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Section 1 State Specific

Chapter 1

FLORIDA LONG TERM CARE PARTNERSHIP PROGRAM

THE HISTORY OF PARTNERSHIP PLANS

The purpose of this course is to first develop a thorough understanding of the Florida 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 Florida) currently are implementing a partnership program. In a 2005 General Accounting Office (GAO) report it is detailed that as of 2003 there were approximately 172,000 partnership long term care policies in force in these four states.

THE CARROT AND THE STICK

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

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

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

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

**FEDERAL BARRIER TO PARTNERSHIP EXPANSION**

The Omnibus Budget Reconciliation Act of 1993 limited most states from adopting partnership programs and thus slowed the spread of the partnership concept beyond the initial four states. With the passage of The Deficit Reduction Act of 2005 (DRA) many of the barriers were removed and more states are now likely to establish a long term care partnership program. DRA was signed by the president in February of 2006 and Florida Passed the long term care partnership program on June 20, 2006. From a legislative perspective that is quick action.

**CHOICE AFFORDED BY A PARTNERSHIP PROGRAM**

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

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

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

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

4) The Florida 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 Florida 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 Florida partnership we will review section 1 of Florida Statute 409.9102 (aka House Bill 947) as approved by the Governor on June 20, 2006. The text reads as follows:

1. The program shall:

   • 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.
   • The Agency for Health Care Administration is authorized to amend the Medicaid state plan and adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section.
   • The Department of Children and Family Services, when determining eligibility for Medicaid long-term care services for an individual who is the beneficiary of an approved long term care partnership program policy, shall reduce the total countable assets of the individual by an amount equal to the insurance benefit payments that are made to or on behalf of the individual. The department is authorized to adopt rules pursuant to implement this section.
So what we learn from the first section of House Bill 947 is that Florida 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.

**Unlimited Asset Protection:**

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

**Hybrid Asset Protection:**

Indiana provides a combination of the models above. The hybrid plan provides dollar-for-dollar asset protection (like the Florida 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.

**INCOME AND SUITABILITY**

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

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

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

The consumer must be able to afford the premium for the long term care policy now and have sufficient income levels to continue to afford the policy premiums in the future. Premiums for long term care policies can be increased if the insurer can demonstrate that they have exceeded the mandated loss ratio. Generally speaking an individual with annual income below $22,428/$1,869/month or a couple with annual income below $44,856/$3,738/month (2007 Florida Medicaid Income Eligibility 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.

**OTHER HEALTH COSTS**

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

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

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

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

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

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

DRA 05 DEFINITION OF “QUALIFIED STATE LTC PARTNERSHIP”

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

A policy that meets all of the requirements specified in a Qualified State LTC Partnership SPA is referred to as a “Partnership policy.”

The insurance benefits upon which a disregard may be based include benefits paid as direct reimbursement of LTC expenses, as well as benefits paid on a per diem,
or other periodic basis, for periods during which the individual received LTC services.

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

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

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

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

**PARTNERSHIP REQUIREMENTS UNDER THE DEFICIT REDUCTION ACT**

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

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

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

  - The State Medicaid agency may also accept certification from the same authority that the policy meets the Internal Revenue Code definition of a qualified LTC insurance policy, and that it includes the requisite inflation protections.

  - If the State Medicaid agency accepts the certification of the
Commissioner or other authority, it is not required to independently verify that policies meet these requirements.

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

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

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

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

- This information must be incorporated into the training of individuals who will sell LTC insurance policies in the State. This section resulted in changes to Florida Statutes Title 30 (State Welfare Section) Sections 409.905 and the addition of section 409.9102.

- 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. This section resulted in the addition of section 690-157.1155 “Producer Training” which requires all Florida licensed long term care producers to complete an approved 8 hour training course on The Florida Long Term Care Partnership by 12/31/07.

- 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. Florida added to the Florida Statutes under Title 27 section 690-157.201 to address this issue. Within 690-157.210 sections (5)(A) (1 & 2) require the insurance companies offering Partnership Long Term care policies to provide this information.

- 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.

FLORIDA IMPLEMENTATION

Florida made numerous changes and additions to existing law to implement the Partnership Program such as:

- Changes to the Medicaid Institutional Care Program (ICP) eligibility sections to implement asset disregard for the beneficiary of a Partnership Long Term Care Policy.
- Adding a section that sets minimum standards for approved Long Term Care partnership policies
- Addressing consumer protections should the policyholder of an existing non-partnership policy wish to exchange for a partnership policy
- Producer training as mentioned above
- Provide for the development of standards through The Agency for Health Care Administration, Office of Insurance Regulation, and Department of Children and Family Services for information disseminated through insurance companies to the public about the Partnership Program.
- Provide a mechanism within The Office of Program Policy Analysis and Government Accountability for down stream evaluation and report of results on the results of the Partnership Program to be presented to the Governor, President of the Senate, and The Speaker of the House.
- Clarify the time limit on certain defenses by setting parameters on when and how a Partnership policy can be contested.

We will address each of these elements to gain an in-depth understanding of Florida Law as it relates to each of these issues.

MINIMUM STANDARDS FOR PARTNERSHIP POLICIES

In order to set standards for Partnership Long Term Care Policies Florida added section 690-157-201 to the Florida Administrative Code. The material text of that section is displayed below along with annotations for clarity.

A policy or certificate, herein referred to as policy, marketed or represented to qualify as an approved long-term care partnership program policy as provided by Section 409.9102,
F.S., hereinafter referred to as a ‘partnership’, shall be a policy where:

- Such form and rates are filed and approved pursuant to the provisions of Part II of this Rule Chapter and Chapter 69O-149, F.A.C.,
- The policy is intended to be a qualified long-term care insurance policy under the provisions of the Florida Long term Care Partnership,
- The insured individual was a resident of Florida or another state that has entered into a reciprocal agreement with Florida when coverage first became effective under the policy. If the policy is later exchanged for a different long-term care policy, the individual was a resident of Florida or another state that has entered into a reciprocal agreement with Florida when coverage under the earliest policy became effective,
- NOTE: The Deficit Reduction Act of 2005 provides that standards relating to reciprocity and portability of asset protection between state long term care partnerships will be developed at the federal level. Currently most states with partnership plans have reciprocity agreements usually on a dollar for dollar basis as described earlier in this text
- The policy is issued with and retains inflation coverage which meets the inflation standards based on the insured’s then attained age.
- The effective date of the coverage is on or after January 1, 2007, and
- Compliance is met with the provisions of these rules.

POLICY BENEFITS THAT COUNT TOWARDS ASSET DISREGARD

Insurance benefit payments, for purposes of asset disregard when applying for Medicaid long-term care services, are payments made for long-term care benefits and services and do not include such benefits as cash surrender values, return of premiums, premium waiver, or death benefits.

REQUIRED Disclosure

An insurer issuing or marketing policies that qualify as partnership policies, shall provide a disclosure notice, on the insurer’s letterhead, indicating that at the time of issue of the coverage, the policy is an approved long-term care partnership policy. The disclosure notice shall also explain the benefits associated with a partnership policy, and disclose that the partnership status may be lost if the insured moves to a different state or modifies the coverage after issue, or if changes in federal or state laws occur.
The insurer may use Form OIR-B2-1786 (1/2007), Partnership Status Disclosure Notice, which is hereby adopted and incorporated into this rule by reference. This notice shall be provided to the insured no later than the time of policy or certificate delivery. If the insurer uses Form OIR-B2-1786 without modification, no filing is required. If the carrier chooses to modify the language found in this disclosure notice, such notice shall be filed for approval with the Office.

LOSS OF PARTNERSHIP STATUS

When an insurer is made aware that the policyholders or certificateholders initiate action that will result in the loss of partnership status, the insurer shall provide an explanation of how such action impacts the insured in writing. The policyholders or certificateholders shall also be advised how to retain partnership status if possible.

If a partnership plan subsequently loses partnership status, the insurer shall explain to the policyholders or certificateholders in writing the reason for the loss of status.

NOTICE TO CURRENT HOLDERS OF LTC POLICIES

An insurer issuing or marketing policies that qualify as partnership policies, shall notify all of its policyholders with existing long-term care coverage issued on or after March 1, 2003, of the benefits associated with a partnership policy.

OFFER TO EXCHANGE

The insurer shall offer all such existing policyholders the option to exchange their policy, as provided by Rule 69O-157.1100, F.A.C., for a partnership policy.

Any policyholder that exchanges their policy shall be provided the required disclosure as provided in subsection (2) above.

The effective date of the partnership policy shall be the date of the exchanged policy.

INFLATION RIDER REQUIREMENTS

The issued policy shall meet the following inflation coverage limitations:
• Policies or certificates issued to an individual who has not yet attained age 61 shall contain annual compound inflation coverage.

• Policies or certificates issued to an individual who has attained age 61 but has not attained age 76 shall contain annual inflation coverage.

• For policies or certificates issued with inflation coverage, the policyholders or certificateholders must have the inflation coverage at a level based upon the insured’s current age as described above.

REPORTING BY INSURERS

All insurers shall report to the Health and Human Services Secretary such information as required by Centers for Medicare & Medicaid Services (CMS), including but not limited to:

• Notification regarding when insurance benefits provided under partnership plans have been paid and the amount of such benefits paid, and

• Notification regarding when such policies otherwise terminate.

THE DRA REQUIRES QUALIFIED LTC POLICIES

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

DEFINITION OF QUALIFIED LONG TERM CARE POLICIES

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

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

<table>
<thead>
<tr>
<th>Attained age as of 12/31/2007</th>
<th>Deductible Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 or younger</td>
<td>$290</td>
</tr>
<tr>
<td>Older than 40 but not older than 50</td>
<td>$550</td>
</tr>
<tr>
<td>Older than 50 but not older than 60</td>
<td>$1,110</td>
</tr>
<tr>
<td>Older than 60 but not older than 70</td>
<td>$2,950</td>
</tr>
<tr>
<td>Older than 70</td>
<td>$3,680</td>
</tr>
</tbody>
</table>

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

Generally benefits received under qualified or non-qualified long term care policies are not includable in income. Benefits from actual cost (also called reimbursement policies), which pay for the actual services a beneficiary receives, are not included in income. Benefits from per diem or indemnity policies, which pay a predetermined amount each day, are not included in income except amounts that exceed the beneficiary's total qualified long-term care expenses or $250 per day (for 2008), whichever is greater. So the real tax difference between a qualified and non-qualified long term care policy is the deductibility (subject to the above table) of some or possibly all of the premiums for the federal income tax return of the policyholder.

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 an converted policy which is substantially equivalent to the policy which was terminated. In order for an insured to benefit from this provision, he or she must have been covered under the terminated plan for at least six month immediately prior to the termination.

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

POST CLAIMS UNDERWRITING

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

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

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

PREMIUM DEDUCTIBILITY FOR BUSINESS ENTITIES

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

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

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

BENEFIT TRIGGERS

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

OR

Needing substantial supervision due to cognitive impairment (see below)

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

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

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

FINAL TREASURY REGULATIONS SECTIONS 7702B

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

Long term care policies issued before January 1, 1997 that meet state requirements in effect at that time are grandfathered as qualified long term care policies (regardless of the new HIPAA sections), however; if a contract has material changes it will lose the grandfathered status.
• Qualified contracts can not accrue cash values
• Qualified contracts must be guaranteed renewable
• Qualified contracts can only use policy dividends to reduce future premiums
• Qualified contracts must be issued within 30 days of approval
• If an insured request information pertaining to a claim denial it must be delivered within 60 days
• Non-qualified policies do not qualify for a premium deduction on the policyholder’s federal tax return

FLORIDA EXCHANGE CONCERNS

Florida as part of the implementation of the Long Term Care Partnership Program anticipated that many policyholder of existing non-partnership policies would want to exchange or convert their existing long term care coverage to or for a Qualified Partnership Policy.

If not addressed this could present a problem with policy replacements and all of the concerns related to the replacement process. The experience of the implementation process in the pioneer states shows us that this is something that should be addressed in a proactive fashion.

REQUIREMENTS FOR EXCHANGE OF COVERAGE

Florida added section 690-157.110 to the Florida Administrative to code to require an outreach to existing policyholders and to regulate the exchange or conversion process to ensure consumer protections are observed. The material text of that section is displayed below along with annotations for clarity.

An insurer may offer policyholders or certificateholders the option to exchange an existing Long-Term Care contract for a new Long-Term Care contract.

WHEN DOES AN EXCHANGE OCCUR

An exchange occurs when an insurer offers an existing long-term care policyholder or certificateholder the option to replace an existing policy with a different long-term care policy or certificate, and the policyholder or certificateholder accepts the offer to terminate the existing contract and accepts the new contract.

NON DISCRIMINATION OF OFFER

Any offer shall be made to all policyholders or certificateholders on a nondiscriminatory basis.

An exchange offer shall be deferred to all policyholders or certificateholders that are
currently eligible for benefits, within an elimination period on a claim, or who would not be eligible to apply for coverage due to issue age limitations under the new contract, until such time when such condition expires.

OFFERED ON A NON-UNDERWRITTEN BASIS

If the new coverage has the actuarial value of benefits equal or lesser than the actuarial value of benefits of the existing coverage, based on constant morbidity and uniform pricing assumptions as determined on the date of issue of a new insured determined using the same underwriting class and issue age, such new coverage shall be offered on a nonunderwritten basis.

UNDERWRITING ON INCREASED BENEFITS ONLY

If the new coverage has the actuarial value of benefits exceeding the actuarial value of benefits of the existing coverage, the insurer shall apply consistent new business underwriting for the increased benefits only.

ORIGINAL ISSUE AGE FOR EXISTING COVERAGE AMOUNT

If the new coverage has the actuarial value of benefits equal or lesser than the actuarial value of benefits of the existing coverage, the rate charged for the new coverage shall be determined using the original issue age and risk class of the insured used in determining the rate of the existing coverage.

ATTAINED AGE FOR ADDITIONAL COVERAGE AMOUNTS

If the new coverage has the actuarial value of benefits exceeding the actuarial value of benefits of the existing coverage, the rate charged for the new coverage shall be determined using the above paragraph above (original age and risk class) for the original level of benefits, increased by the rate for the increased benefits using the then current attained age and underwriting class of the insured for the increased benefits only. All rates charged must be filed and approved with the Office.

The new coverage offered shall be on a form that is currently offered for sale in the general market.
In lieu of the two paragraphs above, an insurer may make a filing to the Office for approval to utilize a different issue age for the new contract, or in some other way recognize the policy reserve build-up. Such filing shall demonstrate why the use of the original issue age is inappropriate and that the policy reserve build-up due to the prefunding inherent in the use of an issue age rate basis is credited to the benefit of the insured.
In an ongoing effort to standardize the rate increase process Florida has also passed recent legislation to set standards for rate increases of all long term care policies issued on or after July 1, 2006 or if issued prior to that date they come under the new standards on the next renewal occurring on or after July 1, 2008. These rate standards are included in section 690-157.301 of the Florida Administrative Code which is summarized below with annotation and headings.

**FLORIDA RATE INCREASE STANDARDS**

Rate increase filings for long term care insurance shall be filed in accordance with filing requirements and standards of Rule Chapters 69O-149 and 69O-157, F.A.C.

**CURRENTLY ACTIVE INSURERS**

Pursuant to the provisions of Section 627.9407(7)(c), F.S., for insurers that are currently actively marketing and issuing similar coverage, the rates resulting after a rate increase filing shall not exceed the insurer’s new business rate.

**INSURERS NOT CURRENTLY ISSUING NEW POLICIES**

The Office of Insurance Regulation will annually determine and publish the currently available new business rates for similar coverage being sold in Florida. The published new business rates represent the maximum annual rate that may be charged after a rate increase for insurers not currently issuing new coverage.

- The published rates shall be determined by first identifying those carriers currently issuing policies with similar coverage. For each of the similar coverage categories, the Florida new business earned premium, defined as first year premium in Florida, is determined for the prior calendar year. Those insurers reporting at least the top 80% of that earned premium, cumulatively, starting with the largest, will be used to tabulate the new business rate. The new business rate shall be the weighted average of the insurers’ rates, using the market share, as measured by first year premium in Florida, as the weight.

- The new business rates are for the standard underwriting class for the insurer. Standard underwriting class is the underwriting class with the most predominant sales, measured by number of policies, regardless of the name given to it by the insurer.

- The new business rates for other underwriting classes shall bear the same relationship to the standard rate schedules that the insurer has filed and approved. For example, if an insurer’s preferred rate is 85% of its standard rate, the premium limit applicable to the rate increase for business sold as preferred will be 85% of the standard rate schedule.
The published new business rates represent the particular benefit configuration listed. If an insurer has policies in force that have benefits different from the benefit used to determine the published rates, the insurer may contact the office for the new business rate that reflect the different benefits.

DIFFERENT BENEFIT CONFIGURATIONS

The office shall determine the new business rates for the requested benefit configuration in the same manner as it used for determining the published rates. The resulting rates shall be consistent with the published new business rates reflecting benefit differences only.

Insurers needing a different benefit configuration should make such request of the office in advance of a rate filing so as to give the office time to determine such rates and provide them to the insurer.

If the office is unable to determine the rates by a tabulation of the insurers currently selling similar coverage, the office shall use its best actuarial judgment in determining the new business rates using the information available from the insurers in the 80% market share.

Alternatively in such cases, at the option of the insurer, the insurer may submit the results of a model used to price new long term care products by an actuarial consulting firm currently pricing long term care for other clients, who is independent of the insurer, acceptable to the office, and contracted by the insurer.

The assumptions used shall be available to the office for review and approval. The model will be used to develop the new business pricing for the insurer’s policy benefit configuration, the new business pricing for the published benefit configuration, and to develop a factor which is the ratio of the insurer’s policy benefits to the published benefits.

It is noted that the provisions of Section 627.9407(7)(c), F.S., provide that the differences shall be benefit differences only; all other provisions of the two policies being modeled shall be identical. Such factor, representing benefit differences only, shall be used to adjust the published new business rates.

Independent, as used in this section, shall mean that the actuarial consulting firm or the actuary to be involved in the project has no relationship currently or for the last three years with the insurers for pricing, valuation, or other reviews.
FLORIDA TIME LIMIT ON CERTAIN DEFENSES

Prior to 2006 Florida used section 627.607 of the Florida Statute to deal with the incontestable period for a long term care policy. In 2006 Florida passed section 627.94076 which will eventually totally replace the previous section for long term care policies.

OLD LAW

The old law (which is still in effect for policies issued prior to July 1, 2006 until the next renewal on or after July 1, 2008) gave the insurer the latitude to contest a policy beyond the 2 year period for fraudulent misstatements and or exclude from the 2 year period any periods during which the insured is disabled. Once these previously issued policies come under the new law they must provide an endorsement to the effect to the policyholder.

NEW LAW

The new law (below) is very straightforward. Once the policy has been in force for 2 years it is incontestable (no qualifiers added).

The material portion of the new law section (627.94076) reads as follows:

Notwithstanding (read as regardless of) the provisions of s. 627.607, each long-term care insurance policy shall provide that the policy shall be incontestable after it has been in force during the lifetime of the insured for a period of 2 years after its date of issue except for nonpayment of premiums.

In order to understand the laws relating to long term care insurance it is beneficial to take a look at some of the definitions used with the Florida Lon Term Care related law.

DEFINITIONS IN THE FLORIDA PARTNERSHIP PROGRAM

"Long-term care insurance policy" means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited
health insurance coverage not otherwise defined as long-term care insurance.

"Applicant" means:

- In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits.
- In the case of a group long-term care insurance policy, the proposed certificateholder.

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

"Chronically ill" means certified by a licensed health care practitioner as:

- 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
- Requiring substantial supervision for protection from threats to health and safety due to severe cognitive impairment.

"Cognitive impairment" means a deficiency in a person's short-term or long-term memory, orientation as to person, place, and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

"Licensed health care practitioner" means any physician, nurse licensed under part I of chapter 464, or psychotherapist licensed under chapter 490 or chapter 491, or any individual who meets any requirements prescribed by rule by the commission.

"Limited benefit policy" means any long-term care insurance policy that limits coverage to care in a nursing home or to one or more lower levels of care required or authorized to be provided by this part or by commission rule.

"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.

"Policy" means any policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in this state by any of the entities specified in s. 627.9403.

"Qualified limited benefit insurance policy" means an accident and health insurance contract as defined in s. 7702B of the Internal Revenue Code and all applicable
sections.

"Qualified long-term care services" means necessary diagnostic, preventive, curing, treating, mitigating, 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.

"Qualified long-term care insurance policy" means an accident and health insurance contract as defined in s. 7702B of the Internal Revenue Code and all applicable sections.

**Disclosure, advertising, and performance standards for long-term care insurance.**

In 2006 Florida passed section 627.94076 of the Florida Statutes which covers disclosure, advertising, and performance standards for long term care insurance. This law affects all policies issued on or after July 1, 2006. Policies issued prior to July 1, 2006 must comply with this law on the next renewal on or after July 1, 2008. As the previously issued policies come under the new law they must provide an endorsement to the effect to the policyholder. Below are the main points within this section.
OIR SETS STANDARDS

The commission shall adopt rules that include standards for full and fair disclosure setting forth the manner, content, and required disclosures of the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, disclosure of tax consequences, benefit triggers, prohibition against post-claims underwriting, reporting requirements, standards for marketing, and definitions of terms.

ADVERTISING

The commission shall adopt rules setting forth standards for advertising, marketing, and sale of long-term care policies in order to protect applicants from unfair or deceptive sales or enrollment practices.

- An insurer shall file with the office any long-term care insurance advertising material intended for use in this state at least 30 days before the date of use of the advertisement in this state.
- Within 30 days after the date of receipt of the advertising material, the office shall review the material and shall disapprove any advertisement if, in the opinion of the office, such advertisement violates any of the provisions of this part or of part IX of chapter 626 or any rule of the commission.
- The office may disapprove an advertisement at any time and enter an immediate order requiring that the use of the advertisement be discontinued if it determines that the advertisement violates any of the provisions of this part or of part IX of chapter 626 or any rule of the commission.

POLICY PERFORMANCE STANDARDS

RESTRICTIONS

A long-term care insurance policy may not:

- Be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificateholder; however, the office may authorize nonrenewal for an insurer on a statewide basis on terms and conditions determined to be necessary by the office to protect the interests of the insureds, if the insurer demonstrates that renewal will jeopardize the insurer's solvency or that substantial and unexpected loss experience cannot reasonably be mitigated or remedied.
- Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same insurer or any affiliated insurer, except with respect to an increase in benefits
voluntarily selected by the insured individual or group policyholder.

- Restrict its coverage to care only in a nursing home licensed pursuant to part II of chapter 400 or provide significantly more coverage for such care than coverage for lower levels of care. The commission shall adopt rules defining what constitutes significantly more coverage in nursing homes licensed pursuant to part II of chapter 400 than for lower levels of care.
- Contain an elimination period in excess of 180 days. As used in this paragraph, the term "elimination period" means the number of days at the beginning of a period of confinement for which no benefits are payable.

PREEXISTING CONDITION

A long-term care insurance policy or certificate, other than a policy or certificate issued to a group referred to in s. 627.9405(1)(a), may not use a definition of "preexisting condition" which is more restrictive than the following:

"Preexisting condition" means a condition for which medical advice or treatment was recommended by or received from a provider of health care services within 6 months preceding the effective date of coverage of an insured person.

A long-term care insurance policy or certificate, other than a policy or certificate issued to a group referred to in s. 627.9405(1)(a), may not exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within 6 months following the effective date of coverage of an insured person.

- The office may extend the limitation periods set forth in paragraphs (a) and (b) as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.
- The definition of "preexisting condition" specified in paragraph (a) does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in paragraph (b) expires.
- A long-term care insurance policy or certificate may not exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described above.

PRIOR INSTITUTIONALIZATION

A long-term care insurance policy may not be delivered or issued for delivery in this state if the policy:

- Conditions eligibility for any benefits on a prior hospitalization requirement;
• Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or
• Conditions eligibility for any benefits other than waiver of premium, postconfinment, postacute care, or recuperative benefits on a prior institutionalization requirement.
• A long-term care insurance policy containing postconfinment, postacute care, or recuperative benefits must clearly specify, in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits," the applicable limitations or conditions, including any required number of days of confinement.
• A long-term care insurance policy or rider that conditions eligibility for noninstitutional benefits on the prior receipt of institutional care may not require a prior institutional stay of more than 30 days.

LOSS RATIO AND RESERVE STANDARDS

The commission shall adopt rules establishing loss ratio and reserve standards for long-term care insurance policies. The rules must contain a specific reference to long-term care insurance policies. Such loss ratio and reserve standards shall be established at levels at which benefits are reasonable in relation to premiums and that provide for adequate reserving of the long-term care insurance risk.

RATE STRUCTURE

A long-term care insurance policy may not be issued if the premiums to be charged are calculated to increase based solely on the age of the insured.

Any long-term care insurance policy or certificate issued or renewed, at the option of the policyholder or certificateholder, shall make available to the insured the contingent benefit upon lapse as provided in the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners in the second quarter of the year 2000. Note: Contingent benefits as specified by the NAIC include the ability to continue the policy in force at a reduced benefit amount.

Any premium increase for existing insureds shall not result in a premium charged to the insureds that would exceed the premium charged on a newly issued insurance policy, except to reflect benefit differences. If the insurer is not currently issuing new coverage, the new business rate shall be as published by the office at the rate representing the new business rate of insurers representing 80 percent of the carriers currently issuing policies with similar coverage as determined by the prior calendar year earned premium.

RIGHT TO RETURN; FREE LOOK

An individual long-term care insurance policyholder has the right to return the policy within 30 days after its delivery and to have the premium refunded if, after examination of the
policy, the policyholder is not satisfied for any reason.

An individual long-term care insurance policy must have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder has the right to return the policy within 30 days after its delivery and to have the premium refunded directly to the policyholder if, after examination of the policy, the policyholder is not satisfied for any reason.

STAMPED NOTICE TO BUYER

A long-term care insurance policy must contain a stamp prominently displayed on the first page of the policy that the policy has been approved as a "Long-Term Care Insurance Policy" meeting the requirements of Florida law.

In addition, the following statement shall be prominently displayed on the first page of the policy: "Notice to Buyer: This policy may not cover all of the costs associated with long-term care which may be incurred by the buyer during the period of coverage. The buyer is advised to periodically review this policy in relation to the changes in the cost of long-term care."

OUTLINE OF COVERAGE

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

- A description of the principal benefits and coverage provided in the policy;
- A statement of the principal exclusions, reductions, and limitations contained in the policy;
- If the policy is not expected to cover 100 percent of the cost of services for which coverage is provided, a statement clearly describing any such limitation;
- A statement of the renewal provisions, including any reservation in the policy of a right to change premiums;
- A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions; and
- A statement that the policy has been approved as a long-term care insurance policy meeting the requirements of Florida law.

CERTIFICATE

- A certificate issued pursuant to a group long-term care insurance policy, which policy is delivered or issued for delivery in this state, shall include:
- A description of the principal benefits and coverage provided in the policy;
- A statement of the principal exclusions, reductions, and limitations contained in
the policy; and

- A statement that the description of principal benefits is a summary of the policy and that the group master policy should be consulted to determine governing contractual provisions.

DISCLOSURE

A qualified long-term care insurance policy must include a disclosure statement within the policy and within the outline of coverage that the policy is intended to be a qualified long-term contract.

A long-term care insurance policy that is not intended to be a qualified long-term care insurance contract must include a disclosure statement within the policy and within the outline of coverage that the policy is not intended to be a qualified long-term care insurance contract.

The disclosure shall be prominently displayed and shall read as follows: "This long-term care insurance policy is not intended to be a qualified long-term care insurance contract. You need to be aware that benefits received under this policy may create unintended, adverse income tax consequences to you. You may want to consult with a knowledgeable individual about such potential income tax consequences."

ADDITIONAL DISCLOSURE

A limited benefit policy qualified under s. 7702B of the Internal Revenue Code must include a disclosure statement within the policy and within the outline of coverage that the policy is intended to be a qualified limited benefit insurance contract.

A limited benefit policy that is not intended to be a qualified limited benefit insurance contract must include a disclosure statement within the policy and within the outline of coverage that the policy is not intended to be a qualified limited benefit insurance contract.

The disclosure must be prominently displayed and must read as follows: "This limited benefit insurance policy is not intended to be a qualified limited benefit insurance contract. You need to be aware that benefits received under this policy may create unintended, adverse income tax consequences to you. You may want to consult with a knowledgeable individual about such potential income tax consequences."
Another element of implementing the Florida Long term Care Partnership Program involves amending the eligibility rule for Medicaid to allow for necessary changes and effect asset disregard.

The next few pages contain the relevant chapter within the Florida Administrative Code (FAC) that was changed as part of the implementation process. The insurance producer should be familiar with this information but should stop short of attempting to make an eligibility determination. When queried about eligibility the insurance producer should refer to the appropriate Medicaid official.

SSI RELATED MEDICAID RESOURCE ELIGIBILITY

65A-1.712
SSI-Related Medicaid Resource Eligibility Criteria.

(1) Resource Limits. If an individual’s total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C., with the following exceptions:

SPECIFIC RESOURCE LIMITS

(a) For MEDS-AD Demonstration Waiver an individual whose income is equal to or below 88 percent of the federal poverty level must not have resources exceeding the current Medically Needy resource limit specified in Rule 65A-1.716, F.A.C.

(b) For QMB, an individual cannot have resources exceeding the Medically Needy resource limit.

(c) For WD, an individual cannot have resources exceeding the Medically Needy resource limit.

(d) For SLMB, an individual cannot have resources exceeding the Medically Needy resource limit.

(e) For Medically Needy, an individual or couple cannot have resources exceeding the applicable Medically Needy resource level set forth in subsection 65A-1.716(3), F.A.C.

(f) For a Home and Community Based Waiver Services (HCBS) Program an individual cannot have countable resources that exceed $2,000. If the individual’s income falls within the MEDS-AD Demonstration Waiver limit, the individual can have resources up to $5,000.

(2) Exclusions. The department follows SSI policy prescribed in 20 C.F.R. Part 416 in determining what is counted as a resource with the following exceptions, as mandated
by federal Medicaid policies, or additional exclusions, as adopted by the department under section 42 U.S.C. § 1396a(r)(2). SSI policy requires resources in a blocked account to be countable resources. This applies regardless of whether the individual or their representative is required to petition the court to withdraw funds for the individual’s care. A blocked account is one in which state law protects an individual’s funds by specifically requiring that the funds be made available for the care and maintenance of the individual.

**RESOURCES OF A COMATOSE PATIENT**

(a) Resources of a comatose applicant (or recipient) are not considered as available when there is no known legal guardian or other individual who can access and expend the resource(s).

(b) The value of a life estate interest in real property is excluded.

(c) The cash surrender value of life insurance policies is excluded as resources if the combined face value of the policies is $2,500 or less.

(d) The individual, and their spouse, may designate up to $2,500 each of their resources for burial funds for any month, including the three months prior to the month of application. The designated funds may be excluded regardless of whether the exclusion is needed to allow eligibility. The $2,500 is not reduced by the value of excluded life insurance policies or irrevocable burial contracts. The funds may be commingled in the retroactive period.

(e) One automobile is excluded, regardless of value.

(f) Property that is essential to the individual’s self-support shall be excluded from resources if it is producing income available to the individual which is consistent with its fair market value. This includes real and personal property used in a trade or business; non-business income-producing property; and property used to produce goods or services essential to an individual’s daily activities. Liquid resources other than those used as part of a trade or business are not property essential to self-support. For the purpose of this section, mortgages are considered non-liquid resources, if they were entered into on or before September 30, 2004.

(g) An individual who is a beneficiary under a qualified state Long-Term Care Insurance Partnership Policy issued after November 1, 2007 is given a resource disregard equal to the amount of the insurance benefit payments made to or on behalf of the individual for long term care services when determining if the individual’s countable resources are within the program limits to qualify for Medicaid nursing home care.

**TRANSFER OF RESOURCES AND INCOME**

(3) Transfer of Resources and Income. According to 42 U.S.C. § 1396p(c), if an
individual, the spouse, or their legal representative, disposes of resources or income for less than fair market value on or after the look back date, the department must presume that the disposal of resources or income was to become Medicaid eligible and impose a period of ineligibility for nursing facility care services, institutional hospice or HCBS waiver services. The department will mail a notice to individuals who report a transfer for less than fair market value (Form CF-ES 2264, Feb 2007, Notice of Determination of Assets (Or Income) Transfer, incorporated herein by reference), advising of the opportunity to rebut the presumption and of the opportunity to request and support a claim of undue hardship per subparagraph (c)5. below. If the department determines the individual is eligible for Medicaid on all other factors of eligibility except the transfer, the individual will be approved for general Medicaid services (not long-term care services) and advised of their penalty period (Form 2358, Feb 2007, Medicaid Transfer Disposition Notice, incorporated herein by reference.) The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application.

(a) The department follows the policy for transfer of assets mandated by 42 U.S.C. §§ 1396p and 1396r-5. Transfer policies apply to the transfer of income and resources.

(b) When funds are transferred to a retirement fund, including annuities, within the transfer look back period the department must determine if the individual will receive fair market compensation in their lifetime from the fund. If fair compensation will be received in their lifetime there has been no transfer without fair compensation. If not, the establishment of the fund must be regarded as a transfer without fair compensation. Fair compensation shall be calculated based on life expectancy tables published by the Office of the Actuary of the Social Security Administration. See Rule 65A-1.716, F.A.C.

1. Individuals and their spouses must disclose their ownership interest in any annuity, including annuities that are not subject to the transfer of assets provision, and if purchased after November 1, 2007 must name the state as a remainder beneficiary (for applicants at the time of approval or for recipients at time of annual review) in the first position for no more than the total amount of medical assistance paid on behalf of the annuitant or in the second position after the community spouse and/or minor or disabled child unless the spouse, child or their representative disposes of the remainder for less than fair market value.

2. A purchase of an annuity (and other transactions that change the course of an annuity payment or treatment of income or principal) made after November 1, 2007 will be considered a transfer of assets for less than fair market value unless the annuity meets all of the following criteria for applicants at the time of approval and recipients at the time of annual review: (a) the state is named as the primary beneficiary (or secondary as appropriate
pursuant to subparagraph (b)1. above); (b) the annuity is irrevocable and non-assignable; (c) the annuity pays principal and interest in equal amounts during the term of the annuity, with no balloon or deferred payments; and (d) the annuity is actuarially sound based on standards published by the Office of the Chief Actuary of the Social Security Administration called the Period of Life Table as set forth in Rule 65A-1.716, F.A.C. (Life Expectancy Tables). Annuities purchased for the community spouse after November 1, 2007 must name the state as primary (or secondary) beneficiary pursuant to subparagraph (b)1. above and must be actuarially sound based on the community spouse’s age and the life expectancy tables.

3. Individual Retirement Accounts (IRAs) or annuities (as described in Section 408 of the Internal Revenue Code) established by an employee or employer are not considered under the transfer of assets provision and are not required to name the state as the primary remainder beneficiary in accordance with subparagraph (b)1. above.

(c) No penalty or period of ineligibility shall be imposed against an individual for transfers described in 42 U.S.C. § 1396p(c)(2).

1. In order for the transfer or trust to be considered to be for the sole benefit of the spouse, the individual’s blind or disabled child, or a disabled individual under age 65, the instrument or document must provide that: (a) no individual or entity except the spouse, the individual’s disabled child, or disabled individual under age 65 can benefit from the resources transferred in any way, either at the time of the transfer or at any time in the future; and (b) the individual must be able to receive fair compensation or return of the benefit of the trust or transfer during their lifetime.

2. If the instrument or document does not allow for fair compensation or return within the lifetime of the individual (using life expectancy tables noted in paragraph (b) above), it is not considered to be established for the sole benefit of the indicated individual and any potential exemption from penalty or consideration for eligibility purposes is void.

3. A transfer penalty shall not be imposed if the transfer is a result of a court entering an order against an institutional spouse for the support of the community spouse.

4. A transfer penalty shall not be imposed if the individual provides proof that they disposed of the resource or income solely for some purpose unrelated to establishing eligibility.

5. A transfer penalty shall not be imposed if the department determines that the denial of eligibility due to transferred resources or income would work an undue hardship on the individual. Undue hardship exists when imposing a
period of ineligibility would deprive an individual of medical care such that their life or health would be endangered. Undue hardship also exists when imposing a period of ineligibility would deprive the individual of food, clothing, shelter or other necessities of life. All efforts to access the resources or income must be exhausted before this exception applies. The facility in which the institutionalized individual is residing may request an undue hardship waiver on behalf of the individual with the consent of the individual or their designated representative.

CALCULATING TRANSFER VALUES

(d) Except for allowable transfers described in 42 U.S.C. § 1396p(c)(2), in all other instances the department must presume the transfer occurred to become Medicaid eligible unless the individual can prove otherwise.

1. An individual who disposes of a resource for less than fair market value or reduces the value of a resource prior to incurring a medical or other health care related expense which was reasonably capable of being anticipated within the applicable transfer look back period shall be deemed to have made the transfer, in whole or part, in order to qualify for, or continue to qualify for, medical assistance.

2. In cases where resources are held by an individual in common with others in a joint tenancy, tenancy in common, or similar arrangement, the individual is considered to have transferred resources or a portion thereof, as applicable, when action is taken by the individual or any other person authorized to access the resources that reduces or eliminates the individual’s ownership or control of such resource.

3. Promissory notes, loans and mortgages signed after November 1, 2007 will be considered transfers of assets without fair compensation to become Medicaid eligible unless the promissory notes, loans or mortgages meet all of the following criteria: (a) the repayment term is actuarially sound in accordance with the Life Expectancy Tables as referenced in paragraph (b) 2.; (b) payments must be made in equal amounts during the term of the loan, with no deferral and no balloon payments being possible; and (c) debt forgiveness is not allowed. If these criteria are not met, for purposes of transfer of assets, the value of the promissory notes, loans or mortgages will be the outstanding balance due as of the date of application for long-term care services.

4. A life estate interest purchased in another individual’s home after November 1, 2007 is considered a transfer of assets for less than fair market value. If the individual has not lived in the home for at least one year, the full amount of the purchase price paid for the life estate will be considered an uncompensated transfer without considering the value of the life estate. If the individual has resided in the home for at least one continuous year, the value
of the life estate will be considered compensation and will be calculated by multiplying the current market value of the property at the time of the purchase by the life estate factor that corresponds to the individual’s age at the time of the purchase. The life estate tables are incorporated by reference from the Social Security Administration’s online Program Operations Manual System (SI 01140.120) as found in Appendix A-17 of the Department’s online manual located at www.dcf.state.fl.us/ess/. Brief absences from the life estate property such as stays in a rehabilitation facility or vacations may not disrupt the client’s residency in the home. The facts of each absence will be evaluated to determine if the home continued to be the individual’s principal place of residence such as whether the person’s mail was delivered and received there or whether they paid the property taxes.

(e) Each individual shall be given the opportunity to rebut the presumption that a resource or income was transferred for the purpose of qualifying for Medicaid. No period of ineligibility shall be imposed if the individual provides proof that they intended to dispose of the resource or income at fair market value or for other valuable consideration, or provides proof that the transfer occurred solely for a reason other than to become Medicaid eligible or if the individual’s total countable resources (including the transferred resources) are below the program limits.

CALCULATING THE INELIGIBILITY PERIOD

(f) The uncompensated value of a transferred resource is the difference between the fair market value of the transferred resource at the time of the transfer, less any outstanding loans, mortgages or other encumbrances on the resource, and the amount of compensation received at or after the time of the transfer.

(g) For transfers prior to November 1, 2007, periods of ineligibility are calculated beginning with the month in which the transfer occurred and shall be equal to the actual computed period of ineligibility, rounded down to the nearest whole number. For transfers made on or after November 1, 2007, periods of ineligibility begin with the later of the following dates: (1) the day the individual is eligible for medical assistance under the state plan and would otherwise be receiving institutional level care based on an approved application for such care but for the application of the penalty period; or (2) the first day of the month in which the individual transfers the asset; or (3) the first day following the end of an existing penalty period. The department shall not round down, or otherwise disregard, any fractional period of ineligibility of the penalty period but will calculate the period down to the day. There is no limit on the period of ineligibility. Once the penalty period is imposed, it will continue although the individual may no longer meet all factors of eligibility and may no longer qualify for Medicaid long-term care benefits.

1. Monthly periods of ineligibility due to transferred resources or income are determined by dividing the total cumulative uncompensated value of all transferred resources or income computed in accordance with paragraph
65A-1.712(3)(f), F.A.C., by the average monthly private pay nursing facility rate at the time of application as determined by the department (refer to paragraph 65A-1.716(5)(d), F.A.C.

a. For transfers prior to November 1, 2007, where resources or income have been transferred in amounts or frequency or both that would make the calculated penalty periods overlap, the value of all transferred resources or income is added together and divided by the average cost of private nursing home care.

b. For transfers prior to November 1, 2007, where multiple transfers are made in such a way that the penalty periods for each would not overlap, each transfer is treated as a separate event with its own penalty period.

c. For transfers after November 1, 2007, the uncompensated value of all transfers will be added together to arrive at one total value with a penalty period assigned.

2. If an institutionalized individual is ineligible for medical assistance due to a transfer of resources or income by the community spouse, and the community spouse becomes potentially eligible for ICP, HCBS, or institutional hospice services, any remaining penalty period must be apportioned between the spouses. The department shall apportion penalty periods by dividing any new or remaining penalty periods by 2 and attribute the quotient to each spouse. Any excess months may be attributed to the spouse that caused the penalty or according to the wishes of the couple or their representative.

3. Individuals who are ineligible due solely to the uncompensated value of a transferred resource or income are ineligible for nursing home, institutional hospice or HCBS waiver services payment, but are eligible for other Medicaid benefits.

**Spousal Impoverishment**

(4) Spousal Impoverishment. The department follows 42 U.S.C. § 1396r-5 for resource allocation and income attribution and protection when an institutionalized individual, including a hospice recipient residing in a nursing facility, has a community spouse. Spousal impoverishment policies are not applied to individuals applying for, or receiving, HCBS waiver services, except for individuals in the Long-Term Care Community Diversion Program, the Assisted Living Facility waiver or the Cystic Fibrosis waiver.

(a) When an institutionalized applicant has a community spouse all countable resources owned solely or jointly by the husband and wife are considered in determining eligibility.
(b) At the time of application only those countable resources which exceed the community spouse’s resource allowance are considered available to the institutionalized spouse.

(c) The community spouse resource allowance is equal to the maximum resource allocation standard allowed under 42 U.S.C. § 1396r-5 or any court-ordered support, whichever is larger.

(d) After the institutionalized spouse is determined eligible, the department allows deductions from the eligible spouse’s income for the community spouse and other family members according to 42 U.S.C. § 1396r-5 and paragraph 65A-1.716(4)(c), F.A.C.

(e) If either spouse can verify that the community spouse resource allowance provides income that does not raise the community spouse’s income to the State’s MMMIA, the resource allowance may be revised through the fair hearing process to an amount adequate to provide such additional income as determined by the hearing officer. Effective November 1, 2007 the hearing officers must consider all of the community spouse’s income and all of the institutionalized spouse’s income that could be made available to a community spouse. The hearing officers will base the revised community spouse resource allowance on the amount necessary to purchase a single lifetime annuity that would generate a monthly payment that would bring the spouse’s income up to the MMMIA (adjusted to include any excess shelter costs). The community spouse does not have to actually purchase the annuity. The community spouse will have the opportunity to present convincing evidence to the hearing officer that a single lifetime annuity is not a viable method of protecting the necessary resources for the community spouse’s income to be raised to the State’s MMMIA. If the community spouse requests that the revised allowance not be based on the earnings of a single lifetime annuity, the community spouse must offer an alternative method for the hearing officer’s consideration that will provide for protecting the minimum amount of assets required to raise the community spouse’s income to the State’s MMMIA during their lifetime.

(f) Either spouse may appeal the post-eligibility amount of the income allowance through the fair hearing process and the allowance may be adjusted by the hearing officer if the couple presents proof that exceptional circumstances resulting in significant inadequacy of the allowance to meet their needs exist. Exceptional circumstances that result in extreme financial duress include circumstances other than those taken into account in establishing maintenance standards for spouses. An example is when a community spouse incurs unavoidable expenses for medical, remedial and other support services which impact the community spouse’s ability to maintain themself in the community and in amounts that they could not be expected to be paid from amounts already recognized for maintenance and/or amounts held in resources. Effective November 1, 2007, the hearing officers must consider all of the community spouse’s income and all of the institutionalized spouse’s income that could be made available to a community spouse. If the
expense causing exceptional circumstances is a temporary expense, the increased income allowance must be adjusted to remove the expenses when no longer needed.

(g) The institutionalized spouse shall not be determined ineligible based on a community spouse’s resources if all of the following conditions are found to exist:

1. The institutionalized individual is not eligible for Medicaid institutional services because of the community spouse’s resources and the community spouse refuses to use the resources for the institutionalized spouse; and

2. The institutional spouse assigns to the State any rights to support from the community spouse by submitting the Assignment of Support Rights form referenced in Rule 65A-1.400, F.A.C., signed by the institutionalized spouse or their representative; and

3. The institutionalized spouse would be eligible if only those resources to which they have access were counted; and

4. The institutionalized spouse has no other means to pay for the nursing home care.

OTHER RESOURCE POLICIES

(5) Other Resource Policies.

(a) Individuals shall not be eligible for long-term care services after November 1, 2007, if the individual’s equity interest in the individual’s home exceeds $500,000.

1. The individual’s equity interest is based on the current market value of the home (including all contiguous property), minus any encumbrances such as a mortgage or other associated loans. Long-term care services include Medicaid services authorized under the Institutional Care Program, institutional hospice, home and community based waiver services and the Program of All Inclusive Care for the Elderly (PACE).

2. Paragraph (5)(a) does not apply if the individual’s spouse, individual’s child under age 21 or the individual’s blind or disabled child (based on the federal definitions of “blindness” and “disability” in 20 CFR 416) of any age are residing in the institutionalized individual’s home.

3. The home equity provision may be waived when denial of long-term care services would result in demonstrated hardship to the institutionalized individual.

4. The department will mail a notice to individuals whose home equity interest exceeds $500,000 (Form CF-ES 2354, Feb 2007, Notice of Excess Home Equity Interest, incorporated herein by reference), advising of the
opportunity to have the home equity interest policy waived.

(b) An individual’s entrance fee in a continuing care retirement community or life care community shall be considered a resource, as set forth in 1917(g) of the Social Security Act, which is incorporated herein by reference.

Specific Authority 409.919 FS. Law Implemented 409.902, 409.903, 409.904, 409.906, 409.919 FS. History—New 10-8-97, Amended 1-27-99, 4-1-03, 9-28-04, 8-10-06 (1)(a), (f), 8-10-06 (1)(f), 8-10-06 (3)(g)1., 11-1-07.
CHAPTER 1 REVIEW QUESTIONS

Which of the following answers/completes each question/sentence the best?

(Answers are in the back of the text.)

1. The ___________ limited most states from adopting partnership programs and slowed the spread of the partnership concept.
   a) Omnibus Budget Reconciliation Act of 1993
   b) NAIC Long Term Care Model Act
   c) Medicaid Income Eligibility Act
   d) Social Security Act

2. Before the Florida Partnership was implemented, residents had three basic choices to finance the costs of long-term care. Which choice was added by the Partnership?
   a) Pay for needed care out of assets and income
   b) Transfer assets prior to needing LTC services
   c) Purchase a traditional LTCI policy
   d) Purchase a partnership policy

3. What feature do all partnership programs have in common?
   a) You have to qualify for Medicare Part A before you can purchase a partnership policy.
   b) You have to qualify for Medicare Parts A & B before you can purchase a partnership policy.
   c) Your income goes to pay for the cost of care once you qualify for Medicaid.
   d) You have to have a sufficient amount of money to be able to pay your own LTC expenses for the first year.
ETHICAL BEHAVIOR AND THE LAW

The fear of nursing homes makes the senior market especially vulnerable.

THE SENIOR MARKET’S VULNERABILITY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SHORT-FORM UNDERWRITING

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

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

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

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

POST-CLAIMS UNDERWRITING

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

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

GATEKEEPERS LIMIT RIGHTS TO BENEFITS

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

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

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

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

Continence is usually defined as the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

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

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

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

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

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

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

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

Most policies give consumers choices in the following areas:

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

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

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

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

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

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

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

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

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

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

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

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

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

THE STATUTE OF LIMITATIONS IN BAD FAITH CASES

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

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

RATING LONG-TERM CARE INSURERS

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

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

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

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

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

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

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

**EXCELLENT RATING**

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

**GOOD RATING**

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

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

**WEAK RATING**

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

**VERY WEAK RATING**

The company currently demonstrates what we consider to be significant weaknesses and has also failed some of the basic tests that we use to identify fiscal stability. Therefore, even in a favorable economic environment, it is our opinion that policyholders could incur significant risks.
CHAPTER 2 REVIEW QUESTIONS

Which of the following answers/completes each question/sentence the best?
(Answers are in the back of the text.)

1. If a client is unsure about a medical question on the application, what should the agent do?
   a) Advise the client to answer to the best of his recollection.
   b) Advise the client to add an asterisk on any section of which he is unsure and make a notation regarding further information.
   c) Advise the client to state he never had the condition in question – Better to understate than to overstate.
   d) Advise the client to state he had the condition before, but couldn’t remember when – Better to overstate than to understate.

2. Most policies give consumers choices in which of the following areas?
   a) Benefit amounts and duration of benefits
   b) Elimination period
   c) Inflation protection and nonforfeiture benefits
   d) All of the above

3. Falsely written advertisements give rise to a cause of action against the carrier.
   a) TRUE
   b) FALSE
Chapter 3

FEDERAL REGULATION OF LONG-TERM CARE POLICIES

Excerpts are 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:

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

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

CANCELATION

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 3 REVIEW QUESTIONS

Which of the following answers/completes each question/sentence the best?

(Answers are in the back of the text.)

1. Which of the following factors constrict the number of LTCI policies available on the market?
   a) Lack of interest from large group markets
   b) Lack of data
   c) Inconsistent/Inappropriate and rapidly changing regulatory standards
   d) All of the above

2. In order to address consumer protection and regulation of long term care insurance, the federal government has identified several courses of action. Which of the following have NOT been identified as a possible course of action?
   a) Increase consumer awareness
   b) Increase insurance coverage
   c) Establish consistent regulations
   d) Concentrate sales on the elderly population

3. To qualify for favorable tax treatment, a long-term care policy sold after ______ must contain the consumer protection standards in HIPAA.
   a) 1901
   b) 1996
   c) 2010
   d) 2012

4. Consumers must receive a __________ and a description of the policy’s benefits and limitations (i.e., Outline of Coverage) early in the sales process.
   a) Shopper’s Guide
   b) Cancellation procedure guideline
   c) Definition of cognitive impairment
   d) HIPAA outline
Chapter 4

GOVERNMENT ASSISTANCE - MEDICAID

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

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

ELIGIBILITY FOR MEDICAID ASSISTANCE

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

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

ASSETS AND INCOME DETERMINE ELIGIBILITY

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

**ASSETS**

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

Non-Exempt Assets
Medicaid will only extend financial aid to individuals who are, in essence, virtually bankrupt. The individual receiving Medicaid benefits must not own or have any of the following non-exempt assets:
• Cash over $2,000 (in most states);
• Stocks;
• Bonds;
• IRAs;
• Keoghs;
• Certificates of deposit;
• Single premium deferred annuities;
• Treasury notes and treasury bills;
• Savings bonds;
• Investment property;
• Whole life insurance above a certain amount;
• Vacation homes;
• Second vehicles;
• Pension programs;
• Interest on bank accounts;
• Rental Income; and
• Social Security.

Exempt Assets
Even though it is commonly recognized that the value of the following assets may well be over any amount that common sense would deem appropriately bankrupt status, Medicaid does not consider them in determining eligibility.
• A house used as a primary residence (in most states, this can include two and three-family homes);
• Currency not exceeding $2,000;
• A car;
• Personal jewelry;
• Household furnishings;
• A pre-paid funeral plan;
• A burial account (not to exceed $2,500 in most states); and
• Term life insurance policies with no cash surrender value.*

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

**Countable Assets**

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

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

**THE DEFINITION OF INCOME**

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

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

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

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

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

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

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

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

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

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

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

**UNCOMPENSATED TRANSFERS**

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

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

**Bargain sale**
Where someone sells an asset to another at a bargain price (usually a relative). If a parent sells an asset worth $100,000 to a child for $1 (hoping to classify it as a sale and not a gift) it will still be classified as an uncompensated transfer of $99,999. So the difference between the fair market value of the asset transferred and compensation received is considered an uncompensated transfer.
Transfer of assets to an irrevocable trust
When one transfers assets to an irrevocable trust for less than fair market value it is considered an 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 $12,000 (2008) per donor per donee a federal gift tax return (form 709) should be filed by the next tax filing deadline. This is often overlooked and can cause considerable tax problems downstream for the donee.

MEDICAID TRUSTS

There are two types of Medicaid Trusts:

- Revocable; and
- Irrevocable.

**Revocable Trusts**

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

**Irrevocable Trusts**

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

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

THE SPOUSAL IMPOVERISHMENT ACT

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

ASSESSING RESOURCES AND DETERMINING ELIGIBILITY

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

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

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

Example – Determining Spousal Share of Assets

<table>
<thead>
<tr>
<th>Date of Overview</th>
<th>Date of Entry</th>
<th>Total Assets</th>
<th>One-Half</th>
<th>Spouse’s Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1</td>
<td>January 1</td>
<td>$30,000</td>
<td>$15,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>January 1</td>
<td>January 1</td>
<td>$40,000</td>
<td>$20,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>January 1</td>
<td>January 1</td>
<td>$20,000</td>
<td>$10,000</td>
<td>$12,000</td>
</tr>
<tr>
<td>January 1</td>
<td>January 1</td>
<td>$18,000</td>
<td>$9,000</td>
<td>$12,000</td>
</tr>
<tr>
<td>January 1</td>
<td>January 1</td>
<td>$100,000</td>
<td>$50,000</td>
<td>$50,000</td>
</tr>
</tbody>
</table>
If assets have to be spent down by the institutionalized spouse in order to qualify, the applicant for Medicaid may not take place for months. Regardless of what the total assets are on the day he applies, the stay-at-home spouse’s share will always be determined on the day of the snapshot.

*The combined eligible assets are always determined on the date of entry into the nursing home.

<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>

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

**MEDICAID ESTATE RECOVERY EFFORTS**

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

This is often the motivation of many people to engage in ill planned uncompensated transfers in order to avoid losing the home. In most states Medicaid will lien your real property assets that were not required to be spent down during the asset determination phase of the eligibility process. Usually this results in a lien being placed on your principle residence which will prevent transfer of title without the lien being satisfied.

One the institutionalized recipient of Medicaid assistance dies the non-institutionalized spouse may continue to live in the home. Since a lien is not a forecloseable instrument it will not force the sale of the home; however, once the lien is in place the title can not transfer without he lien being paid. Once the spouse of
the Medicaid recipient dies the heirs may not take title to the home until the lien has been satisfied. If the amount of the lien exceeds the value of the home Medicaid can make attempts to recover other assets but rarely does. It should be noted that the heirs are in no way liable for the debts of their parents generated by receipt of Medicaid assistance. The heirs have the option of walking away from the home and often do if the amount of the lien is greater than the value of the home.

**Disadvantages to Using Medicaid for LTC Costs**

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

**Care Proximity**

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

**Heirs Lose Inheritance**

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

**Financial Straightjacket**

By applying for Medicaid assistance you are in essence putting yourself into a financial straightjacket and the loss of independence and sense of self worth is often overwhelming to the patient. It is humiliating for an individual who has been self-supporting all their life to rely on public assistance and go through the Medicaid eligibility process. This humiliation is not by design within the Medicaid system but is a result of having to be inspective to assure public funds are spent in a judicious manner.
CHAPTER 4 REVIEW QUESTIONS

Which of the following answers/completes each question/sentence the best?

(Answers are in the back of the text.)

1. 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:
   a) establish your state of residence.
   b) publish your birth certificate in the local newspaper.
   c) prove that you haven’t lived outside the U.S. within the last year.
   d) that you are at least age 32.

2. Medicaid considers three groups of assets. Which of the following is NOT applicable?
   a) Countable
   b) Non-countable
   c) Dependents
   d) Inaccessible

3. The ________________ allows the spouse of the person in the nursing home to keep a certain amount of assets and income.
   a) Health Accountability and Portability Act
   b) Deficit Reduction Act
   c) Social Security
   d) Spousal Impoverishment Act
THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

A BRIEF OVERVIEW OF THE NAIC

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

THE NAIC MODEL ACT

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

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

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

To facilitate flexibility and innovation in the development of long-term care insurance coverage.

**CONTINUAL REVIEW AND STATE ADHERENCE TO LEGISLATION**

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

**NAIC MODEL STANDARDS**

The NAIC Standards currently contain the following protections.

**Prior Approval of Policies**

- Preexisting 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).

**Premium Rate Control and Solvency Requirements**

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

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

**Policies Currently in Force That Adhere to NAIC Standards**

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

**NAIC and the Uniform Policy Provision Model Act**

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

**Mandatory Policy Provisions**

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

ENTIRE CONTRACT PROVISION

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

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

INCONTESTABILITY CLAUSE

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

GRACE PERIOD PROVISION

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

Example

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

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**REINSTATEMENT PROVISION**

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

**NOTICE OF CLAIMS**

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

**Example – Exception to Mandatory 20-Day Notification Rule**

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

**CLAIM FORMS**

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

**PROOF OF LOSS**

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

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

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</td>
<td>* Submits claim, receives periodic payments of disability income from January 1 through June 1.</td>
</tr>
<tr>
<td>after an accident January 1.</td>
<td></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, the 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.

**IN'Toxicants 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 5 REVIEW QUESTIONS

Which of the following answers/completes each question/sentence the best?

(Answers are in the back of the text.)

1. Most states have based their regulation of long-term-care insurance on model standards developed by the:
   a) NAIC.
   b) DOI
   c) DHHS
   d) USN

2. State adherence to NAIC model legislation is:
   a) required by the federal government.
   b) required by state insurance departments.
   c) mandatory.
   d) voluntary.

3. According to NAIC Standards for LTC, preexisting condition exclusion periods of longer than _________ are prohibited.
   a) 72 hours.
   b) 3 months.
   c) 6 months.
   d) 18 months.

4. Companies are required to have reserves and to meet an expected premium-to-loss ratio of at least _______ for individual policies.
   a) 35%
   b) 60%
   c) 90%
   d) 100%

5. If the beneficiary is a(n) “_________” beneficiary, the insured has a right to change the beneficiary. If the beneficiary is an “_________” beneficiary,” it may not be changed.
   a) revocable; irrevocable
   b) irrevocable; revocable
Chapter 6

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 (as noted in Chapter 1.)

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

**MEDICAID BENEFITS**

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

About 70 percent of 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 pay out and this annuity and the income would be
exempt from the Medicaid spend down (asset test) or income test. This loophole
has been closed and an annuity has no special status under the Medicaid eligibility
test.

**ANNUITIES WITH LTC RIDERS**

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

**MANAGED CARE PLANS**

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

**MEDICARE SUPPLEMENTAL INSURANCE**

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

The benefits and costs of these plans vary widely.

INCREASING COSTS WITH AGE

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Policy Age</th>
<th>Annual Premium</th>
<th>Years of Coverage</th>
<th>Cumulative Premiums@ Age 85</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>$600</td>
<td>35</td>
<td>$21,000</td>
</tr>
<tr>
<td>60</td>
<td>$1,500</td>
<td>25</td>
<td>$37,500</td>
</tr>
<tr>
<td>70</td>
<td>$4,000</td>
<td>15</td>
<td>$60,000</td>
</tr>
<tr>
<td>75</td>
<td>$8,000</td>
<td>10</td>
<td>$80,000</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
• Nonforfeiture 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. Washington State uses the term benefit trigger to describe the condition that must be present (covered event) for a long term care policy to pay a benefit.

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

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

NUMBER OF ADL’s LOST FOR BENEFIT

In addition regulations specify a minimum number of benefit triggers that must be included in a contract but an insurance company can offer additional benefit triggers. They 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 3 or more of the minimum benefit triggers described below then they qualify for a contract benefit. If an insurer adds additional benefit triggers they can not require that an insured need hands on assistance with more than 3 benefit triggers.

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

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

QUALIFIED LONG TERM CARE POLICIES

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

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

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

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

Generally benefits received under qualified or non-qualified long term care policies are not includable in income. Benefits from actual cost (also called reimbursement policies), which pay for the actual services a beneficiary receives, are not included in income. Benefits from per diem or indemnity policies, which pay a predetermined amount each day, are not included in income except amounts that exceed the beneficiary's total qualified long-term care expenses or $260 per day (for 2007...no increase announced for 2008), whichever is greater. So the real tax difference between a qualified and non-qualified long term care policy is the deductibility (subject to the above table) of some or possibly all of the premiums for the federal income tax return of the policyholder.
A group qualified long-term care policy must provide for continuation of coverage or conversion. In the event that the insured is no longer in the group and is subject to losing coverage. The insured must be able to maintain his/her coverage under the group policy by the payment of premiums. If the benefits or services covered are restricted to certain providers, which the insured can no longer use, the insurance company must provide for a continuation of benefits which are substantially equivalent. Similarly, if a group policy it terminated the insurance company must provide the insured with an converted policy which is substantially equivalent to the policy which was terminated. In order for an insured to benefit from this provision, he or she must have been covered under the terminated plan for at least six month immediately prior to the termination.

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

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

HIPAA also established minimum standards for home health and community care benefits in qualified policies. If the policy provides benefits for home health or community care, it may not limit or exclude benefits by requiring that skilled care be required first or that the services be provided by registered or licensed practical nurses or that the provider be Medicare-certified. The policy may not exclude coverage for personal care services provided by a home health aide or adult day care service. The policy may not require that benefits be triggered by an acute illness.
Inflation protection is also included as a required element of a qualified plan. It is intended that meaningful inflation protection be provided. The legislation requires that the insurance company use reasonable hypothetical or graphic demonstrations that disclose how the inflation protection will work.

**BUSINESS RELATED**

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

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

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

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

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

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

**OR**

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

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

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

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

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

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

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

VIATICAL SETTLEMENTS

A terminally 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 preexisting conditions, without a waiting period, if these are disclosed when he applies;
• Offers five percent (5%) compound inflation protection; and
• Allows policyholders to upgrade or downgrade their coverage if they can not afford premiums.
CHAPTER 6 REVIEW QUESTIONS

Which of the following answers/completes each question/sentence the best?
(Answers are in the back of the text.)

1. The average length of stay in a nursing home is:
   a) 2 to 3 weeks.
   b) 2 to 3 months.
   c) 2½ to 3 years.
   d) 5 to 10 years.

2. The probability of needing long-term health care at some time in the future is
   estimated at:
   a) 2%
   b) 50%.
   c) 90%.
   d) 100%

3. Medicare Supplemental Insurance is often called:
   a) Medigap.
   b) MSI.
   c) MIS.
   d) Medicare Ancillary Insurance.

4. If the only source of income is a minimum Social Security benefit or Supplemental
   Security Income (SSI):
   a) they would be a good candidate for a low-cost LTC policy.
   b) they should be encouraged to purchase an LTC policy, because their need will
      be greater.
   c) it would not be in a client’s best interest to purchase a long-term care.
   d) they should purchase a Medigap policy with the most benefits.

5. All qualified long term care policies must have a provision to protect the insured
   against:
   a) false advertising.
   b) high premiums.
   c) low premiums.
   d) unintended lapse.
Chapter 7

FORMS OF CARE AND COVERAGE AVAILABLE

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

THE SCOPE OF THE NURSING HOME ORGANIZATION

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

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

There are three ways in which nursing homes function:

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

MEDICALLY NECESSARY CARE

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

SKILLED NURSING CARE

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

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

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

**INTERMEDIATE NURSING CARE**

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

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

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

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

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

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

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

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

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

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

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

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

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

CUSTODIAL CARE

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

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

HOSPICE

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

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

**ADULT DAY CARE**

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

**PERSONAL HOME CARE**

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

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

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

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

**CONTINUING CARE RETIREMENT COMMUNITIES**

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

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

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

What most of these CCRC’s have in common is that when you first “check in” you have your own separate dwelling and live independently. Part of your contract stipulates an upfront 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 7 REVIEW QUESTIONS

Which of the following answers/completes each question/sentence the best?
(Answers are in the back of the text.)

1. There are three ways in which nursing homes function. Which of the following is INCORRECT?
   a) Medically necessary care
   b) Skilled nursing care
   c) Home health care
   d) Intermediate care

2. 50% of all couples and 70% of single persons are impoverished within one year of entering a nursing home facility.
   a) TRUE
   b) FALSE

3. ________________ is intended to assist with daily living, which includes bathing, eating, dressing, and other routine activities.
   a) Skilled nursing care
   b) Custodial care
   c) Adult day care
   d) Hospice
Chapter 8

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 you income is above the Federal Poverty Level the state may still pay some of the costs depending on several income/asset tests and the cost of the total services needed.

LIFE CARE FACILITIES

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

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

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

One of the many benefits offered by a Life Care Facility is continuity of care setting. The resident is guaranteed to have all of their non hospital care provided in the location they “buy into”. This is particularly valuable to a couple where if one of the 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 can not admit non-residents to the long term care beds unless they can prove that they have an excess of bed capacity and that residents will not have to wait for an inpatient bed as a result.

WHO FOOTS THE BILL?

**HOSPITAL EXPENSES**

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

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

**PERSONAL SAVINGS**

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

**MEDICARE**

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

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

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

In 1984, the Medicare system underwent a radical reform. Because Medicare paid all hospital care expenses prior to 1984, the cost to the federal government was astonishing. The “Diagnostic Related Groups” (DRGs) system was developed. Under this reimbursement system, hospitals are paid a flat rate for designated illnesses. If the hospital is able to stabilize the patient for under the Medicare flat rate, the hospital can keep the overage amount. However, if the hospital is unable to stabilize the patient for the Medicare flat rate or under, the hospital must absorb the cost differential. Therefore, there is a strong monetary motivation for hospitals to release patients as soon as possible.

Consequently, the meaning of the word “stabilized” has changed significantly since 1984. Prior to 1984, a person’s stay in the hospital could go on almost indefinitely, or at least until he either got significantly better or died. Today, stabilized means that the hospital has determined that the medical condition will not get worse.

**MEDICAID**

Medicaid is not available to everyone. It is a public assistance program designed for lower income individuals who can qualify both financially and medically.

Medicaid is a program of medical aid designed for those applicants who meet the following two requirements:

- Financial eligibility; and
- Medical eligibility.

State and federal governments finance this program. Currently, an individual’s assets (excluding their home) must be less than $2000, but these amounts are subject to review by Congress and could be changed at any time. Medicaid is used when all other systems and requirements fail to cover costs.

**PRIVATE INSURANCE**

Most employers today provide health care plans for their employees (i.e., HMO,
PPO). DRGs are usually a part of these policies.

**CARING FOR YOUR LOVED ONE**

Once a patient has been stabilized in a hospital, it is time for the patient to be released. Now it is up to the family to decide where that patient will go. There are usually only two options:

- Take the patient home; and
- Take the patient to a nursing home.

If the person’s medical condition is slight, home care may be the option to choose; at least for the time being. As long as the condition requires minimal care, it would not be too difficult to work into the caregiver’s normal routine.

However, if and when the person’s medical condition takes a turn for the worst, more time and attention will be needed and that may prove too difficult to work into a normal routine. In most families, every member tries to help out; but the majority of the care usually falls to the female of the household (i.e., wife, daughter, and mother). Something has to give. It could be the time normally spent on the other members of the household, and it could also be the caregiver’s health that suffers. For instance, if the ill person is no longer able to lift themselves out of a chair, or bed, and into a wheelchair without assistance, or to lift themselves onto and off of the bathroom facilities, the caregiver’s physical well-being can become at risk.

The errands that the caregiver normally runs for her family (i.e., shopping, running the kids here and there) will have to be done by someone else. And that someone else probably already has a full schedule. This can put even more strain on the family. So much strain that relationships have suffered severely, even end in divorce.

Sometimes the amount of care necessary requires the caregiver to quit her outside job in order to stay home with the chronically ill person* 24 hours a day if necessary. Such a situation can cause even more stress on the family, due to financial burdens.

**LONG TERM CARE INSURANCE THAT WILL PAY FOR FAMILY CARE**

While most long term care policies will only pay for home health care when the services are performed by a qualified individual and that individual is not a family member you can buy long term care policies (even partnership policies) that still require the individual to be qualified but will allow the individual to be a family member. These same policies will pay a training benefit for the family member to get training and this benefit is in addition to the daily benefit otherwise payable. With this type of policy the concerned family member could provide home health care for their loved one and use the daily benefit to pay a qualified individual to perform the services meanwhile the family member is also being paid a training benefit to become a certified caregiver. Once the family member is qualified they can take over the 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** 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 8 REVIEW QUESTIONS

Which of the following answers/completes each question/sentence the best?
(Answers are in the back of the text.)

1. In order for an individual to participate in PACE, they must be:
   a) over age 21.
   b) at least 55 years of age.
   c) at least 62 years of age.
   d) in an unstable health condition.

2. The intent of the _________________ Program is to allow as many people as possible to continue to live in their home and receive services on an outpatient basis.
   a) Community Care
   b) HMO
   c) PACE
   d) Hospice

3. In order for an individual to be eligible for the Community Care Program, they must be:
   a) at least age 45.
   b) diagnosed with chronic illness.
   c) diagnosed with Alzheimer’s.
   d) at least age 60.

4. What distinguishes Life Care Facilities from other levels of care is the:
   a) quality of care.
   b) location of care.
   c) guarantee of future treatment.
   d) medical specialization.
COMPARING LTC POLICIES

Both benefits and restrictions vary from company to company and from policy to policy.

Comparing policies is extremely difficult because companies are selling policies with many different combinations of benefits and coverage. Most offer to pay a fixed dollar amount each day you receive care. Other companies offer to pay a percentage of the cost of services or a specified dollar amount to cover the actual charges for care. These policies however may not be beneficial to consumers, unless they provide for benefits to increase as nursing home costs rise. Without inflation protection [described below] a consumer could be left with a benefit that is meaningless.

POLICY RESTRICTIONS VARY

There are so many different restrictions written by insurance companies that it is virtually impossible to list them all. Common descriptions include the type of nursing supervision, the size of the facility, type of care provided and level of licensing.

HOW LONG TERM CARE POLICIES PAY BENEFITS

Long term care insurance policies are designed to cover a range of care settings and services. Some contracts will cover nursing facility only coverage and some will cover home health care only. In addition many contracts are integrated and cover both major subheading of care. The consumer faces many choices and to features and benefit or riders that can be added to many long term care insurance policies. This course section will cover theses care setting and consumer choices in long term care insurance policies.

NURSING FACILITY COVERAGE ONLY

Older long term care policies covered only inpatient and often mirrored the requirement under Medicare part A for admission to a skilled nursing facility that one must have been inpatient in a hospital for at least 3 days prior to benefit. Many states disallow this requirement in a long term care policy. A nursing facility only policy will cover the insured for a confinement to a nursing facility but will not pay a benefit if they elect home health care instead. Premiums for a nursing facility only policy reflect this restriction on care setting by being lower than a policy covering both nursing facility and home health care settings.

TAX QUALIFIED, NON-TAX QUALIFIED

Long term care policies are available as either tax qualified or non-tax qualified. Tax
qualified policies are written to take advantage of the tax preferences afforded by The Health Insurance Portability and Accountability Act of 1996. While tax qualified long term care policies do give the insured a margin of tax relief the tradeoff is more restrictive contract requirements. Many consumers opt for the non-qualified plans because of the considerably less restrictive contract language as a result the tax qualified plans are the minority of in-force long term care policies today. A tax qualified plan has more restrictive language in the benefit triggers. Tax qualified policies require the following for benefit to be paid:

- Insured to be certified as chronically ill by a physician within 12 months of applying for benefits;
- Insured to be unable to perform at least two activities of daily living as a result of loss of functional capacity or severe cognitive impairment, this condition must have already or be expected to last for a continuous period of not less than 90 days. OR
- Insured diagnosed with severe cognitive impairment

When the assessment of the insured is performed the physician must certify that insured needs “substantial assistance” in the case of severe cognitive impairment.

This presents a stark contrast to the benefit triggering language in non tax qualified policies which do not require the diagnosis of chronic illness or the continuous 90 day period of loss of functional capacity.

**NURSING FACILITY WITH HOME HEALTH CARE RIDER**

Many companies offer a long term care policy which covers nursing facility and offers a rider to optionally add coverage for home health care. This is a very popular choice with consumers because they would rather (if medical factors allow) to have care provided in a home setting versus inpatient. The consumer is usually offered the option of purchasing differing benefit amounts for nursing facility care and home health care. By purchasing a policy that covers both nursing facility and home health care the consumer is also protected if there medical condition necessitates the nursing facility (inpatient) level of care:

Home health care coverage routinely pays for the services of the following professions:

- licensed nurse
- home health care aide
- comprehensive outpatient rehabilitation specialist
- physical therapist
- speech pathologist
- respiratory therapist
- occupational therapist

In addition to services of the professionals above home health care will also pay for:

- Homemaker services
- General assistance with ADLs
• Respite care to relieve a primary care giver

Most companies require that these services be performed by a qualified persona and that person can not be a relative. There are some long term care policies that allow relatives to be the care giver and will even pay an additional benefit for the relative to be trained as a care giver. In a compressed course format one can be qualified in most states in as little as six weeks.

INTEGRATED POLICIES
An integrated long term care policy has automatically included nursing facility care and home health care into the same contract. Both coverages are hard coded in the policy and are not added by rider. This is the most common long term care policy marketed today. The consumer has reserved the option of receiving needed services on an outpatient basis but is also protected should they have to go inpatient to receive the proper services needed.

It is common for the contract to stipulate a lower benefit amount for home health care than for nursing facility care (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 can not.

INTERMEDIATE CARE
This care occurs in an inpatient setting, which can be a freestanding building, or a designated wing, room, or bed within a Medicaid qualified nursing facility, or hospital. The care provided is not skilled in nature but is more involved than custodial care. The patient needs less than 24 hour supervision but is not ready to be discharged. The patient may need occasional (at least daily) injection or tests that can not be performed in an outpatient setting. Intermediate care is often performed at the direction of or under the indirect supervision of a physician. A long term care policy can not require a pre-hospitalization to cover intermediate care.

CUSTODIAL CARE
Custodial care is services that do not have to be performed by skilled medical personnel to prevent risk of injuring the patient. It includes assistance with the activities of daily living and other personal assistance. This care can occur in a nursing facility, at home, in adult day care, or in one of many other alternate care arrangements such as assisted living. A good example of custodial care in an inpatient setting would be helping the patient to get out of bed, bathe and, dress.

ASSISTED LIVING
Another form of custodial care is assisted living which has been mentioned through out 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 care homes, adult foster care homes, residential care facilities, adult family homes are all names for essentially the same type of care. This level of care entails 24 hour non-medical supervision, room and board, as well as assistance with ADLs, all in a group setting. The care setting can be as small as a converted principle residence with five patients and one care giver to a larger 100 patient facility. The majority of care settings trend towards the smaller end of this scale and many are small,
one location facilities. Licensing requirements vary widely from state to state so it is wise to check licensing.

NO PRIOR HOSPITAL STAY REQUIREMENT ALLOWED
As mentioned above Medicare requires a three day inpatient hospital stay (within the immediately preceding 30 day period before a person can be admitted to a nursing facility for skilled nursing care. Under most state laws, a person can be admitted at any time after a physician certifies the need for care under the insurance policy assessment criteria. In order to receive custodial care paid for by a long term care policy the physician need only certify the insured’s need for assistance with three or more activities of daily living.

PATHOLOGICAL DIAGNOSIS DEFINED
A pathological diagnosis is one where the decision is arrived at by observing information (often as a result of a test) where the patient participated in the test (by giving blood, urine, or submitting to an X-Ray or MRI etc.) but the patient could not affect the outcome of the test results. Further two physicians observing the test results of a pathological diagnostic procedure are likely to agree on the results (the bone is broken, blood glucose is elevated etc.).

CLINICAL DIAGNOSIS DEFINED
A clinical diagnosis is arrived at by the physician observing the actions and reactions of the patient to a series of stimuli. A range clinical diagnosis depends on the patients participation and relies on the patient understanding the stimuli (often a question) and responding truthfully. Further two physicians observing the results of a clinical test are not as likely to agree on what the diagnosis should be.

Most clinical diagnostic tools are employed in the areas of mental and nervous conditions and physical therapy. Range of motion tests (which are clinical in nature) are often used to demonstrate a persons need for hands on assistance for an ADL.

Cognitive impairment (which is an ADL) is a trigger all by itself in that a person may have the physiological ability to perform the ADL’s as described above but need verbal instruction or reminders (cuing) or may need supervision to prevent injury to the insured or others.

The diagnosis of cognitive impairment (while the patient is alive) relies on a clinical tests. There is a postmortem biopsy (which is a pathological diagnostic test) that can be performed to demonstrate elevated aluminum levels in the brain. While not universally accepted there are pathological test that can be performed while the patient is alive to detect chemical imbalances in the blood that some believe demonstrate some level of cognitive impairment. Most medical professionals agree that currently a clinical diagnosis of cognitive impairment is the most reasonable approach; therefore under most state regulations insurance companies must accept a clinical diagnosis for this ADL and are more likely to request a second opinion for cognitive impairment than with the assessment of any other ADL.
UNDERWRITING AND COGNITIVE IMPAIRMENT
Cognitive impairment also affects underwriting a long term care policy. Since a LTC policy can not exclude coverage of cognitive impairment the insurance company tries to avoid adverse selection but determining cognitive ability in advance of policy issue. Cognitive impairment is a gradual onset illness and often the proposed insured and/or those close to the proposed insured will notice the onset well before it impairs function, Couple this gradual onset with the definition of preexisting conditions and it is entirely possible for a person to notice the beginnings of cognitive impairment and seek coverage prior to “having treatment provided by or recommended by a physician”.

CASE MANAGER REQUIRED
Many States require a case manager for Long term care claims which work with the physician to develop a plan of care for the insured.

In order to avoid adverse selection in the area of cognitive impairment insurance companies will try to ascertain cognitive function during underwriting. Some companies will screen all applicants while some will set a combination of age and benefit amount to determine when to utilize screening as an underwriting tool. The most common screening process is a phone call. The proposed insured will receive a phone call during the underwriting process, the caller will be very affable and attempt to put the proposed insured at ease. The called will be a trained mental health professional who will ask a series of questions designed to illicit from the proposed insured their degree of mental acuity.

The need for hands on assistance that a person must demonstrate to be eligible for a benefit is minimal. If the insured 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.

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 can not put on and/or take off all items of clothing or attach a brace. Note that the code does not address manipulating buttons, zippers, hooks, or tying shoes. It is assumed that you wear Velcro closure garments or other attire that does not require the fine motor skills that are required to fasten some of the more fashionable garments.

**EATING AS A BENEFIT TRIGGER**

Eating is considered the ability of the insured to feed themselves by manipulating the food and drink from a receptacle (plate, cup, or table) into the body including intravenously or tube feeding.

There are four type of assistance one might need with feeding

**Spoon Feeding**

Spoon feeding is when an individual can chew and swallow food but cannot (usually because of a range of mobility issue) affix the food to the utensil, grasp the cup, and make the round trip from the table to the mouth. The act of feeding someone orally (spoon feeding) is not considered skilled care and is not covered by Medicare.

**Nasogastric Feeding**

This method of feeding involves the insertion of a tube into the nose and down the throat. The food is prepared then pureed in a blender and put into a hypodermic injector and sent down the tube to the stomach. The act of feeding someone nasogastrically is not considered skilled care and therefore is not covered by Medicare.

**Introgastric Feeding**

Introgastric feeding involves having a shunt surgically inserted into the upper G.I. tract. The feeding is then performed through a tube as describe above (nasogastric feeding) except that enzymes are added to aid in absorption of nutrients. Sometimes the feeding is performed by using a constant drip from an IV bag. Feeding someone 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 can not manipulate themselves on and off of a standard height toilet.

**TRANSFERRING AS A BENEFIT TRIGGER**

Transferring as the ability of the insured to move in and out of a chair, bed, or wheelchair. By definition someone claiming the need for hands on assistance under this trigger has issues with mobility. The assessment standards in long term care policies assume that the insured is transferring laterally and there is minimal height difference between the seating surface of the wheelchair and bed or chair. This is not to say the assumption is made that the insured is confined to a wheelchair. An insured may need the use of a walker, crutch, or cane for general mobility but have trouble transferring to seating or laying positions.

Transferring is the one benefit trigger where an insurance company is most likely to liberalize their contract definition. Some companies will introduce the concept of wheeling. Wheeling assumes that you are confined to a wheelchair but cannot (without assistance) cause the wheelchair to move in predictably and consistent manner. When this is included in the benefit definition the insured can expect to pay a higher premium. The relative value of the wheeling can be great. While one can secure a totally electric wheelchair the concern would be what if the battery runs down while the insured is in the middle of the room and can’t reach an outlet to recharge the chair. Another scenario would be the battery is depleted and the insured needs immediate egress from the house (fire, or other emergency).

No insurance company may combine any of the six activities of daily living to create a combined or compound assistance requirement.

In order for the insured to evidence their need for assistance the following must occur:

Insured must have the inability to perform three of six activities of daily living (some policies only require two of six) which is certified by a physician.

OR:

Have a clinical diagnosis of cognitive impairment.
The amount of the benefit paid to the insured will depend on the type of policy they have. One approach to policy benefits is the traditional daily indemnity benefit where the insured will be paid the amount of benefit they purchased irrespective of the actual expenses incurred. Another approach is a reimbursement contract which will pay for the covered expenses that are actually incurred.

The case manager mentioned earlier will work with the insured and physicians to determine the care setting and services needed.

**UNIVERSAL EXCLUSIONS**

Even though policies and their benefits and restrictions vary, there are certain circumstances under which no insurance company will make provisions, such as the following:

- Addictions to drugs and alcohol;
- Injuries and illnesses caused by war;
- Treatment paid by the government; or
- Self-inflicted injuries, such as in suicide attempts.

**LTC BENEFITS UNDER LIFE INSURANCE POLICIES**

Long-term care benefits are offered as part of some individual life insurance policies. Under these plans, a percentage of a policy's death benefit is paid when long-term care is needed and death benefit and cash values are reduced accordingly. These policies also commonly have strict rules for qualifying for coverage. It should be noted that most LTC riders in life insurance policies are not considered long term care insurance policies and are therefore not regulated by laws governing long term care insurance contracts. One way to tell is look within the life policy at the contract section dealing with the LTC rider and you will see a disclaimer stating that this does not qualify as a long term care policy. Any life insurance policy that offers an accelerated death benefit must have a similar disclaimer because of past market conduct issues where unscrupulous agents would sell a life policy with an accelerated death benefit as a long term care policy.

**SWITCHING POLICIES OR BUYING A NEW ONE**

Of course, the agent must keep the interests of his client uppermost in all transactions. It’s a good idea to supply your customer with an outline of coverage, which summarizes the proposed policy’s benefits and highlights important features. Allow your customer to take his time and compare outlines of coverage. After all, this is a very vulnerable time of life for most people; and keep in mind that someday you may find yourself in the same or similar situation.

**FREE-LOOK PERIOD**

If your client decides he does not want the policy after purchasing it, make sure he
knows he can cancel the policy and get his money back if he notifies the company within a certain number of days after the policy is delivered. This is called the "free-look" period. Check with your state insurance department to find out how long the free-look period is in your state. If your client decides he wants to cancel, he should:

- Keep the envelope the policy was mailed in;
- Return the policy to the insurance company along with a brief letter asking for a refund;*
- Send both the policy and letter by certified mail and obtain a mailing receipt;
- Keep a copy of all correspondence;

*The refund process usually takes 4 to 6 weeks.

Make sure your client:

- Understands the policy;
- Is not misled by advertising (endorsements by celebrities of a certain product can be misleading; however, they are professional actors and are paid to advertise; they are not insurance experts);
- Is aware that neither Medicare nor any other federal agency endorses or sells long-term care policies (be skeptical of any advertising that suggests the federal government is involved with this type of insurance – be wary of cards received in the mail that look as if they were sent by the federal government);
- Understands that it is not necessary to purchase multiple policies to get enough coverage (one good policy is enough);
- Knows that disclosing his medical history accurately is extremely important;
- Does not pay you in cash (writes a check and makes it payable to the insurance company);
- Has your name, address and telephone number and the same information about the insurance company you represent;
- Knows that if he doesn’t receive his policy within 60 days, he should contact either you or the company;
- Re-reads the application he signed before it is submitted.

When he receives the policy, he should read the policy again and make sure it provides the coverage he wants.
AGENT’S RESPONSIBILITIES

It is the agent’s responsibility to collect the initial premium payment and deliver it to the insurance company while the insured remains in good health. Once this has been done and the policy is accepted by the insurance company, the agent’s delivery responsibilities come into play.

DELIVERING THE POLICY

The agent is responsible for explaining the policy to the insured. The rates established and reasons for those rates, any exclusions, riders, or provisions should be explained to the policy owner.

It is the agent’s responsibility to deliver the policy to the insured. The delivery of the policy must be accomplished as soon as possible after the policy is issued. Though the policy may be issued, it is not effective until the agent receives the initial premium payment.

When the policy is delivered to the insured, and the initial premium payment is collected from the insured, the policy is in effect.

RECOMMENDING ELECTRONIC PAYMENTS

It may be a good idea to suggest that your client have premiums automatically deducted from his bank account and paid electronically by his bank. Of course, everyone varies on their opinions regarding the use of electronic payments; however, should an illness delay or prevent your client from paying his statements on time, his coverage would not lapse.

LTC POLICY OPTIONS

Neither Medicare nor Medigap policies offer long-term care as a benefit.

LONG-TERM CARE AND STANDARD PROVISIONS

In the beginning, the long-term care policies carried many more restrictions than the current generation of policies. Some were tied to Medicare restrictions, prior hospitalization, nursing facility only, no in-home coverage, minimal level of service and most excluded Alzheimer and Dementia.

Long-Term Care policies have evolved over the past decade in an attempt to standardize provisions for the consumer, insurance industry and federal and state governments. It started with the National Association of Insurance Commissioners developing a model to help state legislatures in an effort to keep regulation on a state level. More than half of the states currently use the NAIC or a similar type model. In an effort to alleviate bewildering policy language to the consumer and create uniformity among long-term
policies in general, some major key standard provisions were:

- Standardization of waiting periods;
- Standardization of benefit periods;
- Full coverage for all levels of care;
- No prior hospitalization confinement necessary; and
- Standards for covering preexisting 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.

**PREEXISTING CONDITIONS**

Most policies that involve any type of health issue contain a preexisting clause. A preexisting 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 Preexisting 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 DUE TO COGNITIVE IMPAIRMENT**

In order to protect an insured who develops cognitive impairment and as a result does not pay the required premiums on their long term care policy most states require a 5 month reinstatement window. If the insured is diagnosed with cognitive impairment within 5 months of having let lapse a long term care policy they have the right to reinstate the coverage without proof of insurability by paying the premium in arrears. This course will cover unintentional lapse of a long term care policy in more detail in chapter three.

**THIRD PARTY NOTICE OF LAPSE**

At application the insured has the option (but not the requirement) to name a third party (including name and address) to receive notice of lapse of coverage for a long term care policy. The policy must remain in force for 30 days following the notice to the third party. If an insured elects not to provide a third party for lapse notification the insurer must be informed every two years of their right to name a third party for lapse notification.
RETURN OF PREMIUM

This is a non-mandated rider that may be offered in a long term care policy and is similar to the return of premium see on other contracts in the life/health category. Since it is an optional rider if selected it will increase premiums. The way this rider functions is that it will refund premiums paid less claims or benefits paid. Each policy will specify a minimum time period and then policy anniversaries when the insured can surrender/cancel the policy and receive the claims netted premium balance. If the insured dies there will be a refund of the claims netted premiums to the estate or named beneficiary.

NONFORFEITURE BENEFITS

As the popularity of long-term care policies grow, the insured is going to have to be afforded nonforfeiture options that protect their policy and benefits and protects them from forfeiting the same.

Life insurance policies currently contain these three nonforfeiture options, but, their wording will be different as in long-term care policies.

Nonforfeiture benefits in policies provide that at least some benefits will be paid even if the buyer fails to keep up premium payments and the policy is cancelled for non-payment. The benefits provided are usually minimal.

The promise is that the carrier will return to the policyholders some of their "investment" in the policy if they discontinue coverage. These companies usually offer a nonforfeiture benefit in the form of a reduced paid-up policy in which lesser benefits are provided after the client drops the coverage. A nonforfeiture benefit is a cost item carefully calculated by the carrier's actuary; it has a cost that is added to the underlying policy.

Other carriers may offer a "return of premium" in which they return a portion of the premiums after a certain number of years if the policy is cancelled.

The National Association of Insurance Commissioners reports that 16 percent of all nursing home insurance buyers drop their coverage each year because they can no longer afford it. Insurance companies know that of those who buy coverage at age sixty, 95 percent will have cancelled the coverage by age 80. The U.S. General Accounting Office confirmed those figures. Of insurance company files that were investigated and excluding those who had died, 60 percent or more of the original policyholders allowed their policies to lapse within 10 years and one insurance company reported a lapse rate approaching 90 percent.

Nonforfeiture benefits provide consumers who most probably will not be able to maintain their premium payments at least something for their premium dollars. Without nonforfeiture benefits, once a consumer stops paying all rights under the policy end. The most popular nonforfeiture benefits are:
• Cash Value;
• Reduced Paid-Up Benefit; and
• Extended Term Benefit.

**Cash Value**

This would provide a guaranteed amount to be paid to the insured should the policy be surrendered or lapsed.

**Reduced Paid-Up Benefit**

This benefit provides that the daily benefit be reduced for the policy’s benefit period and that the insured not be required to continue payment of premiums. The Reduced Paid-Up Benefit does exactly as its name implicates; it pays policy benefits at a reduced rate, depending upon how much money was paid into the insurance company. For example, if an individual paid premiums for 10 years, he might receive one-third of the benefit of a $100 a daily policy or $34 per day. The amount of reduced benefits is specified in the original contract. The reduced paid-up benefit amount will not increase for inflation and all policy restrictions apply.

**Extended Term Benefit**

Another type of nonforfeiture option that has come upon the long-term care scene is a cash back feature. Under this provision, an insured might typically receive 50, 60, 70, or even 80 percent of the total premiums paid upon discontinuing a policy either by surrender or having the policy lapse. Of course, as is the case in most cash-back features, claims paid are deducted from the amount of returned premiums.

Extended Term is the extension of coverage for the full amount that the policy would have ordinarily paid without any future payments of premiums for a limited extension of time.

Under this concept the customer receives the originally specified daily benefit, but only for a reduced period depending upon how much money was paid to the carrier over the life of the policy. For example, after 10 years, 25 percent of the premium paid is credited to a "benefit account" and, if the policyholder qualifies, the company will pay benefits until the money in the account runs out. So after paying nearly $30,000 over 10 years the customer would be entitled to $7,500 in long-term care benefits - little more than the cost of one month in a nursing home today in a metropolitan area; the insurance company would only pay benefits from this account until the account was depleted.
CHAPTER 9 REVIEW QUESTIONS

Which of the following answers/completes each question/sentence the best?
(Answers are in the back of the text.)

1. While tax qualified long term care policies give the insured a margin of tax relief, the tradeoff is:
   a) stricter adherence to ADL requirements.
   b) more restrictive contract requirements.
   c) higher costs.
   d) less benefits.

2. A home health care only policy requires that covered services be performed in a(n):
   a) outpatient care setting.
   b) inpatient care setting.
   c) adult day care facility.
   d) skilled care facility.

3. ___________ is services that do not have to be performed by skilled medical personnel to prevent risk of injuring the patient.
   a) Assisted living care
   b) Hospice
   c) Custodial care
   d) Skilled nursing care

4. Under most state laws, a person can be admitted to a hospital:
   a) at any time after a physician certifies the need for care.
   b) within 10 days after a physician certifies the need for care.
   c) within 30 days after a physician certifies the need for care.
   d) within 10 days but not after 30 days from the date the physician certifies the need for care.

5. Which of the following is NOT considered a universal exclusion?
   a) Addiction to drugs and alcohol
   b) Injuries and illnesses caused by war
   c) Recurring flu virus
   d) Self-inflicted injuries
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 10 REVIEW QUESTIONS

Which of the following answers/completes each question/sentence the best?

(Answers are in the back of the text.)

1. The U.S. House Select Committee on Aging concluded in a study that without __________, long-term care insurance policies are not a wise purchase.
   a) inflation protection
   b) home health care benefits
   c) nursing home benefits
   d) skilled care benefits

2. The __________ inflation option increases the daily benefit annually by a given percent of the original base benefit.
   a) Guaranteed
   b) Simple
   c) Compound
   d) Indexed

3. The __________ inflation option gives the buyer the right to increase the amount their policy will pay once every three years.
   a) Guaranteed
   b) Simple
   c) Compound
   d) Indexed
Chapter 11

UNDERWRITING

SOURCES OF INFORMATION

There are four sources of information utilized in the underwriting process.

- The Application Form;
- The Agent Participation;
- Verification Reports; and
- Medical Records and History.

THE APPLICATION

An application form must be completed by the purchaser and accepted by the insurer in order for a contract to be valid and in force. This form must be answered truthfully, to the best of the purchaser’s knowledge, and will contain the information upon which the company relies.

THE AGENT

An agent used to be able to accept an application by mail or by phone, as long as the agent acquired the applicant’s signature. However, that is no longer the case. An agent must assist the purchaser in completing the application in person. Thereby, the agent will be able to make observations that would be unavailable to the home office underwriter.

VERIFICATION REPORTS

Just because the application is completed by the purchaser, that does not mean that all information has been answered honestly and with integrity. The insurance company has the right to verify that the information presented is true and correct. A verification report is used for this purpose, not only to legitimize the information presented, but also may in fact yield additional information that might even change the outcome of the decision.

MEDICAL RECORDS AND HISTORY

It is also extremely important to verify medical records and history. Many companies utilize the Medical Information Bureau (MIB) as well as Attending Physician’s Reports (APR’s) in the underwriting verification process.
UNDERWRITING MANNER INFLUENCES PREMIUMS

There are two ways to underwrite a policy that have a direct effect on premiums:

- Standard Underwriting; and
- Substandard Underwriting.

**STANDARD UNDERWRITING**

An application can be accepted and approved “as submitted” for a policy to be issued. If the application is approved as submitted, then a standard premium would be set for the insured.

**SUBSTANDARD UNDERWRITING**

Many times, there are certain underlying factors that will affect policy premiums. These factors will put the company at higher risk for potential loss and, therefore, a higher premium may be charged. Such factors include:

- Preexisting conditions;
- Past medical condition;
- Current medical condition;
- Future medical condition;
- Age; and
- Moral issues.
CHAPTER 11 REVIEW QUESTIONS

Which of the following answers/completes each question/sentence the best?
(Answers are in the back of the text.)

1. Underwriters rely on specific sources of information in their underwriting process. Which of the following is NOT a source an LTC underwriter would consider?
   a) The application form
   b) Verification reports
   c) Geographical location
   d) Medical records and medical history

2. If an application is accepted and approved as submitted, a __________ premium will be set for the insured.
   a) Standard
   b) Substandard
ANSWERS TO CHAPTER REVIEW QUESTIONS

Following are the correct answers to the chapter review questions—listed by chapter, question number, the correct answer, and the section where the answers can be found within the course material.

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