unearned premium to the policyholder.

(b) A group long-term care policy may not be described as a guaranteed renewable policy unless the insurer and policyholder have agreed by policy contract provision that the policy cannot be terminated by either the insurer or the policyholder until there are no certificates remaining thereunder. The term "guaranteed renewability" may apply to a group certificate of coverage if and only if the certificate form provides that:

1. In accordance with the provisions of §3.3828 of this title (relating to Continuation or Conversion; Discontinuance and Replacement):
   A) a conversion policy will be issued with substantially equivalent benefits upon termination of coverage under the group policy for any reason, including termination of the group policy; or
   B) the certificate may be continued in force under the group policy when the certificate holder is no longer a member of the group, pursuant to a written agreement between the certificate holder and the policyholder regarding such continuation, and that a conversion policy with substantially equivalent benefits must be provided in the event of policy termination;

2. provisions of the policy may not be changed unilaterally.

TEXAS USE OF TERM NONCANCELLABLE

Texas Administrative Code: Title 28, Part 1, Chapter 3, Subchapter Y: 3.3810
(a) The term "noncancellability" may be used only when the policyholder 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 make any change in any provision of the insurance or in the premium rate. The policyholder retains the right to cancel the long-term care insurance contract with the required notice of cancellation, as outlined in the contract. Upon such cancellation by the policyholder, the insurer must return any unearned premium to the policyholder.

(b) A group long-term policy may not be described as a noncancellable policy unless the insurer and policyholder have agreed by policy contract provision that the policy cannot be terminated by either the insurer or the policyholder until there are no certificates remaining thereunder. The term "noncancellable" may apply to a group certificate of coverage if and only if the certificate form provides that:

1. In accordance with the provisions of §3.3828 of this title (relating to Continuation or Conversion; Discontinuance and Replacement):
   A. a conversion policy will be issued with substantially equivalent benefits upon termination of coverage under the group policy for any reason, including termination of the group policy; or
   B. the certificate may be continued in force under the group policy when the certificate holder is no longer a member of the group, pursuant to a written agreement between the certificate holder and the policyholder regarding such continuation, and that a conversion policy with substantially equivalent benefits must be provided in the event of policy termination; and

2. Provisions of the policy, including rates, may not be changed unilaterally.

(c) The term "level premium" may only be used to describe long-term care coverage that is non-cancellable.

**Texas Minimum Standards for Home Health Care Coverage**

Texas Administrative Code: Title 28, Part 1, Chapter 3, Subchapter Y: 3.3815

(a) No long-term care insurance policy or certificate which provides benefits for home health care or adult day care services may exclude or limit benefits by requiring any of the following:

1. that the insured would need care in a nursing facility if home health care services were not provided;
2. that the insured first or simultaneously receive nursing and/or therapeutic services in a home, community, or institutional setting before home health care services are covered;
3. that eligible services be provided by a registered nurse or nurses or licensed
practical nurse or nurses;
(4) 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) that the provision of home health care services be at a level of certification or licensure greater than that which is required for the eligible service to be performed under the laws of this state;
(6) that the insured have an acute condition before home health care services are offered; or
(7) that benefits be limited to services provided by Medicare certified agencies or providers.

(b) If a long-term care policy or certificate provides coverage for home health care or adult day care services, it shall not exclude or limit benefits for:

(1) adult day care services; or
(2) maintenance or personal care services provided by a home health aide.

(c) If a long-term care insurance policy or certificate provides for home health or adult day care services, it shall provide total home health or adult day care services coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or adult day care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

(d) Home health care coverage may be applied to the total health care benefits provided in the policy or certificate when determining the maximum coverage under the terms of the policy or certificate.

**TEXAS PREEXISTING CONDITIONS**

Texas Administrative Code: Title 28, Part 1, Chapter 3, Subchapter Y: 3.3824

(a) No long-term care insurance policy or certificate issued under provisions of this subchapter may contain a provision which denies a claim for losses incurred more than six months from the effective date of coverage for a preexisting condition, as defined in §3.3804 of this title (relating to Definitions).

(b) The definition of preexisting condition does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subsection (a) of this section expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for
specifically named or described preexisting diseases or physical conditions beyond the waiting period described in subsection (a) of this section.

(c) Any long-term care insurance policy or certificate which replaces another long-term care policy or certificate shall contain provisions that waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy or certificate for similar benefits to the extent that such time periods have been satisfied under the policy being replaced.

**Texas Incontestability**

Texas Administrative Code: Title 28, Part 1, Chapter 3, Subchapter Y: 3.3846

(a) For a policy or certificate that has been in force for 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 and an intent to deceive by the insured in the application for insurance.

(b) After a policy or certificate has been in force for two years it is not contestable except for the grounds stated in Article 3.51-6, §1(d)(2)(ii) for a group policy and Article 3.70-3(A)(2) for an individual policy.

(c) No long-term care insurance policy or certificate may be field issued based on medical or health status. For purposes of this section, "field issued" means a policy or certificate issued by an agent or a third-party administrator pursuant to the underwriting authority granted to the agent or third-party administrator by an insurer.

**Texas Nonforfeiture Requirements**

Texas Administrative Code: Title 28, Part 1, Chapter 3, Subchapter Y: 3.3844

(a) Required Offering of Nonforfeiture Benefits and Contingent Benefits upon Lapse. No insurer or other entity may offer a long-term care insurance policy or certificate in this state unless such insurer or other entity also offers to the prospective insured, or to the group policyholder, the option to purchase a policy that contains nonforfeiture benefits. On or after July 1, 2002, in the event a policyholder or certificate holder declines the option to purchase a policy that contains nonforfeiture benefits, the insurer shall provide contingent benefits upon lapse as described in subsection (g) of this section. In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(b) Nonforfeiture Benefit Provisions.

(1) The nonforfeiture provision shall provide for a benefit available in the event of a
default in the payment of any premiums. 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.

(2) The nonforfeiture provision shall be clearly and conspicuously captioned.

REQUIRED NONFORFEITURE OPTIONS.

(c) Nonforfeiture Benefit Options. Insurers shall offer at least one of the following nonforfeiture options:

(1) reduced paid-up;
(2) extended term;
(3) shorten benefit period; or
(4) other offerings approved by the U.S. Secretary of Health and Human Services as provided by the Internal Revenue Code §7702B(g)(4)(B).

(d) Nonforfeiture and Contingent Benefit Standards/Requirements.

(1) Except as provided in paragraph (2) of this subsection, no policy or certificate shall begin a nonforfeiture benefit 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 years as well as thereafter.

(2) For a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

(A) The end of the tenth year following the policy or certificate issue date; or
(B) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(3) 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.

(4) 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 have been payable if the policy or certificate had remained in premium paying status.

(5) There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

(6) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit upon lapse shall be subject to the requirements of §3.3831 of this title (relating to Standards and Rates) treating the policy as a whole.

(7) To determine whether the contingent nonforfeiture upon lapse provisions are triggered, 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.
(8) A qualified actuary shall certify as to the reasonability of rates charged for each nonforfeiture benefit and the reserving required by §3.3819 of this title (relating to Requirement for Reserve) shall include reserving for the nonforfeiture options.

(e) Additional Requirements for Shortened Benefit Period. An insurer offering a shortened benefit period shall comply with the following:

(1) The shortened benefit period shall provide 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 (2) of this subsection.

(2) The standard nonforfeiture credit will be equal to 100 percent 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 limits specified in the policy or certificate.

(f) Disclosure of Nonforfeiture Benefits. The application or a separate form shall include an election to accept or reject the nonforfeiture benefit. The rejection notice shall state: "I have reviewed the outline of coverage and the explanation of nonforfeiture benefits and I reject the nonforfeiture option." The agent shall provide information to assist the prospective policyholder in accurately completing the rejection statement.

CONTINGENT BENEFIT UPON LAPSE

(g) Contingent Nonforfeiture Benefits.

(1) 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 in Triggers for a Substantial Premium Increase 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. Policyholders shall be notified at least 45 days prior to the due date of the premium reflecting the rate increase.

(2) On or after the effective date of a substantial premium increase as set forth in paragraph (1) of this subsection, the insurer shall:

(A) 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) offer to convert the coverage to a paid-up status with a shortened benefit
period in accordance with the terms of subsection (e) of this section. This option may be elected at any time during the 120-day period referenced in paragraph (1) of this subsection; and
(C) notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in paragraph (1) of this subsection shall be deemed to be the election of the offer to convert in subparagraph (B) of this paragraph.

TEXAS UNINTENTIONAL LAPSE

Texas Administrative Code: Title 28, Part 1, Chapter 3, Subchapter Y: 3.3841

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

(1) Procedures applicable to unintentional lapse.

(A) 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. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. 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. 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 30 days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice." The insurer shall notify the insured of the right to change this written designation, no less often than once every two years.

(B) Payroll or pension deduction. When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in paragraph (1)(A) of this section need not be met until 60 days after the policyholder or certificate holder 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.

(C) 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 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to paragraph (1)(A) of this section at the address provided by the insured for 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 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.

(2) Reinstatement. In addition to the requirement in paragraph (1) of this section, a long-term care insurance policy or certificate shall include a provision which provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof of impairment of cognitive ability or the loss of functional capacity. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of impairment of cognitive ability or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on impairment of cognitive ability or the loss of functional capacity contained in the policy and certificate.

TEXAS LTC POLICY STANDARDS

Texas Administrative Code: Title 28, Part 1, Chapter 3, Subchapter Y: 3.3823

(a) No long-term care insurance policy may be cancelled, nonrenewed, or otherwise terminated on the grounds of age or the deterioration of the mental or physical health of the insured individual or certificate holder.

(b) No long-term care insurance policy may contain a provision establishing a new waiting period in the event existing coverage is converted to, or replaced by, a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder.

(c) No long-term care insurance policy may provide coverage for skilled nursing care only, or provide significantly more coverage for skilled care than coverage for lower levels of care.

(d) No long-term care insurance policy or certificate shall be utilized in such manner as would result in post-claims underwriting.

(1) All applications for long-term care insurance policies or certificates, except those that do not provide the company any rights to deny benefits or to rescind coverage based on answers in the application, shall contain questions designed to ascertain the health condition of the applicant, and such questions shall be clear and unambiguous.

(2) If an application for long-term care insurance contains a question which 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. 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 do not provide the company any rights to deny benefits or to rescind coverage based on answers in the application, the following language shall be set out conspicuously in bold print and in close proximity to the applicant's signature block on an application for a long-term care insurance policy or certificate: "Caution: If your answers on this application are incorrect or untrue, (company) may have the right to deny benefits or rescind your coverage."

(4) Except for policies or certificates which do not provide the company any rights to deny benefits or to rescind coverage based on answers in the application, the following language, or language substantially similar to the following, shall be set out conspicuously in bold print 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 incorrect or untrue, the company may have the right to deny benefits or rescind your coverage. 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)."

(5) Prior to issuance of a long-term care policy or certificate to an applicant age 80 or older, the insurer shall obtain one of the following:

(A) a report of a physical examination;
(B) an assessment of functional capacity;
(C) an attending physician's statement; or
(D) copies of medical records.

(6) A copy of the completed application (or enrollment form if 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.

**Texas Provision for Individuals Eligible for Coverage**

Texas Administrative Code: Title 28, Part 1, Chapter 3, Subchapter Y: 3.3806

A long-term care insurance policy and/or certificate shall contain a provision which sets forth the individuals eligible to be covered under the policy and/or certificate and which specifies the conditions applicable to an individual who may become covered under the policy and/or certificate by subsequent addition.

(1) Eligible individuals may include:
(A) for group coverage:
   (i) the prospective certificate holder (the individual whose employment or other membership status, except for family dependency, is the basis for eligibility for enrollment under the group policy);
   (ii) the certificate holder's spouse;
   (iii) the certificate holder's children;
   (iv) the certificate holder's spouse's children;
   (v) the certificate holder's parents;
   (vi) the certificate holder's spouse's parents; and
   (vii) any other individual included as an eligible individual under a long-term care policy.

(B) For individual coverage:
   (i) the prospective policyholder;
   (ii) the policyholder's spouse;
   (iii) the policyholder's children;
   (iv) the policyholder's spouse's children;
   (v) the policyholder's parents;
   (vi) the policyholder's spouse's parents; and
   (vii) any other individual included as an eligible individual under a long-term care policy.

(2) The provision shall state the conditions under which coverage will become effective for an individual who becomes insured subsequent to policy and/or certificate issuance. Such conditions shall include:

   (A) any requirements relating to evidence of insurability;
   (B) any requirements relating to the necessity of application or notice from the individual;
   (C) any requirements relating to the payment of premiums as to such addition; and
   (D) the time within which any action is to be taken by the individual.

**TEXAS EXCLUSIONS AND LIMITATIONS**

Texas Administrative Code: Title 28, Part 1, Chapter 3, Subchapter Y:3.3826

(a) No policy or certificate may be delivered or issued for delivery in this state as a long-term care insurance policy or certificate if such policy or certificate limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:

   (1) a preexisting condition or disease, as defined in §3.3804(b) of this title (relating to Definitions); and §3.3824 of this title (relating to Preexisting Conditions Provisions);
   (2) mental or nervous disorders; however, this shall not permit exclusion or limitations of benefits on the basis of the following:
(A) Alzheimer's disease or related disorders, where a clinical diagnosis of Alzheimer's disease by a physician licensed in this state, including history and physical, neurological, psychological and/or psychiatric evaluation, and laboratory studies, has been made to satisfy any requirement or demonstrable proof of organic disease or other proof under the coverage; or

(B) biologically based brain diseases/serious mental illness, including schizophrenia, paranoid and other psychotic disorders, bipolar disorders (mixed, manic, and depressive); major depressive disorders (single episode or recurrent); and schizo-affective disorders (bipolar or depressive);

(3) alcoholism and drug addiction;

(4) illness, treatment, or medical condition arising out of any of the following:

   (A) war or act of war, whether declared or undeclared;
   (B) participation in a felony, riot, or insurrection;
   (C) service in the armed forces or units auxiliary thereto;
   (D) suicide, attempted suicide, or intentionally self-inflicted injury; or
   (E) aviation activity as a nonfare-paying passenger; or

(5) treatment provided in a governmental facility (unless otherwise required by law); benefits provided 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 performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.

(b) Provisions of this section are not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

**Texas Replacement**

Texas Administrative Code: Title 28, Part 1, Chapter 3, Subchapter Y: 3.3832

(a) Individual, direct-response-solicited, and group long-term care insurance application forms shall include questions designed to elicit information as to whether, as of the date of application, the applicant has another long-term care insurance policy or certificate in force or the proposed insurance is intended to replace any other accident and sickness or long-term care insurance policy presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing such questions may be used. With regard to a replacement policy issued to an employer, labor union, or continuing care retirement community, 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, however, that the certificate holder has been notified of the
replacement. The following questions shall be included in the application.

(1) Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?
(2) Did you have another long-term care insurance policy or certificate in force during the last 12 months?
   (A) If so, with which company?
   (B) If that policy lapsed, when did it lapse?
(3) Are you covered by Medicaid?
(4) Do you intend to replace any of your medical or health insurance coverage with this policy (certificate)?

(b) Agents shall list any other health insurance policies and certificates they have sold to the applicant and shall also:
   (1) list policies and certificates sold which are still in force;
   (2) list policies and certificates sold in the past five years which are no longer in force.

(c) Agents shall list any other health insurance policies or certificates the applicant has in force.

(d) Upon a determination that a sale will involve replacement, an insurer or its agent, if that insurer is other than one using direct-response solicitation methods, 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.

(e) 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 or certificate. The required notice shall be provided in the following manner.

(f) When replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy or certificate shall be identified by the insurer, name of the insured, and policy number or address including zip code. Such notice shall be made within five working days from the date the application is received by the replacing insurer at its home office, or the date the policy is issued, whichever is sooner.

(g) An application for a long-term care policy or certificate that contains benefits under
§3.3818(b) of this title (relating to Standards for Eligibility for Benefits) shall in equal prominence reflect the benefit levels payable for the inability to perform two activities of daily living, three activities of daily living, and cognitive impairment.

TEXAS CONTINUATION OR CONVERSION

Texas Administrative Code: Title 28, Part 1, Chapter 3, Subchapter Y: 3.3828

(a) Continuation or conversion. In conjunction with the provisions of §3.3807 of this title (relating to Policy or Certificate Standards for Guaranteed Renewability) and §3.3810 of this title (relating to Policy or Certificate Standards for Noncancellability), an insurer or other entity providing group long-term care insurance coverage shall provide a basis for continuation or conversion of coverage.

(1) For the purposes of this section, the term "a basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies which restrict provision of benefits and services to, or contain incentives to use, certain providers and/or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The 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.

(2) For the purposes of this section, the term "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.

(3) For the purposes of this section, the term "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 greater than, those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use, certain providers and/or facilities, the 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.

(4) 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 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.

(5) 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 the inception of coverage under the group policy replaced.

(6) 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 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 greater than, those provided by the terminating coverage; and
(ii) the premium for which is calculated in a manner consistent with the requirements of paragraph (5) of this section.

(7) Notwithstanding any other provision of this section, a converted policy, issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100% 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.

(8) 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.

(9) Notwithstanding any other provision of this section, any insured individual, whose eligibility for group long-term care coverage is based upon his or her relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

(10) For the purpose of this section, the term "managed care arrangement plan" is a health care arrangement or assisted living arrangement designed to coordinate...
patient care or control costs through utilization review, case management, or use of specific provider networks.

DISCONTINUANCE OR REPLACEMENT

(b) Discontinuance and replacement. If a group long-term care policy is replaced by another group long-term care policy issued to 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 any exclusion for preexisting 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.

TEXAS PROHIBITION AGAINST PRIOR HOSPITALIZATION REQUIREMENT

Texas Administrative Code: Title 28, Part 1, Chapter 3, Subchapter Y: 3.3825

(a) No long-term care insurance policy or certificate may be delivered or issued for delivery in this state which conditions the eligibility for benefits on prior hospitalization.

(b) No long-term care insurance policy or certificate may be delivered or issued for delivery in this state if such policy conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care.

(c) No long-term care insurance policy or certificate may be delivered or issued for delivery in this state which conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care, or recuperative benefits on a prior institutionalization requirement.

(d) Any long-term care insurance policy or certificate containing post-confinement, post-acute care, or recuperative benefits, which are subject to any limitations or conditions for eligibility, including any required number of days of confinement, shall clearly label such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate, entitled "Limitations or Conditions on Eligibility for Benefits."

(1) No long-term care insurance policy or certificate containing a benefit advertised, marketed, or offered as a home care or a home health care benefit may condition receipt of benefits on a prior institutionalization requirement.

(2) No long-term care insurance policy or certificate which conditions eligibility of noninstitutional benefits on the prior receipt of institutional care shall require a prior institutional stay of more than 30 days for which benefits are paid.
TEXAS OUTLINE OF COVERAGE REQUIREMENT

Texas Administrative Code: Title 28, Part 1, Chapter 3, Subchapter Y: 3.3831

(a) An outline of coverage shall be delivered to an applicant for an individual or group long-term care insurance policy or certificate at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose. In the case of agent solicitations, the outline of coverage shall be delivered prior to the presentation of an application or enrollment form. In the case of direct-response solicitations, the outline of coverage shall be delivered in conjunction with any application or enrollment form. The outline of coverage shall comply with the following standards and standard format. The contents of the outline of coverage shall include the following prescribed text.

(1) The outline of coverage shall be a freestanding document, in no smaller than 12-point type.
(2) The outline of coverage shall contain no material of an advertising nature.
(3) Text which is capitalized in the standard format outline of coverage shall be capitalized. Text which is underscored in the standard format outline of coverage may be emphasized by boldfacing or by other means which provide prominence equivalent to such underscoring.
(4) Use of text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

(b) The outline of coverage shall be in the following format.

(1) POLICY DESIGNATION. 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 some of the important features of your policy. This is not the insurance contract and only the actual policy provision will control the rights and obligations of the parties to it. The policy itself sets forth in detail those rights and obligations applicable to both you and your insurance company. It is very important, therefore, that you READ YOUR POLICY OR CERTIFICATE CAREFULLY.

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

(A) (Provide a brief description of the right to return--"free look" provisions of the policy. State that the person to whom the policy is issued is permitted to return the policy within 30 days (or more, if so provided for in the policy) of its delivery to that person, and that in the instance of such return the premium shall be fully refunded.)

(B) (Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or
surrender of the policy or certificate. If the policy contains such provisions, include a
description of them.)

(4) MEDICARE SUPPLEMENT INSURANCE DISCLAIMER. THIS IS NOT
MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the
Guide to Health Insurance for People with Medicare available from the insurance
company.

(A) (For agents) Neither (insert company name) nor its agents represent Medicare, the
federal government, or any state government.

(B) (For direct response) (insert company name) is not representing Medicare, the
federal government, or any state government.

(5) LONG-TERM CARE COVERAGE. Long-term care insurance is designed to
provide coverage for necessary or medically necessary diagnostic, preventive,
therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or
personal care services, provided in a setting other than an acute care unit of a hospital,
such as in a nursing home, in the community, or in the home. Coverage is provided for
the benefits outlined in paragraph (6) of this subsection. The benefits described in
paragraph (6) of this subsection may be limited by the limitations and exclusions in
paragraph (7) of this subsection.

(6) BENEFITS PROVIDED BY THIS POLICY.

(A) (Describe covered services and benefits, related deductible(s), waiting periods,
elimination periods, and benefit maximums.)

(B) (Describe institutional benefits, by skill level.)

(C) (Describe noninstitutional benefits, by skill level.)

(D) Eligibility for Payment of Benefits (NOTE: This portion of the outline of coverage
must include an explanation of any instance in which provision of benefits is predicated
upon the insured's having met a specific standard of eligibility for that benefit under the
terms of the policy. The procedural requirements must be stated for such screening for
the provision of benefits. The inability to perform activities of daily living and the
impairment of cognitive ability shall be used to measure an insured's eligibility for long-
term care and must be defined and described as part of the outline of coverage in
conformance with the provisions of §3.3804 of this title (relating to Definitions). The
outline of coverage also shall specify when an attending physician or other specified
person must certify that the insured has a certain level of functional dependency in order
for the insured to be eligible for benefits. If the policy or certificate contains provisions
allowing for additional benefits (such as waiver of premiums, respite care, etc.) upon the
occurrence of a certain contingency or contingencies, this paragraph also shall delineate
each such benefit and specify the criteria for eligibility for each benefit.

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(7) LIMITATIONS AND EXCLUSIONS. (State the principal exclusions, reductions, limitations, restrictions, or other qualifications to the payments of benefits contained in the policy, including:

(A) (preexisting conditions;

(B) (noneligible facilities/providers;

(C) (noneligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(D) (exclusions/exceptions; and

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

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

(A) (that the benefit level will not increase over time;

(B) (any automatic benefit adjustment provisions;

(C) (whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

(D) (if such a guarantee is present, 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) (whether any additional premium charge will be imposed, and how that is to be calculated.)

(9) TERMS UNDER WHICH THE (POLICY) (CERTIFICATE) MAY BE CONTINUED IN FORCE AND IS CONTINUED. (For long-term care insurance policies or certificates, describe one of the following permissible policy renewability provisions.)

(A) (Policies and certificates which are guaranteed renewable shall contain the following statement:

(i) 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.

   (ii) (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, a specific description of continuation/ conversion provisions applicable to the certificate and group policy); and

   (C) (a description of waiver of premium provisions or a statement that there are no such provisions.)

   (10) ALZHEIMER'S DISEASE, OTHER ORGANIC BRAIN DISORDERS, AND BIOLOGICALLY BASED BRAIN DISEASES/SERIOUS MENTAL ILLNESS. (State that the policy provides coverage for insureds who meet the eligibility requirements explained above in paragraph 6 of this subsection because of a clinical diagnosis of Alzheimer's disease or related degenerative illnesses and illnesses involving dementia, or due to biologically based brain diseases/serious mental illnesses, including schizophrenia, paranoid and other psychotic disorders, bipolar disorders (mixed, manic, and depressive); major depressive disorders (single episode or recurrent); and schizo-affective disorders (bipolar or depressive). Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.)

   (11) PREMIUM.

      (A) (State the total annual premium for the policy. In the event the total premium for the policy is different from the annual premium, then the total premium also shall be stated. Initial policy fees shall be stated separately.)

      (B) (If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.)

      (C) (This paragraph also shall include a statement of the policy grace period.)

   (12) TEXAS DEPARTMENT OF INSURANCE'S CONSUMER HELP LINE. An insurer shall include notification that the prospective insured may call the Texas Department of Insurance's Consumer Help Line at 1-800-252-3439 for agent, company, and any other insurance information, and 1-800-599-SHOP to order publications related to long-term care coverage, and the Texas Department of Aging at (1-800-252-9240 or current number if different) to receive counseling regarding the purchase of long-term
care or other health care coverage.

(13) DENIAL OF APPLICATION. A long-term care insurer shall state that within 30 days of denial of an application, it will refund any premiums paid by a long-term care applicant.

(14) OFFER OF INFLATION PROTECTION. Insurers shall include the information set out in subparagraphs (A) and (B) of this paragraph regarding the offer of inflation protection.

(A) A graphic comparison of the benefit levels of a policy and certificate, if applicable, that increases benefits due over the policy interval with a policy that does not increase benefits, depicting benefit levels over at least a 20-year period, shall be provided.

(B) A disclosure of any expected premium increases or additional premiums to pay for automatic or optional benefit increases shall be made. 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. An insurer may use a reasonable hypothetical or a graphic demonstration for the purposes of this disclosure.

(15) OFFER OF NONFORFEITURE BENEFITS. Insurers shall include the information set out in subparagraphs (A), (B) and (C) of this paragraph regarding the offer of nonforfeiture benefits.

(A) A complete and clear explanation of each nonforfeiture option being offered, including an actual numerical example.

(B) Disclosure of the premium and percentage increase in premium associated with each of the nonforfeiture benefits offered.

(C) Disclosure that if the nonforfeiture offer is rejected that a contingent benefit upon lapse will be provided and a description of such benefit.

(16) DISCLOSURE REGARDING FEDERAL TAX TREATMENT OF LONG-TERM CARE INSURANCE POLICY.

(A) Policies intended to be qualified long-term care insurance policies. Include disclosure language substantially similar to the following: "This policy is intended to be a qualified long-term care contract as defined by the Internal Revenue Code of 1986, §7702B(b). There may be tax consequences associated with the purchase of a qualified long-term care insurance contract, such as the tax deductibility of premiums and the exclusion from taxable income of benefits. The prospective insured is urged to consult with a qualified tax advisor."

(B) Policies which are not intended to be a qualified long-term care insurance contract.
Include disclosure language substantially similar to the following: "This policy is not intended to be a qualified long-term care insurance contract as defined by the Internal Revenue Code of 1986, §7702B(b). This policy will not qualify the insured for the favorable tax treatment provided for in the Internal Revenue Code of 1986, §7702B. The prospective insured is urged to consult with a qualified tax advisor." Additionally, the insurer shall disclose the criteria which result in the policy or certificate not being classified as a qualified long-term care insurance contract.

(17) ADDITIONAL FEATURES.
(A) (Indicate if medical underwriting is used.)
(B) (Describe other important features such as: unintentional lapse as provided by §3.3841 of this title (relating to unintentional lapse and reinstatement).

TEXAS REQUIRED DISCLOSURES

Texas Administrative Code: Title 28, Part 1, Chapter 3, Subchapter Y: 3.3829

(a) Required Disclosure of Policy Provisions.

(1) Long-term care insurance policies and certificates shall contain a renewability provision as required by §3.3822 of this title (relating to Minimum Standard for Renewability of Long-term Care Coverage). Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the coverage for which the policy is issued and for which it may be renewed.

(2) Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder under a long-term care insurance policy and/or certificate, all riders or endorsements added to a long-term care insurance policy and/or certificate after the date of issue or at reinstatement or renewal, which reduce or eliminate benefits or coverage in the policy and/or certificate, shall require a signed acceptance by the policyholder. 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 signed by the policyholder, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits in connection with riders or endorsements, such premium charge shall be set forth in the policy, certificate, rider, or endorsement.

(3) A long-term care insurance policy and certificate which provides for the payment of benefits 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.

(4) If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."

(5) Long-term care insurance applicants shall have the right to return the policy or
certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

(6) A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in the Insurance Code, Article 3.70-12, or §3.3824 of this title (relating to Preexisting Conditions Provisions) shall set forth a description of such limitations or conditions in a separate paragraph of the policy and certificate and shall label each paragraph "Limitations or Conditions on Eligibility for Benefits."

(7) Long-term care insurance policies and certificates shall appropriately caption and describe the nonforfeiture benefit provision, if elected.

(8) Long-term care insurance policies and certificates shall contain a claim denial provision which shall be appropriately captioned. Such provision shall clearly state that if a claim is denied, the insurer shall make available all information directly relating to such denial within 60 days of the date of a written request by the policyholder or certificate holder, unless such disclosure is prohibited under state or federal law.

(9) A long-term care insurance policy and certificate which includes benefit provisions under §3.3818(b) of this title (relating to Standards for Eligibility for Benefits) shall disclose, within a common location and in equal prominence, a description of all benefit levels payable for the coverage described in §3.3818(b). Criteria utilized to determine eligibility for benefits shall be disclosed in all long-term care insurance policies and certificates, in the manner prescribed by §3.3818.

(10) If the insurer intends for a long-term care insurance policy or certificate to be a qualified long-term care insurance contract as defined by the Internal Revenue Code of 1986, §7702B(b), the policy or certificate shall include disclosure language substantially similar to the following. "This policy is intended to be a qualified long-term care contract as defined by the Internal Revenue Code of 1986, §7702B(b)."

(11) If the insurer does not intend for the policy to be a qualified long-term care insurance contract as defined by the Internal Revenue Code of 1986, §7702B(b), the policy or certificate shall include disclosure language substantially similar to the following. "This policy is not intended to be a qualified long-term care insurance contract. This long-term care insurance policy does not qualify the insured for the favorable tax treatment provided for in the Internal Revenue Code of 1986, §7702B."

(12) A long-term care policy or certificate which provides for increases in rates shall include a provision disclosing that notice of an upcoming premium rate increase will be provided no later than the 45th day preceding the date of the implementation of the rate increase.

(b) Required disclosure of rating practices.
(1) Other than non-cancellable policies, the required disclosures of rating practices, as set forth in paragraph (2) of this subsection, shall apply to any long-term care policy or certificate delivered or issued for delivery in this state on or after July 1, 2002, except for certificates issued under a group long-term care policy delivered or issued for delivery in this state and issued to one or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations that was in effect on January 1, 2002, in which case this subsection shall apply on the policy anniversary following January 1, 2003.

(2) Insurers shall provide the following information in the same order as set forth in this paragraph to the applicant at the time of application or enrollment or, if the method of application does not allow for delivery at that time, the information shall be provided at the time of delivery of the policy or certificate:

   (A) a statement that the policy may be subject to rate increases in the future;
   (B) an explanation of potential future premium rate revisions, including an explanation of contingent benefit upon lapse, and the policyholder's or certificate holder's option in the event of a premium rate revision;
   (C) the premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;
   (D) a general explanation for applying premium rate or rate schedule adjustments that shall include:
      (i) a description of when premium rate or rate schedule adjustments will become effective (e.g., next anniversary date, next billing date, etc.); and
      (ii) the right to a revised premium rate or rate schedule as provided in subparagraph (C) of this subsection if the premium rate or rate schedule is changed;
   (E) Information regarding each premium rate increase on this policy form or similar policy forms over the past 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 also may be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(3) Subsequent to the information required by paragraph (2) of this subsection, insurers may, in a manner that is not misleading, provide in addition to the
information required in paragraph (2)(E) of this subsection, explanatory information related to the rate increases.

(4) Insurers may exclude from the disclosure required by paragraph (2)(E) of this subsection 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.

(5) If an acquiring insurer files for a rate increase either on a long-term care policy form acquired from a nonaffiliated insurer, or on a block of policy forms acquired from a nonaffiliated insurer on or before January 1, 2002 or the end of the 24-month period after the date of the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling insurer shall include the disclosure of that rate increase in accordance with paragraph (2)(E) of this subsection.

(6) If the acquiring insurer in paragraph (5) of this subsection files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from a nonaffiliated insurer or block of policy forms acquired from a nonaffiliated insurer referenced in paragraph (5), the acquiring insurer shall make all disclosures required by paragraphs (2)(E), (3), (4) and (5) of this subsection.

(7) An applicant shall sign an acknowledgement at the time of application that the insurer has made the disclosure(s) required under paragraph (2) of this subsection. 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.

(8) An insurer may use such form as the department prescribes to comply with the requirements of this section. Persons may obtain the required form by making a request to the Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9107 or 333 Guadalupe, Austin, Texas 78701, or by accessing the department website at www.tdi.state.tx.us. Insurers who elect not to use the prescribed form shall file the disclosure form with the Life/Health Division of the department for review 60 days prior to use.

(9) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, as applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by paragraph (2) of this subsection in the same order as set forth in paragraph (2) when the rate increase is implemented.

**TEXAS REQUIRED REPORTING**

Texas Administrative Code: Title 28, Part 1, Chapter 3, Subchapter Y: 3.3837

(a) Every insurer shall maintain records, for each agent, of that agent's number and dollar amount of replacement sales as a percentage of the agent's total number and amount of annual sales attributable to long-term care products, as well as the number and dollar amount of lapses of long-term care insurance policies sold by the agent and expressed as a percentage of the agent's total annual sales attributable to long-term care products.
(1) Each insurer shall report by June 30 of every year the 10% of its agents with the greatest percentages of lapses and replacements as measured by this subsection; provided, however, that any agent with 20 or fewer sales of long-term care policies for any reporting period shall not be included in such report, even if such agent's replacement-and-lapse percentage rates would otherwise result in inclusion in such report.

(2) 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 agent activities regarding the sale of long-term care insurance.

(3) Every insurer shall report by June 30 of every year the number of lapsed long-term care policies as a percentage of its total annual sales of such policies and as a percentage of its total number of long-term care policies in force as of the end of the preceding calendar year.

(4) Every insurer shall report by June 30 of every year the number of replacement long-term care policies sold as a percentage of its total annual sales of such products, and as a percentage of its total number of such policies in force as of the preceding calendar year.

(5) Every insurer by June 30 of each year shall file the annual rate filing required by Insurance Code Article 3.70-12, §4(b).

(b) Every insurer issuing long-term care insurance benefits shall maintain a record of all policy, contract, or certificate rescissions relating to such long-term care insurance benefits, both for coverage in this state and nationwide, except for those which the insured voluntarily effectuated, and shall report to the commissioner by June 30th of every year this information utilizing Form LTC RESCIND as referenced in §3.3848 of this title (relating to Adoption by Reference of Department Form Utilized in Reporting).

(c) Every insurer issuing long-term care insurance benefits shall maintain a record by class of business the number of long-term care claims for long-term care services denied during the preceding calendar year. The insurer shall report this information expressed as a percentage of claims denied (other than claims denied for failure to meet the waiting period or because of any applicable preexisting conditions or because the service for which the claim was submitted is not the type of service covered by a long-term care policy) to the commissioner by June 30th of every year.

(d) For purposes of this section, reporting requirements relate only to long-term care insurance and coverages that are delivered or issued for delivery in this state.

**TEXAS REQUIREMENT TO OFFER INFLATION PROTECTION**

Texas Administrative Code: Title 28, Part 1, Chapter 3, Subchapter Y: 3.3820

(a) No insurer or other entity may offer a long-term care insurance policy or certificate in this state unless such insurer or other entity also offers to the prospective insured, or to the group policyholder, if the group policy will be issued to an employer, labor union, or
continuing care retirement center, the option to purchase a policy that provides for benefit levels to increase throughout the interval of coverage to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each applicant, at the time of purchase, the option to purchase a policy that provides the inflation protection set out in paragraphs (1), (2), or (3) of this subsection.

(1) The policy and certificate shall be structured so that benefit levels increase annually, in a manner so that the increases are compounded at a rate not less than 5.0% annually throughout the interval of coverage.

(2) The policy and certificate shall guarantee the policyholder and certificate holder, if applicable, the opportunity to increase benefit levels on the annual policy anniversary date throughout the interval of coverage without providing evidence of insurability or health status, such that the additional benefit amount is not less than 5.0% greater than the original benefit amount, compounded annually. Such increase to benefit levels shall occur automatically unless the policyholders and certificate holders, if applicable, specifically rejected the option to increase in writing within 30 days following the anniversary date of the policy or coverage.

(3) The policy shall cover a specified percentage of actual or reasonable charges throughout the interval of coverage and not include a maximum specified indemnity or per diem amount or limit.

(b) The inflation protection provisions in subsection (a) of this section shall be required to be included in any long-term care insurance policy and certificate unless an insurer obtains a written rejection of inflation protection signed by the prospective policyholder, as provided in this subsection.

(1) The rejection shall be considered 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 (and certificate, if applicable) with and without inflation protection. I realize that based on current health care cost trends, the benefits provided by a long-term care plan which does not have meaningful inflation protection may be significantly diminished in terms of real value to me, depending on the amount of time which elapses between the date I purchase the policy and the date on which I first become eligible to use them. Specifically I have reviewed Plans __________, and I reject inflation protection."

(2) The agent shall provide information to assist the prospective policyholder in accurately completing the statement with respect to the plans reviewed by the applicant and specified in paragraph (1) of this subsection.

(c) Where the policy is offered to a group, the offer required by provisions of this subsection shall be made to the group policyholder; except that in the instance where the group policy will not be issued to an employer, labor union, or continuing care retirement community, the offering shall be made to each prospective covered individual.

(d) Inflation protection benefit increases under a policy which contains provisions for such increases, whether automatic or optional with the insured, 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) An offer of inflation protection providing for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. Such offer shall disclose in a conspicuous manner, in no smaller than 12-point (where one point is 1/72 of an inch) boldface type, that the premium may change in the future unless the premium is guaranteed to remain constant.

(f) Upon rejection of the inflation protection set forth in subsection (a) of this section, an insurer may offer other forms of inflation protection.

TEXAS BENEFIT TRIGGER STANDARDS

Texas Administrative Code: Title 28, Part 1, Chapter 3, Subchapter Y 3.3818

(a) A long-term care insurance policy or certificate shall contain provisions conditioning eligibility for benefits or services upon the occurrence of the following events:

(1) the inability to perform, without assistance, any two activities of daily living, as set forth by the insurer; provided, however, that such activities of daily living shall include at a minimum those which are set forth and defined in §3.3804 of this title (relating to Definitions); or

(2) the impairment of cognitive ability. For purposes of this subchapter, the term "impairment of cognitive ability" shall not be defined more restrictively than the deterioration or loss in intellectual capacity requiring substantial supervision for protection of self or others, as established by the clinical diagnosis of any licensed practitioner in this state authorized to make such a diagnosis. Such diagnosis shall include the patient's history and physical, neurological, psychological and/or psychiatric evaluations, and laboratory findings.

(b) Any insurer or other entity that offers a long-term care insurance policy or certificate that complies with subsection (a) of this section may also offer a long-term care policy or certificate that provides coverage based on the inability to perform without assistance any three activities of daily living, provided:

(1) the policy or certificate meets the requirements of subparagraphs (A) through (D) of this paragraph:

(A) the policy and certificate shall provide coverage based on meeting the eligibility requirements of subsection (a)(1) of this section,

(B) the coverage based on the inability to perform, without assistance, any three activities of daily living shall:

(i) be identical to the coverage provided under subparagraph (A) of this paragraph;

(ii) provide a level of benefits for facility coverage that is higher than the
level of benefits payable for facility coverage under subparagraph (A)
of this paragraph;
(iii) provide a level of benefits for non-facility coverage that is not less
than the level of benefits payable for non-facility coverage under
subparagraph (A) of this paragraph; however, in complying with
§3.3815(c) of this title (relating to Standards for Home Health and
Adult Day Care Benefits), home health or adult day care services
coverage must be a dollar amount equivalent to at least one-half of
one year's coverage available for the nursing home benefit associated
with the corresponding number of activities of daily living.

(C) the activities of daily living shall include those set forth and defined in
§3.3804 of this title for coverage provided under subparagraphs (A) and
(B) of this paragraph;
(D) coverage provided based on meeting the eligibility requirements of
subsection (a)(2) of this section for impairment of cognitive ability shall be
identical to the coverage provided under subparagraph (A) of this
paragraph and the benefit level shall not be less than the applicable benefit
level payable under subparagraph (B)(ii) or (B)(iii) of this paragraph; and

(2) the insurer or other entity shall offer the prospective insured, or where the policy
is offered to a group, the offer required by provisions of this paragraph shall be
made to the group policyholder; except that in the instance where the group policy
will not be issued to an employer, labor union, or continuing care retirement
center, the offering shall be made to each prospective covered individual, the
option to purchase a policy or certificate that provides benefits set out in
subsection (a) of this section and obtain either: a written rejection of such offer or
written acknowledgement of such offer. Written rejection or acknowledgment of
offer may be by a rejection or acknowledgment receipt, attached to or made part
of the application, or by a certificate of rejection or offer signed by the
prospective insured or group policyholder if the group policyholder will be an
employer, labor union, or continuing care retirement center.

(c) For purposes of only subsection (b)(1)(B) of this section, the term "facility," to the
extent coverage for care at any of the following is provided in the policy or certificate,
means an assisted living facility, skilled nursing facility, extended care facility,
intermediate care facility, convalescent nursing home, or maintenance or personal care
facility.

**TEXAS QUALIFIED LTC POLICY STANDARDS**

Texas Administrative Code: Title 28, Part 1, Chapter 3, Subchapter Y: 3.3847

(a) In marketing and issuing long-term care insurance contracts in Texas, no person shall
state that any such contract is intended to be a "qualified long-term care insurance
contract" as defined in §3.3804 of this title (relating to Definitions) unless the contract:
(1) provides insurance protection only for services which are "qualified long-term care services," as defined in §3.3804 of this title (relating to Definitions);
(2) does not provide for a cash surrender value or other money that can be paid, assigned or pledged as collateral for a loan or borrowed, except on a complete surrender or cancellation of the contract;
(3) provides that all refunds of premium and all policyholder dividends or similar amounts are applied as a reduction in future premiums or to increase future benefits, except for any refund on the death of the insured, or on a complete surrender or cancellation of the contract, which cannot exceed the aggregate premiums paid under the contract;
(4) does not pay or reimburse expenses incurred under Medicare or which would be reimbursable under Medicare but for the application of a deductible or coinsurance amount, except expenses which are reimbursable under Medicare only as a secondary payor; and
(5) otherwise meets the applicable requirements of this subchapter.

(b) Neither this section, nor any other provision of law, shall be construed or applied so as to prohibit the offering of a long-term care insurance contract on the basis that the contract coordinates its benefits with those provided under Medicare.

**TEXAS SUITABILITY REQUIREMENTS**

Texas Administrative Code: Title 28, Part 1, Chapter 3, Subchapter Y: 3.3842

Suitability

In recommending the purchase or replacement of any long-term care insurance policy or certificate, the company and the agent shall make reasonable efforts to determine the appropriateness of the recommended purchase or replacement.

**TEXAS TRAINING REQUIREMENT FOR LTC PRODUCERS**

Texas Administrative Code: Title 28 Part 1 Chapter 19 Subchapter K: 19.1022

a) Except as provided in subsection (b) of this section, an individual may not perform any action constituting the act of an agent under the Insurance Code §4001.051 with regard to a long-term care partnership insurance policy unless the individual:

(1) holds a current Life, Accident, and Health license issued by the department; and
(2) has completed a long-term care partnership certification course meeting the requirements of this subchapter.

(b) An individual who holds a current Life, Accident, and Health license issued by the department and is performing an action constituting the act of an agent under the Insurance Code §4001.051 with regard to a long-term care insurance policy at the time of
the effective date of this section may perform an action constituting the act of an agent under the Insurance Code §4001.051 with regard to a long-term care partnership insurance policy at the time of the effective date of this section, provided the individual completes a long-term care partnership certification course meeting the requirements of this subchapter no later than January 1, 2009.

(c) This section establishes the standards for a long-term care partnership certification course. The course shall:

(1) be submitted to the department for approval in compliance with §19.1007 of this subchapter (relating to Course Certification Submission Applications, Course Expirations, and Resubmissions);
(2) be at least eight hours in length; and
(3) cover the subjects described in subsection (g) of this section.

(d) Licensees may count a long-term care partnership certification course toward completion of the continuing education requirements prescribed in §19.1003 of this subchapter (relating to Licensee Requirements). If a licensee chooses to use a long-term care partnership certification course to satisfy a portion of the continuing education requirements prescribed in §19.1003, the licensee shall comply with §19.1013 of this subchapter (relating to Licensee Record Maintenance).

(e) A licensee shall maintain proof of completion of a long-term care partnership certification course for a period of four years from the date of completion of the course. Upon request, the licensee shall provide proof of completion of the long-term care partnership certification course to the department.

(f) A provider issued completion certificate for a long-term care partnership certification course must comply with the requirements of §19.1011 of this subchapter (relating to Requirements for Successful Completion of Continuing Education Courses).

**REQUIRED CURRICULUM**

(g) Course subjects for a long-term care partnership certification course outline must include topics that address:

(1) long-term care insurance;
(2) long-term care services and providers;
(3) qualified state long-term care insurance partnership programs, which must include:
   (A) state and federal requirements;
   (B) the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services, including Medicaid;
   (C) available long-term care services and providers; and
   (D) changes or improvements in long-term care services or providers;
(4) alternatives to the purchase of private long-term care insurance;
(5) the effect of inflation on benefits and the importance of inflation protection;
(6) consumer suitability standards and guidelines;
(7) Medicaid eligibility criteria and requirements, including financial eligibility criteria and requirements; and
(8) asset disregard under qualified state long-term care insurance partnership programs, including the interaction between asset disregard and Medicaid rules.

(h) Providers must meet all of the requirements of this subchapter before offering a long-term care partnership certification course to licensees.

(i) A non-resident licensee is not required to complete a long-term care partnership certification course required by this subchapter if:

(1) the non-resident licensee holds a comparable, current license issued in his or her home state;
(2) the home state of the non-resident licensee qualifies as a long-term care partnership state;
(3) upon department request, an insurer who has appointed the non-resident licensee is able to provide proof of the non-resident licensee's completion of a long-term care partnership certification course in the non-resident licensee's home state with requirements substantially similar to those in this subchapter; and
(4) upon department request, the non-resident licensee is able to provide proof of his or her completion of a long-term care partnership certification course in his or her home state with requirements substantially similar to those in this section.

(j) A non-resident licensee whose home state does not qualify as a long-term care partnership state may comply with the requirements of this subchapter by:

(1) completing a department certified long-term care partnership certification course in this state that meets the requirements of this subchapter; or
(2) designating a home state that qualifies as a long-term care partnership state and meeting the requirements of subsection (i) of this section.

(k) Licensees that may qualify for the exemptions provided under §19.1004 of this subchapter (relating to Licensee Exemption from and Extension of Time for Continuing Education) are not exempt from the provisions of this section.

(l) Information and resource material relating to the course subjects required in subsection (g) of this section, including a section entitled, "Resource Document for Agent Training: Texas Medicaid Eligibility and the Long-Term Care Partnership", may be found at the following website sponsored by the Texas Long-Term Care Partnership, located at www.Ownyourfuturetexas.com.

CONTINUING EDUCATION FOR LTC PRODUCERS

Texas Administrative Code: Title 28 Part 1 Chapter 19 Subchapter K: 19.1023
a) In addition to completing the long-term care partnership certification course required by §19.1022 of this subchapter (relating to Long-Term Care Partnership Program Certification Course), in each reporting period following the reporting period in which a licensee completed a certification course, a licensee intending to perform any action constituting the act of an agent under the Insurance Code §4001.051 with regard to a long-term care partnership insurance policy must also complete at least four hours of department certified continuing education during each reporting period as part of the licensee's continuing education requirements prescribed in §19.1003 of this subchapter (relating to Licensee Requirements).

(b) The department certified continuing education required under subsection (a) of this section must:

1. comply with the requirements of §19.1006 of this subchapter (relating to Course Criteria); and
2. enhance the knowledge, understanding, and professional competence of the student with regard to subjects described in §19.1022 of this subchapter.

(c) Providers must meet all the requirements of this subchapter before offering a long-term care partnership continuing education course to licensees.

(d) A non-resident licensee is not required to complete four hours of long-term care partnership continuing education required by this subchapter if:

1. the non-resident licensee is in compliance with the long-term care partnership continuing education requirements of his or her home state; and
2. the home state of the non-resident licensee qualifies as a long-term care partnership state.

(e) A non-resident licensee whose home state does not qualify as a long-term care partnership state may comply with the requirements of this subchapter by:

1. completing four hours of department certified long-term care continuing education in this state that meets the requirements of this subchapter; or
2. designating a home state that qualifies as a long-term care partnership state and meeting the requirements of subsection (d) of this section.

(f) Licensees that may qualify for the exemptions provided under §19.1004 of this subchapter (relating to Licensee Exemption from and Extension of Time for Continuing Education) are not exempt from the provisions of this section.
AVAILABILITY OF NEW SERVICES OR PROVIDERS

Texas has not addressed the area of what is requirements are placed on an insurer relative to previously issued policies (existing policy holders) when a company begins to offer a new policy that offers improvements to or changes in services and/or providers. Since most states have addressed this area we will summarize the issue below with the most common approach other states have taken.

**REQUIRED NOTICE**

Most states require that a notice be sent to all existing policy holders within 12 months after the insurer begins to offer the new coverage.

**HOW TO MAKE NEW COVERAGE AVAILABLE**

Most states require that the new coverage be offered as a rider, endorsement, or by exchanging the existing policy for the new policy. Items typically addressed include original issue age for premiums in the new policy, and underwriting is allowed on increased benefits.
Chapter 2

TEXAS MEDICAID ELIGIBILITY AND ASSET DISREGARD

The purpose of this section is to provide a general understanding of the rules relating to eligibility for Medicaid payment of long-term care services in Texas and the interaction between Medicaid eligibility and the Long-Term Care Partnership.

Policy governing Medicaid for people who are elderly and people with disabilities is very complex and has many exceptions and special rules for various situations. For this reason Medicaid eligibility, including resource disregard, is determined on a case-by-case basis by staff with the Texas Health and Human Services Commission (HHSC). Resource disregard for estate recovery purposes are determined by staff at the Texas Department of Aging and Disability Services (DADS), the state’s agency for administering long-term care and the Medicaid Estate Recovery Program.

Insurance agents are not to determine Medicaid eligibility or guarantee specific resource disregards. They should direct potential policyholders to HHSC for questions on eligibility and to DADS for questions on the Medicaid Estate Recovery Program.

If there are questions about a person’s status in Medicaid, those questions must be asked by that person or that person’s authorized representative. Questions about how Medicaid for people who are elderly or people with disabilities policy would be applied to a specific person’s circumstances cannot be provided in advance of that person filing an application and providing the information necessary to determine eligibility. Both HHSC and DADS staff may explain policy relating to these issues but will not give advice.

Policy information is available through the Medicaid Eligibility Handbook and on the Medicaid Estate Recovery Program website.

Introduction

Medicaid provides a full range of benefits to people who qualify. Medicaid services include but are not limited to some services in each of the following categories:

- Inpatient and outpatient hospital and clinic services.
- Emergency hospital services.
- Laboratory and x-ray services.
- Physician services.
- Prescription drugs.
• Long-term care services such as home health, hospice, adult daycare, assisted living or nursing facility care.

Medicaid long-term care provider information is available through the DADs Quality Reporting System.

Medicaid programs are operated by each state but overseen by the federal government through the Centers for Medicare and Medicaid Services (CMS).

The Long-Term Care Partnership is a joint effort between private long-term care insurers and Texas state agencies. The partnership encourages people to plan for their long-term care needs. Specifically, the partnership involves collaboration among private long-term care insurers, agents authorized to sell long-term care policies the Texas Department of Insurance, HHSC, and DADS.

A qualified Long-Term Care Partnership policy must meet all the rules set out by the Texas Department of Insurance and must include a specific amount of inflation protection based on the person’s age at the time he or she purchases the policy.

Owning a qualified Long-Term Care Partnership policy does not guarantee access to Medicaid, even if the policyholder exhausts his or her policy benefits. A person must still meet all Medicaid eligibility requirements to be determined eligible for Medicaid. In those situations, the value of a Long-Term Care Partnership policy emerges when a policyholder applies for Medicaid. In that process, the policyholder’s countable resources may be “disregarded” in an amount equal to the value of benefits paid through the Long-Term Care Partnership policy.

If the policyholder then needs to rely on Medicaid for payment of long-term care services, the person may qualify for various Medicaid long-term care programs and still own countable resources in excess of the statutory resource limit. Additionally, when the policyholder dies, resources that were disregarded in the Medicaid eligibility process will not be subject to recovery by Medicaid for the policyholder’s Medicaid costs.

This section will provide you with:

• A discussion of the general eligibility criteria for Medicaid payment of long-term care services.
• An explanation of the interaction between the Medicaid eligibility and the Long-Term Care Partnership.
• Information about how people can apply for Medicaid.

A. General Eligibility Criteria for Medicaid Payment for Long-Term Care Services

1. Texas Residency
• Texas Medicaid follows the federal Medicaid residency rules, which require that a person must be a Texas resident at the time of application and must intend to remain in Texas. There is no time requirement for living in Texas to establish residency.

2. Citizenship and Immigration Status

• To be eligible for Medicaid a person must be either a U.S. citizen or a non-citizen with a qualified immigration status.

3. Medicaid Eligibility Group

• To be eligible for Medicaid a person must qualify under a group authorized for coverage under the federal Medicaid rules and covered by Texas Medicaid.

4. Third Party Resource (TPR)

• Medicaid is typically the payer of last resort.

A person with other health care coverage or who has another party liable for the medical expenses must have medical costs paid by those sources before Medicaid pays claims. A person is required to cooperate with providing information regarding other payment sources.

5. Specific Requirements for Medicaid Payment of Long-Term Care Services

A person must:

• Have a medical necessity designation requiring a level of care provided in a long-term care facility such as a nursing facility or an Intermediate Care Facility for Persons with Mental Retardation. The medical necessity designation also determines if the person qualifies to receive home and community-based services through a Medicaid home and community-based waiver program.
• Meet functional assessment criteria for personal care services.
• Be a resident of a long-term care facility or qualify to receive home and community-based services under one of the Medicaid waiver programs.
• Not have home equity in excess of $500,000.
• Not be in a penalty period for an uncompensated transfer of income or resources.
• Penalty periods are assessed when a person or the person’s spouse make an uncompensated transfer during a specified period of time (called the look-back period) prior to a person requesting Medicaid payment of long-term care services or anytime while the person is receiving Medicaid payment of long-term care services.

• The look back period is currently 36 months but was increased to 60 months in the federal Deficit Reduction Act of 2005 (DRA). The 60 month look-back period will be phased in. Beginning February 2009 the look-back period will increase by one month each month through January 2011 at which time it will reach 60 months.

• The penalty period is calculated by dividing the value of the uncompensated transfer by the Statewide Average Daily Rate for Nursing Care in effect at the time a person requests Medicaid payment for long-term care services. This calculation results in a number of days during which the person is ineligible for Medicaid payment for long-term care services.

For uncompensated transfers made prior to Oct. 1, 2006, the penalty period begins in the month in which the transfer occurred; for uncompensated transfers made on or after Oct. 1, 2006 the penalty period begins with the date the person applies for Medicaid and would otherwise be eligible for Medicaid payment for long-term care services.

• Disclose any annuity interest, and if married, annuity interest of a spouse and name the State of Texas as a remainder beneficiary of any annuity owned by the person or person’s spouse.

Note: Home equity in excess of $500,000 or a transfer penalty applied to long-term care services does not restrict payment for Medicaid services other than for long-term care services. This means an applicant with excess home equity or on whom a transfer penalty has been applied, may still qualify for Medicaid coverage of benefits other than long-term care.

B. Financial Eligibility Criteria for People Requesting Medicaid Payment for Long-Term Care Services

1. Income
• General

Medicaid income eligibility is based on countable income. The rules for determining countable income vary by eligibility group. Policy rules for each group determine the specific types of income that are excluded, which family members’ income is counted toward another family members’ eligibility, and which deductions are subtracted from gross income.

People with countable income equal to or less than the income limit of the person’s eligibility group are income eligible for Medicaid.

• Payment for the Cost of Long-Term Care

When a person is determined income eligible for Medicaid long-term care services, a separate income calculation is made to determine how much of the person’s income must be paid toward the cost of Medicaid long-term care services. The amount of the person’s contribution (copayment) is the income left after allowable deductions. Deductions vary based on the type of long-term care and the person’s circumstances. The copayment is generally made to the long-term care facility or to the waiver service provider.

2. Resources

• Resource limit

Texas limits the amounts of resources people can own in order to be eligible for Medicaid coverage. The Medicaid eligibility specialist determines if the person has countable resources at or below the Medicaid resource limit. Currently the resource limit for a single person is $2,000 and $3,000 for couples applying for long-term care services.

• Resource treatment for certain married couples

A special set of rules, called spousal impoverishment rules, apply to a married person requesting Medicaid payment for long-term care services. Married couples may complete the resource assessment (Spousal Protected Resource Assessment (SPRA)) as soon as possible when one spouse requires long-term care services that are anticipated to last for more than 30 days, even though they may not be requesting Medicaid payment. This allows the married couple to know when the spouse receiving long-term care services may be eligible to receive Medicaid payment for long-term care services. The actual amount of resources that can be kept by the spouse not receiving Medicaid services is determined by HHSC’s Medicaid eligibility specialist.

C. Interaction between the Long-Term Care Partnership and Medicaid Payment of Long-Term Care Services.

1. How Resource Protection works Under the Long-Term Care Partnership
A person with a qualified Long-Term Care Partnership policy may designate countable resources for a dollar-for-dollar disregard in an amount equal to the value of benefits paid out by the policy.

Once the countable resource is designated, Medicaid:

- Disregards the value of the designated countable resource in the resource limit calculation.
- Allows the person to transfer the designated countable resource without penalty.

However, Medicaid will not **pay for long-term care services until these same benefits paid under the person's Long-Term Care Partnership policy have been exhausted. This is consistent with federal law that Medicaid is the payer of last resort.**

The policyholder must provide a written resource designation and must verify the value of the designated resources.

- Once the countable resources are designated, the policyholder must:
  
  o Report any sale, transfer or conversion of designated resources and verify the value of the designated resources as of the date the reported transaction took place.
  o Document and verify any designated resources still owned by the person at the time of each Medicaid redetermination. (Special reviews may be performed periodically prior to each annual redetermination.)

**Note:** If a designated resource is expended, no additional resource designation is allowed, nor may any otherwise excluded resource be substituted in its place.

People receiving Medicaid payments for long-term care services who secure additional resources and have not designated resources up to the amount of benefits paid by the Long-Term Care Partnership policy may then designate additional countable resources up to the amount of benefits paid by the policy.

### 2. Policy Concepts for Resource Disregards

Under Medicaid long-term care policy, certain resources such as a person’s home may not be included when determining a person’s statutory countable resource limit. For this reason, only countable resources may be designated for the disregard when determining Medicaid eligibility for those with qualified Long-Term Care Partnership policies.
If a designated resource declines in value, additional countable resources may be designated up to the amount of benefit paid under the Long-Term Care Partnership policy.

A person may expend a designated countable resource, however no additional disregard is allowed in this circumstance.

Transferred countable resources may be designated for the disregard.

The countable resource disregard may not be applied to home equity value in excess of $500,000.

The countable resource disregard is applicable only to the person who has received benefits under the Long-Term Care Partnership policy.

When a policyholder has fewer countable resources than the Long-Term Care Partnership policy has paid, the unused disregard balance will be protected after the policyholder dies and Medicaid Estate Recovery becomes applicable.

Texas intends to participate in reciprocal recognition with other states with Long-Term Care Partnerships.

**D. How to Apply for Texas Medicaid Programs**

A person may do one of the following to apply for Texas Medicaid:

- Dial 2-1-1, select a language, then select Option 2.
- Visit your local HHSC benefits office.
Section 2 Non State Specific

Chapter 3

ETHICAL BEHAVIOR AND THE LAW

The fear of nursing homes makes the senior market especially vulnerable

THE SENIOR MARKET’S VULNERABILITY

Seniors abhor losing physical independence and becoming financially dependent. They buy long-term care insurance coverage to avoid becoming dependent on family or friends.

Loneliness clearly magnifies seniors' concerns and their vulnerabilities as consumers. One-third of those who are older than 65 live alone and the ratio of women to men is two to one. Looking at those who own their own homes and who are often targeted to buy long-term care insurance, more than half live alone.

The opportunity for fraud to occur in this setting is unchecked. The most common tactic is known as “turning,” “turn to earn,” or “churning,” in which sales agents return once a year to pitch a “new and improved” insurance policy. By convincing a buyer to cancel a good policy, a sales agent subjects a customer to higher premiums and new waiting periods for the sake of earning a new commission.

Insurance companies cannot unilaterally raise premiums on any one individual policy, but they can petition state insurance commissioners or departments of insurance for legal authority to raise premiums for all policyholders in a given pool of insured and then raise rates for everyone in that class.

That’s why it is imperative that agents do not mislead their customers by stating or inferring that premiums are fixed and will not increase; premiums have increased and are expected to increase in the future.

The U.S. Government Accounting Office reported that "the next five years will produce rate increases as the rule rather than the exception for most companies currently marketing long-term care insurance." The U.S. Government Accounting Office also found that, "because the long-term care insurance market is still developing, the extent to which policy prices will increase remains uncertain."
COMPANY AND AGENT SCRUPULES

Planning for the day when you can no longer take care of yourself can be a difficult task. Today's senior citizens have the opportunity to select from a vast array of elder care living choices, depending on their individual needs and preferences. At the same time though, the increasing number of choices can be both confusing and overwhelming.

Private insurance companies, both stock and mutual companies, sell long-term care policies through agents. Some sell coverage through the mail and others through senior citizen organizations, fraternal societies, continuing care retirement communities and other groups. Employers are beginning to offer long-term care policies to their employees, their employees' parents, and their retirees.

Filling this need for our senior population with scrupulous agents who will not take advantage of them can be an arduous task for insurance companies however. Consider the insurance company's sales commission structure. Insurance agents' commissions on such policies as long-term care typically run from 30 percent to 65 percent of the first year's premium (far more than the typical 10 percent commission many auto insurance agents earn). State regulatory agencies are insufficiently staffed to monitor sales presentations, except in undercover investigations that have taken place throughout many states.

Government has not acted because in large part insurance companies spend thousands of dollars in lobbying and consumers do not. In addition consumers lack the financial standing to prosecute cases and many times the actual damage is not suffered until the victim's health has so deteriorated that they are physically incapable of assisting their attorneys in fighting a major insurance company.

However, most insurance agents are professional, honest people who give their clients the assistance they need to plan for the future and are there for them when they need additional help. Making sure your clients are protected “in the long run” is planning for their future. The proper long-term care insurance policy can fill a desperate need.

When it comes to the major long-term care insurance players, the wise agent has made himself familiar with their strengths and weaknesses. Understanding the companies and their products allow the agent the opportunity to develop programs and make company recommendations around the individual comfort levels of his clients.

The senior market also requires a great deal of patience. The average consumer needs to be taken through a learning curve since long-term care insurance typically requires a great deal more explanation than previous policies the senior has purchased throughout his lifetime. The agent needs to take the time (usually anywhere from one to two hours depending on the client) to give a complete explanation of benefits, policy features, definitions, benefit triggers, tax ramifications, claim procedures, etc.
QUESTIONABLE FORMS OF UNDERWRITING

Not all underwriting techniques are unscrupulous; some can seem on the shady side. Two examples of questionable underwriting behavior are:

- Short-Form Underwriting; and
- Post-Claims Underwriting.

SHORT-FORM UNDERWRITING

Some companies follow "short-form" underwriting. On the application for coverage, the client will be asked to answer a few health-related questions, such as:

- Have you been in a hospital during the last 12 months; or
- Are you confined to a wheelchair?

If the answer is "no" to all of the questions on the form, the company believes the client will be a good customer who will pay money in and not force them to pay out. In this form of underwriting, the insurance agent is authorized to issue coverage as soon as the client writes a check.

Other companies are more selective. They will examine the client’s current medical records and ask for a statement regarding his health from his physician.

POST-CLAIMS UNDERWRITING

The client must answer all health questions truthfully. If you complete the form as you ask your client questions, encourage him to change any entries that he is not sure are 100 percent correct before he signs the application. Trying to remember every condition you ever had and when you had it is not easy. It is far better to state that the client believes he had that condition but does not recall when or the details. An asterisk (*) can be added to every section of the application where he is not sure and at the place for explanations, add an asterisk and the words “please see the records of Dr. ‘Smith’” (or whoever can provide the necessary information). If you follow this procedure, your client will never be denied benefits after the fact because you were honest in disclosing what he remembered and offered the carrier access to a specific doctor’s records where the information could be found.

The reason is simple. An insurer can rescind a policy and refuse to honor a claim where the policyholder has not provided full and complete information in the application. Any future claim may be denied due to misstatement on the original application. These companies do not investigate the client’s medical record until a claim is filed, and then they investigate it with extremely fine attention to every conceivable reason why they should deny benefits based on inconsistencies. This
practice is called "post-claims underwriting." It is illegal in many states. Companies that do their underwriting studies at the outset and thoroughly check on a client’s health before issuing a policy are not as likely to engage in post-claims underwriting.

GATEKEEPERS LIMIT RIGHTS TO BENEFITS

All policies have "gatekeepers" who have the power to decide if an insured is eligible for benefits. Every policy contains terms usually referred to as "eligibility for benefits," "qualifying for benefits," or "benefit conditions." Under the best policies, a client can qualify for benefits if his doctor orders specific care.

Other policies will require that care be "medically necessary for sickness and injury." The insurance company has the right to determine whether the insured is “sick or injured.” A possible loophole to this is that the patient may be in need of nursing home services, but is not sick or injured, and therefore might not qualify for benefits. The insurance company has the right to determine whether he is considered “sick or injured.”

Another type of rule limiting rights to benefits requires that the insured be unable to perform a certain number of "activities of daily living," commonly referred to as ADLs. These normally include bathing, dressing, walking, transferring, toileting, maintaining continence and eating.* ADL criteria are not the same from one company to another. The more specifically a company describes its requirements, the opportunities for disagreements and disputes will be lessened.

*Bathing, when referring to ADLs, is usually defined as washing oneself by sponge bath in either a tub or shower and includes the task of getting into or out of the tub or shower.

Continence is usually defined as 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).

Dressing is usually defined as having the ability of putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

Eating in this context is usually defined as feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenous feeding.

Toileting is usually defined as having the physical ability of getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring is usually defined as moving into or out of a bed, chair or wheelchair.
Some policies evaluate mental functions to determine the qualifications for benefits. This gatekeeper standard is important in cases of Alzheimer's disease. Even though insurance regulators require policies to cover Alzheimer's disease, a policyholder who has the disease can be denied benefits if he or she is physically able to perform the activities of daily living specified in the policy, unless there is a mental functioning criteria.

There are some very important gatekeepers a well-informed agent needs to understand and recognize so that he can assist his client in making well-informed decisions.

- Limiting services to those provided by registered nurses or licensed practical nurses;
- Requiring providers to be certified by Medicare;
- Covering only "skilled" care. "Skilled" care is insurance language meaning services provided by a doctor or a nurse. Most "skilled" care is already covered by Medicare and most Medicare supplemental insurance. Nearly 50 percent of people receiving nursing home services do not require skilled care;
- The inability to perform three or more Activities of Daily Living (ADLs). The commonly recognized ADLs are: bathing, dressing, toileting, transferring (getting in and out of a chair or bed), and continence (voluntary bowel and bladder functions). Approximately 2.9 million U.S. citizens need assistance with only one or two ADLs;
- Vaguely defining the inability to perform an Activity of Daily Living. What constitutes "needing assistance" with performing an ADL can be made a subjective standard by the insurance company, when it should be subject to objective verification. Many carriers define the inability to perform an activity as needing "continual one-on-one assistance;"
- "Service-based" not "disability-based" coverage. According to Consumer Reports, "the most liberal coverage would be provided by policies that allowed policyholders to obtain services wherever they wish when disabled." This is known as disability-based coverage. No long-term care policies have been discovered that meet this standard for nursing-home care. Instead, current policies are "service-based," so that regardless of the type or level of disability, policyholders are limited to receiving particularly defined services at specific facilities; and
- All companies reserve the right to demand that policyholders be examined by company's physician or "benefit advisors" who can overrule a consumer's own doctor. Patients have close relationships with their doctors and expect to be covered for services their doctors prescribe. This restriction places the decision for health care in the hands of insurance companies.*

*Read the policy: "we reserve the right, as part of the review, to do a face-to-face assessment or to require you to take a physical examination paid for by us. Similar reviews may be required, at reasonable intervals, to determine your eligibility for continued benefits. We may use an outside service to assist in evaluating your condition; but any decision will be made by us based on consistently applied, reasonable standards."
LAWS AND LEGAL INTERPRETATIONS

Most policies give consumers choices in the following areas:

- Benefit amounts;
- Duration of benefits;
- Elimination period;
- Inflation protection; and
- Nonforfeiture benefits.

In virtually all states the laws applying to the interpretation of the enforcement of insurance contracts are generally the same, but there are variations.

American law routinely provides that should there be an ambiguity or uncertainty in a policy, an uncertainty in choice of wording or ambiguity in meaning would be resolved in favor of the policyholder and against the insurer.

Insurance contracts are interpreted by judges and courts to effectuate only the objectively reasonable expectations of the insured. Any personal, or subjective, expectation of a policyholder, which cannot be reasonably supported by the language of the contract, is unenforceable. So, it matters not what the policyholder/customer truly and honestly believes in his or her own mind. That subjective opinion is never in issue in a court of law.

Courts do not lean over backwards to interpret a contract to create losses for policyholders.

So, when reading an insurance policy, the words selected by the insurance company are to be interpreted by judges according to their plain meaning. A plain meaning is one which an ordinary person would attach to such words, not as the meaning which might be utilized by an insurance company executive or an attorney.

If there is more than one meaning to be given to an exclusion or a limitation, the narrowest interpretation will be adopted by the court. Any exclusionary clause that is not clear and conspicuous will be interpreted in the interests of the insured.

In cases where a policyholder's lack of knowledge could result in the loss of benefits or the forfeiture of rights under a policy, an insurer is required to bring such fact to the insured's attention and to provide relevant information to enable the insured to take action to secure rights provided by the policy.

Unfortunately, an insurance agent is not obligated to advise a policyholder on the adequacy of the limits of coverage selected by the policyholder. But when an insurance agent gives assurance of proper coverage and it turns out to be false, that agent may be held liable for negligent misrepresentation.
When an insurance company has used advertising and solicitation materials that are unfair or deceptive, some states provide legal protection to the policyholders and others do not.

Falsely written advertisements do not give rise to a cause of action against the carrier. Policyholders must realize that they are buying the contract, not the advertising.

Every insurance contract contains an unwritten, invisible, or implied term referred to as the covenant or promise of good faith and fair dealing. In direct terms, this is a promise by an insurance company to always act in good faith and to act fairly towards its insureds in handling their claims. Whether or not such a clause is included in the policy, judges will read the policy as if it were there.

Where a policyholder successfully shows that an insurer breached the covenant of good faith and fair dealing, the insured can recover all damages caused by the breach. This includes all consequential losses, loss of use of the insurance proceeds, general damages, attorneys' fees and in cases of egregious and outrageous misconduct, punitive damages.

To recover for emotional distress it must be shown to have been caused directly as a result of the insurer's conduct. Normally, once actual economic loss is established, the policyholder is entitled to recover damages for emotional distress as well, as long as that injury was caused by the insurer's breach of the covenant of good faith and fair dealing.

THE STATUTE OF LIMITATIONS IN BAD FAITH CASES

The statute of limitations in a bad faith case varies from state to state. A statute of limitations is the legal deadline after which a lawsuit cannot be filed. In most states, the two-year statute for personal injuries and emotional distress governs a lawsuit for bad faith. For instance, California has a one-year statute.

Many insurance policies impose a contractual obligation on the insured to bring any lawsuit within one year after breach of the contract, no matter what the rule is under state law concerning when a lawsuit can be lawfully filed. Calculating this one-year period, though, is not simple. Most states hold the time limit in the contract is enforceable but suspend the running of the one-year statute between the period of time the policyholder gives notice of the loss and the date on which the claim is denied.

RATING LONG-TERM CARE INSURERS

We all want to work for the best company we can; and there are ways to investigate the financial stability of the insurance company you represent. Try to make sure the insurance company you choose is highly rated. Many premium increases to your clients are the result of one insurance company assuming the obligations of another company that has gone out of business.

A weak long-term care company represents a potential for financial loss to its policyholders, as well as a number of headaches and hassles. This includes the prospect
of being left without coverage. Therefore, it is important for both the consumer and the
agent to check the financial security offered by an insurer prior to representing a policy to
your clients and then periodically monitor the company's condition going forward.
Low-rated insurance companies should be avoided in favor of highly-rated companies.
(Ratings from some agencies are available at most public libraries.)

Weiss Ratings, Inc., an independent publisher of insurance company ratings, was the
most accurate in identifying life and health insurers that subsequently became insolvent
or financially impaired, according to the U.S. General Accounting Office (GAO). Weiss
publishes the Life and Health Insurance Directory, as well as the HMO and Health
Insurance Directory -- the only directory available which includes ratings and financial
data on nearly all HMOs, Blue Cross/Blue Shield companies, life insurance companies
and property/casualty insurers that write health policies.

The General Accounting Office also reported that Weiss was the only agency to rate
more than half of all insurers. Both Weiss and Moody's were less likely than others to
assign insurers their top ratings.

On average Weiss' ratings reflected financial vulnerability much sooner than other
companies. In addition, Weiss has a record of reporting adverse ratings well before public
regulatory commissions and state departments of insurance.

The firm’s rating scale runs from A to E with + or – accordingly:

- A = Excellent
- B = Good
- C = Fair
- D = Weak
- E = Very Weak

**EXCELLENT RATING**

The company offers excellent financial security. It has maintained a conservative
stance in its investment strategies, business operations and underwriting
commitments. While the financial position of any company is subject to change,
we believe that this company has the resources necessary to deal with severe
economic conditions.

**GOOD RATING**

The company offers good financial security and has the resources to deal with a
variety of adverse economic conditions. It comfortably exceeds the minimum
levels for all of our rating criteria, and is likely to remain healthy for the near
future. However, in the event of a severe recession or major financial crisis, we
feel that this assessment should be reviewed to make sure that the firm is still
maintaining adequate financial strength.
**FAIR RATING**

The company offers fair financial security and is currently stable. But during an economic downturn or other financial pressures, we feel it may encounter difficulties in maintaining its financial stability.

**WEAK RATING**

The company currently demonstrates what we consider to be significant weaknesses, which could negatively impact policyholders. In an unfavorable economic environment, these weaknesses could be magnified.

**VERY WEAK RATING**

The company currently demonstrates what we consider to be significant weaknesses and has also failed some of the basic tests that we use to identify fiscal stability. Therefore, even in a favorable economic environment, it is our opinion that policyholders could incur significant risks.
Chapter 4

FEDERAL REGULATION OF LONG-TERM CARE POLICIES

Excerpts taken from the U.S. Department of Health and Human Services report on the Federal Role in Consumer Protection and Regulation of Long-Term Care Insurance

The U.S. Department of Health and Human Services report on the federal role was developed in conjunction with a study of long-term care financing reform conducted by the Office of the Assistant Secretary for Planning and Evaluation. Other reports also developed during the course of the study include:

- Access to nursing home care;
- Medicaid spend-down; and
- The combined burden of acute and long-term care expenses.

Copies of the reports may be obtained by writing to:

The Department of Health and Human Services
Room 410E, Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

FEDERAL GOVERNMENT GOALS AND ROLES

In November 1990, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) assembled a panel of experts of varying backgrounds to discuss the potential goals and roles of the federal government in the long-term care insurance market. The panel included representatives from the insurance industry, consumer groups, the National Association of Insurance Commissioners (NAIC), the Health Insurance of America (HIAA), and government, as well as persons with expert knowledge of long-term care insurance.

EXECUTIVE SUMMARY

BACKGROUND

Long-term care insurance provides the elderly with an opportunity to reduce the
risk of the potentially catastrophic costs of long-term care. It reduces the risk by spreading the costs of long-term care among all purchasers of insurance. Spreading the costs of long-term care across all insurance purchasers reduces the financial risk of long-term care to any single individual. As a result, the well being of both purchasers who incur the risk and those who do not incur the risk is increased. Purchasers who incur long-term care costs pay less than they would have because they have insurance. The well being of purchasers who do not incur the risk is also increased because they know that if the risk does occur they will be protected by insurance.

There is a sharp contrast between the elderly's lack of insurance for long-term care and their protection against the risks of acute care. As of the end of 1990, over 1.9 million long-term care insurance policies had been purchased. Although analysts estimate that between 10 and 40 percent of the elderly could afford to purchase long-term care insurance, less than five percent have done so. In contrast, almost all elderly persons are protected from high acute care costs by Medicare insurance and most elderly have private Medigap insurance.

BARRIERS TO INSURANCE COVERAGE

Both supply and demand barriers help explain the disparity between the number of persons who could afford long-term care insurance and the number who have actually purchased it. Key factors limiting consumer demand for long-term care insurance include:

**CONSUMER DEMAND BARRIERS**

**Lack of Information**

Many elderly underestimate the likelihood of requiring long-term care services and the potential cost of those services.

**Misperception of Public and Private Programs**

Many people believe that the Medicare program covers long-term care services, when in fact Medicare accounts for less than two percent of nursing home expenditures. There is also a misperception that retiree health plans or Medicare supplemental insurance covers long-term care services.

**Delayed Preparation for/Denial of Long-term Care Needs**

Many persons do not think about preparing for long-term care needs until they are too old or disabled to purchase insurance.

**Complexity of Product and Lack of Standard Terminology**

Long-term care insurance is a complex product that is rapidly changing as it matures. Due to this evolution of the product and the absence of standard terms it is often unclear how a particular product compares to other products.
Uncertainty Concerning the Value of Products

Some consumers are reluctant to purchase long-term care insurance because they are not sure if the products will cover the types of care they may need in the future. In addition, a general misunderstanding and mistrust toward all insurance products inhibits demand.

Lack of Clarity of Benefit Triggers / Premium Increase Provisions

Many policies contain vague language that make the circumstances under which benefits will be paid unclear, as well as when and how much premiums may increase over time.

Consumer Confusion/Dissatisfaction

Consumer confusion and dissatisfaction caused by misperceptions, the complexity of the product, rapidly changing product lines, unclear benefit triggers, and uncertainty concerning the value of the product, increases indecision among those considering long-term care insurance and also increases the likelihood that purchase decisions will be delayed in order to wait for future products to be developed.

Long Lag Time Between Purchase and Benefit Payment

The substantial amount of time between the purchase of long-term care insurance and when benefits are likely to be paid means that consumers may want to spend their current dollars on items with a more rapid benefit, such as Medigap policies.

Misleading Marketing Practices

Consumers have reported problems with the marketing, sale, and payment of benefits of long-term care insurance. Misleading and fraudulent marketing practices, denial of claims, premium increases, and policy cancellations by a few insurance companies have resulted in some long-term care insurance purchasers failing to receive benefits.

Affordability

Many of today's elderly have low incomes and therefore cannot afford long-term care insurance premiums that average well over $100 per month at age 65. However, most elderly do spend comparable amounts on Medigap insurance.

Perception of Need

Some consumers with adequate information and without confusion decide they do not need long-term care insurance because they have too few assets to protect or have family and friends available to provide care.
SUPPLY BARRIERS

On the supply side, the following factors constrict the number of long-term care insurance policies available on the market:

**Lack of Interest from Large Group Markets**

Unlike most major health/life products sold, long-term care insurance has yet to capture the interest of many large group markets. These large markets would allow insurers to spread risks and reduce advertising and overhead costs.

**Lack of Data**

Most insurers do not have the claims experience necessary to confidently price long-term care insurance, which leads to coverage limitations and conservative pricing.

**Inconsistent/Inappropriate and Rapidly Changing Regulatory Standards**

Regulatory standards vary from state to state, and insurers must tailor their products to the regulatory provisions of each state. With the many changes in regulatory standards in the past five years, insurers' cost of developing products has increased. Also, some regulation modeled after Medicare supplemental policies regulation may be inappropriate for long-term care insurance.

CURRENT REGULATION

In order to address the barriers to demand, some states have undertaken consumer education efforts to address the lack of information on the risk of using long-term care and the misperception of public programs. Some have also instituted counseling programs to reduce consumer confusion.

Most states have concentrated their efforts on regulation of long-term care insurance products. Virtually all states have regulations against fraudulent and misleading marketing practices, guidelines for standardized language to reduce confusion, and reporting requirements for determining the equitability of premiums. In addition to these standards, every state has an insurance department that enforces these regulations.

Some argue that current regulation and consumer education efforts related to long-term care insurance do not adequately protect consumers. Others contend that once the market matures and a large proportion of states institute the National Association of Insurance Commissioners (NAIC) model standards (which are discussed in this report) that many of the current problems will be addressed.
POTENTIAL FEDERAL GOVERNMENT ROLE

Given the state role, what role (if any) should the federal government play in consumer protection and the regulation of long-term care insurance? How should the federal government address the supply and demand barriers to the purchase of long-term care insurance? By reducing or eliminating barriers to the long-term care insurance market, the federal government could contribute to increasing the economic security of those who purchase long-term care insurance and, to some extent, reduce public expenditures for long-term care in the long run.

There are at least four major goals the federal government might pursue if the current regulatory and incentive structures are judged inadequate. These four goals and possible courses of action for the federal government in the long-term care insurance market are:

- Increase Consumer Awareness;
- Increase Insurance Coverage;
- Protect Consumers; and
- Establish Consistent Regulations.

INCREASE CONSUMER AWARENESS

By increasing consumer awareness regarding the risk of long-term care use, the lack of third party coverage for the costs of such care and the availability of mechanisms, such as long-term care insurance, to cover the cost of such care, the government could assist individuals to reach more informed decisions about how to plan for their future long-term care needs. Increased consumer awareness would address the lack of information, misperception of public and private programs, delayed preparation for and denial of long-term care needs, and some of the confusion experienced by consumers when considering long-term care insurance purchase. The federal government could increase consumer awareness through:

- Information provided through current consumer education programs (e.g., by funding state counseling programs and/or disseminating information through Area Agencies on Aging);
- Expanded beneficiary assistance programs and new information campaigns; and/or
- Nominal tax subsidies for the purchase of long-term care insurance that would help educate consumers as well as reduce the after-tax cost of insurance.
INCREASE INSURANCE COVERAGE

Similar to the consensus developing concerning health insurance, the government may determine that Americans should have protection against the cost of long-term care services and that the best mechanism for ensuring that protection is long-term care insurance. Establishing a goal of increased long-term care insurance purchase implies efforts to eliminate most of the barriers to the growth of the market discussed above. If the government determines that the purchase of long-term care insurance by Americans is desirable, the federal government could increase the number of individuals who purchase long-term care insurance by:

- Increasing consumer confidence in the market through mandated and/or encouraged requirements for policies;
- Assisting states in enforcement of regulations, data collection, monitoring, and consumer education efforts;
- Assisting insurers by providing a reinsurance pool (a mechanism to protect any one insurer from unusually high claims) or data;
- Launching a consumer education campaign; and/or
- Clarifying the federal tax code that applies to long-term care insurance and/or offering tax subsidies for the purchase of long-term care insurance.

PROTECT CONSUMERS

By protecting consumers who purchase long-term care insurance, the government could reduce many consumer demand barriers and increase the confidence level of prospective purchasers. The government could protect consumers by ensuring:

The Financial Strength of Insurers

Many experts recommend that one of the foremost factors to consider when purchasing long-term care insurance is the financial status of the insurer. Financially strong insurers are more likely to be able to pay future product benefits. The federal government could ensure that insurers are financially strong through:

- Additional and uniform mandated and/or encouraged solvency requirements for insurers;
- Assistance to states in enforcement of regulations and technical expertise; and/or
- Assistance for insurers by providing a reinsurance pool to reduce the risk of offering products and product features where there is little known about the risk.
**Benefit Payments**

One concern of consumers is that insurers may not provide promised benefits. The federal government could ensure the payment of benefits through:

- Efforts to maintain the solvency of insurers through reporting requirements or other regulations,
- Mandated and/or encouraged requirements, such as loss ratios; and/or
- Assistance to states in preventing fraud, particularly in the enforcement of regulations.

**Consistent Enforcement**

Consistent enforcement of regulations in all states would guarantee all purchasers of long-term care insurance a minimum level of protection, possibly increasing consumer confidence and minimizing abuses. The government could ensure consistent enforcement of regulations for long-term care insurance through:

- Federally mandated and/or encouraged requirements to which states must adhere; and/or
- Assistance to states through funding or technical expertise.

**The Sale of Only "High Quality" Products**

By guaranteeing that only "high quality" long-term care insurance products are marketed by insurers, the federal government could protect consumers. This could be accomplished by requiring that long-term care insurance products meet rigorous minimum standards or by providing a government seal of approval for those products that meet certain standards.

**Informed Consumers**

Informed consumers are more likely to be able to make decisions concerning long-term care insurance products that are in their best interest, as well as recognize misleading or inappropriate marketing practices.

**Establish Consistent Regulations**

Consistent regulatory requirements in all states would assist insurers in the marketing and development of long-term care insurance products, as well as serve to increase insurance coverage and protect consumers. The government could establish consistent regulation for long-term care insurance through federally mandated requirements or by encouraging states to adopt minimum standards similar to the approach used for Medicare supplemental insurance.

These goals and their corresponding roles are not necessarily mutually exclusive. However, some goals are conflicting. For example, if the goal of protecting consumers by ensuring that only "high quality" products are sold were adopted, increasing insurance
purchase may be difficult because the products are likely to become more expensive as a result of these regulatory requirements. Also, some of the roles may bring about unwanted consequences. For example, establishing minimum regulatory requirements to boost consumer confidence and in turn increase insurance purchase could also have the effect of stifling product innovation and make premiums unaffordable for many. Any contemplated federal role must have goals and intentions weighed against likely outcomes and adverse consequences.

**CURRENT FEDERAL GOVERNMENT REGULATION**

Prior to discussing the potential roles the federal government may wish to pursue in the long-term care insurance market, it is important to understand the current system of government regulation in order to make a determination as to whether the current system should change. Current long-term care insurance regulation includes state regulatory efforts and model standards adopted by the National Association of Insurance Commissioners (NAIC).

**REGULATION OF PRIVATE LONG-TERM CARE INSURANCE**

Like other insurance products, states are responsible for the regulation and monitoring of long-term care insurance. There are three primary areas of state regulation:

- Prior approval of policies generally based on a review of policy readability, standardization of policy terms, and minimum benefit requirements;
- Monitoring marketing and business practices to protect consumers from unfair or deceptive acts under unfair trade practice regulations; and
- Premium rate review/control and efforts to ensure solvency of companies selling policies.

State legislatures have great leeway in instituting minimum standards for benefits, financial reserves, solvency, loss ratios, and cancellation of policies, and in instituting other forms of regulation of long-term care insurance products. Because it is a relatively new form of insurance, there is little uniformity in the regulation of long-term care insurance across states. Insurers, therefore, must tailor their individual products to the regulatory provisions of each state.

**HIPAA’S IMPACT**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), affects long-term care insurance in the following manners:

**TAX CLARIFICATION**

The tax clarification provisions for long-term care insurance are contained in HIPAA. The clarifications assure that the tax treatment for qualified long-term
care insurance is the same as for major medical coverage.

With the clarifications, benefits from qualified long-term care coverage generally are not taxable. Without the clarifications, benefits from long-term care insurance might be considered taxable income.

Consumers can take a tax deduction for the cost of tax-qualified long-term care insurance and can deduct from their taxes costs associated with receiving long-term care. Since qualified long-term care insurance will now receive the same tax treatment as accident and health insurance, premiums for long-term care insurance, as well as consumers’ out-of-pocket expenses for long-term care, can be applied toward meeting the 7.5 percent floor for medical expense deductions contained in the federal tax code. However, there are limits based upon one’s age for the total amount of premiums paid for long-term care insurance that can be applied toward the 7.5 percent floor. (An accountant should be consulted to determine if the individual consumer is eligible to take this deduction.)

Generally, employers will be able to deduct as a business expense both the cost of setting up a long-term care insurance plan for their employees and the contributions they may make toward paying for the cost of premiums. Employer contributions will be excluded from the taxable income of employees.

Individual Retirement Accounts (IRAs) and 401k funds cannot be used to purchase private long-term care insurance. However, under a demonstration project, tax-free funds deposited in Medical Savings Accounts can be used to pay long-term care insurance premiums.

**CONSUMER PROTECTION STANDARDS**

To qualify for favorable tax treatment, a long-term care policy sold after 1996 must contain the consumer protection standards in HIPAA. Also, insurance companies must follow certain administrative and marketing practices or face significant fines. Generally speaking, policies sold prior to January 1, 1997, automatically will be eligible for favorable tax treatment. Lastly, nothing in the new law prevents states from imposing more stringent consumer protection standards.

To protect consumers, insurance companies must comply with the following procedures:

- Consumers must receive a “Shopper’s Guide” and a description of the policy’s benefits and limitations (i.e., Outline of Coverage) early in the sales process – The Outline of Coverage allows consumers to compare policies from different companies;

- Companies must report annually the number of claims denied and information on policy replacement sales and policy terminations;
• Sales practices such as “twisting” (knowingly making misleading or incomplete comparisons of policies) are prohibited, as are high-pressure sales tactics.

No policy can be sold as a long-term care insurance policy if it limits or excludes coverage by type of treatment, medical condition or accident. However, several exceptions to this rule exist:

• Pre-existing conditions or diseases;
• Mental or nervous disorders (but not Alzheimer’s); or
• Alcoholism or drug addiction.

A policy cannot, however, exclude coverage for pre-existing conditions for more than six months after the effective date of coverage.

CANCELLATION

The law prohibits a company from canceling a policy except for nonpayment of premiums. Policies cannot be canceled because of age or deterioration of mental or physical health. In fact, if a policyholder is late paying a premium, the policy can be reinstated up to five months later if the reason for nonpayment is shown to be cognitive impairment.*

*Cognitive Impairment is usually defined as 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.
Chapter 5

GOVERNMENT ASSISTANCE - MEDICAID

The federal government allows each state leeway in the interpretation of regulations and the application of the law.

It is wise to become familiar with the laws of the state in which you reside, or in which nursing home care may become a necessity for your clients, in order to be better informed to assist your clients in being better prepared. Your local Department of Public Welfare can supply you with information on changing regulations in your state. The following are generalizations. Certain rules and regulations vary from state to state.

ELIGIBILITY FOR MEDICAID ASSISTANCE

In order to receive assistance with the costs of long term care services from Medicaid you must first prove that you are either a U.S Citizen or legal resident alien and establish your state of residence. In addition most states require that you be at least 55 or permanently disabled.

Functional eligibility is determined by your physician in conjunction with local (usually county based) Medicaid personnel. The functional eligibility criteria will vary from one program to another. For example in a state with PACE sights (more about PACE later in the text) the functional eligibility requires less assistance that the functional eligibility for nursing home confinement. Generally the medical/functional eligibility criteria resemble those used in long term care policies in that they measure the patient’s ability to perform the essential activities of daily living without assistance. The more assistance the patient needs the more likely they are to qualify for assistance.

ASSETS AND INCOME DETERMINE ELIGIBILITY

Assets and income are the dynamics that determine eligibility for public assistance.

ASSETS

Anything of value that you own is considered an asset. Financial institutions break down assets into categories such as fixed assets and liquid assets. Medicaid also breaks down assets into certain categories. There are three groups of assets that Medicaid considers:
• Countable;

• Non-Countable; and

• Inaccessible.

**Non-Exempt Assets**

Medicaid will only extend financial aid to individuals who are, in essence, virtually bankrupt. The individual receiving Medicaid benefits must not own or have any of the following non-exempt assets:

- Cash over $2,000 (in most states);
- Stocks;
- Bonds;
- IRAs;
- Keoghs;
- Certificates of deposit;
- Single premium deferred annuities;
- Treasury notes and treasury bills;
- Savings bonds;
- Investment property;
- Whole life insurance above a certain amount;
- Vacation homes;
- Second vehicles;
- Pension programs;
- Interest on bank accounts;
- Rental Income; and
- Social Security.

**Exempt Assets**

Even though it is commonly recognized that the value of the following assets may well be over any amount that common sense would deem appropriately bankrupt status, Medicaid does not consider them in determining eligibility.

- A house used as a primary residence (in most states, this can include two and three-family homes);
- Currency not exceeding $2,000;
- A car;
- Personal jewelry;
- Household furnishings;
- A pre-paid funeral plan;
- A burial account (not to exceed $2,500 in most states); and
• Term life insurance policies with no cash surrender value.*

*Term insurance is only worth the face value on the policy and payable only upon death. Most states permit unlimited term insurance when applying for Medicaid, but only a limited amount of whole life insurance as they have cash surrender values.

**Countable Assets**

These are assets that are inaccessible to Medicaid through the following means:

• Giving away as gifts;
• Medicaid trusts;
• Certain types of joint accounts; and
• When the asset owner is too debilitated to gain access to them.

**THE DEFINITION OF INCOME**

Income is the gain or recurrent benefit usually measured in money that derives from capital or labor. Like countable assets, any of the following are in jeopardy.

• Social Security;
• Stocks;
• Bonds;
• Investments of any kind;
• Interest;
• Trusts;
• Rental Properties;
• Family Assistance;
• Pensions;
• Annuities; and
• Royalties.

If you can’t get it, Medicaid can’t get it. On the other hand, if you can get it, Medicaid wants it.

To qualify for income eligibility, the nursing home resident must have a monthly income that is less than the expenses incurred while in the nursing home. Once the resident has paid all of his income to the home, Medicaid will then cover the balance due.

In many states, the single resident may withhold certain amounts for:

• Personal needs;
• A home maintenance allowance, if they are planning to return home; and
• Existing medical insurance monthly premium.

The spouse remaining at home is free to sustain employment and retain his or her salary and any additional monthly income and, in most states, his or her half of the assets that generate income investments, interest, etc.

By law, states are required to stipulate the amount of total joint income the remaining spouse is allowed to retain. Even though there are minimum and maximum guidelines to follow, the spouse has the potential to increase the previously set amount if she can prove that her housing expenses are unusually excessive.

While the law protects the spouse of a patient, it also protects the Medicaid system from fraud. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes criminal liability on those who knowingly and willingly dispose of or transfer assets to become financially eligible for Medicaid.

When Medicaid application is made, the state examines the applicant’s financial information for the last three to five years. If within that time an asset was transferred for less than the fair market value, Medicaid benefits will be denied. The period of eligibility is determined by dividing uncompensated value of the transfer by the state’s average monthly cost of nursing home care.

For example, if an applicant sold a piece of land valued at $20,000 to his daughter for only $1000, he could be found ineligible for Medicaid until the cost of his nursing home care exceeds the $19,000 difference he should have received for the sale of the property to his daughter. Using the formula above, that means ineligibility for a little longer than seven months.

UNCOMPENSATED TRANSFERS

An uncompensated transfer occurs anytime one transfers an asset out of their ownership and/or control for less than fair market value. These uncompensated transfers can take many forms such as:

**Outright gift**
Where one gifts an asset to someone else with no return consideration or compensation

**Bargain sale**
Where someone sells an asset to another at a bargain price (usually a relative). If a parent sells an asset worth $100,000 to a child for $1 (hoping to classify it as a sale and not a gift) it will still be classified as an uncompensated transfer of $99,999. So the difference between the fair market value of the asset transferred and compensation received is considered an uncompensated transfer.
Transfer of assets to an irrevocable trust
When one transfers assets to an irrevocable trust for less than fair market value it is considered an un-compensated transfer.

Forgiveness of debt
If one forgives debt owed by another it is considered an un-compensated transfer. The date of the un-compensated transfer is considered to be the date the debt was forgiven not the date the original loan amount was transferred to the recipient of the loan proceeds.

Gift tax return
A potential problem of making an un-compensated transfer (gift) is that if the gift exceeds $12,000 (2008) per donor per donee a federal gift tax return (form 709) should be filed by the next tax filing deadline. This is often overlooked and can cause considerable tax problems downstream for the donee.

MEDICAID TRUSTS
There are two types of Medicaid Trusts:

- Revocable; and
- Irrevocable.

Revocable Trusts
A revocable trust is a legal means utilized to set up and hold assets for the future. At least one person must be designated to make decisions on behalf of the trust (a trustee). A beneficiary of the trust must also be designated. However, there can be more than one beneficiary named. The owner of the trust has the right to change the rules at any time and the trustee must follow them accordingly. The owner even has the right to terminate (revoke) the trust at any time. A revocable trust acts as a will wherein the rules you make include who gets your money and under what circumstances after you die. This kind of trust is useful in protecting your house so that while you are alive you continue to receive the benefits; however, it will not protect countable assets.

Irrevocable Trusts
An irrevocable trust is also a legal means utilized to set up and hold assets for the future. At least one person must be designated to make decisions on behalf of the trust. A beneficiary of the trust must also be designated, however there can be more than one beneficiary named. The owner has the right to make the rules, but not to change them. Therefore, you give up control. An irrevocable trust is the only trust that will protect countable assets but limits the amount of discretion a trustee has.

In 1986 Congress restricted the use of irrevocable trusts. It allows that an irrevocable trust can be set up in such a way as to name yourself as a beneficiary
and give the power to your trustee to give you a specified amount of the income and assets. Whether it is the case or not, Medicaid recognizes the power of the trustee to make all the income and principal available to you and, therefore, you can use them for the nursing home if you so choose. The assets are considered countable and therefore transferable, as if they were not even in trust at all. The trust must be set up to restrict the trustee’s abilities. For instance, if the trustee has only been given the power to hold the assets and not the power to give you the assets, Medicaid won’t be able to get them either.

THE SPOUSAL IMPOVERISHMENT ACT

The Spousal Impoverishment Act (SIA) allows the spouse of the person in the nursing home to keep a certain amount of assets and income. Medicaid set the guidelines effective October 1, 1989.

ASSESSING RESOURCES AND DETERMINING ELIGIBILITY

The spousal impoverishment provisions apply where the member of the couple who is in a nursing facility or medical institution is expected to remain there for at least 30 days. When the couple applies for Medicaid, an assessment of their resources is conducted. The couple's resources are combined and exemptions for the home, household goods, an automobile and burial funds are made. The result is the spousal resource amount, which the State determines. The spousal resource amount is the State's minimum resource standard ($20,880 in 2008); or the spousal share, which is equal to one-half of the couple's combined resources not to exceed the maximum permitted by the State ($104,400 in 2008).

When Medicaid determines the day a spouse goes into a nursing home or medical institution, the married couple is required to list all their countable assets. It doesn’t matter whose name the assets are in, jointly or singularly, how long they’ve been held or who earned them. Medicaid then takes an overall view of the combined assets eligible on that day.* The spouse of the nursing home patient is allowed to keep one-half of the total assets amount. The spouse is able to keep a minimum to a maximum amount, though states vary in the amounts and this figure is escalated yearly.*

*Figures in all examples are fictitious and for illustration purposes only.

Example – Determining Spousal Share of Assets

<table>
<thead>
<tr>
<th>Date of Overview</th>
<th>Date of Entry</th>
<th>Total Assets</th>
<th>One-Half</th>
<th>Spouse’s Share</th>
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</thead>
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<td>January 1</td>
<td>January 1</td>
<td>$30,000</td>
<td>$15,000</td>
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<tr>
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<td>January 1</td>
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<td>$9,000</td>
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<tr>
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<td>$50,000</td>
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<tr>
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<td>January 1</td>
<td>$200,000</td>
<td>$100,000</td>
<td>$60,000</td>
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</table>
*The combined eligible assets are always determined on the date of entry into the nursing home.

If assets have to be spent down by the institutionalized spouse in order to qualify, the applicant for Medicaid may not take place for months. Regardless of what the total assets are on the day he applies, the stay-at-home spouse’s share will always be determined on the day of the snapshot.

<table>
<thead>
<tr>
<th>Date of Overview</th>
<th>Date of Entry</th>
<th>Total Assets</th>
<th>One-Half</th>
<th>Spouse’s Share</th>
<th>Patient Must Spend</th>
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</thead>
<tbody>
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<td>January 1</td>
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<td>$50,000</td>
<td>$50,000</td>
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*$50,000 - $2,000 Medicaid Allows = $48,000 Must be spent on care

<table>
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<tr>
<th>Date of Overview &amp; Entry</th>
<th>Asset Amount</th>
<th>Date of Application</th>
<th>Asset Amount</th>
<th>Total Assets</th>
<th>One-Half</th>
<th>Spouse’s Share</th>
<th>Patient Must Spend</th>
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<tbody>
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<td>$100,000</td>
<td>February 1</td>
<td>$80,000</td>
<td>$100,000</td>
<td>$50,000</td>
<td>$30,000</td>
<td>$28,000*</td>
</tr>
</tbody>
</table>

*$30,000 - $2,000 Medicaid Allows = $28,000 Must be spent on care

**MEDICAID ESTATE RECOVERY EFFORTS**

If an individual receives Medicaid assistance with long term care costs the state Medicaid agency is required by federal law to implement asset recovery mechanisms to recover as much funds as possible for the Medicaid program.

This is often the motivation of many people to engage in ill planned uncompensated transfers in order to avoid losing the home. In most states Medicaid will lien your real property assets that were not required to be spent down during the asset determination phase of the eligibility process Usually this results in a lien being placed on your principle residence which will prevent transfer of title without the lien being satisfied. One the institutionalized recipient of Medicaid assistance dies the non-institutionalized spouse may continue to live in the home. Since a lien is not a forecloseable instrument it will not force the sale of the home; however, once the lien is in place the title can not transfer without he lien being paid. Once the spouse of the Medicaid recipient dies the heirs may not take title to the home until the lien has been satisfied. If the amount of the lien exceeds the value of the home.
Medicaid can make attempts to recover other assets but rarely does. It should be noted that the heirs are in no way liable for the debts of their parents generated by receipt of Medicaid assistance. The heirs have the option of walking away from the home and often do if the amount of the lien is greater than the value of the home.

**DISADVANTAGES TO USING MEDICAID FOR LTC COSTS**

If one relies on Medicaid for assistance with the costs of long term care services they are depending on a needs based benefit with limited resources. The intent in this section is not to be critical of Medicaid nor any of the good people working within Medicaid and the related care setting but rather to point out that Medicaid must engage in certain austerity measures to stretch their limited budget across the many eligible individuals.

**CARE PROXIMITY**

One of the most common pitfalls of relying on Medicaid is that you will get the closest Medicaid bed available and that bed may be far removed from your home, spouse, friends and family. Most major metropolitan areas have a waiting list for Medicaid qualified beds and often the first 90 to 120 days of your inpatient stay in a Medicaid bed will be out of town. If you followed the assets and income tests that were necessary to become Medicaid eligible in earlier chapters you will agree that there will not be a lot of extra income for your spouse to travel and or stay out of town to be near you. When this happens the patient is put on a waiting list for a bed closer to home and will be transferred closer to home as soon as their name comes up on the list.

**HEIRS LOSE INHERITANCE**

The assets that intended to pass on to your children may well have to be spent down or have a lien placed against them greatly diminishing the assets you wanted to pass to your heirs. With this in mind it could also be in a child’s best interest to make sure their parents have long term care insurance and help with the premiums if necessary.

**FINANCIAL STRAIGHTJACKET**

By applying for Medicaid assistance you are in essence putting yourself into a financial straightjacket and the loss of independence and sense of self worth is often overwhelming to the patient. It is humiliating for an individual who has been self-supporting all their life to rely on public assistance and go through the Medicaid eligibility process. This humiliation is not by design within the Medicaid system but is a result of having to be inspective to assure public funds are spent in a judicious manner.
Chapter 6

THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

A BRIEF OVERVIEW OF THE NAIC

Headquartered in Kansas City, Mo., the National Association of Insurance Commissioners (NAIC) is a voluntary organization of the chief insurance regulatory officials of the 50 states, the District of Columbia and four U.S. territories. The association’s overriding objective is to protect consumers and help maintain the financial stability of the insurance industry by offering financial, actuarial, legal, computer, research, market conduct and economic expertise. Formed in 1871, it is the oldest association of state officials. For more information, visit NAIC on the Web at www.naic.org/pressroom.

THE NAIC MODEL ACT

Most states have based their regulation of long-term-care insurance on model standards developed by the NAIC. In 1986, the initial model act, developed by the NAIC in conjunction with the Department of Health and Human Services (DHHS) and consumer and insurance representatives, was endorsed by the NAIC. A model regulation followed a year later. The model act generally outlines recommended minimum requirements for long-term care insurance in legislative language. The model regulation provides more specificity to implement the model act. For example, the model act requires that an outline of coverage in a standard format with basic descriptions and exclusions be delivered to all prospective applicants. The model regulation actually prescribes a standard format and content of the outline of coverage, including specific wording and presentation instructions.

The NAIC has attempted to balance the need for strong consumer protection with the need for innovation and flexibility in the development of a new product. The Model Act's stated purpose is:

- To promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance from unfair or deceptive enrollment practices;
- To establish standards for long-term care insurance;
- To facilitate public understanding and comparison of long-term care insurance policies; and
- To facilitate flexibility and innovation in the development of long-term care insurance coverage.

**CONTINUAL REVIEW AND STATE ADHERENCE TO LEGISLATION**

The NAIC has reviewed the model act and regulation every six months (although it is not required to), and several versions have subsequently been issued. States do not necessarily amend their regulations as often as the NAIC updates the Model Act because state adherence to NAIC model legislation is voluntary. Also, some states only partially adopt the NAIC guidelines. Therefore, even in states that have adopted the “NAIC Model Act,” the standards in place may differ from the most recent NAIC Model Act.

**NAIC MODEL STANDARDS**

The NAIC Standards currently contain the following protections:

**Prior Approval of Policies**

- Pre-existing condition exclusion periods of longer than six months are prohibited. Also, in issuing replacement policies for similar benefits preexisting conditions are prohibited.
- Policies may not exclude or limit benefits for persons with Alzheimer's disease (model regulation only).
- Policies may not limit coverage to skilled nursing care nor provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.
- Policies may not make nursing home or home care benefits contingent on a prior hospital stay.
- Conditioning eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care ("step-down") is prohibited.
- Minimum standards for home health care benefits are prescribed if a policy provides home health care services (home health care services are distinct from post-confinement home health benefits), including prohibitions against tying benefits for home care to the need for skilled nursing, covering only services by registered or licensed practical nurses, or limiting coverage to services provided by Medicare-certified agencies or providers (model regulation only).
- Individual policies must be guaranteed renewable -- which means that policies may not be individually canceled due to the age or diminishing health status of the insured. Group products must provide for continuation or conversion of coverage.

**Monitoring Marketing and Business Practice**
• Purchasers have a 30-day "free-look" period during which they may return the policy for a full refund.

• Purchasers must be offered the opportunity to purchase a product with inflation protection either in the form of annual increases, the right to periodically increase benefit levels without requiring evidence of health status, or a percentage of actual charges. Annual increases, as well as periodic upgrades, should be compounded annually at a rate not less than five percent (model regulation only).

• Post-claims underwriting [checking a policy holder's medical history only after a claim is filed, instead of when the application is taken] is limited by denying payment based on technicalities or omission of information that was not requested on the application. Insurers must clearly inform applicants that the policy can be invalidated if the information provided is not correct and complete. For applicants age 80 and over, the insurer is also required to obtain some form of documented medical assessment [report of a physical, an assessment of functional capacity, physician's statement, or medical records]. Insurers must also keep records of policy rescissions and report them to insurance commissioners (model regulation only).

• A detailed and uniform outline of coverage must be delivered to all prospective applicants for long-term care insurance at the time of initial in-person solicitation. Solicitations through direct response mailings must provide an outline of coverage at least by the time the policy is delivered. This outline should include a description of principal benefits and coverage; a statement of principal exclusions, reductions and limitations; a statement of terms under which the policy may be continued in force or discontinued, including any provisions in the policy of a right to change premiums; a description of terms under which the policy may be returned and premium refunded; and a brief description of the relationship of benefits that do increase to benefits that do not increase, including a graph over at least 20 years.

• A "Shopper's Guide" approved by NAIC must be delivered to applicants (model regulation only).

• Insurers must maintain information concerning lapsed and replacement policies in relation to total annual sales for each agent and report these figures annually for the 10 percent of agents with the greatest percentages of lapses and replacements and for each company overall (model regulation only).

• Insurers must provide a copy of long-term care insurance advertisement to the State Insurance Commissioner for review or approval at the Commissioner's discretion (model regulation only).

• Agents must demonstrate knowledge of long-term care insurance by passing a test and maintaining a license (model regulation only).
• Insurers are required to adhere to the following marketing standards: fair and accurate comparisons to other products; assure excessive insurance is not sold; inform consumers that the policy may not cover all of the costs of long-term care, and provide written notice to prospective policyholders of the availability of senior insurance counseling programs.

• Agents and insurers are prohibited against: (1) twisting [knowingly misrepresenting or fraudulently comparing insurance policies or insurers to convert. an existing policy or initiate a new policy]; (2) high pressure sales tactics; and (3) deceptive cold lead advertising [marketing which is not represented as a solicitation] (model regulation only).

• Fines are permitted to be levied by State Insurance Commissioners [the greater of three times any commission for a policy involved in a violation or up to $10,000 per violation per agent and per insurer].

• Included as an optional provision are regulations to limit agent compensation in order to address marketing abuses that result from the large difference between first year and renewal commissions. This provision is listed as optional due to the lack of consensus on the extent of abuses and the emerging nature of the long-term care insurance market because many replacements may be appropriate (model regulation only).

**NAIC Premium Rate Control and Solvency Requirements**

• Companies are required to have reserves and to meet an expected mandated loss ratio of at least 60 percent for individual policies. The expected loss ratio does not require that the target loss ratio be demonstrated. Traditionally, premium-to-loss ratios have been used with health and accident policies as a benchmark of a reasonable relationship between premiums and benefits paid. The recommended interpretation of the loss ratio for long-term care insurance policies is based on factors designed to provide latitude to the company. This is because long-term care insurance policies are not purchased primarily for immediate protection like accident and health benefits, but rather for a need that normally occurs toward the end of the life span, similar to life insurance. Also, long-term care insurance policies have a relatively small claims rate and are subject to variable lengths of nursing home stays. Permitting additional factors not normally allowed in interpreting loss ratios is intended to foster development of products and permit leeway for the lack of claims experience. Regulators are permitted to take into account such factors because of the need for adequate reserving of the long-term care insurance risk. Factors include: statistical credibility of incurred claims experience and earned premiums; the period for which rates are computed to provide coverage; experienced and projected trends; concentration of experience within early policy duration; expected claim fluctuation;
experience refunds, adjustments or dividends; renewability features; all appropriate expense factors; interest; experimental nature of the coverage; policy reserves; mix of business by risk classification; and product features such as long elimination periods, high deductibles, and high maximum limits.

- The NAIC will require companies to report loss ratios for long-term care insurance on both a calendar year basis and a cumulative basis by calendar year duration for the policies in the state and nationwide. This will assist insurance regulators in tracking expected to actual results.

POLICIES CURRENTLY IN FORCE THAT ADHERE TO NAIC STANDARDS

Information concerning the number of policies currently in force that meet the current NAIC standards is not available. In general, the top-selling policies currently offered meet the most recent NAIC standards. Most of the major companies in the long-term care insurance market, those insurance companies selling the top 15 individual products that make up 75 percent of the market, market on a national basis. In general, these companies design a product that adheres to NAIC standards and then may alter the product on a state-specific basis to conform to particular state provisions, which may be more or less stringent than NAIC standards.

NAIC AND THE UNIFORM POLICY PROVISION MODEL ACT

The National Association of Insurance Commissioners (NAIC) developed the Uniform Policy Provision Law, which standardizes and outlines mandatory and optional policy provisions. The optional provisions are considered at the discretion of the insurance company in order to better service their individual policy needs. However, it is prohibited to use any substitute language in any of the provisions unless, of course, the language used is for the benefit of the insured. Standardized insurance policy provisions vary by state, but most are outlined below.

MANDATORY POLICY PROVISIONS

- Entire Contract Provision;
- Incontestability Clause (Time Limit on Certain Defenses);
- Grace Period Provision;
- Reinstatement Provision;
- Notice of Claim (Notice of Disability Continuance);
- Claim Forms;
- Proofs of Loss;
• Time of Payment of Claims;
• Payment of Claims;
• Physical Examination and Autopsy;
• Legal Actions; and
• Change of Beneficiary.

**ENTIRE CONTRACT PROVISION**

Under no circumstances and at no time is an agent at liberty to make changes to any policy provisions. Any changes (i.e., riders, endorsements, waivers) must be approved in writing and must be executed by an officer of the company. The Entire Contract Provision states that the life insurance policy document, the life insurance application together with any attached riders constitute the entire life insurance contract.

• The Insurance Policy;
• Endorsements;
• Attachments; and
• Any Riders (if applicable).

**INCONTESTABILITY CLAUSE**

The Incontestable Clause or provision specifies that after a certain period of time, the insurer no longer has the right to contest the validity of the insurance policy. This provision states that after two years from the date of issue of the policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing the expiration of such two-year period.

**GRACE PERIOD PROVISION**

As in most loan installments, insurance companies grant the insured a grace period. The Grace Period Provision states that the policy owner is permitted an additional 30 days grace period during which premiums may be paid to keep the insurance policy in force. The grace period can vary from company to company, however it is usually 30-31 days. At any time during the grace period, if payment is not received, the insured is subject to penalty and/or late fees. After the grace period, the company has the option of terminating the contract.

**Example**

<table>
<thead>
<tr>
<th>Premium Due Date</th>
<th>Grace Period</th>
<th>Period Ends</th>
</tr>
</thead>
</table>

33
Policy remains in force Payment required with or without payment or cancellation

REINSTATEMENT PROVISION

With some limitations, the Reinstatement Provision provides the insurance policy owner with the ability to restore the insurance policy to its original status with its values brought back up to date. However, there are mandatory procedures to follow. A reinstatement request usually requires that an application for reinstatement be filed with the company. Most insurance carriers will require payment of all the back insurance premiums owed with interest, repayment of any loans as well as provide additional evidence of insurability. (An application for reinstatement does not necessarily mean that the application will be approved however.)

NOTICE OF CLAIMS

An insured is required to give written notice of claim to the insurer within 20 days after the loss occurs or as soon as reasonably possible. This notification can go either to the address the insurer provides or to the agent.

Example – Exception to Mandatory 20-Day Notification Rule

The insured is involved in an accident and was in a coma for five or six weeks, thus did not provide written notice of claim within the required 20 days allotted. The insurance company is still liable for the claim since the insurer could not reasonably have required the insured to be able to file during the time the insured was in a coma.

CLAIM FORMS

Once the company has received a claim, they must supply the insured a claim form for filing purposes within 15 days. If the company does not adhere to this time limit, the insured may file proof of loss detailing the claim, the extent of the loss and the nature of the loss on any written form available to him or her.

PROOF OF LOSS

Normally, written proof of loss must be filed within 90 days after the date of loss. But when the claim is of a continuing loss, which requires periodic payments, proof of loss must be furnished within 90 days after the end of the period for which the insurance company is liable.

Example - One-Time Filing vs. Periodic Filing
One-Time Filing                                                   Periodically Filing

* Submits a claim for hospital expenses after an accident January 1. 

* Submits claim, receives periodic payments of disability income from January 1 through June 1.

* Must file proof of loss within 90 days after January 1, the date of the loss, since no periodic benefits are involved. 

* Must file proof of loss within 90 days after June 1, the date the insurer’s liability for payment ended.

If the insured fails to file the claim within 90 days, and it is found that it was reasonably possible to do so, the claim will not be validated. Still, proof of loss must be furnished no later than one year from the date it was otherwise due.

**TIME PAYMENT OF CLAIMS**

The insurance company has a time period in which to pay the claim, if it is not denied. The provision states that “the company must pay the claim immediately,” after receiving proof of loss. Payments of period indemnities (for example, disability payments) are to be paid monthly. However, most payments are usually paid within 30 to 60 days.

**PAYMENT OF CLAIMS**

Loss of life payments can be made several different ways. The beneficiary would be first on the list. If no beneficiary has been designated, the insurance company will pay the benefit to the insured’s estate. If the insured was receiving monthly indemnities and some accruals benefits remain at the time of death, then the insurance company must pay these accruals to either the beneficiary or the insured’s estate. The insured also has a right to request that payment for services be made directly to the hospital or physician.

**AUTOPSY OR PHYSICAL EXAM**

While the insured is alive and receiving benefits, the insurance company may require that he or she submit to a physical examination. If an insured has died, the insurance company may request an autopsy if that state’s laws allow. However, the insurance company must do so at their own expense.

**LEGAL ACTIONS**

No action of law can take place for at least 60 days after written proof of loss has been submitted to the insurance company. The insured has the option to challenge the company in regard to a claim after the company decision, up to a maximum of 5 years.
CHANGE OF BENEFICIARY

If the beneficiary is a “revocable,” the insured has a right to change the beneficiary. If the beneficiary is an “irrevocable beneficiary,” it may not be changed.

OPTIONAL POLICY PROVISIONS

- Change of Occupation;
- Misstatement of Age or Sex Provision;
- Other Insurance with This Insurer;
- Insurance with Other Insurers;
- Insurance with An Other Insurer;
- Relation of Earnings to Insurance;
- Unpaid Premiums;
- Cancellation;
- Conformity with State Statutes;
- Illegal Occupation; and
- Intoxicants and Narcotics.*

CHANGE OF OCCUPATION

If a change of occupation occurs without the company’s knowledge and a claim is filed, the company may adjust the benefit amount accordingly. For instance, if John the insured, purchased his policy but then changed to a higher risk profession, then suffered a disabling injury, the insurance company can adjust the benefits paid to reflect the higher rate that would have been charged in the first place. By the same token, if the purchaser changes to a lower risk profession, a refund would be made to the insured for the excess premium amount collected.

MISSTATEMENT OF AGE OR SEX PROVISION

The Misstatement of Age or Sex Provision states that if the applicant misstates his or her age or sex, then his or her premium or face amount will be adjusted appropriately. If the age of the applicant is stated incorrectly in the original application, there will be an adjustment made before any benefits are paid. The benefits will be changed to reflect what would have been purchased and paid had the correct age been stated in the first place.

OTHER INSURANCE WITH THIS INSURER

In order to avoid over-insurance and also to limit a company’s risk, no matter how many policies an insured may have, coverage written is restricted to a maximum amount. Premiums that have been applied to the excess coverage will be refunded to the insured or to their estate. Over-insured is a situation that insurance
companies try to avoid.

**INSURANCE WITH OTHER INSURERS**

The same as “Insurance With An Other Insurer” (where only one other insurer is involved); again, in order to avoid over-insurance, if the company finds that there was other existing coverage for the same risk, the excess premiums will be refunded to the policyholder. This will prevent the insured from receiving benefits greater than his or her actual loss.

**RELATIONS OF EARNINGS TO INSURANCE**

If the insured becomes disabled and the monthly benefit amounts due are more than the insured’s monthly earnings, or the average of his earnings for the previous two years, the insurance company is only liable for the amount that is their proportionate share to the loss income that the insured is eligible for.

**UNPAID PREMIUMS**

If a premium is due, or past due, when a claim becomes due and payable, the premium due will be subtracted from the claim amount due and the difference will be sent to the insured or designated beneficiary.

**CANCELLATION**

The insured may terminate the policy following the expiration date of the policy’s original term. The company may terminate the policy with 20 days written notice to the insured.

**CONFORMITY WITH STATE STATUTES**

A policy must be in coherence with state statutes. Should a conflict arise, the policy automatically amends itself to be consistent with the statutory requirements in question. This provision not only helps the insurers avoid issuing policies that conflict with existing state laws, it can also prevent reissuing policies that are in conflict with any ruling enacted during the time a policy is being issued.

**ILLEGAL OCCUPATION**

If the insured is found to have been engaged in any illegal act, or to be an accomplice to any illegal act, or is engaged in an illegal occupation at the time of loss, benefits are not payable.

**INTOXICANTS AND NARCOTICS**

If the insured is under the influence of narcotics or intoxicants,* the company is not liable for any losses, unless such were administered on the advice of a physician.
*2001 studies demonstrated that 35-50% of injured patients treated in emergency departments and trauma centers were alcohol and/or drug intoxicated.
Chapter 7

THE BEGINNING OF LONG-TERM CARE SERVICES FOR THE AGED

*The average length of stay in a nursing home is 2½ to 3 years*

FROM THE 1890’S TO 1935

In terms of history, there were three paths by which the origin of today’s nursing homes evolved, private homes for the aged, almshouses or country poor farms, or proprietary boarding homes. The almshouse was one of the first forms of living facilities for the elderly, dating back to the 1890’s. In the early 1900’s, the elderly population began to increase and so did the need for nursing home type facilities. The Social Security Act of 1935 passed by the Roosevelt Administration gave the elderly population some financial stability, thus allowing them to be somewhat self-supporting.

FEDERAL LEGISLATION BEGINS

Legislative, Administrative and Regulatory Federal Policy toward nursing homes began in the year 1950. The federal matching of medical vendor payments was the first Act passed under the Old Age Assistance Program (OAA) during this timeframe.

INSURANCE COMPANIES RELUCTANCE TO ENTER THE LTC MARKET

Insurance companies were reluctant at the beginning to enter into the long-term care market. There were no previous claims data or trends analyses that they could follow. It was difficult to set premium costs for long-term care policies without this vital information.

However, even though history purports long-term care as originally created for the elderly, keep in mind that it is no longer strictly for the aged.

“BABY BOOMERS” GIVE RISE TO NEED FOR LONG-TERM CARE

*The probability of needing long-term health care at some time in the future is estimated at fifty percent*

Needing long-term health care is not rare. It is virtually guaranteed. The latest statistics
show that nearly one out of every two persons age 65 and older will probably spend some
time in a nursing home.

Seventy percent of couples who are older than 65 can expect one spouse to need
long-term care services. By the year 2020, one in three workers will provide some type of
eldercare.

By the year 2030, it is estimated that there will be at least 19 million people needing the
assistance of long-term care. People are living longer, thanks mostly to advancements in
medicine and technology. By the year 2050, it is projected that there will be one million
people over 100 years of age. As more of us are entering our Golden Years, long-term
care coverage is emerging as an important tool to assure that we can afford the care we
need and avoid depleting our estates.

Women outnumber men in nursing homes according to some studies. Thirteen percent of
the women as compared to four percent of the men in a nursing home are projected to
spend five or more years in a nursing home. And obviously the risk of needing nursing
home care increases with age; however, the nature and extent of the care to be required in
the future is at best a guess.

The estimated average length of time a person stays in a long-term care facility can only
be guesstimated. Most statistics show that over 50 percent spend less than 90 days in a
nursing home, but this figure distorts the real numbers that affect most people and do the
most financial damage. Some stays are under 90 days (however, most of these are for
transitional care), but in reality, most stays can add up to 9 years and more.

However, age is not necessarily a gauge to use when determining the necessity of a
long-term care policy; long-term care facilities are not only for the severely aged.
Surprisingly enough, most residents are under the age of 65. They can range from the
child who is brain-dead due to a horrific accident, to the middle-aged who has suffered a
stroke, to the more elderly Alzheimer disease patient.

**NATIONAL AVERAGE COST RANGES**

With the average annual cost for a nursing home around $74,095 (private room) to
$64,240 (semi private room), long-term care has become one of the largest selling forms
of protection for Americans. As the Baby Boomer generation reaches its elderly years,
estimates on the need for long-term care are rising. In major metropolitan areas, the
average long-term care costs escalates to $80,000 and even as much as $100,000 per
year, not including medical bills and prescription medications. With an average nursing
home stay of 19 months, seniors are finding it difficult to plan for these eventual
expenses.

Fearful of losing economic independence, older Americans are looking for security in
long-term care insurance. Even though for seniors over 65, premiums can range from
$2,000 to over $10,000 per year, long-term care insurance is the fastest growing type of
health insurance sold in recent years. Still, only five percent of those over 65 have
purchased private long-term care insurance. Uninsured seniors constitute a lucrative market and as a result over 100 insurance companies now offer long-term care policies.

**PAYING FOR CARE**

One must consider that if such an arrangement becomes necessary, where will the money come from?

- Medicare benefits;
- Medicaid benefits;
- Personal resources;
- Managed Care plans;
- Medicare supplemental insurance; and
- Long-Term Care insurance.

**MEDICARE BENEFITS**

Under certain limited conditions, Medicare will pay some nursing home costs for Medicare beneficiaries who require skilled nursing or rehabilitation services. To be covered, the individual must receive the services from a Medicare certified skilled nursing home after a qualifying hospital stay. A qualifying hospital stay is the amount of time spent in a hospital just prior to entering a nursing home; this is at least three days.

Medicare covers up to 100 days of skilled nursing confinement per benefit period. However, after 20 days, beneficiaries must pay a coinsurance ($128 per day in 2008). Medicare will only pay for nursing home care preceded by a three-day hospital stay. Medicare's eligibility requirements are established at the federal level by the Health Care Financing Administration (HCFA).

**MEDICAID BENEFITS**

Medicaid is a State and Federal program that will pay most nursing home costs for people with limited income and assets. Eligibility varies by State. Medicaid will pay only for nursing home care provided in a facility certified by the government to provide service to Medicaid recipients.

About 70 percent of all nursing home residents are supported, at least in part, by Medicaid. Medicaid reimbursement systems for nursing homes vary considerably from state to state.

**PERSONAL RESOURCES**

About half of all nursing home residents pay nursing home costs out of their own
savings. After these savings and other resources are spent, many people who stay in nursing homes for long periods eventually become eligible for Medicaid.

**Using Home Equity to Pay Long Term Care Costs**

For many seniors a large portion of their net worth is not liquid and is tied up in their principle residence. A very common way to afford LTC services (in the absence of long term care insurance) is to somehow tap the equity in the home. The different ways to gain access to the equity vary widely. Most of the instances where someone uses home equity to pay these costs are reactionary in nature and evidence of lack of proactive planning for the potential cost. In other word most people would not actively plan in advance to choose home equity as a way to finance eldercare costs.

**Reverse Mortgage**

From an organized commerce perspective there is the reverse mortgage whereby the homeowner will sell their home to a financial institution and receive monthly payments for life. While the home owner is alive no payments are due and upon death of the homeowner the heir can elect to walk away from the home or pay off the mortgage lien. The monthly amount that a reverse mortgage provider will pay a homeowner is reduced by the rental value of the home because the homeowner continues to live in the home or if they are institutionalized they may rent the home.

**Home Equity Loan**

Another way to use home equity to pay LTC costs is through the use of a home equity line of credit. One drawback to this method is that it requires the borrower (homeowner) to make monthly payments and can impose a burden for someone living on a fixed income.

**Advantages and Disadvantages of Using Home Equity**

The advantage of using home equity is that it will often provide the immediate cash needed to afford long term care and is often the largest concentration of wealth for a senior. In the case of a reverse mortgage it also does not require the senior to immediately make payments against the home equity used. The reverse mortgage unlike the home equity loan does not provide an immediate lump sum payment but rather makes monthly payments to the homeowner. The lump sum provided by a home equity loan will be viewed as an asset if the homeowner applies for Medicaid assistance and may be required to be spent down prior to eligibility for assistance. The monthly payments provided by a reverse mortgage will be generally not be viewed as an income stream (because it is a loan) provided the funds are spent within the month received. There is a possibility that unspent month payments from a reverse mortgage could accumulate and cause one to be ineligible from a countable resource standpoint.
USING ANNUITIES TO PAY LTC COSTS

If a senior has an annuity there are several ways that this asset can assist with the costs associated with eldercare. If the annuity is annuitized it can provide an income stream which may be sufficient when added to other streams of income to afford long term care. Since each individual is unique in their financial circumstances much care must be taken when deciding how to handle an annuity owned by a senior needing long term care services. If the individual owns an annuity that has not yet been annuitized it will be treated as an asset during the Medicaid eligibility determination whereas if it has already been annuitized it will be treated as an income stream. Obviously the risk the annuitant runs in annuitization is that the annuity income when added to their existing income streams (Social Security, pension plan etc) will be sufficient to cause them to lose eligibility for Medicaid but not enough to pay for needed care and/or provide support for a non-institutionalized spouse.

In recent past many insurance agents would counsel a client to buy an immediate annuity with a three year pay out and this annuity and the income would be exempt from the Medicaid spend down (asset test) or income test. This loophole has been closed and an annuity has no special status under the Medicaid eligibility test.

ANNUITIES WITH LTC RIDERS

A newer form of annuity with a long term care benefit has hit the radar in the last several years. Often the sales approach will include the term “Asset Based Long Term Care” or “Premium Elimination Long Term Care”. The approach taken by these annuities is that if the annuitant needs LTC services those costs can be paid out of the annuity account value (usually up to three times the single premium paid for the annuity) before the LTC benefit runs out. If the annuitant never needs LTC services they still have their annuity account value. Upon closer inspection it is discovered that indeed LTC premiums are charged against the annuity account value and affect the account values (if only the growth) even if no LTC benefits are paid. These LTC riders within annuity contracts are usually not full blown long term care policies and as such are not regulated by the same laws as a stand alone long term care policy. Look for more product innovation and market share growth of this approach in the future.

MANAGED CARE PLANS

A managed care plan will not help pay for care unless the nursing home has a contract with the plan.

MEDICARE SUPPLEMENTAL INSURANCE

This is private insurance. It's often called Medigap because it helps pay for gaps in Medicare coverage such as deductibles and co-insurances. Most Medigap plans will help pay for skilled nursing care, but only when that care is covered by
Medicare. Some people use employer group health plans or long-term care insurance to help cover nursing home costs.

**LONG-TERM CARE INSURANCE**

The benefits and costs of these plans vary widely.

**INCREASING COSTS WITH AGE**

It is estimated that 50 percent of all couples and 70 percent of single persons are impoverished within one year of entering a nursing home facility.

The older the individual, the greater the chances of one day needing long-term care services. However, the older the individual at the time of purchasing long-term care insurance, the higher the premiums will be also. Therefore, your client would be wise to keep the following in mind:

- Buy while you are still insurable, before illness, accident, or disability strikes;
- Buy after you have learned more about long-term insurance and have received unbiased guidance (your client could be encouraged to consult the State Health Insurance Assistance Program (SHIP) available in the area); and
- If you buy when you are younger, premiums will be lower (however, your client should realize that he will be paying them for a longer period of time).

The annual premium for long-term care policies with good inflation protection is in the neighborhood of $2,000 for 65-year-olds. At age 75, the premium will be two and a half times greater than if the policy had been purchased at age 65 and six times higher than if bought at age 55. It's common for a husband and wife age 65 to spend approximately $7,500 a year for health insurance coverage. A policy with a large daily benefit that lasts for several years is more expensive. Inflation protection can add 25 to 40 percent to the benefits and nonforfeiture rights can add 10 to 100 percent to the bill.

Premiums usually remain level for the duration of a policy. The table below is an example of premiums based on years of coverage. Premiums vary according to the benefit duration and benefit types.

You can see by the illustration below that a delay can be drastically more expensive. The same policy that would cost a 50-year-old $600 per year would cost a 75-year-old $8,000 annually. This shows you that a 75-year-old would pay more in two years than a 50-year-old would pay in 25 years.

**EXAMPLE – AGE, PREMIUM, YEARS OF COVERAGE & CUMULATIVE PREMIUMS AT AGE 85**

<table>
<thead>
<tr>
<th>Policy Age</th>
<th>Annual Premium</th>
<th>Years of Coverage</th>
<th>Cumulative Premiums@ Age 85</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>$600</td>
<td>35</td>
<td>$21,000</td>
</tr>
<tr>
<td>60</td>
<td>$1,500</td>
<td>25</td>
<td>$37,500</td>
</tr>
</tbody>
</table>
However, buying long-term care insurance at a younger age can also be a mistake. Many policies limit increases for inflation after 20 years or at the point where the original benefit doubles, so a consumer buying early in life could be left with inadequate benefits when really needed.

**LTC POLICIES ARE NOT FOR EVERYONE**

Even with all the statistics on aging and needed care, long-term care insurance is not for everyone; for many people, it is not a good idea. To find out if your client is really a good candidate for a long-term care policy and, if so, to assign the appropriate policy requires a full financial analysis.

Buying a policy is a function of age, health status, overall retirement objectives, income and wealth. If the only source of income is a minimum Social Security benefit or Supplemental Security Income (SSI), it would not be in a client’s best interest to purchase a long-term care policy.

Long-term care policies are best suited for people with significant assets they want to preserve for family members, and to assure independence and not burden family members with nursing home bills.

**AVAILABLE SOURCES OTHER THAN INSURANCE AGENTS**

Long-term care insurance is available for purchase from a number of sources, not only insurance agents:

- Insurance brokers, including companies that sell many other kinds of insurance;
- Some financial planners;
- Some continuing care retirement communities;
- Banks;
- Employers who offer it as part of a benefits package; and
- Large membership organizations.

**PLAN CHOICES – DECISION GUIDELINES**

There is a wide variety of choices available for your client once the decision has been made to buy long-term care insurance; and what to buy depends on the coverage your client wants or needs. Following are few considerations:

- Nursing home only;
- Home care only;
• An entire continuum of care (nursing home, assisted living, adult day care, etc.);
• Daily benefit amount;
• Benefit period;
• Elimination (deductible) period;
• Inflation protection; and
• Non-forfeiture benefits.

Choosing a long-term care plan doesn’t have to be confusing. You can follow four easy steps to determine which plan will best meet your client’s needs by using these steps.

• Step One: Select a Plan Type;
• Step Two: Choose a Daily Benefit Amount;
• Step Three: Pick a Total Coverage Amount; and
• Step Four: Decide on Inflation Protection.

**SELECT A PLAN TYPE**

All insurance companies vary in the plans that they offer; however, there are three plans that most companies utilize in some way, shape or form:

• Comprehensive Plans;

• Nursing Home/Assisted Living Facility Plans; and

• Combination Home Care and Facility Plans.

**Comprehensive Plans**

Most Comprehensive Plans cover care at home, care in a nursing home as well as care in an assisted living facility. For those individuals who want complete coverage no matter where their circumstances lead them, this type of plan usually provides the best available options; and, of course, this type of complete coverage plan is the most expensive plan as well.

**Nursing Home and Assisted Living Facility Plans**

This type of plan covers any licensed facility, whether care is provided in a nursing home or in an assisted living facility. This type of plan is, of course, less expensive than a comprehensive plan; however, it calls for out-of-pocket expenses if your client’s long-term care is being provided at home. However, since at-home expenses are not generally as costly as facility-based care, this type of plan may be very appealing.

**Combination Home Care and Facility Plans**

These types of plans cover both home care and facility-based care, though it does not provide the larger total coverage amounts that comprehensive
plans do. Even though the premiums are lower, the coverage amounts are limited.

Some people want a long-term care plan to pay for as much of their care costs as possible. Others are willing to pay some of those costs on their own in order to have a lower premium payment.

MINIMUM STANDARDS FOR BENEFIT TRIGGERS

As an agent assisting a consumer to understand the need for long term care coverage it is important that the agent be fluent in the language of the contracts. All insurance policies insure against a covered event. In the case of a long term care policy the consumer is trading a small certain loss (premium) to cover a larger uncertain loss (the covered event). In order for the consumer to make an educated decision they need to fully understand the covered event. Most States uses the term benefit trigger to describe the condition that must be present (covered event) for a long term care policy to pay a benefit.

Central to understanding the benefit triggers is learning how the activities of daily living (ADL’s) are defined. In general activities of daily living are very basic tasks of daily living. These ADLs are so basic that most have mastered these tasks by the Age of 4 or 5 and will continue to perform these task for ourselves (without assistance) as long as we continue to live independently.

Regulations sets the minimum standards for these benefit triggers but an insurance company (with approval from the commissioner) may use less restrictive language than required.

NUMBER OF ADL’S LOST FOR BENEFIT

In addition regulations specify a minimum number of benefit triggers that must be included in a contract but an insurance company can offer additional benefit triggers. They can not substitute one benefit trigger for another or combine benefit triggers where doing so would cause the contract wording to be more restrictive than required.

If an insured needs hands on assistance (of any degree) with 3 or more of the minimum benefit triggers described below then they qualify for a contract benefit. If an insurer adds additional benefit triggers they can not require that an insured need hands on assistance with more than 3 benefit triggers.

If different benefit triggers would result in the payment of different benefits then the eligibility for those benefits (the benefit trigger) must accompany the description of the benefit. It is not uncommon for an insurance company to offer additional benefits (above the mandated minimum) and since these benefits are not required they can have differing benefit triggers. Each of the benefits and associated benefit triggers must be submitted to the commission for review and approval. Examples of additional benefits might be the
installation of assistive devices such as rails and grip bars around the toilet and tub or pull up bars over the bed if the person is shown to need assistance with transferring.

Another key element of benefit eligibility is the assessment process or how does an insured demonstrate that they meet the eligibility standards for a benefit to be paid. Regulations specify that a physician must specify the need due to illness or infirmity. It is common practice for the insurer to reserve the right to (at their own expense) obtain a second opinion from a physician of their choosing. If this is included in the contract it must be approved prior to marketing.

QUALIFIED LONG TERM CARE POLICIES

Qualified long-term care insurance is defined as a contract that provides insurance coverage only for qualified long-term care services; does not pay or reimburse for expenses that are covered by Medicare; is guaranteed renewable; does not provide a cash surrender value or that could be assigned or pledged as collateral for a loan; provides that all refunds of premiums and policy holder dividends are to be applied as a reduction of future premiums or to increase future benefits. In addition to the above, a qualified plan must meet certain consumer protections which are set out in the Model Regulations and Long-Term Care Insurance Model Act. Further, the policy must meet disclosure and nonforfeiture requirements.

A qualified long term care policy meets the requirements for favorable tax treatment. The tax advantage of a qualified long term care versus a non-qualified long term care policy is the limited deductibility of the premiums. The policyholder of a long term care policy will be able to deduct some or all of their long term care premiums depending on their age. Below is a table showing the age thresholds and amount of long term care premiums that may be deducted in tax year 2008. These amounts are adjusted for inflation and will go up periodically.

<table>
<thead>
<tr>
<th>Attained age as of 12/31/2008</th>
<th>Deductible Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 or younger</td>
<td>$310</td>
</tr>
<tr>
<td>Older than 40 but not older than 50</td>
<td>$580</td>
</tr>
<tr>
<td>Older than 50 but not older than 60</td>
<td>$1,150</td>
</tr>
<tr>
<td>Older than 60 but not older than 70</td>
<td>$3,080</td>
</tr>
<tr>
<td>Older than 70</td>
<td>$3,850</td>
</tr>
</tbody>
</table>
In order to deduct the long term care premiums the policyholder must file IRS form 1099-LTC, Long Term Care and Accelerated Benefits with their tax return.

Generally benefits received under qualified or non-qualified long term care policies are not includable in income. Benefits from actual cost (also called reimbursement policies), which pay for the actual services a beneficiary receives, are not included in income. Benefits from per diem or indemnity policies, which pay a predetermined amount each day, are not included in income except amounts that exceed the beneficiary's total qualified long-term care expenses or $260 per day (for 2007...no increase announced for 2008), whichever is greater. So the real tax difference between a qualified and non-qualified long term care policy is the deductibility (subject to the above table) of some or possibly all of the premiums for the federal income tax return of the policyholder.

A group qualified long-term care policy must provide for continuation of coverage or conversion. In the event that the insured is no longer in the group and is subject to losing coverage. The insured must be able to maintain his/her coverage under the group policy by the payment of premiums. If the benefits or services covered are restricted to certain providers, which the insured can no longer use, the insurance company must provide for a continuation of benefits which are substantially equivalent. Similarly, if a group policy it terminated the insurance company must provide the insured with an converted policy which is substantially equivalent to the policy which was terminated. In order for an insured to benefit from this provision, he or she must have been covered under the terminated plan for at least six month immediately prior to the termination.

All qualified long term care policies must have a provision to protect the insured against unintended lapse. The policy must not be issued until the company has received a written designation from the applicant identifying at least one other person who is to receive notice from the insurance company before the policy may be terminated. The form used to identify the additional person must have a space for the person's full name and address. If for any reason the policy is to lapse, the insurance company is required to provide written notice to the insured and his/her designated agent identified on the form. Further, the insurance company may not terminate a policy for nonpayment of premiums until it has given the insured 30 days notice of the potential termination. Notice must be provided by first class mail, postage paid to the insured and all the persons identified by the insured.

Another important feature of qualified plans, is that post-claim underwriting is restricted and limited. Post-claim underwriting occurs when after a claim is filed by the policyholder, the insurance company declines the coverage on the ground that it would not have issued to policy if it had know about some medical condition. Under HIPAA, applications for long-term care insurance must contain clear and unambiguous questions designed to elicit information about the healthy status of the applicant. Further, if the application asks whether the applicant takes prescribed medications, it must ask for a list of those medications. The insurance company, if it receives the medication list, may not deny coverage for any condition which was being treated by any of the medications listed, even if that condition would have been grounds for a denial of coverage at the
application stage. The application must contain a clear bold caution to applicants that states that if the answers on the application are incorrect or untrue, the company has the right to deny coverage or rescind the contract. Therefore, it is important for applicants to fill out the application fully and correctly and list all the prescribed medications being taken.

HIPAA also established minimum standards for home health and community care benefits in qualified policies. If the policy provides benefits for home health or community care, it may not limit or exclude benefits by requiring that skilled care be required first or that the services be provided by registered or licensed practical nurses or that the provider be Medicare-certified. The policy may not exclude coverage for personal care services provided by a home health aide or adult day care service. The policy may not require that benefits be triggered by an acute illness.

Inflation protection is also included as a required element of a qualified plan. It is intended that meaningful inflation protection be provided. The legislation requires that the insurance company use reasonable hypothetical or graphic demonstrations that disclose how the inflation protection will work.

**BUSINESS RELATED**

- **Sole Proprietor:** A business owner who files IRS form Schedule C (Profit or Loss from a Business or Profession) is considered an individual for tax purposes and can deduct the premiums as noted in the table above. Must be a qualified long term care policy.

- **Sub (s) Corporation.** A sub (s) corporation can deduct the limits described in the table above and the covered employee does not pay income tax on the premiums or benefits (subject to the limits on benefits described above). Must be a qualified long term care policy.

- **C Corporations.** A C corporation is entitled to the deduction of 100% of the premium. The covered employee does not pay income tax on the premiums or benefits (subject to the limits on benefits described above). Must be a qualified long term care policy.

- **L.L.C.** A limited liability company is allowed to deduct the limits described in the table above and the covered employee does not pay income tax on the premiums or benefits (subject to the limits on benefits described above). Must be a qualified long term care policy.

- **Partnership.** A partnership is allowed to deduct the limits described in the table above and the covered employee does not pay income tax on the premiums or benefits (subject to the limits on benefits described above). Must be a qualified long term care policy.

HIPAA sets the standard for benefits as needing substantial (either hands on or standby) assistance with two or more activities of daily living.

OR
Needing substantial supervision due to cognitive impairment (see below)

The benefit trigger requirement of qualified long-term care insurance is considerably more restrictive than non qualified policies. The services under a qualified plan must be triggered by certification by a licensed health care provider that the beneficiary is chronically ill. Chronic illness is defined as:

1) as being unable to perform, without substantial assistance, at least two activities of daily living for at least 90 calendar days due to a loss of functional capacity or

2) requiring substantial supervision in order to be protected from threats to health and safety due to cognitive impairment. The 90 day period may be presumptive, which means that the doctor may certify that in their opinion the impaired performance will last at least 90 days.

As part of the HIPAA process final treasury regulations were implemented in December of 1998 and became internal revenue code (IRC) section 7702(b). Following is a summary of this code section:

Long term care policies issued before January 1, 1997 that meet state requirements in effect at that time are grandfathered as qualified long term care policies (regardless of the new HIPAA sections), however; if a contract has material changes it will lose the grandfathered status.

- Qualified contracts can not accrue cash values
- Qualified contracts must be guaranteed renewable
- Qualified contracts can only use policy dividends to reduce future premiums
- Qualified contracts must be issued within 30 days of approval
- If an insured request information pertaining to a claim denial it must be delivered within 60 days
- Non-qualified policies do not qualify for a premium deduction on the policyholder’s federal tax return

VIATICAL SETTLEMENTS

A terminally ill insured individual can sell their in force life insurance policy to a Viator (Viatical settlement company). This transaction involves the insured receiving a payment in advance of death (lump sum) in return for selling their life insurance policy. The new policy owner (Viator) has all rights and benefits of the policy and is not entitled to the death benefit.

There are several viatical settlement providers that adhere to ethical business standards and voluntarily submit their contracts and business practices to standards higher than local law requires.
In addition most states now regulate the viatical business and have formalized contract approval processes, and broker licensing and continuing education requirements.

**Choose a Daily Benefit Amount (DBA)**

The Daily Benefit Amount part of coverage is what the insurer will pay for the services your client will receive. The amounts available depend on what plan is chosen. Each plan offers different benefit amounts.

**Example – How DBA Affects Coverage Amount**

<table>
<thead>
<tr>
<th>DBA</th>
<th>Coverage Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$110</td>
<td>$110/day for nursing home</td>
</tr>
<tr>
<td></td>
<td>$77/day for assisted living</td>
</tr>
<tr>
<td></td>
<td>$1,650/mo. for home &amp; facility-based care</td>
</tr>
<tr>
<td>$150</td>
<td>$150/day for nursing home</td>
</tr>
<tr>
<td></td>
<td>$105/day for assisted living</td>
</tr>
<tr>
<td></td>
<td>$2,250/mo. for home &amp; facility-based care</td>
</tr>
</tbody>
</table>

**Pick a Total Coverage Amount**

Next, your client must choose the total amount of benefits that will be made available for his care for as long as he is eligible for coverage. Most insurers offer total coverage amount options in either of two ways:

- A specific pool-of-dollars basis; or
- A lifetime coverage basis.

Again, these choices are dependent upon which plan type has been chosen and which daily benefit amount has been designated.

**Decide on Inflation Protection**

The final decision your client will have to make is on inflation protection coverage. Inflation is a fact of life and it’s important to think about how inflation will impact the cost of long-term care services and the value of coverage in the future. Since experts say we can assume care costs will continue to increase by 5 percent each year, if inflation is not planned for now, your client might not have all the coverage he needs later.

Carriers offer purchasers the option to buy inflation protection under different options in an attempt to protect buyers against increasing nursing home costs:

- Simple Inflation Protection;
• Five Percent Compounded Inflation Protection; and
• Indexed Inflation Option.

OPTIONS TO LOOK FOR IN A POLICY

If your client is considering purchasing a long-term care policy, make sure that any policy he is considering:

• Does not require prior hospitalization to receive benefits;
• Is guaranteed renewable as long as he pays the premiums;
• Offers a premium waiver while he is receiving benefits;
• Has one deductible for the life of the policy;
• Covers pre-existing conditions, without a waiting period, if these are disclosed when he applies;
• Offers five percent (5%) compound inflation protection; and
• Allows policyholders to upgrade or downgrade their coverage if they can not afford premiums.
FORMS OF CARE AND COVERAGE AVAILABLE

Typically, care is broken down to Skilled Nursing Care, Intermediate Nursing Care, Custodial Care, Nursing Home Care and Personal Home Care

THE SCOPE OF THE NURSING HOME ORGANIZATION

A nursing home is usually one of the last places families choose to send their loved ones. It is not unusual for family members to fight against this decision for years. You want your loved ones to stay at home in familiar surroundings with family members and friends; however, most conditions that result in the need for nursing home care develop over a period of years (excluding accidents and strokes). Most family members believe that they will be able to remain the primary caregiver until such time as a hospital is needed. Those who have already been in this position can attest to the fact that it is more difficult than it sounds. The physical and emotional responsibility can be overwhelming and devastating to the family as well.

That is certainly not to exclude the financial responsibility. At first, the financial impact tends to go unnoticed. It is commonly believed that, at some latter point in time when the patient’s health declines, the hospital will take over.

There are three ways in which nursing homes function:

- Medically Necessary Care;
- Skilled Nursing Care; and
- Intermediate Care.

MEDICALLY NECESSARY CARE

Medically Necessary Care assimilates hospital care, and the associated expenses are covered by Medicare.

SKILLED NURSING CARE

Skilled nursing care is 24-hours a day, seven days a week (24/7) for nursing and rehabilitative care and is very expensive care. Therefore, it is only available by a prescription issued through a doctor’s orders. Medicare will cover this level of care under Part A benefits for up to 100 days.
Skilled nursing care is needed for medical conditions that require care by specially trained nurses or therapists, who routinely are licensed by the state. This level of care is on the specific orders of a doctor who dictates the care to be provided and is usually required around the clock, 24 hours a day. It is the care given as part of a severe illness and can extend well after the severest level of an illness has passed. Skilled care can be provided in a person's home with help from practical, as opposed to registered, nurses.

Skilled nursing care at home with two-hour visits by a nurse three times a week over a year, would cost approximately $12,500.

Only in certain cases will Medicare cover the cost of some skilled nursing care in approved nursing homes or in the patient’s home.

**INTERMEDIATE NURSING CARE**

Intermediate Care does not necessarily have to be provided by a Registered Nurse, but must be provided by a skilled medical practitioner. A Licensed Practical Nurse or a Physical Therapist can administer Intermediate Care. A prescription from a licensed medical doctor is not necessary for this type of care.

Intermediate Care supplies help for everyday activities. Neither Medicare nor other medical insurance plans will cover these expenses as they are considered custodial care.

Intermediate nursing care is associated with stable conditions that require daily supervision, but not around the clock care. It is less specialized than skilled nursing care, often involves more personal care and is supervised by registered nurses. Intermediate care is commonly needed for a matter of months and years.

**WHEN NURSING HOMES DO NOT PARTICIPATE IN MEDICAID**

Under the statute signed by former President Clinton, nursing homes that do not participate in the Medicaid program must warn incoming residents they can be evicted or transferred if they cannot continue to pay privately, e.g., with long-term care insurance.

However, a Medicaid participating nursing home cannot evict or transfer existing Medicaid patients if and when the nursing home decides to withdraw from Medicaid.

Almost half of all nursing home care billings are satisfied by Medicaid programs. However, this coverage is only for those who meet federal poverty guidelines for income and assets.

So why would nursing homes not participate in (or why would they withdraw from) Medicaid? Medicaid typically pays only 80 percent of the private pay rate and in some cases Medicaid reimburses less than the cost of providing care. Therefore, private individual policies pay more.
More than half of nursing home bills are paid out-of-pocket by individuals and their families, and somewhat less than half are paid by state Medicaid programs.

Recent studies based upon nursing home admissions indicate that at least 43 percent of all persons aged 65 and over will enter a nursing home in the future. In fact, a New England Journal of Medicine report suggested that of the 43 percent who entered nursing homes, 50 percent would stay an average of two years.

Statistics show that 47 percent of all nursing home residents have chronic illnesses. Chronic illnesses are those that are ongoing, long lasting and not likely to subside, including Alzheimer's disease, senile dementia, immune system dysfunctions, and a host of slowly progressive illnesses that simply do not get better.

Remember, 50 percent of all couples and 70 percent of single persons are impoverished within one year of entering a nursing home facility.

Some policies require that insureds must be discharged from a nursing home for a stated time period before they can be re-admitted. Others calculate the second admission as part of the first if the patient returns within 30, 90 or 180 days. Some policies require an elimination period to run again for a second stay. Repeat nursing home admissions are not the rule, but it is a consideration when comparing policies.

Gain familiarity with the general charges for nursing homes in your area before you sell long-term care policies to your clients. There is a simple formula that allows you to determine the length of time it will take for a price to double at a given rate of interest.

CUSTODIAL CARE

Custodial care is intended to assist with daily living, which includes bathing, eating, dressing, and other routine activities. Special training or medical skills are not required. It is provided by unskilled nursing assistants in nursing homes, day care centers, and at home. It is often called personal care.

Medicare provides no coverage for custodial care or prolonged home health care.

HOSPICE

Hospice is a remarkable organization for the terminally ill. Care is provided by RNs and Social Workers who provide comfort to individuals during their last days, but does not extend treatment or utilize life saving devices. Hospice care is a CHOICE you make to enhance life for a dying person. Statistics show that the mental and physical health of a person improves dramatically if they could only stay at home. Hospice Care allows the patient to spend their last days at home in familiar surroundings with family members, friends and caring professionals. This organization does not charge for its services and thereby provides care to all income families. Hospice also provides social and spiritual support for the patient and his or her family.

There are over 2,500 hospices in the United States. About one-half of the hospices are
associated with home health agencies or hospitals.

ADULT DAY CARE

Adult Day Care usually caters to those who are mentally or physically impaired. The center or facility provides participants with transportation to and from the facility where they can join in social activities, group exercises, therapeutic activities, nutritional education, medical care, meals, speech and occupational and physical therapy.

PERSONAL HOME CARE

Home care is growing in popularity with patients and carriers so policies need to be read carefully for limits. Personal care at home from a home health aide varies widely in costs based on the frequency of visits and length of each visit.

Home Health Care is provided to patients while they are still in their own home and are generally able to function for themselves in most areas. A qualified, but not necessarily medical, person helps you in performing the essential activities of daily living such as meals, shopping and/or physical therapy. It eliminates the burden and embarrassment of informal health care and the need for a long nursing home stay.

Many policies usually agree to pay for home care at rates that are one-half of nursing home rates. Other policies limit the benefits for home care to a specified daily sum or limit the number of hours at a specific rate per hour.

Under home care provisions, the benefit period is usually more limited than for nursing home stays and benefit periods of one to two years are typically available.

CONTINUING CARE RETIREMENT COMMUNITIES

Continuing Care Retirement Communities (CCRC) are a fast growing answer for many seniors. Entering a CCRC is a major change in lifestyle and a large financial commitment. Many of the facilities require that you enter before you need medical assistance or supervision. The concept allows the seniors to "age in place," and is a forward looking proactive way to address the concern of elder care versus a reactive reimbursement approach.

Retirement Communities require the residents to sign a long term contract which is all inclusive. The CCRC provides housing communal meals, meals on wheels, and many other non-medical amenities. Some CCRC facilities have their own hospital and nursing home, community center, golf course, theater, and even police force.

These organizations vary widely in the cost and services offered. An example of one of the more posh and oldest CCRC’s is Sun City in Phoenix, Arizona. Sun City is a walled city within the city of Phoenix and is so feature rich that the Phoenix Philharmonic has used the Sun City performing arts venue for concerts. Sun City has their own golf course, hospital, shopping, etc Few seniors can afford this Mecca for retirees. On a more modest
scale Grace Community in Morganton, North Carolina has their own nursing home and community center but they do not have an on site hospital or golf course.

What most of these CCRC’s have in common is that when you first “check in” you have your own separate dwelling and live independently. Part of your contract stipulates and up front buy in fee and on-going monthly payments for the rest of your life. If your health deteriorates the same monthly contracted fee covers you for any level of medical care you need. You are expected to have Medicare (all parts) but the CCRC in essence becomes your landlord, your provider of board, your LTC policy as well as the provider of other included lifestyle amenities.

One particularly attractive feature for a senior couple is care proximity. If one of the couple needs to be inpatient in the nursing home the non-institutionalized spouse is only several hundred yards away and continues to live in a very supportive community of like minded folks.

Continuing Care Retirement Communities are also known as:

- Continuing Care Retirement Facilities
- Life-Care Facilities, and
- Life-Care Communities.

Some CCRC’s offer a fee for service contract that does not provide the financial protection should you need expensive care. While they will offer a fixed price for the room, board and other amenities you will still need to address the concern of long term care through other means.

Licensing of CCRC’s is not uniform with some states being more inspective that others so a word of caution is in order to check local licensing and financial requirements. There was a CCRC that failed financially in the Memphis area about a decade ago and it left many seniors financially destitute because they had invested heavily in the CCRC and lost their money.
Chapter 9

ALTERNATIVES TO NURSING HOME CARE

PACE is an optional benefit under both Medicare and Medicaid that focuses entirely on older people who are frail enough to meet their State’s standards for nursing home care.

PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

PACE features comprehensive medical and social services that can be provided at an adult day health center, at home, and/or at inpatient facilities. For most patients, the comprehensive service package permits them to continue living at home while receiving services, rather than be institutionalized. A team of doctors, nurses and other health professionals assess participant needs, develop care plans, and deliver all services which are integrated into a complete health care plan. PACE is available only in States which have chosen to offer PACE under Medicaid. As of October 2008 there are PACE providers in El Paso and Amarillo.

ELIGIBILITY

Eligible individuals who wish to participate must voluntarily enroll. PACE enrollees also must:

- Be at least 55 years of age;
- Live in the PACE service area;
- Be screened by a team of doctors, nurses, and other health professionals; and
- Sign and agree to the terms of the enrollment agreements.

SERVICES

PACE offers and manages all of the medical, social and rehabilitative services their enrollees need to preserve or restore their independence, to remain in their homes and communities, and to maintain their quality of life. The PACE service package must include all Medicare and Medicaid services provided by that State. At a minimum, there are an additional 16 services that a PACE organization must provide (e.g., social work, drugs, nursing facility care).
Minimum services that must be provided in the PACE center include primary care services, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals. When an enrollee is receiving adult day care services, these services also include meals and transportation. Services are available 24 hours a day, 7 days a week, 365 days a year.

Generally, these services are provided in an adult day health center setting, but may also include in-home and other referral services that enrollees may need. This includes such services as medical specialists, laboratory and other diagnostic services, hospital and nursing home care.

An enrollee's need is determined by PACE's medical team of care providers. PACE teams include:

- Primary care physicians and nurses;
- Physical, occupational, and recreational therapists;
- Social workers;
- Personal care attendants;
- Dietitians; and
- Drivers.

Generally, the PACE team has daily contact with their enrollees. This helps them to detect subtle changes in their enrollee's condition and they can react quickly to changing medical, functional, and psycho-social problems.

**PAYMENT**

PACE receives a fixed monthly payment per enrollee from Medicare and Medicaid. The amounts are the same during the contract year, regardless of the services an enrollee may need.

Persons enrolled in PACE also may have to pay a monthly premium, depending on their eligibility for Medicare and Medicaid.

**CURRENT PACE SITES**

The number of PACE sites throughout the United States changes periodically and each site has about 200 enrollees. Limited new sites may be added each year. To view a list of current PACE sites go to http://www.cms.hhs.gov and enter PACE sites in the search box. The resulting page will show all available PACE sites with location and contact information of each location.
SOCIAL HEALTH MAINTENANCE ORGANIZATIONS (S/HMO)

A Social HMO is an organization that provides the full range of Medicare benefits offered by standard HMO's plus additional services which include care coordination, prescription drug benefits, chronic care benefits covering short term nursing home care, a full range of home and community based services such as homemaker, personal care services, adult day care, respite care, and medical transportation. Other services that may be provided include eyeglasses, hearing aids, and dental benefits. These plans offer the full range of medical benefits that are offered by standard HMO's plus chronic care and extended care services. Membership offers other health benefits that are not provided through Medicare alone or most other senior health plans. Each plan has different requirements for premiums. All plans have co-payments for certain services.

COMMUNITY CARE PROGRAM (CCP)

Many states offer a Community Care Program. The intent of this program is to allow as many people as possible to continue to live in their home and receive services on an outpatient basis. A case coordination unit is approved by the state to determine eligibility and suitability on a case by case basis.

- Service covered include Homemaker Services, Adult Day Services, and in more densely populated areas, Senior Companion.

- Homemaker Services are available to dust, vacuum, clean the kitchen and bathroom, prepare meals for older adults. Homemakers also assist in personal care such as grooming and bathing.

- Adult Day Services include the opportunity to interact with other older adults outside your home (usually in an adult day care center) a mid-day meal is offered as well as organized activities. Some of these organizations offer transportation services as well as physical therapy and counseling. Adult Day Services can also be employed on an intermittent basis to provide a respite for a primary caregiver. Some adult day care centers offer specialized services for older individuals suffering from cognitive impairment.

- Senior Companions are volunteers who provide in home companionship and assistance.

Eligibility for the Community Care Program.

- Aged 60 or older
- You are determined to be physically in need of service, meaning you are at least moderately impaired
- You are a resident of the state
- You are a U.S. citizen or legal alien
- You meet the asset requirements
- You apply for medical benefits

The cost of the Community Care Program will be paid by Medicaid if your family income is below the Federal Poverty level. If your income is above the Federal Poverty Level the state may still pay some of the costs depending on several income/asset tests and the cost of the total services needed.

**LIFE CARE FACILITIES**

Life Care Facilities and Life Care Communities both provide a continuum of care for older adults. The levels of care most often include several levels of care beginning with independent living and progressing in level of assistance as the patients need for care changes.

What distinguishes Life Care Facilities from other levels of care is the guarantee of future treatment. The Life Care Facility assumes the risk of providing future care to the residents in return for an initial deposit (often called an endowment) and/or periodic (usually monthly) payments. These facilities often require the proposed resident (applicant) to be underwritten as to current medical condition. If the applicant is accepted they will pay an upfront deposit or endowment and agree to make monthly payments of a stated amount for the rest of their lives. In return the applicant (called a resident if accepted) has exclusive use of living space in the independent living section so long as their medical condition allows them to live independently.

In order to allow an independent lifestyle as long as possible these Life Care Facilities offer home health care services, meals on wheels, and a variety of other benefits designed to keep you in your home longer. If at some point the resident’s health deteriorates to the point where they can not have their medical needs met in a home environment they are transferred to a long term care or hospice bed within the same life care facility.

One of the many benefits offered by a Life Care Facility is continuity of care setting. The resident is guaranteed to have all of their non hospital care provided in the location they “buy into”. This is particularly valuable to a couple where if one of the is in the long term care facility they non-inpatient spouse is still in the independent living mode and remains in a community surrounded by other people their own age with similar concerns and interests.

Before a Life Care Facility can begin operations they must first be granted a license by the State Department of Public Health or State Hospital Authority. The licensing process includes a filing of copies of the “Life Care Contract” proposed to be used as well as audited financial statements. In addition to meeting all of the medical protocol requirements for a elder care and/or long term care/hospice facility the Life Care Facility
must also meet strict financial requirements. There are specific escrow requirements for the advance payments made by the residents and ongoing financial reporting to assure financial solvency of the Life Care Facility.

In addition the Life Care Facility must maintain adequate inpatient beds to actuarially provide space for any resident who needs an inpatient bed. The Life Care facility can not admit non-residents to the long term care beds unless they can prove that they have an excess of bed capacity and that residents will not have to wait for an inpatient bed as a result.

WHO FOOTS THE BILL?

HOSPITAL EXPENSES

Since hospitals must charge for their services (and they can be astronomical), payment must be secured somehow. There are four methods of paying hospital expenses:

- Personal Savings (Cash);
- Medicare;
- Medicaid; and
- Private insurance.

PERSONAL SAVINGS

A person’s savings can be used to pay for the services of the hospital. At the going rate of up to a $1,300 or more a day however, savings can rapidly be depleted.

MEDICARE

Medicare is a federal insurance program providing medical care, especially for the aged. Long-term care hospitals, in general, are defined in the Medicare law as hospitals that have an average inpatient length of stay greater than 25 days. These hospitals typically provide extended medical and rehabilitative care for patients who are clinically complex and may suffer from multiple acute or chronic conditions. Services may include comprehensive rehabilitation, respiratory therapy, cancer treatment, head trauma treatment and pain management.

Medicare is the principal insurance plan for anyone 65 or older, people of any age with permanent kidney failure, or those receiving Social Security disability benefits. Medicare Part A helps to pay for inpatient hospital care, inpatient care in a skilled nursing facility and certain home health care services. Medicare Part B helps to pay doctor’s services and other medical services not covered by Medicare hospital insurance Part A.
**MEDICARE ELIGIBILITY**

To be eligible for Medicare you must be 65 or older and either you or your spouse must have accumulated at least 40 quarters of coverage by paying Social Security taxes on earned income. At any given time about 10% of all Medicare enrollees enrolled in Medicare through one of the alternate eligibility portholes such as end stage renal disease or 29 months of disability. There is another way to enroll in Medicare and that is being at least age 65 and having never paid Social Security taxes or having paid less than the required 40 quarters in order to utilize this eligibility you must either be a citizen or a resident legal alien who has lived in the United State for at least 5 out of the last 7 years.

In 1984, the Medicare system underwent a radical reform. Because Medicare paid all hospital care expenses prior to 1984, the cost to the federal government was astonishing. The “Diagnostic Related Groups” (DRGs) system was developed. Under this reimbursement system, hospitals are paid a flat rate for designated illnesses. If the hospital is able to stabilize the patient for under the Medicare flat rate, the hospital can keep the overage amount. However, if the hospital is unable to stabilize the patient for the Medicare flat rate or under, the hospital must absorb the cost differential. Therefore, there is a strong monetary motivation for hospitals to release patients as soon as possible.

Consequently, the meaning of the word “stabilized” has changed significantly since 1984. Prior to 1984, a person’s stay in the hospital could go on almost indefinitely, or at least until he either got significantly better or died. Today, stabilized means that the hospital has determined that the medical condition will not get worse.

**MEDICAID**

Medicaid is not available to everyone. It is a public assistance program designed for lower income individuals who can qualify both financially and medically.

Medicaid is a program of medical aid designed for those applicants who meet the following two requirements:

- Financial eligibility; and
- Medical eligibility.

State and federal governments finance this program. Currently, an individual’s assets (excluding their home) must be less than $2000, but these amounts are subject to review by Congress and could be changed at any time. Medicaid is used when all other systems and requirements fail to cover costs.

**PRIVATE INSURANCE**

Most employers today provide health care plans for their employees (i.e., HMO,
PPO). DRGs are usually a part of these policies.

CARING FOR YOUR LOVED ONE

Once a patient has been stabilized in a hospital, it is time for the patient to be released. Now it is up to the family to decide where that patient will go. There are usually only two options:

- Take the patient home; and
- Take the patient to a nursing home.

If the person’s medical condition is slight, home care may be the option to choose; at least for the time being. As long as the condition requires minimal care, it would not be too difficult to work into the caregiver’s normal routine.

However, if and when the person’s medical condition takes a turn for the worst, more time and attention will be needed and that may prove too difficult to work into a normal routine. In most families, every member tries to help out; but the majority of the care usually falls to the female of the household (i.e., wife, daughter, and mother). Something has to give. It could be the time normally spent on the other members of the household, and it could also be the caregiver’s health that suffers. For instance, if the ill person is no longer able to lift themselves out of a chair, or bed, and into a wheelchair without assistance, or to lift themselves onto and off of the bathroom facilities, the caregiver’s physical well-being can become at risk.

The errands that the caregiver normally runs for her family (i.e., shopping, running the kids here and there) will have to be done by someone else. And that someone else probably already has a full schedule. This can put even more strain on the family. So much strain that relationships have suffered severely, even end in divorce.

Sometimes the amount of care necessary requires the caregiver to quit her outside job in order to stay home with the chronically ill person* 24 hours a day if necessary. Such a situation can cause even more stress on the family, due to financial burdens.

LONG TERM CARE INSURANCE THAT WILL PAY FOR FAMILY CARE

While most long term care policies will only pay for home health care when the services are performed by a qualified individual and that individual is not a family member you can buy long term care policies (even partnership policies) that still require the individual to be qualified but will allow the individual to be a family member. These same policies will pay a training benefit for the family member to get training and this benefit is in addition to the daily benefit otherwise payable. With this type of policy the concerned family member could provide home health care for their loved one and use the daily benefit to pay a qualified individual to perform the services meanwhile the family member is also being paid a training benefit to become a certified caregiver. Once the family member is qualified they can take over the caregiver services and be paid a daily benefit by the long term care policy.
*Chronically ill individual is usually defined as any individual who has been certified by a licensed health care practitioner as (1) being unable to perform (without substantial assistance from another individual) at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity or (2) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

Entire lives have changed in such a short time and it may take a long time before everyone can recover.

Everyone wishes they were able to care for a loved one who can no longer care for themselves at home, but the realities of the situation must be closely examined. If the situation is much too difficult and the sacrifice is too great, the alternative is a nursing home.

**VETERANS’ ADMINISTRATION**

It is a common misconception that the VA will cover all medical expenses for veterans. Unless the care is necessary due to a service-related illness or injury, the VA rarely pays as once again, this care is considered custodial care.

However, the VA is in the present time compiling new information on health care programs for elderly veterans.

A new web site will soon be available with information about hospice care, home-based primary care, geriatric evaluation and management, domiciliary care, Alzheimer's/dementia program, adult day health care, and respite care. In the meantime, you can contact them at [www.va.gov](http://www.va.gov) and click on the link to send an e-mail to the Senior’s Mailbox for the latest available help and information.

**CANCER PROGRAM**

The VA cancer program ensures that users of the veterans health care system have easy access to consistently high quality cancer prevention, detection, and treatment services. Its Web site offers cancer facts, information about care, a list of VHA designated comprehensive cancer centers, and the VA's national cancer strategy.

**LONG-TERM NURSING HOME CARE EXPENSES**

If a family has not prepared themselves financially for the possibility of long-term nursing home care, the situation can be devastating. It can rob them of their own retirement, their children’s college funds and/or a comfortable way of life in their own declining years.

Remember who does NOT pay for long-term nursing home care:

- Private health insurance companies;
• The Veterans’ Administration;
• Health Maintenance Organizations (HMO’s); and
• Medicare.

So how do the expenses get paid?

• Private currency;
• Medicaid; and
• Nursing Home Insurance.

PRIVATE CURRENCY

At a low-end national average cost of $43,000 a year for nursing home care it will not take long to wipe out a family’s savings. A recent poll by the AARP found that an average family’s life savings would be totally depleted within nine months.

NURSING HOME INSURANCE

It is possible to protect your savings in order to provide for a surviving spouse and/or your children should they require assistance in the future.

Nursing Home Insurance may be the way to protect yourself and your family from financial ruin. Many insurance companies now offer plans that offer custodial care payments for a specified number of years.

MAKING ARRANGEMENTS FOR THE FUTURE

One way to avoid the pitfalls of procrastination is to make sure your client makes prior arrangements to protect his assets just in case he should become unable to manage his own financial affairs at some future point in time. Also, if you are assisting your client in making arrangements for a loved one who is unable to handle their own financial affairs, there are some key instruments you and your client should be aware of.

POWER OF ATTORNEY

A Power of Attorney is a legal instrument that can be given to anyone, but it is usually granted to a relative or close friend. Giving a Power of Attorney enables that person to handle an individual’s financial affairs, such as accessing their bank account, or handling their stock portfolio, on their behalf. Explicit instructions should be devised as to how and when this instrument should be used.

One must be careful when considering giving someone a Power of Attorney. It is a way of giving up control and can, if not placed in the most trusted hands, be used to that person’s detriment. Always be careful of whom you are deciding to give this power to. Your client might also consider another means of protection,
which is giving a Power of Attorney to more than one person, if your state allows it. This would create an additional safeguard for your client.

Be mindful of the fact that, even though there is no explicit expiration date on a Power of Attorney, some financial institutions may refuse to accept them after a certain amount of time. A Power of Attorney should be updated at least every two years to guard against an institution’s refusal to accept the document and also to protect your client in regard to any changes he might want to make later on.

There are two types of Powers of Attorney:

- A Regular Power of Attorney; and
- A Durable Power of Attorney.

**Regular Power of Attorney**

This legal instrument usually gives explicit, yet restricted, powers. An expiration date is usually not included in the document; however, its power terminates the moment you become debilitated.

**Durable Power of Attorney**

The difference between a regular power of attorney and a durable power of attorney is that the durable power of attorney remains valid even if you become debilitated. It can be used very efficiently in planning to protect assets, which otherwise might have to be spent on long-term care facility expenses.

Another option is the “springing” durable power of attorney. This document differs in the respect that it does not become effective until you become debilitated, whereas the others are effective the moment they are signed.

**CONSERVATORSHIPS**

A conservatorship can be just as effective as a durable power of attorney, with the same privileges and responsibilities. However, a power of attorney can be done with almost total privacy, whereas a conservatorship must be granted by the courts.

When a person becomes incapacitated, another may seek appointment by an appropriate court to handle the assets and affairs of the debilitated person, thereby establishing a conservatorship. In some states, the debilitated person (the ward) can assist in naming a conservator. The conservator is granted the power to handle the ward’s assets in his stead; however, unless the ward has at least 30 months to plan to protect countable assets, a conservatorship may be rendered almost useless.

Conservatorships are most effective when the nursing home resident becomes so
sickly that long-term management of his assets becomes necessary.

Remember that Medicaid planning means taking the assets out of the ward’s name, and this is not accomplished through a conservatorship. A conservatorship only gives the conservator legal control, but the assets remain in the ward’s name. Therefore, a conservator actually protects and saves assets for Medicaid rather than protecting assets from Medicaid.

**GUARDIANSHIPS**

The difference between a conservatorship and a guardianship is that the guardian also has the right to control what happens physically to the ward as well as financially. The courts grant the guardian the power to make decisions regarding the ward’s physical well-being and care.
Chapter 10

COMPARING LTC POLICIES

Both benefits and restrictions vary from company to company and from policy to policy

Comparing policies is extremely difficult because companies are selling policies with many different combinations of benefits and coverage. Most offer to pay a fixed dollar amount each day you receive care. Other companies offer to pay a percentage of the cost of services or a specified dollar amount to cover the actual charges for care. These policies however may not be beneficial to consumers, unless they provide for benefits to increase as nursing home costs rise. Without inflation protection [described below] a consumer could be left with a benefit that is meaningless.

POLICY RESTRICTIONS VARY

There are so many different restrictions written by insurance companies that it is virtually impossible to list them all. Common descriptions include the type of nursing supervision, the size of the facility, type of care provided and level of licensing.

HOW LONG TERM CARE POLICIES PAY BENEFITS

Long term care insurance policies are designed to cover a range of care settings and services. Some contracts will cover nursing facility only coverage and some will cover home health care only. In addition many contracts are integrated and cover both major subheading of care. The consumer faces many choices and to features and benefit or riders that can be added to many long term care insurance policies. This course section will cover theses care setting and consumer choices in long term care insurance policies.

NURSING FACILITY COVERAGE ONLY

Older long term care policies covered only inpatient and often mirrored the requirement under Medicare part A for admission to a skilled nursing facility that one must have been inpatient in a hospital for at least 3 days prior to benefit. Many states disallow this requirement in a long term care policy. A nursing facility only policy will cover the insured for a confinement to a nursing facility but will not pay a benefit if they elect home health care instead. Premiums for a nursing facility only policy reflect this restriction on care setting by being lower than a policy covering both nursing facility and home health care settings.

TAX QUALIFIED, NON-TAX QUALIFIED
Long term care policies are available as either tax qualified or non-tax qualified. Tax qualified policies are written to take advantage of the tax preferences afforded by The Health Insurance Portability and Accountability Act of 1996. While tax qualified long term care policies do give the insured a margin of tax relief the tradeoff is more restrictive contract requirements. Many consumers opt for the non-qualified plans because of the considerably less restrictive contract language as a result the tax qualified plans are the minority of in-force long term care policies today. A tax qualified plan has more restrictive language in the benefit triggers. Tax qualified policies require the following for benefit to be paid:

Insured to be certified as chronically ill by a physician within 12 months of applying for benefits;

Insured to be unable to perform at least two activities of daily living as a result of loss of functional capacity or severe cognitive impairment, this condition must have already or be expected to last for a continuous period of not less than 90 days. OR

Insured diagnosed with severe cognitive impairment

When the assessment of the insured is performed the physician must certify that insured needs “substantial assistance” in the case of severe cognitive impairment.

This presents a stark contrast to the benefit triggering language in non tax qualified policies which do not require the diagnosis of chronic illness or the continuous 90 day period of loss of functional capacity.

NURSING FACILITY WITH HOME HEALTH CARE RIDER

Many companies offer a long term care policy which covers nursing facility and offers a rider to optionally add coverage for home health care. This is a very popular choice with consumers because they would rather (if medical factors allow) to have care provided in a home setting versus inpatient. The consumer is usually offered the option of purchasing differing benefit amounts for nursing facility care and home health care. By purchasing a policy that covers both nursing facility and home health care the consumer is also protected if there medical condition necessitates the nursing facility (inpatient) level of care:

Home health care coverage routinely pays for the services of the following professions:

- licensed nurse
- home health care aide
- comprehensive outpatient rehabilitation specialist
- physical therapist
- speech pathologist
- respiratory therapist
- occupational therapist

In addition to services of the professionals above home health care will also pay for:
- Homemaker services
- General assistance with ADLs
- Respite care to relieve a primary care giver

Most companies require that these services be performed by a qualified persona and that person can not be a relative. There are some long term care policies that allow relatives to be the care giver and will even pay an additional benefit for the relative to be trained as a care giver. In a compressed course format one can be qualified in most states in as little as six weeks.

INTEGRATED POLICIES

An integrated long term care policy has automatically included nursing facility care and home health care into the same contract. Both coverages are hard coded in the policy and are not added by rider. This is the most common long term care policy marketed today. The consumer has reserved the option of receiving needed services on an outpatient basis but is also protected should they have to go inpatient to receive the proper services needed.

It is common for the contract to stipulate a lower benefit amount for home health care than for nursing facility care. Some of these policies make no distinction in benefit amounts between levels of care and will pay up to the same amount of benefit for home health care as nursing facility care.

HOME HEALTH CARE COVERAGE ONLY

A home health care only policy requires that covered services be performed in an outpatient care setting such as a home or adult day care and specifically does not cover nursing facility care settings. This is the least common approach to insuring the long term care risk. Coverage is the same as described above under Nursing Facility with Home Health Care Rider.

NURSING FACILITY BENEFITS

The following details many pertinent issues relative to nursing facility care and how policies address these care and insurance benefit issues.

LEVELS OF CARE

As mentioned earlier most states prohibit a long term care policy from requiring a hospital stay as a prerequisite for covering skilled care, intermediate care, or custodial care. Below is a brief description of each of these levels of care and the setting in which they occur.

SKILLED CARE

The term skilled care often refers to a benefit level under Medicare part A “Skilled Nursing Care” occurs in an inpatient setting, can be a freestanding building, or a designated wing, room, or bed within a Medicaid qualified nursing facility, or hospital.
Medical care provided by skilled medical personnel under the direction or supervision of a licensed physician. This level of care is considered rehabilitative or recuperative and includes speech, physical, and occupational therapy. All services must be ordered by a physician and provided by a professionally trained person. Medicare will not pay for a skilled nursing stay unless the patient had been inpatient for at least three days out of the immediately preceding 30 day period for the same reason they are seeking admission to skilled nursing care. It is this preadmission requirement that many early long term care policies mirrored in their limitation of when they would pay for skilled nursing care. While Medicare does still impose this re-admission requirement a long term care policy can not.

INTERMEDIATE CARE
This care occurs in an inpatient setting, which can be a freestanding building, or a designated wing, room, or bed within a Medicaid qualified nursing facility, or hospital. The care provided is not skilled in nature but is more involved than custodial care. The patient needs less than 24 hour supervision but is not ready to be discharged. The patient may need occasional (at least daily) injection or tests that can not be performed in an outpatient setting. Intermediate care is often performed at the direction of or under the indirect supervision of a physician. A long term care policy can not require a pre hospitalization to cover intermediate care.

CUSTODIAL CARE
Custodial care is services that do not have to be performed by skilled medical personnel to prevent risk of injuring the patient. It includes assistance with the activities of daily living and other personal assistance. This care can occur in a nursing facility, at home, in adult day care, or in one of many other alternate care arrangements such as assisted living. A good example of custodial care in an inpatient setting would be helping the patient to get out of bed, bathe and, dress.

ASSISTED LIVING
Another form of custodial care is assisted living which has been mentioned throughout this text. The terminology or nomenclature used to describe many of these less formal forms of care varies widely regionally. What all of these care settings have in common is that they provide non-medical supervisions (usually on a 24 hour basis) and are group care settings.

Adult Day Care
Adult day care is a form of custodial care that is usually as the name implies limited to the daytime hours.

Adult Boarding Care
Adult boarding care, adult care homes, adult foster care homes, residential care facilities, adult family homes are all names for essentially the same type of care. This level of care entails 24 hour non-medical supervision, room and board, as well as assistance with ADLs, all in a group setting. The care setting can be as small as a converted principle residence with five patients and one care giver to a larger 100 patient facility. The
majority of care settings trend towards the smaller end of this scale and many are small, one location facilities. Licensing requirements vary widely from state to state so it is wise to check licensing.

NO PRIOR HOSPITAL STAY REQUIREMENT ALLOWED
As mentioned above Medicare requires a three day inpatient hospital stay (within the immediately preceding 30 day period before a person can be admitted to a nursing facility for skilled nursing care. Under most state laws, a person can be admitted at any time after a physician certifies the need for care under the insurance policy assessment criteria. In order to receive custodial care paid for by a long term care policy the physician need only certify the insured’s need for assistance with three or more activities of daily living.

PATHOLOGICAL DIAGNOSIS DEFINED
A pathological diagnosis is one where the decision is arrived at by observing information (often as a result of a test) where the patient participated in the test (by giving blood, urine, or submitting to an X-Ray or MRI etc) but the patient could not affect the outcome of the test results. Further two physicians observing the test results of a pathological diagnostic procedure are likely to agree on the results (the bone is broken, blood glucose is elevated etc).

CLINICAL DIAGNOSIS DEFINED
A clinical diagnosis is arrived at by the physician observing the actions and reactions of the patient to a series of stimuli. A range clinical diagnosis depends on the patients participation and relies on the patient understanding the stimuli (often a question) and responding truthfully. Further two physicians observing the results of a clinical test are not as likely to agree on what the diagnosis should be as with a pathological diagnosis.

Most clinical diagnostic tools are employed in the areas of mental and nervous conditions and physical therapy. Range of motion tests (which are clinical in nature) are often used to demonstrate a persons need for hands on assistance for an ADL.

Cognitive impairment (which is an ADL) is a trigger all by itself in that a person may have the physiological ability to perform the ADL’s as described above but need verbal instruction or reminders (cuing) or may need supervision to prevent injury to the insured or others.

The diagnosis of cognitive impairment (while the patient is alive) relies on a clinical tests. There is a postmortem biopsy (which is a pathological diagnostic test) that can be performed to demonstrate elevated aluminum levels in the brain. While not universally accepted there are pathological test that can be performed while the patient is alive to detect chemical imbalances in the blood that some believe demonstrate some level of cognitive impairment. Most medical professionals agree that currently a clinical diagnosis of cognitive impairment is the most reasonable approach; therefore under most state regulations insurance companies must accept a clinical diagnosis for this ADL and are more likely to request a second opinion for cognitive impairment than with the
assessment of any other ADL.

UNDERWRITING AND COGNITIVE IMPAIRMENT
Cognitive impairment also affects underwriting a long term care policy. Since a LTC policy can not exclude coverage of cognitive impairment the insurance company tries to avoid adverse selection but determining cognitive ability in advance of policy issue. Cognitive impairment is a gradual onset illness and often the proposed insured and/or those close to the proposed insured will notice the onset well before it impairs function. Couple this gradual onset with the definition of preexisting conditions and it is entirely possible for a person to notice the beginnings of cognitive impairment and seek coverage prior to “having treatment provided by or recommended by a physician”.

CASE MANAGER REQUIRED
Many States require a case manager for Long term care claims which work with the physician to develop a plan of care for the insured.

In order to avoid adverse selection in the area of cognitive impairment insurance companies will try to ascertain cognitive function during underwriting. Some companies will screen all applicants while some will set a combination of age and benefit amount to determine when to utilize screening as an underwriting tool. The most common screening process is a phone call. The proposed insured will receive a phone call during the underwriting process, the caller will be very affable and attempt to put the proposed insured at ease. The called will be a trained mental health professional who will ask a series of questions designed to illicit from the proposed insured their degree of mental acuity.

The need for hands on assistance that a person must demonstrate to be eligible for a benefit is minimal. If the insured can not perform an ADL without even the slightest amount of hands on assistance then they are considered eligible. If they need any hands on assistance with three or more ADLs then the insurance company must pay the benefit.

Each Activity of Daily Living addresses a different aspect of living independently.

BATHING AS A BENEFIT TRIGGER
Bathing is a necessary function of daily living and part of independent living. If the insured can not wash themselves and/or have safe ingress and egress to a tub or shower then they need hands on assistance. It is assumed that the insured will have a properly equipped tub or shower with grip bars, anti-slip mat, and bathing seat to bathe in. It is common after a stroke for the patient to have temporary or permanent inner ear balance problems that could make it dangerous for them to attempt to bathe alone. A person with a limited range of motion may not be able to manipulate their hands into the positions necessary to bathe themselves.

CONTINENCE AS A BENEFIT TRIGGER
Continence, something most of us take for granted is considered an activity of daily living. The ability to control the timing of our bowel and bladder is necessary for living independently. If an individual has incontinence (the inability to control bowel and/or bladder) then an activity of daily living would be to properly care for a catheter and/or colostomy bag (if so prescribed). Notice continence is a separate ADL from toileting.

**DRESSING AS A BENEFIT TRIGGER**

Dressing is considered an activity of daily living (including attaching a prosthesis) and the insured will be considered to need hands on assistance if they can not put on and/or take off all items of clothing or attach a brace. Note that the code does not address manipulating buttons, zippers, hooks, or tying shoes. It is assumed that you wear Velcro closure garments or other attire that does not require the fine motor skills that are required to fasten some of the more fashionable garments.

**EATING AS A BENEFIT TRIGGER**

Eating is considered the ability of the insured to feed themselves by manipulating the food and drink from a receptacle (plate, cup, or table) into the body including intravenously or tube feeding.

There are four type of assistance one might need with feeding

**Spoon Feeding**

Spoon feeding is when an individual can chew and swallow food but cannot (usually because of a range of mobility issue) affix the food to the utensil, grasp the cup, and make the round trip from the table to the mouth. The act of feeding someone orally (spoon feeding) is not considered skilled care and is not covered by Medicare.

**Nasogastric Feeding**

This method of feeding involves the insertion of a tube into the nose and down the throat. The food is prepared then pureed in a blender and put into a hypodermic injector and sent down the tube to the stomach. The act of feeding someone nasogastrically is not considered skilled care and therefore is not covered by Medicare.

**Introgastric Feeding**

Introgastric feeding involves having a shunt surgically inserted into the upper G.I. tract. The feeding is then performed through a tube as describe above (nasogastric feeding) except that enzymes are added to aid in absorption of nutrients. Sometimes the feeding is performed by using a constant drip from an IV bag. Feeding someone introgastically is considered skilled care and is covered by Medicare.

**Intravenous Feeding**

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This method of feeding is where the patient is receiving all nutrition and/or hydration through an intravenous drip or pump. Intravenous feeding is considered skilled care and is covered by Medicare.

TOILETING AS A BENEFIT TRIGGER

Toileting includes getting to and from the toilet, getting on and off the toilet, and performing the personal hygiene tasks related to toileting. In the assessment standards for most insurance companies the insured is responsible for having a handicapped accessible toilet outfitted with the necessary grip rails and bars. Often a toilet chair (properly adjusted) will suffice. The essence of the assessment process is to make sure that the height of the toilet is somewhat higher than a standard toilet. It is not enough for an insured to claim they can not manipulate themselves on and off of a standard height toilet.

TRANSFERRING AS A BENEFIT TRIGGER

Transferring as the ability of the insured to move in and out of a chair, bed, or wheelchair. By definition someone claiming the need for hands on assistance under this trigger has issues with mobility. The assessment standards in long term care policies assume that the insured is transferring laterally and there is minimal height difference between the seating surface of the wheelchair and bed or chair. This is not to say the assumption is made that the insured is confined to a wheelchair. An insured may need the use of a walker, crutch, or cane for general mobility but have trouble transferring to seating or laying positions.

Transferring is the one benefit trigger where an insurance company is most likely to liberalize their contract definition. Some companies will introduce the concept of wheeling. Wheeling assumes that you are confined to a wheelchair but cannot (without assistance) cause the wheelchair to move in predictably and consistent manner. When this is included in the benefit definition the insured can expect to pay a higher premium. The relative value of the wheeling can be great. While one can secure a totally electric wheelchair the concern would be what if the battery runs down while the insured is in the middle of the room and can’t reach an outlet to recharge the chair. Another scenario would be the battery is depleted and the insured needs immediate egress from the house (fire, or other emergency).

No insurance company may combine any of the six activities of daily living to create a combined or compound assistance requirement.

In order for the insured to evidence their need for assistance the following must occur:

Insured must have the inability to perform three of six activities of daily living (some policies only require two of six) which is certified by a physician.
OR:
Have a clinical diagnosis of cognitive impairment.
The amount of the benefit paid to the insured will depend on the type of policy they have. One approach to policy benefits is the traditional daily indemnity benefit where the insured will be paid the amount of benefit they purchased irrespective of the actual expenses incurred. Another approach is a reimbursement contract which will pay for the covered expenses that are actually incurred.

The case manager mentioned earlier will work with the insured and physicians to determine the care setting and services needed.

**UNIVERSAL EXCLUSIONS**

Even though policies and their benefits and restrictions vary, there are certain circumstances under which no insurance company will make provisions, such as the following:

- Addictions to drugs and alcohol;
- Injuries and illnesses caused by war;
- Treatment paid by the government; or
- Self-inflicted injuries, such as in suicide attempts.

**LTC BENEFITS UNDER LIFE INSURANCE POLICIES**

Long-term care benefits are offered as part of some individual life insurance policies. Under these plans, a percentage of a policy's death benefit is paid when long-term care is needed and death benefit and cash values are reduced accordingly. These policies also commonly have strict rules for qualifying for coverage. It should be noted that most LTC riders in life insurance policies are not considered long term care insurance policies and are therefore not regulated by laws governing long term care insurance contracts. One way to tell is look within the life policy at the contract section dealing with the LTC rider and you will see a disclaimer stating that this does not qualify as a long term care policy. Any life insurance policy that offers an accelerated death benefit must have a similar disclaimer because of past market conduct issues where unscrupulous agents would sell a life policy with an accelerated death benefit as a long term care policy.

**SWITCHING POLICIES OR BUYING A NEW ONE**

Of course, the agent must keep the interests of his client uppermost in all transactions. It’s a good idea to supply your customer with an outline of coverage, which summarizes the proposed policy’s benefits and highlights important features. Allow your customer to take his time and compare outlines of coverage. After all, this is a very vulnerable time of life for most people; and keep in mind that someday you may find yourself in the same or similar situation.
FREE-LOOK PERIOD

If your client decides he does not want the policy after purchasing it, make sure he knows he can cancel the policy and get his money back if he notifies the company within a certain number of days after the policy is delivered. This is called the "free-look" period. Check with your state insurance department to find out how long the free-look period is in your state. If your client decides he wants to cancel, he should:

- Keep the envelope the policy was mailed in;
- Return the policy to the insurance company along with a brief letter asking for a refund;*
- Send both the policy and letter by certified mail and obtain a mailing receipt;
- Keep a copy of all correspondence;

*The refund process usually takes 4 to 6 weeks.

Make sure your client:

- Understands the policy;
- Is not misled by advertising (endorsements by celebrities of a certain product can be misleading; however, they are professional actors and are paid to advertise; they are not insurance experts);
- Is aware that neither Medicare nor any other federal agency endorses or sells long-term care policies (be skeptical of any advertising that suggests the federal government is involved with this type of insurance – be wary of cards received in the mail that look as if they were sent by the federal government);
- Understands that it is not necessary to purchase multiple policies to get enough coverage (one good policy is enough);
- Knows that disclosing his medical history accurately is extremely important;
- Does not pay you in cash (writes a check and makes it payable to the insurance company);
- Has your name, address and telephone number and the same information about the insurance company you represent;
- Knows that if he doesn’t receive his policy within 60 days, he should contact either you or the company;
- Re-reads the application he signed before it is submitted.
When he receives the policy, he should read the policy again and make sure it provides the coverage he wants.

AGENT’S RESPONSIBILITIES

It is the agent’s responsibility to collect the initial premium payment and deliver it to the insurance company while the insured remains in good health. Once this has been done and the policy is accepted by the insurance company, the agent’s delivery responsibilities come into play.

DELIVERING THE POLICY

The agent is responsible for explaining the policy to the insured. The rates established and reasons for those rates, any exclusions, riders, or provisions should be explained to the policy owner.

It is the agent’s responsibility to deliver the policy to the insured. The delivery of the policy must be accomplished as soon as possible after the policy is issued. Though the policy may be issued, it is not effective until the agent receives the initial premium payment.

When the policy is delivered to the insured, and the initial premium payment is collected from the insured, the policy is in effect.

RECOMMENDING ELECTRONIC PAYMENTS

It may be a good idea to suggest that your client have premiums automatically deducted from his bank account and paid electronically by his bank. Of course, everyone varies on their opinions regarding the use of electronic payments; however, should an illness delay or prevent your client from paying his statements on time, his coverage would not lapse.

LTC POLICY OPTIONS

Neither Medicare nor Medigap policies offer long-term care as a benefit.

LONG-TERM CARE AND STANDARD PROVISIONS

In the beginning, the long-term care policies carried many more restrictions than the current generation of policies. Some were tied to Medicare restrictions, prior hospitalization, nursing facility only, no in-home coverage, minimal level of service and most excluded Alzheimer and Dementia.

Long-Term Care policies have evolved over the past decade in an attempt to standardize provisions for the consumer, insurance industry and federal and state governments. It started with the National Association of Insurance Commissioners developing a model to
help state legislatures in an effort to keep regulation on a state level. More than half of the states currently use the NAIC or a similar type model. In an effort to alleviate bewildering policy language to the consumer and create uniformity among long-term policies in general, some major key standard provisions were:

- Standardization of waiting periods;
- Standardization of benefit periods;
- Full coverage for all levels of care;
- No prior hospitalization confinement necessary; and
- Standards for covering pre-existing conditions.

Standardized Medicare supplement policies, Plans D, G, I and J, do contain an at-home recovery benefit that may pay up to $1,600 per year but only for short-term, at-home assistance with activities of daily living, for an illness, injury or surgery during a limited recovery period.

**LONG-TERM CARE POLICY RIDERS**

**Standard Rider**

Long-term care policies can be added to an existing life insurance or disability income policy as a rider. Riders are similar to the standard long-term care policy, in which the elimination and benefit periods and levels of care remain the same.

**Living Benefit Rider**

This rider is specifically for the terminally ill, and can provide the individual with 70 to 80 percent of their existing life insurance policy’s death benefit to cover nursing home care costs. There is also an option that will allow the individual to receive 90 to 95 percent of the death benefit.

**Elimination Periods**

Most long-term care insurance policies require policyholders to pay for their own care for a specified number of days before they are entitled to receive benefits. The days paid for directly by the policyholder are commonly referred to as an "elimination period," which is very much like a deductible in accident insurance.

How the elimination period is calculated differs from company to company. Some carriers count the days cumulatively, where for example a patient moves in and out of a nursing home. Other companies demand that the waiting period be counted consecutively, namely, they do not allow any interruption in the days of nursing home care in order to qualify. Some require only one elimination period for the life of the policy and others begin counting every time a policyholder applies for benefits. Elimination period rules can require consumers to physically pay costs out of their own pockets, not just incur liability for services. Most policies even require the consumer to
continue paying premiums while also paying health care costs during the elimination period.

In selecting a waiting period, your client will have to weigh the trade-off between paying more for coverage that begins upon entrance into a nursing home or paying out-of-pocket for the first days spent in the nursing home.

**BENEFIT PERIODS**

Most policies do not pay benefits until after a waiting period, commonly called an elimination or deductible period. That means benefits begin 20, 30, 60, 90 or 100 days after admission into a nursing home. Some policies have no elimination period and they naturally cost more. During any waiting or elimination period, insureds are responsible for paying for their own care, but there are significant trade-offs. Having a reasonable waiting period during which the insured is personally responsible for his care means the insurance company can expect to pay out fewer benefits and accordingly underwriters can establish lower prices for these contracts.

All policies allow you to specify how long you desire benefits to last. Benefit periods range from one year to life. Obviously policies with long benefit periods cost more.

Once the Elimination Period has been chosen (usually 0 days up to 120 days), the length of time in which benefits are paid will be stated clearly in the policy once it has been issued. Individuals usually can select between $50 and $250 per day for their Daily Benefit. Though policies may differ, most insurers offer benefits of one to five years for the Benefit Period. Some insurers have policies for purchase that offer lifetime benefits.

**PRE-EXISTING CONDITIONS**

Most policies that involve any type of health issue contain a pre-existing clause. A pre-existing condition is any type of medical condition that was discovered or treated before the policy came into effect. Most policies contain a clause that voids any benefits for conditions that were known to exist for a period of 6 months before the date of issue. In addition, some policies require a 6-month moratorium for conditions after the policy effective date, in essence making the 6-month Pre-existing Condition Clause a total of a year.

**EXCLUSIONS**

Just as valuable as benefits in a policy are the exclusions it contains. Certain exclusions are generally contained in most all long-term care policies.

- Veteran’s Hospital care;
- War or military conflict;
- Losses that Workers’ Compensation covers;
- Injuries self inflicted deliberately.
If a nursing home in the area costs $100 a day, a policy with a 30-day elimination period will require the insured to pay $3,000. Consider what your client can afford today for a thirty-day nursing home stay. If your client has the discipline to put that much money into a long-term government treasury bill, he will be guaranteed that money will be there when needed; only then should he buy a policy with a thirty-day waiting. Most people do not have this kind of discipline.

Some companies offer products without an elimination period, but most require as few as 30 days to as long as one year. As a practical matter, there are significant savings the longer the waiting period he can accept.

**WAIVER OF PREMIUM**

A provision waiving premium payments is common in health insurance policies and is usually a standard provision. It discontinues the insured’s legal obligation to pay premiums if he is receiving benefits. Some companies stop billing the client as they make the first benefit payment. Others wait 60 to 90 days. However, often premiums are not waived while the patient is in a hospital or if he is receiving care at home.

**DEATH BENEFITS**

Death benefits are an agreement to refund to the insured’s estate any premiums paid minus benefits paid to the insured. In a policy offering a death benefit, the company agrees to refund to his estate a stated level of the premiums he paid minus the benefits paid to him. To qualify for a death benefit with most companies you must have paid premiums for a certain number of years. Others limit the payback if the policyholder dies before a certain age, usually 65 or 70.

**GUARANTEED RENEWABLE POLICIES**

Today almost all policies are guaranteed renewable. Even if your client’s health worsens after buying the policy, it cannot be cancelled. However, keep in mind that premiums can be raised on guaranteed renewable policies as well.

**REINSTATEMENT OF LAPSE BECAUSE OF COGNITIVE IMPAIRMENT**

In order to protect an insured who develops cognitive impairment and as a result does not pay the required premiums on their long term care policy most states require a 5 month reinstatement window. If the insured is diagnosed with cognitive impairment within 5 months of having let lapse a long term care policy they have the right to reinstate the coverage without proof of insurability by paying the premium in arrears. This course will cover unintentional lapse of a long term care policy in more detail in chapter three.

**THIRD PARTY NOTICE OF LAPSE**

At application the insured has the option (but not the requirement) to name a third party (including name and address) to receive notice of lapse of coverage for a long term care policy. The policy must remain in force for 30 days following the notice to the third
party. If an insured elects not to provide a third party for lapse notification the insurer must be informed every two years of their right to name a third party for lapse notification.

RETURN OF PREMIUM
This is a non mandated rider that may be offered in a long term care policy and is similar to the return of premium see on other contracts in the life/health category. Since it is an optional rider if selected it will increase premiums. The way this rider functions is that it will refund premiums paid less claims or benefits paid. Each policy will specify a minimum time period and then policy anniversaries when the insured can surrender/cancel the policy and receive the claims netted premium balance. If the insured dies there will be a refund of the claims netted premiums to the estate or named beneficiary.

NONFORFEITURE BENEFITS
As the popularity of long-term care policies grow, the insured is going to have to be afforded nonforfeiture options that protect their policy and benefits and protects them from forfeiting the same.

Life insurance policies currently contain these three nonforfeiture options, but, their wording will be different as in long-term care policies.

Nonforfeiture benefits in policies provide that at least some benefits will be paid even if the buyer fails to keep up premium payments and the policy is cancelled for non-payment. The benefits provided are usually minimal.

The promise is that the carrier will return to the policyholders some of their "investment" in the policy if they discontinue coverage. These companies usually offer a nonforfeiture benefit in the form of a reduced paid-up policy in which lesser benefits are provided after the client drops the coverage. A nonforfeiture benefit is a cost item carefully calculated by the carrier's actuary; it has a cost that is added to the underlying policy.

Other carriers may offer a "return of premium" in which they return a portion of the premiums after a certain number of years if the policy is cancelled.

The National Association of Insurance Commissioners reports that 16 percent of all nursing home insurance buyers drop their coverage each year because they can no longer afford it. Insurance companies know that of those who buy coverage at age sixty, 95 percent will have cancelled the coverage by age 80. The U.S. General Accounting Office confirmed those figures. Of insurance company files that were investigated and excluding those who had died, 60 percent or more of the original policyholders allowed their policies to lapse within 10 years and one insurance company reported a lapse rate approaching 90 percent.

Nonforfeiture benefits provide consumers who most probably will not be able to maintain their premium payments at least something for their premium dollars. Without
nonforfeiture benefits, once a consumer stops paying all rights under the policy end. The most popular nonforfeiture benefits are:

- Cash Value;
- Reduced Paid-Up Benefit; and
- Extended Term Benefit.

**Cash Value**

This would provide a guaranteed amount to be paid to the insured should the policy be surrendered or lapsed.

**Reduced Paid-Up Benefit**

This benefit provides that the daily benefit be reduced for the policy’s benefit period and that the insured not be required to continue payment of premiums. The Reduced Paid-Up Benefit does exactly as its name implicates; it pays policy benefits at a reduced rate, depending upon how much money was paid into the insurance company. For example, if an individual paid premiums for 10 years, he might receive one-third of the benefit of a $100 a daily policy or $34 per day. The amount of reduced benefits is specified in the original contract. The reduced paid-up benefit amount will not increase for inflation and all policy restrictions apply.

**Extended Term Benefit**

Another type of nonforfeiture option that has come upon the long-term care scene is a cash back feature. Under this provision, an insured might typically receive 50, 60, 70, or even 80 percent of the total premiums paid upon discontinuing a policy either by surrender or having the policy lapse. Of course, as is the case in most cash-back features, claims paid are deducted from the amount of returned premiums.

Extended Term is the extension of coverage for the full amount that the policy would have ordinarily paid without any future payments of premiums for a limited extension of time.

Under this concept the customer receives the originally specified daily benefit, but only for a reduced period depending upon how much money was paid to the carrier over the life of the policy. For example, after 10 years, 25 percent of the premium paid is credited to a "benefit account" and, if the policyholder qualifies, the company will pay benefits until the money in the account runs out. So after paying nearly $30,000 over 10 years the customer would be entitled to $7,500 in long-term care benefits - little more than the cost of one month in a nursing home today in a metropolitan area; the insurance company would only pay benefits from this account until the account was depleted.
Chapter 11

INFLATION PROTECTION

The U.S. House Select Committee on Aging Supports LTC Inflation Protection

Inflation protection is critically valuable and important. The U.S. House Select Committee on Aging concluded in a study that "without inflation protection, long-term care insurance policies are not a wise purchase."

HOW INFLATION PROTECTION WORKS

Since costs inevitably increase, a policy without inflation protection would be outdated in a few short years. Inflation protection ties back to the daily benefit and allows it to grow on an annual basis to help keep the plan in step with inflation. As in everything else, inflation affects long-term care facilities. Therefore, most policies contain an inflation clause, which is usually a 5 percent increase each year in daily benefits.

However, inflation protection options can increase the cost of a policy nearly 50 percent; therefore, some sales agents don’t urge inflation protection to sales prospects. As a result inflation benefits are not often sold and the Health Insurance Association of America (HIAA) reports that of the major carriers offering inflation protection across the United States only one-quarter of the policies sold include inflation provisions.

When selling a long-term care policy, you must consider whether your client can afford to pay the premium now and more importantly whether they will be able to continue to pay the premiums in the future. If they don’t expect their income to increase, it would not be prudent for them to buy a policy now with a premium that is at the upper limit of what they think they can afford now.

Purchasers have the option of buying inflation production in several different manners:

- Simple Inflation Protection;
- Five Percent Compounded Inflation Protection; and
- Indexed Inflation Option.
- Guaranteed Future Purchase Option

SIMPLE INFLATION PROTECTION

This option increases the daily benefit annually by a given percent of the original base benefit.
**On the Upside**
In other words, a $100-per day nursing home benefit which covers 50 percent of today's costs, increasing at a 5 percent rate would increase the daily benefit by $5 each year, making the daily benefit $150 after ten years and doubling the benefit after 20 years to $200.

**On the Downside**
If inflation in the long-term care market continues at 6 percent, the average daily cost of a nursing home is projected to $364 in ten years and $662 in twenty years. As a result, rather than maintaining a benefit at 50 percent of cost, simple inflation protection allows this coverage to erode to only 15 percent of cost in 20 years.

**FIVE PERCENT COMPOUNDED INFLATION PROTECTION**
Rather than increasing the daily benefit by five percent of the original benefit, this option increases the benefit by five percent compounded, meaning that each successive year's benefits are increased by five percent over the previous year.

**On the Upside**
So while the example above pays simple inflation protection and only covers 15 percent of expected future costs after 20 years, the compounded option at 5 percent compounded per year will pay approximately $265 per day, after twenty years.

**On the Downside**
This approach is the best option available, but given the historical, as well as anticipated, six percent inflation rate for long-term care costs, this plan does not keep pace with inflation.

**INDEXED INFLATION OPTION**
This option gives the buyer the right to increase the amount their policy will pay once every three years.

**On the Upside**
The amount of the increase is indexed and tied to the Consumer Price Index reported by the U.S. government. This option is based on the real rate of inflation.

**On the Downside**
This is not much help for the consumer if the inflation rate for long-term care services continues to be higher than that for goods and services. Additionally as the benefit increases, so does the premium. As the policy and the owner age, the premium increases significantly and for purchasers on fixed incomes it is probable the policy will be discontinued because it
is too expensive at a time when coverage is most needed.

**TWO MAJOR VEHICLES PROVIDING INFLATION PROTECTION**

Insurance companies provide inflation protection through two major vehicles:

- Option to Purchase Additional Coverage; and

- Provide Automatic Benefit Increases.

**Option to Purchase Additional Coverage**

Some companies offer customers the right to buy additional coverage in the future at the future price the company will be charging without having to prove medical eligibility. However, the client must be aware that the new premium will be based on the client’s current age, which means it will be more expensive.

This option offers little benefit to the consumer because it only allows the policyholder to purchase additional benefits at then-current rates. Consumer Reports rated this option as the worst possible option and equivalent to no inflation protection at all.

**Automatic Benefit Increases**

The second approach to inflation protection is to provide for automatic benefit increases which allow the daily benefit to increase by a fixed percentage. However, some carriers cap coverage at the end of 10 or 20 years; some companies may offer unlimited increases; and some companies end benefits when a customer reaches age 80 or 85.

Next, carriers must calculate the percentage increase. Some companies use a "simple interest" method and add to the daily benefit each year by a stated percentage of the original coverage.

**Example – 5% Method vs. Compound Interest Method**

In a 5 percent simple inflator policy, the coverage on a $100 daily benefit would increase by five dollars every year. At the end of fourteen years the daily benefit would be $170 dollars, but if the company used the "compound interest" method, at the end of 14 years the daily benefit would be close to $200 [72 divided by 5]. In this instance, it behooves the customer to purchase a policy with automatic increases that are calculated using the compounded method.

The wise agent makes sure he understands exactly how these policies calculate inflation protection so that he can offer the client the best policy and options that are right for him.
Chapter 12

UNDERWRITING

SOURCES OF INFORMATION

There are four sources of information utilized in the underwriting process.

- The Application Form;
- The Agent Participation;
- Verification Reports; and
- Medical Records and History.

THE APPLICATION

An application form must be completed by the purchaser and accepted by the insurer in order for a contract to be valid and in force. This form must be answered truthfully, to the best of the purchaser’s knowledge, and will contain the information upon which the company relies.

THE AGENT

An agent used to be able to accept an application by mail or by phone, as long as the agent acquired the applicant’s signature. However, that is no longer the case. An agent must assist the purchaser in completing the application in person. Thereby, the agent will be able to make observations that would be unavailable to the home office underwriter.

VERIFICATION REPORTS

Just because the application is completed by the purchaser, that does not mean that all information has been answered honestly and with integrity. The insurance company has the right to verify that the information presented is true and correct. A verification report is used for this purpose, not only to legitimize the information presented, but also may in fact yield additional information that might even change the outcome of the decision.

MEDICAL RECORDS AND HISTORY

It is also extremely important to verify medical records and history. Many companies utilize the Medical Information Bureau (MIB) as well as Attending Physician’s Reports (APR’s) in the underwriting verification process.
UNDERWRITING MANNER INFLUENCES PREMIUMS

There are two ways to underwrite a policy that have a direct effect on premiums:

- Standard Underwriting; and
- Substandard Underwriting.

**STANDARD UNDERWRITING**

An application can be accepted and approved “as submitted” for a policy to be issued. If the application is approved as submitted, then a standard premium would be set for the insured.

**SUBSTANDARD UNDERWRITING**

Many times, there are certain underlying factors that will affect policy premiums. These factors will put the company at higher risk for potential loss and, therefore, a higher premium may be charged. Such factors include:

- Pre-existing conditions;
- Past medical condition;
- Current medical condition;
- Future medical condition;
- Age; and
- Moral issues.