How to gain Maximum Knowledge from this course!

In order to enhance the learning and knowledge process, this course incorporates several adult learning strategies designed to increase comprehension and retention of the material.

Since it may have been several years since you were involved in a formal learning process, we have included a brief description of the learning concepts employed by this course.

The format of this text includes the traditional headings and subheadings as well as highlighting and text borders to bring attention to critical concepts and facts.

1. Highlighting: As you study the text, pay particular attention to areas of text that are highlighted in Yellow. Understanding the concepts and facts contained within the yellow highlighted area are critical to successful completion of the final examination.

Text Borders: In order to reinforce certain material in the text it will be set apart through the use of text borders such as the one surrounding this paragraph. When you encounter text surrounded by a text border pay particular attention to the point being made. Material within the text border will be reinforced latter in the course through the use of review questions.

2. Case Studies: Some of the more variable concepts will be illustrated using case studies. These case studies are designed to reinforce the concept being discussed and it is recommended that you take the necessary time to digest the points made within the case studies.

3. For Insurance Licensees in Non-Monitored States, our exclusive web-based search feature allows quick retrieval of important data for maximizing the learning process. Simply execute Ctrl +F and enter keyword(s) or key phrase(s) to locate those items electronically in the course material.

Understanding all of the material in this text is necessary to achieve the overall learning strategies have been incorporated to Success Continuing Education copyrighted courses to increase exposure to portions of the text that are fundamental to the learning process.
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Chapter 1

LOUISIANA LONG-TERM CARE
PARTNERSHIP PROGRAM

THE HISTORY OF PARTNERSHIP PLANS

The purpose of this course is to first develop a thorough understanding of the proposed Louisiana 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 Louisiana) 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.

**CHOICE AFFORDED BY A PARTNERSHIP PROGRAM**

In the absence of the Louisiana 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 is now 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 Louisiana 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 Louisiana 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 Louisiana 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 Louisiana is providing an incentive in the form of asset retention for an individual 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 Louisiana 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 exhausts 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 Louisiana 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 costs 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 Parts 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). 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 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 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 2011. These amounts are adjusted for inflation and will go up periodically.

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<th>Attained age as of 12/31/2011</th>
<th>Deductible Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 or younger</td>
<td>$340</td>
</tr>
<tr>
<td>Older than 40 but not older than 50</td>
<td>$640</td>
</tr>
<tr>
<td>Older than 50 but not older than 60</td>
<td>$1,270</td>
</tr>
<tr>
<td>Older than 60 but not older than 70</td>
<td>$3,390</td>
</tr>
<tr>
<td>Older than 70</td>
<td>$4,240</td>
</tr>
</tbody>
</table>

In order to for the insured to deduct the long-term care premiums the insurer must file IRS form 1099-LTC, Long-term Care and Accelerated Benefits as required by law. The insured handles the deduction on Schedule A (itemized deductions).

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 $300 per day (for 2011), 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 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.

**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 cannot 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

**LOUISIANA PARTNERSHIP IMPLEMENTATION**

Numerous changes and additions to existing law were necessary to implement the Partnership Program in Louisiana. We will address many of these elements to gain an in-depth understanding of Louisiana Law as it relates to each of these issues as well as cover other Louisiana insurance law that while not partnership specific still governs all long-term care policies.

*So the reader can distinguish between the Text of the law and annotations provided by the author, annotations will be in italics and indented as this section is. When annotations reference the Louisiana Long-Term Care*
Partnership Act we will use the abbreviation “LA Partnership”.

The next several pages explain Louisiana partnership implementation issues that were addresses by the Louisiana Department of Insurance in a December of 2009 Bulletin.

LOUISIANA DOI BULLETIN 09-13

Louisiana Department of Insurance Bulletin 09-13
December 28, 2009

The purpose of Bulletin No. 09-13 is to provide guidance regarding the implementation of the Louisiana Long-Term Care Insurance Partnership Program (hereinafter sometimes the Partnership Program).

BACKGROUND AND PURPOSE

The Partnership Program operates under the direction of the Louisiana Department of Health and Hospitals in consultation with the Louisiana Department of Insurance, and Bulletin No. 09-13 is a collaboration of and is jointly issued by both departments. Federal enabling legislation pertaining to the Partnership Program is set forth in the Deficit Reduction Act of 2005, Pub. L. 109-171 (ORA), and implementing procedures are described in guidance issued by the Centers for Medicare and Medicaid Services (CMS). See State Medicaid Director's Letter (SMDL #06-019) dated July 27, 2006, issued by CMS.

Under the Louisiana Long-Term Care Partnership Program, individuals who purchase long-term care insurance policies that meet certain requirements specified by the ORA (Partnership Policies) can apply for Medicaid under special rules for determining financial eligibility and estate recoveries. In the case of group insurance, each certificate that meets the ORA's requirements constitutes a Partnership Policy. These special rules generally allow the individual to protect assets equal to the insurance benefits received from a Partnership Policy so that such assets will not be taken into account in determining financial eligibility for Medicaid and will not subsequently be subject to Medicaid liens and recoveries.

EFFECTIVE DATE

The Louisiana Long-Term Care Partnership Program is effective October 1, 2009.

ASSET PROTECTION

A" Asset Protection Provided"

Under the Louisiana Long-Term Care Partnership Program, the asset eligibility, adjustment, and recovery provisions of the Louisiana Medicaid plan are applied by
disregarding an amount of assets, above and beyond the asset disregard or allowance otherwise provided under the Medicaid plan, equal to the amount of insurance benefits received from a Partnership Policy. This disregard of assets is referred to herein as the “Asset Disregard”

The Asset Disregard applies to all insurance benefits received from a Partnership Policy. Thus, for example, the Asset Disregard applies to insurance benefits paid on a reimbursement, cash benefit basis, indemnity insurance basis, or on a "per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate" (within the meaning of section 7702B(b)(2)(A) of the Internal Revenue Code of 1986 (26 U"S"C" 7702B(b)(2)(A))" Similarly, the Asset Disregard applies to all insurance benefits received from a Partnership Policy regardless of whether such insurance benefits are in respect of costs for long-term care that would not be covered by Medicaid.

The Asset Disregard as of any date equals the insurance benefits that have been received to that date from a Partnership Policy, even if additional insurance benefits may be received in the future from such Partnership Policy.

If a policy is received after the effective date of the Louisiana Long-Term Care Partnership Program in exchange for a policy issued before such date and the new policy qualifies as a Partnership Policy, the Asset Disregard will apply only with respect to insurance benefits received under such new Partnership Policy and thus will not include insurance benefits, if any, received under the predecessor policy.

Partnership Policies that cover more than one insured are treated as separate Partnership Policies, each of which covers a single insured. With respect to each such insured, the Asset Disregard equals the insurance benefits received from the Partnership Policy on account of such insured having become a chronically ill individual (within the meaning of section 7702B(c)(2) of the Internal Revenue Code of 1986 (26 U"S"C" 7702B(c)(2))

The Asset Disregard does not include return of premium payments made upon the termination of a Partnership Policy because of cancellation or death since such payments do not represent insurance benefits.

Eligibility for benefits under Medicaid is subject to other eligibility requirements, such as applicable income limitations and home equity limitations.

PARTNERSHIP POLICY REQUIREMENTS

B. Partnership Policies.

A Partnership Policy is a long-term care insurance policy (including a certificate issued under a group insurance contract) that satisfies all of the following requirements:

1. Qualified under Federal tax law.
The policy must be a qualified long-term care insurance contract as defined in section 7702B(b) of the Internal Revenue Code of 1986 (26 U.S.C. 7702B(b)). Thus, a qualified long-term care insurance contract that provides insurance benefits on a reimbursement, cash benefit basis, indemnity insurance basis, or on a "per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate," within the meaning of section 7702B(b)(2)(A) of the Internal Revenue Code of 1986 (26 U.S.C. 7702B(b)(2)(A)), will be a Partnership Policy if it satisfies the ORA's other requirements applicable to Partnership Policies, as described herein. Similarly, a long-term care insurance rider or other provision of an insurance contract (such as a rider to a life insurance contract or, after December 31, 2009, a rider to an annuity contract) that constitutes a qualified long-term care insurance contract under section 7702B(e) of the Internal Revenue Code of 1986 (26 U.S.C. 7702B(e)) will be a Partnership Policy if it satisfies the ORA's other requirements applicable to Partnership Policies, as described herein.

ISSUED ON OR AFTER OCTOBER 1, 2009

2. Issue date.

The policy must not be issued earlier than the effective date of the Louisiana Long-Term Care Partnership Program. The issue date is the effective date of coverage under the policy. Thus, for example, in the case of a certificate issued under a group insurance contract, the effective date of coverage with respect to such certificate is the issue date of the certificate.

A policy received in an exchange after the effective date of the Louisiana Long-Term Care Partnership Program is treated as newly issued and thus is eligible for Partnership Policy status. For purposes of applying the Medicaid rules relating to the Partnership Program, the addition of a rider, endorsement, or change in schedule page for a policy may be treated as giving rise to an exchange.


The policy must cover an insured who was a resident of the State when coverage first became effective under the policy. In the case of an exchange, this requirement shall be applied based on the coverage of the first long-term care insurance policy that was exchanged.

A certificate covering an insured who is a resident of Louisiana may qualify as a Partnership Policy even if the situs of the group insurance contract under which such certificate is issued is in another State.

4. Consumer protection requirements.

The Federal consumer protections of section 1917(b)(1)(C)(iii)(III) of the Social
Security Act (42 U.S.C. 1396p(b)(1)(C)(iii)(III)) must be met with respect to the policy. (See also the certification process with respect to this requirement described in C below.)

LOUISIANA PARTNERSHIP INFLATION PROTECTION

5. Inflation protection.

With respect to inflation protection, if the policy is sold to an individual who:

- has not attained age 61 as of the date of purchase, the policy must provide compound annual inflation protection;
- has attained age 61 but has not attained age 76 as of the date of purchase, the policy must provide some level of inflation protection; and
- has attained age 76 as of the date of purchase, the policy may (but is not required to) provide some level of inflation protection.

In each of these three situations, no particular rate for inflation protection is required. Thus, inflation protection increases include but are not limited to increases at a rate less than five percent or at a rate determined by an index-based formula.

For purposes of applying this inflation requirement, the date of purchase means the effective date of coverage under the policy. Thus, for example, the date of purchase of a certificate issued under a group insurance contract means the effective date of coverage under such certificate. In the case of an exchange, the date of purchase is the effective date of coverage under the new policy, i.e., the determination is made without regard to any predecessor policy. If the insured and the policyholder or certificate holder under a policy are different, the insured should be considered the individual to whom a policy is sold for purposes of applying the inflation protection requirements.

C. Certification Process.

Pursuant to section 1917(b)(5)(B)(iii) of the Social Security Act (42 U.S.C. 1396p(b)(5)(B)(iii)), a long-term care insurance policy shall be deemed to meet the consumer protection requirements of section 1917(b)(1)(C)(iii)(III) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(iii)(III)) if the plan amendment provides that the Louisiana Commissioner of Insurance certifies, in a manner satisfactory to the Secretary of the U.S. Department of Health & Human Services (Secretary), that the policy meets such requirements. In addition, the State Medicaid Director's Letter (SMDL #06019) dated July 27, 2006, issued by CMS, provides that the Louisiana Commissioner of Insurance must certify that a policy meets these consumer protection requirements in order for a policy to be a Partnership Policy.

In accordance with the safe harbor procedure specified in section 1917(b)(5)(B)(iii) of the Social Security Act (42 U.S.C. 1396p(b)(5)(B)(iii)), and subject to any guidance from the
Secretary that may be issued providing otherwise, policies shall be considered certified pursuant to section 1917(b)(5)(B)(iii) of the Social Security Act (42 U.S.C. 1396p(b)(5)(B)(iii)) and therefore will be deemed to meet such consumer protection requirements if the issuer: (i) identifies the policy forms on which such policies are issued, and (ii) certifies that the consumer protection requirements of section 1917(b)(1)(C)(iii)(III) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(iii)(III)) are met by such policies. As appropriate, the Louisiana Commissioner of Insurance shall, in turn, certify to the Secretary the compliance of such policies with such consumer protection requirements using the State Certification Form attached as Attachment A. An issuer's identification and certification of policies must be made to the Louisiana Commissioner of Insurance using the Issuer Certification Form attached as Attachment B. Copies of the Louisiana Commissioner of Insurance's certifications will be provided to the Louisiana Department of Health and Hospitals.

Issuers requesting to make use of a previously approved policy form as a Partnership Policy shall submit to the Louisiana Commissioner of Insurance the Issuer Certification Form set forth in Attachment B. This form shall be required for each policy form submitted for partnership qualification.

An issuer and the Louisiana Commissioner of Insurance may submit supplemental Issuer Certification Forms and State Certification Forms, respectively, that identify additional policy forms on which policies are issued that satisfy the consumer protection requirements of section 1917(b)(1)(C)(iii)(III) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(iii)(III)). Copies of the Louisiana Commissioner of Insurance's certifications to the Secretary shall be provided to the Louisiana Department of Health and Hospitals and to the issuer of the policies subject to such certification.

If there is a change made by the Secretary, pursuant to section 1917(b)(5)(C) of the Social Security Act (42 U.S.C. 1396p(b)(5)(C)), in the provisions of the National Association of Insurance Commissioners' LongTerm Care Insurance Model Act or Regulation that apply to new policies covered by Partnerships, appropriate modifications will be made to the Issuer Certification Form to reflect the new requirements.

LOUISIANA PARTNERSHIP DISCLOSURE REQUIREMENTS

D. Partnership Disclosure Requirements:

Notice of Partnership Program.
An issuer or its producer, soliciting or offering to sell a policy that is intended to qualify as a Partnership Policy, shall provide to each prospective applicant a Partnership Program Notice, attached as Attachment C, outlining the requirements and benefits of a Partnership Policy. A similar notice may be used for this purpose if filed and approved by the Louisiana Commissioner of Insurance. The Partnership Program Notice shall be provided with the required Outline of Coverage.
Notice of Partnership Policy Status.
A Partnership Policy issued or issued for delivery in Louisiana shall be accompanied by the Partnership Status Disclosure Notice, attached as Attachment D, explaining the benefits associated with a Partnership Policy and indicating that at the time issued, the policy is a Partnership Policy. A similar notice may be used if filed and approved by the Louisiana Commissioner of Insurance. In the case of a group insurance contract, such Notice must be provided to the insured under a certificate upon the issuance of the certificate. In determining whether to provide this Notice with respect to a policy, the issuer of the policy may rely upon a statement by the policyholder, certificate holder or insured that the insured is a resident of Louisiana.

E. Limitation on Partnership Policy Specific Rules.

In accordance with section 1917(b)(1)(C)(iii)(VII) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(iii)(VII)), and apart from the requirements described in Paragraph B above that are specified by the DRA, no requirement affecting the terms or benefits of a Partnership Policy may be imposed unless such requirement is imposed on long-term care insurance policies without regard to whether the policy is a Partnership Policy. This limitation does not affect the state of Louisiana's ability to generally regulate the terms and sale of long-term care insurance policies where the state of Louisiana imposes requirements without regard to whether policies are Partnership Policies.

LOUISIANA REPORTING REQUIREMENTS

F. Reporting Requirements.
Pursuant to section 1917(b)(1)(C)(iii)(VI) and (v) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(iii)(VI) and (v), respectively), issuers of Partnership Policies must provide regular reports to the Secretary in accordance with regulations of the Secretary. Issuers shall make such regular reports as directed by 45 CFR Part 144 (and as may be amended).

Partnership Policies that cover more than one insured are treated as separate Partnership Policies, each of which covers a single insured. Thus, the reporting requirements described herein apply with respect to each such separate Partnership Policy.

G. Coordination Between Departments.
The Louisiana Department of Health and Hospitals must provide information and technical assistance to the Louisiana Department of Insurance on the role of the Louisiana Department of Insurance to assure that any individual who sells a Partnership Policy receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.
LOUISIANA PARTNERSHIP RECIPROCITY

H. Reciprocity.

Pending the issuance of guidance by the Secretary pursuant to section 6021(b) of the ORA, the Louisiana Long-Term Care Partnership Program shall provide reciprocity with respect to long-term care insurance policies covered under other State long-term care insurance partnerships (i.e., Partnerships and Medicaid plan amendments approved as of May 14, 1993, providing for a long-term care insurance partnership).

In furtherance of this reciprocity, the amount of the Asset Disregard provided with respect to a policy purchased under the State long-term care insurance partnership of another State shall equal the Asset Disregard that would apply to a Partnership Policy covered directly by the Louisiana Long-Term Care Partnership Program. Such reciprocity shall be provided to all States that maintain a State long-term care insurance partnership that provides similar reciprocity for Partnership Policies issued under the Louisiana Long-Term Care Partnership Program. The provision of reciprocity under the Louisiana Long-Term Care Partnership Program does not affect eligibility requirements for Medicaid benefits that apply apart from those pertaining to permissible assets and resources.

After the issuance of guidance by the Secretary pursuant to section 6021(b) of the ORA, the Louisiana Department of Health and Hospitals, if it elects to be exempt from such standards, shall notify the Secretary in writing of such election within the period of time prescribed under such guidance.

I. Federal Long-Term Care Insurance Program

It is recognized that the enabling law for the creation of the Federal Long-Term Care Insurance Program (FL TCIP) set forth at 5 U.S.C. 9001-9009 provides for the preemption of state laws with respect to this program. Therefore, where the Director of the U.S. Office of Personnel Management has certified that a certificate issued pursuant to the FL TCIP meets the requirements of section 1917(b)(1)(C)(iii) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(iii)), such certificate shall be deemed to qualify for the Asset Disregard.

J. Producer Training

The DRA and the State Medicaid Director's Letter (SMDL #06-019) dated July 27, 2006, issued by CMS, require the Louisiana Commissioner of Insurance to provide assurance that any insurance producer who sells, solicits or negotiates "a policy under a Partnership receives training and demonstrates an understanding of Partnership policies and their relationship to public and private coverage to long-term care."

Issuers are to maintain records, subject to the state's record retention requirements, that
verify that those insurance producers who sell, solicit or negotiate long-term care insurance products on their behalf have received the training required for Partnership Policies and that they demonstrate an understanding of the policies and their relationship to public and private long term care coverage.
ATTACHMENT C: PARTNERSHIP PROGRAM NOTICE

Attachment C

Partnership Program Notice

Important Consumer Information Regarding the Louisiana Long-Term Care Insurance Partnership Program

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

Asset Disregard means that an amount of the policyholder’s assets equal to the amount of long-term care insurance benefits received under a qualified Partnership policy will be disregarded for the purpose of determining the insured’s eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership policy without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply and special rules may apply to persons whose home equity exceeds $500,000. Asset Disregard is not available under a long-term care insurance policy that is not a Partnership policy. Therefore, you should consider if Asset Disregard is important to you, and whether a Partnership Policy meets your needs. The purchase of a Partnership policy does not automatically qualify you for Medicaid.

What are the Requirements for a Partnership Policy? In order for a policy to qualify as a Partnership policy, it must, among other requirements:
- Be issued to an individual after October 1, 2009;
- Cover an individual who was a Louisiana resident when coverage first becomes effective under the policy;
- Be a tax-qualified policy under Section 702(B)(b) of the Internal Revenue Code of 1986;
- Meet stringent consumer protection standards; and
- Meet the following inflation requirements:
  - For ages 60 or younger - provides compound annual inflation protection
  - For ages 61 to 65 - provides some level of inflation protection
  - For ages 76 and older - no purchase of inflation protection is required
If you apply and are approved for long-term care insurance coverage, [carrier name] will provide you with written documentation as to whether or not your policy qualifies as a Partnership policy.

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

**Additional Information.** If you have questions regarding long-term care insurance policies please contact [carrier name.] If you have questions regarding current laws governing Medicaid eligibility, you should contact the Louisiana Department of Health and Hospitals.

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ATTACHMENT D: PARTNERSHIP STATUS DISCLOSURE NOTICE

Attachment D

Partnership Status Disclosure Notice

Important Information Regarding Your Policy’s Long-Term Care Insurance Partnership Status

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

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

Asset Disregard means that an amount of the policyholder’s assets equal to the amount of long-term care insurance benefits received under a qualified Partnership policy will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership policy without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply and special rules may apply to persons whose home equity exceeds [$500,000]. Asset Disregard is not available under a long-term care insurance policy that is not a Partnership policy. The purchase of a Partnership policy does not automatically qualify you for Medicaid.

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

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

Additional Information. If you have questions regarding your insurance policy please contact [insert name of carrier.] If you have questions regarding current laws governing Medicaid eligibility, you should contact the Louisiana Department of Health and Hospitals.

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LOUISIANA LONG TERM CARE DEFINITIONS AS USED IN LAW

In order to understand law related to LTC policies in Louisiana it will help to first review definitions used within Louisiana law related to long term care and the definition of terms used within Louisiana long-term care policies. This section immediately below covers definitions used in law and the next section covers the definition of terms when used within a Louisiana long-term care policy.

Chapter 19. Regulation 46—Long-Term Care Insurance

§1905. Definitions
A. For the purpose of this regulation, the terms Applicant, Certificate, Commissioner, Group Long-Term Care Insurance, Long-Term Care Insurance, Policy, and Qualified Long-Term Care Insurance shall have the meanings set forth in R.S. 22:1734. In addition, the following definitions will apply.

Exceptional Increase—

a. only those increases filed by an insurer as exceptional for which the commissioner determines the need for the premium rate increase is justified:
   i. due to changes in laws or regulations applicable to long-term care coverage in this state; or
   ii. due to increased and unexpected utilization that affects the majority of insurers of similar products;

b. except as provided in §1937, exceptional increases are subject to the same requirements as other premium rate schedule increases;

c. the commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase;

d. the commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

Incidental (as used in §1937.J)—that the value of the long-term care benefits provided is less than 10 percent of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

Qualified Actuary—a member in good standing of the American Academy of Actuaries.

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. Certificates of groups that meet the definition in R.S. 22:1734(4)(a) are not considered similar to certificates or policies otherwise issued as long-term care.
insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

LOUISIANA LONG TERM CARE POLICY DEFINITIONS

Chapter 19. Regulation 46—Long-Term Care Insurance

§1907. Policy Definitions

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

**Activities of Daily Living** - at least bathing, continence, dressing, eating, toileting, and transferring.

**Acute Condition**—that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

**Adult Day Care**—a program for six or more individuals, of social and health-related services 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.

**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.

**Cognitive Impairment**—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.

**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).

**Dressing**—putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

**Eating**—feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by feeding tube or intravenously.

**Hands-On Assistance**—physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living.

**Home Health Care Services**—medical and nonmedical services provided to ill, disabled, or infirmed persons in their residences. Such services may include homemaker services, assistance with activities of daily living, and respite care services.

**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.

**Mental or Nervous Disorder**—shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

**Personal Care**—the provision of hands-on services to assist an individual with activities of daily living.

*Skilled Nursing Care, Intermediate Care, Personal Care, Home Care* and other services—shall be defined in relation to the level of skill required, the nature of the care, and the setting in which care must be delivered.

**Toileting**—getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

**Transferring**—moving into or out of a bed, chair, or wheelchair.

All providers of services including, but not limited to, *Skilled Nursing Facility, Extended Care Facility, Intermediate Care Facility, Convalescent Nursing Home, Personal Care Facility, and Home Care Agency*—shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

Additional policy definitions are scattered throughout several other sections of Louisiana law relating to long-term care policies. These terms will be in bold to alert the reader that an important term is being defined.

**NOTE:** One definition that most states include under policy definitions is the definition of pre-existing condition which is: “a condition for which medical advice or treatment was recommended by, received from a provider of health services within six months immediately preceding the effective date of the policy.”

**LOUISIANA LTC POLICY PRACTICES AND PROVISIONS**


**A. Renewability.** The terms *guaranteed renewable and noncancellable* shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of §1913 of this regulation.

1. A policy issued to an individual shall not contain renewal provisions other than guaranteed renewable or noncancellable.

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

3. The term **noncancellable** may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums, during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

4. The term **level premium** may only be used when the insurer does not have the right to change the premium.

5. In addition to the other requirements of §1909.A, a qualified long-term insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

**LIMITATIONS AND EXCLUSIONS**

B. Limitations and Exclusions. A policy may not be delivered or issued for delivery in this state as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:

1. preexisting conditions or diseases;
2. mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;
3. alcoholism and drug addiction;
4. illness, treatment, or medical condition arising out of:
   a. war or act of war (whether declared or undeclared);
   b. participation in a felony, riot, or insurrection;
   c. service in the armed forces or units auxiliary thereto;
   d. suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or
   e. aviation (this exclusion applies only to non-fare paying passengers);
5. treatment provided in a government facility (unless otherwise required by law); services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability, or occupational disease law, or any motor vehicle no-fault law; services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance;
6. expenses for services or items available or paid under another long-term care insurance or health insurance policy;
7. in the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the
Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount;

8. Subsection 1909.B is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

**EXTENSION OF BENEFITS**

C. Extension of Benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization, if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

**CONTINUATION OR CONVERSION**

D. Continuation or Conversion

1. Group long-term care insurance issued in this state on or after the effective date of §1909 shall provide covered individuals with a basis for continuation or conversion of coverage.

2. For the purposes of §1909, 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.

3. For the purposes of §1909, a basis for conversion of coverage means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

4. For the purposes of §1909, converted policy means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group 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.

5. Written application for the converted policy shall be made, and the first premium due, if any, shall be paid as directed by the insurer not later than 31 days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

6. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

7. Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

   a. termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

   b. the terminating coverage is replaced not later than 31 days after termination by group coverage effective on the day following the termination of coverage:

      i. providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

      ii. the premium for which is calculated in a manner consistent with the requirements of §1909.D.6.

8. Notwithstanding any other provision of §1909, a converted policy issued to an individual who, at the time of conversion, is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

9. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

10. Notwithstanding any other provision of §1909, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to
another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

11. For the purposes of §1909, a managed-care plan is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management, or use of specific provider networks.

DISCONTINUANCE AND REPLACEMENT

E. 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 pre-existing conditions that would have been covered under the group policy being replaced; and

2. shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.

F.

1. The premium charged to an insured shall not increase due to either:
   a. the increasing age of the insured at ages beyond 65; or
   b. the duration the insured has been covered under the policy.

2. The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under §1949, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

3. A reduction in benefits shall not be considered a premium change, but for purposes of the calculation required under §1949, the initial annual premium shall be based on the reduced benefits.

G. Electronic Enrollment for Group Policies

1. In the case of a group defined in R.S. 22:1734(4)(a), any requirement that a signature of an insured be obtained by a producer or insurer shall be deemed satisfied if:
   a. the consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;
   b. the telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and
   c. the telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and "privileged information" as defined by applicable state or federal law, is maintained.
2. The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer’s ability to confirm enrollment and coverage amounts.

LOUISIANA MINIMUM STANDARDS FOR HOME HEALTH CARE

While long term care policies are not required to cover home health or community care benefits, they are required to meet certain benefit standards if they do offer these benefits. The section below details the requirements that must be met if an insurer covers home health and/or community care benefits in a long term care policy.

§1923. Minimum Standards for Home Health and Community Care Benefits in Long-Term Care Insurance Policies (former §1917)

PROHIBITED LIMITATIONS OR EXCLUSIONS

A. A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits:

1. by requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;

2. by requiring that the insured or claimant first, or simultaneously, receive nursing or therapeutic services, or both, in a home, community, or institutional setting before home health care services are covered;

3. by limiting eligible services to services provided by registered nurses or licensed practical nurses;

4. by requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

5. by excluding coverage for personal care services provided by a home health aide;

6. by requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

7. by requiring that the insured or claimant have an acute condition before home health care services are covered;

8. by limiting benefits to services provided by Medicare-certified agencies or providers;

9. by excluding coverage for adult day care services.

EQUIVALENCY OF BENEFITS

B. A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care 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 community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

C. Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

LOUISIANA STANDARDS FOR BENEFIT TRIGGERS

Chapter 19. Regulation 46—Long-Term Care Insurance
§1951. Standards for Benefit Triggers (former §1945)
A. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

ACTIVITIES OF DAILY LIVING REQUIRED

B.
1. Activities of daily living shall include at least the following as defined in §1907 and in the policy:
   a. bathing;
   b. continence;
   c. dressing;
   d. eating;
   e. toileting; and
   f. transferring.
2. Insurers may use activities of daily living to trigger covered benefits in addition to those contained in §1951.B.1, as long as they are defined in the policy.

C. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in §1951.A-B.

DETERMINATION OF A DEFICIENCY

D. For purposes of §1951, the determination of a deficiency shall not be more restrictive than:
1. requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

2. if the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

E. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses, or social workers.

F. Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

G. The requirements set forth in §1951 shall be effective January 1, 1999 and shall apply as follows.

1. Except as provided in §1951.G.2, the provisions of §1951 apply to a long-term care policy issued in this state on or after the effective date of the amended regulation.

2. For certificates issued on or after the effective date of §1951, under a group long-term care insurance policy, as defined in R.S. 22:1734(4)(a) that was in force at the time this amended regulation became effective, the provisions of §1951 shall not apply.

ADDITIONAL STANDARDS FOR QUALIFIED POLICIES

§1953. Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts (former §1947)

A. For purposes of this Section the following definitions apply.

1. Qualified long-term care services means services that meet the requirements of Section 7702B(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

2.

   a. Chronically ill individual has the meaning prescribed for this term by Section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

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

      ii. requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.
b. The term *chronically ill individual* shall not include an individual otherwise meeting these requirements unless within the preceding 12-month period a licensed health care practitioner has certified that the individual meets these requirements.

3. **Licensed health care practitioner** means a physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the secretary of the treasury.

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

B. A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

**90 DAY REQUIREMENT**

C. A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.

D. Certifications regarding activities of daily living and cognitive impairment required pursuant to §1953.C shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the secretary of the treasury.

E. Certifications required pursuant to §1953.C may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the 90-day period.

**DISCLOSURE OF APPEALS PROCESS**

F. Qualified long-term care contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

**REQUIREMENT TO DELIVER SHOPPER’S GUIDE**

Chapter 19. Regulation 46—Long-Term Care Insurance

A. A long-term care insurance shopper's guide in the format developed by the NAIC, or a
guide developed or approved by the commissioner, shall be provided to all prospective
applicants of a long-term care insurance policy or certificate.
   1. In the case of producer solicitations, a producer must deliver the shopper's guide
      prior to the presentation of an application or enrollment form.
   2. In the case of direct response solicitations, the shopper's guide must be presented
      in conjunction with any application or enrollment form.

B. Life insurance policies or riders containing accelerated long-term care benefits are not
required to furnish the above-referenced guide, but shall furnish the policy summary
required under R.S. 22:1736(I).

**REQUIREMENT TO OFFER INFLATION PROTECTION**

§1919. Requirements to Offer Inflation Protection

A. No insurer may offer a long-term care insurance policy unless the insurer also
offers to the policyholder, in addition to any other inflation protection, the option
to purchase a policy that provides for benefit levels to increase with benefit
maximums or reasonable durations which are meaningful to account for
reasonably anticipated increases in the costs of long-term care services covered by
the policy. Insurers must offer to each policyholder, at the time of purchase, the
option to purchase a policy with an inflation protection feature no less favorable
than one of the following:

**ALLOWED INFLATION PROTECTION OFFERS**

1. increases benefit levels annually in a manner so that the increases are compounded
   annually at a rate not less than 5 percent;
2. guarantees the insured individual the right to periodically increase benefit levels
   without providing evidence of insurability or health status, so long as the option for
   the previous period has not been declined. The amount of the additional benefit shall
   be no less than the difference between the existing policy benefit and that benefit
   compounded annually at a rate of at least 5 percent for the period beginning with the
   purchase of the existing benefit and extending until the year in which the offer is
   made; or
3. covers a specified percentage of actual or reasonable charges and does not include
   a maximum specified indemnity amount or limit.

B. Where the policy is issued to a group, the required offer in §1919.A shall be made to
the group policyholder; except, if the policy is issued to a group defined in R.S.
22:1734(4)(d), other than to a continuing care retirement community, the offering shall be
made to each proposed certificateholder.

C. The offer in §1919.A shall not be required of life insurance policies or riders
containing accelerated long-term care benefits.
GRAPHIC ILLUSTRATION REQUIRED

D.

1. Insurers shall include the following information in or with the outline of coverage:
   a. a graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period;
   b. any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

2. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

E. Inflation protection benefit increases, under a policy which contains such benefits, shall continue without regard to an insured's age, claim status, or claim history, or the length of time the person has been insured under the policy.

F. An offer of inflation protection which provides 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, that the premium may change in the future, unless the premium is guaranteed to remain constant.

G.

1. Inflation protection, as provided in §1919.A.1, shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection, signed by the policyholder, as required in §1919.G.1. The rejection may be either in the application or on a separate form.

WHEN INFLATION PROTECTION IS REJECTED

2. The rejection shall be considered a part of the application and shall state:

   I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection.

LOUISIANA REQUIREMENT TO FILE ADVERTISING

§1941. Filing Requirements for Advertising (former §1935)

A. Every insurer, health care service plan, or other entity providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state, whether through written, radio, or television medium, to the commissioner of insurance of this state for review or approval by the commissioner to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer, health care service plan, or other entity
for at least three years from the date the advertisement was first used.

B. The commissioner may exempt from these requirements any advertising form or material when, in the commissioner's opinion, this requirement may not be reasonably applied.

LOUISIANA LTC MARKETING STANDARDS

Following is the section of Louisiana law dealing with marketing practices. This section of law requires certain verbiage in the outline of coverage and prohibits certain marketing practices including twisting and high pressure sales tactics. There is also a comprehensive section setting out requirements when an association endorses a LTC policy to be marketed to their members.

§1943. Standards for Marketing (former §1937)

A. Every insurer, health care service plan, or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

1. establish marketing procedures and producer training requirements to assure that:
   a. any marketing activities, including any comparison of policies by its producers or other producers will be fair and accurate; and
   b. excessive insurance is not sold or issued;

REQUIRED NOTICE TO BUYER

2. display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and policy the following:

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

3. provide copies of the disclosure forms required in §1915.C (Appendices B and F) to the applicant;

4. inquire, and otherwise make every reasonable effort to identify, whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness, or long-term care insurance and the types and amounts of any such insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required;

5. establish auditable procedures for verifying compliance with §1943.A;

6. if the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program, approved by the commissioner, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificateholder that such a program is available and the name, address and
telephone number of the program;
7. for long-term care health insurance policies and certificates, use the terms *noncancellable* or *level premium* only when the policy or certificate conforms to §1909.A.3 of this regulation;
8. provide an explanation of contingent benefit upon lapse provided in §1949.D.3.

**PROHIBITED MARKETING PRACTICES**

B. In addition to the practices prohibited in R.S. 22:1211 et seq., the following acts and practices are prohibited.

- **Cold Lead Advertising**—making use directly, or indirectly, of any method of marketing which fails to disclose, in a conspicuous manner, that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.
- **High Pressure Tactics**—employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
- **Misrepresentation**—misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.
- **Twisting**—knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

**MARKETING ASSOCIATION COVERAGE**

C.

1. With respect to the obligations set forth in §1943.C.1, the primary responsibility of an association, as defined in R.S. 22:1734(4)(b), when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues, in general, so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.
2. The insurer shall file with the insurance department the following material:
   a. the policy and certificate;
   b. a corresponding outline of coverage; and
   c. all advertisements requested by the insurance department.
3. The association shall disclose in any long-term care insurance solicitation:
a. the specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and

b. a brief description of the process under which the policies, and the insurer issuing the policies, were selected.

4. If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

5. The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

6.

a. The association shall also:

i. at the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance, not affiliated with the insurer, to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change;

ii. actively monitor the marketing efforts of the insurer and its producers; and

iii. review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

b. Section 1943.C.6.a.i.-iii shall not apply to qualified long-term care insurance contracts.

7. No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the state insurance department the information required in §1943.C.

8. The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in §1943.C.

VIOLATIONS CONSIDERED UNFAIR TRADE PRACTICES

9. Failure to comply with the filing and certification requirements of §1943 constitutes an unfair trade practice in violation of R.S. 22:1211 et seq.

LOUISIANA PROHIBITION OF POST CLAIMS UNDERWRITING

One of the business practices that, in past years, were prevalent in long term care is post claims underwriting. The section below prohibits post claims
underwriting and prescribes application questions designed to illicit sufficient health information to complete an underwriting decision.

1921. Prohibition against Post-Claim Underwriting (former §1915)

A. All applications for long-term care insurance policies or certificates, except those which are guaranteed issue, shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

WHEN MEDICATION QUESTIONS ARE IN APPLICATION

B.

1. 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.

2. 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.

REQUIRED CONSUMER NOTICES

C. Except for policies or certificates which are guaranteed issue:

1. the following language shall be set out conspicuously, and in close conjunction with 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] has the right to deny benefits or rescind your policy;

2. the following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

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

3. 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.

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

REQUIRED RESCISSION REPORTING

E. Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated, and shall annually furnish this information to the insurance commissioner in the format prescribed by the National Association of Insurance Commissioners in §1961, Appendix A.

LOUISIANA PRE-EXISTING CONDITIONS AND REPLACEMENT

§1947. Prohibition against Pre-Existing Conditions and
Probationary Periods in Replacement Policies or Certificates (former §1941)

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

LOUISIANA SUITABILITY REQUIREMENTS

§1945. Suitability (former §1939)

A. Section 1945 shall not apply to life insurance policies that accelerate benefits for long-term care.

INSURER MUST DEVELOP SUITABILITY STANDARDS

B. Every insurer, health care service plan, or other entity marketing long-term care insurance (the issuer) shall:

1. develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;
2. train its producers in the use of its suitability standards; and
3. maintain a copy of its suitability standards and make them available for inspection, upon request, by the commissioner.
CONSUMER INFORMATION REQUIRED FOR SUITABILITY DETERMINATION

C.

1. To determine whether the applicant meets the standards developed by the issuer, the producer and issuer shall develop procedures that take the following into consideration:

   a. the ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

   b. the applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

   c. the values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

REQUIRED USE OF PERSONAL WORKSHEET

2. The issuer, and where a producer is involved, the producer shall make reasonable efforts to obtain the information set out in §1945.C.1. The efforts shall include presentation to the applicant at, or prior to, application the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix B, in not less than 12-point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the commissioner.

3. A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

4. The sale or dissemination outside the company or agency by the issuer or producer of information obtained through the personal worksheet in §1961, Appendix B, is prohibited.

D. The issuer shall use the suitability standards it has developed, pursuant to §1945, in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

E. Producers shall use the suitability standards developed by the issuer in marketing long-term care insurance.

REQUIRED DISCLOSURE FORM

F. At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in §1961, Appendix C, in not less than 12-point type.
IF CONSUMER DOES NOT MEET SUITABILITY STANDARDS

G. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to §1961, Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

INSURER REQUIRED TO REPORT ANNUALLY

H. The issuer shall report annually to the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

LOUISIANA UNINTENTIONAL LAPSE PROTECTIONS

To prevent and remediate unintentional lapse of a long term care policy the section below describes the required offer of the insured to designate a 3<sup>rd</sup> party for lapse notices and establishes remediation of a lapse due to cognitive impairment.

§1911. Unintentional Lapse

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

LAPSE PREVENTION

1. Notice before Lapse or Termination

   a. 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."

b. The insurer shall notify the insured of the right to change this written designation, no less often than once every two years.

c. When the policyholder or certificateholder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in §1911.A.1.a need not be met until 60 days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

d. 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 §1911.A.1.a, 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.

LAPSE REMEDIATION

B. Reinstatement. In addition to the requirement in §1911.A.1, 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 that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured, if requested within five months after termination, and shall allow for the collection of past due premium where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

LOUISIANA INSURER REPORTING REQUIREMENTS

It is important for an agent to understand the agent level reporting each LTC insurer is required to file on annual basis. In addition to agent level reporting the insurer is required to file company level reports detailing lapses, replacement policies sold and claims denied.
§1927. Reporting Requirements (former §1923)

AGENT LEVEL REPORTING

A. Every insurer shall maintain records for each producer of that producer's amount of replacement sales as a percentage of the producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the producer as a percentage of the producer's total annual sales.

B. Each insurer shall report annually, by June 30, the 10 percent of its producers with the greatest percentages of lapses and replacements, as measured by §1927.A (§1961, Appendix G).

C. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely producer activities regarding the sale of long-term care insurance.

INSURER LEVEL REPORTING

D. Every insurer shall report annually, by June 30, the number of lapsed policies as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the end of the preceding calendar year (§1961, Appendix G).

E. Every insurer shall report annually, by June 30, the number of replacement policies sold as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the preceding calendar year (§1961, Appendix G).

F. Every insurer shall report annually, by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied (§1961, Appendix E).

G. For purposes of §1927:

1. policy means only long-term care insurance; and

2. subject to §1927.G.3, claim means a request for a payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

3. denied means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

4. report means on a statewide basis.

H. Reports required under this Section shall be filed with the commissioner.

LOUISIANA REQUIRED DISCLOSURES

In the section of law below several required disclosures are covered. Notice
some of these disclosures are conditional, in that, disclosure is only required if certain wording exists or conditions are true in the LTC policy.


POLICY RENEWABILITY

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

1. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or noncancellable. This provision shall not apply to policies which do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

2. A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

RIDERS AND ENDORSEMENTS

B. Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made, in writing, by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to, in writing and signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider, or endorsement.

PAYMENT OF BENEFITS

C. Payment of Benefits. A long-term care insurance policy which provides for the payment of benefits based on standards described as usual and customary, reasonable and customary or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

LIMITATIONS

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

E. Other Limitations or Conditions on Eligibility for Benefits. A long-term care
insurance policy or certificate containing post confinement, post-acute care, or recuperative benefits shall set forth a description of such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall clearly label such paragraph, "Limitations or Conditions on Eligibility for Benefits."

TAX CONSEQUENCES

F. Disclosure of Tax Consequences. With regard to life insurance policies which provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider, and at the time the accelerated benefit payment request is submitted, that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. §1913.F shall not apply to qualified long-term care insurance contracts.

BENEFIT TRIGGERS

G. Benefit Triggers. Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the policy or certificate in a separate provision and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this provision. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

QUALIFIED/NONQUALIFIED STATUS DISCLOSURE

H. A qualified long-term care insurance contract shall include a disclosure statement in the policy, and in the outline of coverage as contained in §1955.F.3 that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

I. A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in §1955.F.3 that the policy is not intended to be a qualified long-term care insurance contract.

LOUISIANA APPLICATION FORMS AND REPLACEMENT

The next section details the required language in policy applications and consumer notices that must be used when replacing an LTC policy. These documents are designed to determine if a replacement is indicated and to disclose important information to the consumer involved in a replacement transaction.
§1925. Requirements for Application Forms and Replacement Coverage (former §1921)

REPLACEMENT QUESTIONS REQUIRED IN APPLICATIONS

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer, except where the coverage is sold without a producer, containing such questions may be used. With regard to a replacement policy issued to a group defined by R.S. 22:1734(4)(a), the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement.

1. Do you have another long-term care insurance policy or certificate in force (including 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. Producers shall list any other health insurance policies they have sold to the applicant.

1. List policies sold which are still in force.

2. List policies sold in the past five years which are no longer in force.

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

The required notice shall be provided in the following manner.

See Next Page
REQUIRED NOTICE WHEN REPLACEMENT IS INDICATED

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE [Insurance company's name and address] SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY PRODUCER [BROKER OR OTHER REPRESENTATIVE]:

(Use additional sheets, as necessary.)

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

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature of Producer, Broker or Other Representative)
D. Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy.

The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE [Insurance company's name and address] SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions or probationary periods. Your insurer will waive any time periods applicable to pre-existing conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.
REQUIRED NOTIFICATION TO EXISTING INSURER

E. Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured, and policy number or address, including zip code. Such notice shall be made within five working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

F. Life Insurance policies that accelerate benefits for long-term care shall comply with this Section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of Regulation 70. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

LOUISIANA REQUIRED OFFER OF NONFORFEITURE BENEFIT

The next section covers in detail the different requirements related to offering a nonforfeiture benefit on a long-term care policy in Louisiana. Elements covered include: required calculations for the standard nonforfeiture credit, requirements when the nonforfeiture offer is rejected, trigger for the nonforfeiture benefit, and forms of benefit available under the nonforfeiture credit.

§1949. Nonforfeiture Benefit Requirement (former §1943)

A. Section 1949 does not apply to life insurance policies or riders containing accelerated long-term care benefits.

REQUIREMENTS OF NONFORFEITURE OFFER

B. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of R.S. 22:1738:

1. a policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in §1949.E; and

2. the offer shall be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

C. If the offer required to be made under R.S. 22:1738 is rejected, the insurer shall provide the contingent benefit upon lapse described in §1949.

D. 
CONTINGENT BENEFIT UPON LAPSE

1. After rejection of the offer required under R.S. 22:1738, for individual and group policies without nonforfeiture benefits issued after the effective date of §1949, the insurer shall provide a contingent benefit upon lapse.

2. In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

SUBSTANTIAL PREMIUM INCREASE

3. The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least 45 days prior to the due date of the premium reflecting the rate increase.

See table on the next page for “Triggers for a Substantial Premium Increase”
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SUBSTANTIAL PREMIUM INCREASE AS TRIGGER

4. On or before the effective date of a substantial premium increase as defined in §1949.D.3, 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 §1949.E. This option may be elected at any time during the 120-day period referenced in §1949.D.3; and
   c. notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in §1949.D.3 shall be deemed to be the election of the offer to convert in §1949.D.4.b above.

E. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in §1949.E.

1. For purposes of §1949, **attained age rating** is defined as a schedule of premiums, starting from the issue date, which increases with increasing age at least 1 percent per year prior to age 50, and at least 3 percent per year beyond age 50.

2. For purposes of §1949, the nonforfeiture benefit shall be a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in §1949.E.3.

STANDARD NONFORFEITURE CREDIT

3. 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 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of §1949.F.

4.
   a. The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three years as well as thereafter.
   b. Notwithstanding §1949.E.4.a, for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:
      i. the end of the tenth year following the policy or certificate issue date; or
ii. the end of the second year following the date the policy or certificate is no longer subject to attained age rating.

5. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

F. 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.

G. There shall be no difference in the minimum nonforfeiture benefits, as required under §1949, for group and individual policies.

H. The requirements set forth in §1949 shall be effective January 1, 1999 and shall apply as follows.

1. Except as provided in §1949.H.2, the provisions of §1949 apply to any long-term care policy issued in this state on or after the effective date of this amended regulation.

2. For certificates issued on or after the effective date of §1949, under a group long-term care insurance policy, as defined in R.S. 22:1734(4)(a), which policy was in force at the time this amended regulation became effective, the provisions of §1949 shall not apply.

I. Premiums charged for a policy or certificate containing nonforfeiture benefits or a continuing benefit on lapse shall be subject to the loss ratio requirements of §1935 treating the policy as a whole.

J. To determine whether contingent nonforfeiture upon lapse provisions are triggered under §1949.D.3, 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.

K. A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

1. the nonforfeiture provision shall be appropriately captioned;

2. the nonforfeiture provision shall provide that the amount of the benefit available in the event of a default in the payment of any premiums, and the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest, as reflected in changes in rates for premium paying contracts approved by the commissioner for the same contract form; and

3. the nonforfeiture provision shall provide at least one of the following:
   a. reduced paid-up insurance;
   b. extended term insurance;
   c. shortened benefit period; or
d. other similar offerings approved by the commissioner.

AVAILABILITY OF NEW SERVICES OR PROVIDERS

**NOTE: This area is not currently addressed in Louisiana Laws and Regulations:**

Louisiana has not addressed the area of what 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 ONE REVIEW QUESTIONS

Answers are in the back of the text

1. With regard to qualified long-term care policies DRA 2005 states that partnership policies ____________.
   
   A. Must accrue cash values using a minimum interest rate of 3%
   B. Must be non-cancellable
   C. Must be guaranteed renewable
   D. Must cover care provided by a relative of the insured

2. ______________ means a deficiency in a person’s short- or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.
   
   A. Alzheimer’s
   B. Cognitive impairment
   C. Dementia
   D. Senility

3. Chronically illness is defined as being unable to perform, without substantial assistance, at least two activities of daily living for ____________ days due to a loss of functional capacity or ________________ means the provision of hands on services to assist an individual with activities of daily living.
   
   A. At least 30 calendar days
   B. At least 60 calendar days
   C. At least 90 calendar days
   D. At least 100 calendar days
Chapter 2

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 2 REVIEW QUESTIONS
Answers are in the back of the text

1. Many people mistakenly believe that _____________ covers long-term care services.
   A. Medicare
   B. Medicaid
   C. Major Medical Insurance
   D. Life Insurance

2. HIPAA requires that all consumers receive ________ during the sales process.
   A. A Rate Comparison
   B. An insurance company rating disclosure
   C. A Shoppers Guide
   D. At least three separate quotes
Chapter 3

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:

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

**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 Account 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 five years (60 months). 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 uncompensated transfer.

Forgiveness of debt
If one forgives debt owed by another it is considered an uncompensated transfer. The date of the uncompensated 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 uncompensated transfer (gift) is that if the gift exceeds $13,000 (2011) 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 is set at the federal level. The spousal resource amount is the minimum resource standard ($21,912 in 2011); 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 ($109,560 in 2011).

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 indexed*.

*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>
</tr>
</thead>
<tbody>
<tr>
<td>January 1</td>
<td>January 1</td>
<td>$30,000</td>
<td>$15,000</td>
<td>$21,912</td>
</tr>
<tr>
<td>January 1</td>
<td>January 1</td>
<td>$40,000</td>
<td>$20,000</td>
<td>$21,912</td>
</tr>
<tr>
<td>January 1</td>
<td>January 1</td>
<td>$20,000</td>
<td>$10,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>January 1</td>
<td>January 1</td>
<td>$18,000</td>
<td>$9,000</td>
<td>$18,000</td>
</tr>
<tr>
<td>January 1</td>
<td>January 1</td>
<td>$100,000</td>
<td>$50,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>January 1</td>
<td>January 1</td>
<td>$200,000</td>
<td>$100,000</td>
<td>$100,000</td>
</tr>
</tbody>
</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 application for Medicaid may not take place for months. Regardless of what the total assets are on the day he applies, the stay-a-home spouse’s share will always be determined on the day of entry into the nursing home (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>
</tr>
</thead>
<tbody>
<tr>
<td>January 1</td>
<td>January 1</td>
<td>$100,000</td>
<td>$50,000</td>
<td>$50,000</td>
<td>$48,000</td>
</tr>
</tbody>
</table>

*$50,000 - $2,000 Medicaid Allows = $48,000 Must be spent on care

<table>
<thead>
<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>
</tr>
</thead>
<tbody>
<tr>
<td>January 1</td>
<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>

*$80,000 (total assets on application date) minus $50,000 (community spouse’s share established on entry date) equals $30,000 minus $2,000 (Medicaid allowance) equals $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 cannot 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 3 REVIEW QUESTIONS
Answers are in the back of the text

1. Which of the following is not an exempt asset

   A. Rental income
   B. Primary residence
   C. One automobile
   D. Household furnishings

2. 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 ______________.

   A. at least 90 days
   B. at least 60 days
   C. at least 30 days
   D. at least 10 days

3. Which of the following is NOT considered an uncompensated transfer?

   A. Forgiveness of debt
   B. Transfer of assets to an irrevocable trust
   C. A bargain sale
   D. The sale of an asset for fair market value
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.

CONTINUOUS 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**
**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 - Onetime Filing vs. Periodic Filing**
### Filing Proof of Loss

<table>
<thead>
<tr>
<th>One-Time Filing</th>
<th>Periodically Filing</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Submits a claim for hospital expenses after an accident January 1.</td>
<td>* Submits claim, receives periodic payments of disability income from January 1 through June 1.</td>
</tr>
<tr>
<td>* Must file proof of loss within 90 days after January 1, the date of the loss, since no periodic benefits are involved.</td>
<td>* Must file proof of loss within 90 days after June 1, the date the insurer’s liability for payment ended.</td>
</tr>
</tbody>
</table>

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 4 REVIEW QUESTIONS
Answers are in the back of the text

1. The NAIC Model Act requires that purchasers have a “free look” period of __________.
   A. 15 days  
   B. 30 days  
   C. 45 days  
   D. 60 days

2. The NAIC Model Act requires that insurers obtain some form of medical assessment for any applicant age _______ or older.
   A. 70  
   B. 75  
   C. 80  
   D. 85

3. Conditioning eligibility for benefits in an institutional care setting on the receipt of a higher level of institutional care is called ______________ and is prohibited.
   A. Step-up  
   B. Step-down  
   C. a graded benefit  
   D. a ramp benefit
Chapter 5

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 ($141.50 per day in 2011). 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 Centers for Medicare and Medicaid Services (CMS).

**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 income provided by a reverse mortgage
will be viewed as an income stream for Medicaid eligibility purposes and could
make the individual ineligible for Medicaid assistance but still not provide
sufficient income to pay LTC costs or provide needed income for a non-
institutionalized spouse.
**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 payout 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 standalone 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 only for people with significant assets they want to preserve for family members, 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 use 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 cannot 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 2 or more of the minimum benefit triggers described below then they qualify for a contract benefit. If an insurer adds additional benefit triggers they cannot require that an insured need hands on assistance with more than 2 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.

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 cannot afford premiums.
CHAPTER 5 REVIEW QUESTIONS
Answers are in the back of the text

1. It is estimated that by the year 2030 there will be at least _______ people needing assistance with long-term care services.
   - A. 16 million
   - B. 19 million
   - C. 23 million
   - D. 31 million

2. Most states use the term _______ to describe the conditions that must be present for a long-term care policy to pay benefits.
   - A. Covered event
   - B. Benefit trigger
   - C. Activity of daily living
   - D. Usual reasonable and customary
FORMS OF CARE AND COVERAGES 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 onsite 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 6 REVIEW QUESTIONS
Answers are in the back of the text

1. Medicare will cover skilled nursing care under Part A for up to _______.
   A. 30 days
   B. 60 days
   C. 90 days
   D. 100 days

2. Statistics show that _________ of all nursing home residents have chronic illnesses.
   A. 55%
   B. 47%
   C. 31%
   D. 11%
Chapter 7

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.

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. Homemaker 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 care giver. 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 cannot 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 m 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 cannot 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 care giver 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 7 REVIEW QUESTIONS
Answers are in the back of the text

1. To be eligible for P.A.C.E. one must ______________.
   A. Be age 65 or older
   B. Be between ages 65 and 80
   C. Be age 55 or older
   D. Be between ages 55 and 75

2. To be eligible for the Community Care Program one must __________.
   A. Be age 60 or older
   B. Be between ages 60 and 80
   C. Be age 55 or older
   D. Be between ages 55 and 75
Chapter 8

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:

<table>
<thead>
<tr>
<th>Insured to be certified as chronically ill by a physician within 12 months of applying for benefits;</th>
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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 cannot 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 (usually a percent 65% to 75% of the nursing facility benefit.) 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 cannot.

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 cannot 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 cannot require a prehospitalization 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 patient’s 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.

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 person’s 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 cannot 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 cannot 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 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 cannot 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 cannot 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 introgastrically is considered skilled care and is covered by Medicare.
Intravenous Feeding

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 cannot 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.

**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 8 REVIEW QUESTIONS
Answers are in the back of the text

1. For a tax qualified LTC policy to pay benefits requires that an individual is certified as “chronically ill” within ________ of applying for benefits.
   
   A. 3 months  
   B. 6 months  
   C. 9 months  
   D. 12 months 

2. A diagnosis where the patient participates in the process, but cannot affect the outcome is called ______________.
   
   A. A pathological diagnosis  
   B. A clinical diagnosis  
   C. An objective diagnosis  
   D. A concurrent diagnosis 

3. Which of the following is NOT a universal exclusion for LTC policies?
   
   A. Addictions to drugs and/or alcohol  
   B. Intentionally self inflicted injuries  
   C. Care provided by a relative of the patient  
   D. Treatments paid for by the government
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 9 REVIEW QUESTIONS

Answers are in the back of the text

1. The inflation protection option that increases the daily benefit annually by a given percent of the original base benefit is called ____________.

   A. Compound inflation protection
   B. Indexed inflation protection
   C. Simple inflation protection
   D. Averaged inflation protection
ANSWERS TO CHAPTER REVIEW QUESTIONS

CHAPTER 1

1. The correct answer is: C  (Section 1 page 13 )
2. The correct answer is: B  (Section 1 page 27 )
2. The correct answer is: C  (Section 1 page 13 )

CHAPTER 2

1. The correct answer is: A  (Section 2 page 2 )
2. The correct answer is: C  (Section 2 page 9 )

CHAPTER 3

1. The correct answer is: A  (Section 2 page 13 )
2. The correct answer is: C  (Section 2 page 17 )
3. The correct answer is: D  (Section 2 page 15 )

CHAPTER 4

1. The correct answer is: B  (Section 2 page 23 )
2. The correct answer is: C  (Section 2 page 23 )
3. The correct answer is: B  (Section 2 page 22 )

CHAPTER 5

1. The correct answer is: B  (Section 2 page 34 )
2. The correct answer is: B  (Section 2 page 41 )

CHAPTER 6

1. The correct answer is: D  (Section 2 page 45 )
2. The correct answer is: B  (Section 2 page 47 )

CHAPTER 7

1. The correct answer is: C  (Section 2 page 51 )
2. The correct answer is: A  (Section 2 page 53 )
CHAPTER 8

1. The correct answer is: D  (Section 2 page 64)
2. The correct answer is: A  (Section 2 page 67)
3. The correct answer is: C  (Section 2 page 71)

CHAPTER 9

1. The correct answer is: C  (Section 2 page 80)