

## Chapter Eight

### What is Long-Term Care Insurance and Who Needs It?

Scope of Chapter. This chapter deals with coverage for long-term care services paid for through a long-term care insurance policy. It includes an overview on long-term care services, payment options and guidance on counseling clients.

Chapter Questions and Answers. Following some of the paragraphs; there are questions relating to the material covered in the previous paragraphs. An answer key is at the end of the chapter.

#### Overview of Paragraphs:

Paragraphs 1 - 2 explain Long-term care (LTC) services.

Paragraph 3 covers who may need LTC services.

Paragraphs 4 – 13 discusses to counseling people on long-term care.

Paragraphs 14 – 29 address various payment methods.

Paragraphs 14 – 17 discusses topic of LTC and Medicare.

Paragraph 18 covers Medicare supplement insurance.

Paragraphs 19 and 20 cover the use of personal resources or self-funding.

Paragraphs 21 and 22 introduce Medicaid in relation to LTC.

Paragraph 23 covers accelerated death benefits.

Paragraphs 24 and 25 cover the use of viatical settlements.

Paragraphs 26 – 29 address LTC insurance.

Paragraphs 30 – 39 address the Texas LTC Partnership program.

Paragraphs 33 – 36 describe the inflation protection requirements in a Partnership policy.

Paragraph 37 addresses the tax qualification status of Partnership policies.

Paragraph 38 describes the requirements of insurers to offer a one-time exchange from a current policy to a Partnership policy.

Paragraph 39 provides a web link to listing of companies currently selling Partnership policies.

Paragraph 40 addresses common components of LTC insurance policies.

Paragraph 41 discusses who may be a good candidate for a LTC policy.

Paragraph 42 discusses who may not be a good candidate for a LTC policy.

Paragraphs 43 – 47 discuss the types of LTC coverage and common variations.

Paragraph 44 covers nursing facility benefits.

Paragraphs 45 and 46 cover home health care.

Paragraph 47 covers comprehensive LTC policies and coverage.

Paragraph 48 covers payment methods for LTC policies.

Paragraph 49 discusses the expense-incurred method.

Paragraph 50 discusses the indemnity method.

Paragraph 51 discusses when benefits will be paid by a LTC policy.

Paragraphs 52 – 56 address the benefit triggers in a LTC policy.

Paragraphs 57 – 59 speak to tax-qualified policies.

Paragraphs 60 – 61 speak to non-tax qualified policies.

Paragraph 62 addresses the elimination period.

Paragraph 63 addresses the pre-existing condition limitation.

Paragraph 64 cover required policy features/provisions in a LTC policy.

Paragraph 65 addresses the 30-day free look period provision.

Paragraphs 66 and 67 address the guaranteed renewable provision.

Paragraph 68 covers the grace period provision.

Paragraph 69 covers the reinstatement provision.

Paragraph 70 addresses the third party notice of lapse provision.

Paragraph 71 covers the mandated notifications of rate increases.

Paragraph 72 covers the mandated benefit offers required of an insurer selling LTC insurance.

Paragraph 73 covers the required nonforfeiture benefit offer.

Paragraph 74 covers the required inflation protection benefit offer.

Paragraph 75 cover optional benefits an insurer may offer with the sale of an LTC policy.

Paragraph 76 covers refund of premium.

Paragraph 77 covers waiver of premium.

Paragraph 78 covers restoration of benefits.

Paragraph 79 covers Nursing Facility bed reservation.

Paragraph 80 covers alternative plan of care.

Paragraph 81 covers paid-up survivor benefits.

Paragraph 82 covers shared care.

Paragraph 83 addresses how to compare LTC policies.

Paragraph 84 address what should be found in an outline of coverage.

Paragraph 85 addresses LTC insurance shopping tips.

Paragraph 86 provides other resources.

Paragraph 87 is a glossary of terms common to LTC policies.

### Back-up and Support

Benefits Counselors who have questions about the information in this chapter can call the Texas Department of Insurance (TDI) at 800-252-3435 for unlimited back-up and further information. Counselors also have access to HICAP staff at TDI for one-on-one technical assistance; bulk supplies of print and online consumer brochures including the brochure, *A Shopper's Guide to Long-Term Care Insurance*. HICAP staff is responsible for training and for Long-Term Care Certification. Training modules for certifications are available on the TDI web page at:

<http://www.tdi.state.tx.us/consumer/hicap/hicaplctc05.html#HICAP> Consumers with complaints about an existing LTC policy should first make contact with their insurance

carrier. If they still have concerns, they may submit a written complaint to the Consumer Protection Division at TDI.

#### Sources of Law – TDI LTC Policies and Advertising Rules and Regulations.

The statutory support given to the Texas Department of Insurance to review LTC policies and advertising materials can be found in the Texas Insurance Code, Chapter 1651. Under Chapter 1651 TDI has the authority to write rules for LTC policies and advertising materials. LTC policies are distinguished from “nursing facility coverage” paid for by Medicare or other health plans.

LTC policy rules can be found in the Texas Administrative Code, Part 1 of Title 28, Chapter 3, Subchapter Y, §§3.3801 – 3.3874. The advertising rules are located in the Texas Administrative Code, Part 1 of Title 28, Chapter 21, Subchapter B, §§21.101 – 21.122.

Sources of Law – Federal. The Internal Revenue Code of 1986, Section 7702B(b) addresses an allowable tax deduction for part of the premiums paid for Tax-Qualified Long-Term Care policies as defined by the IRS. Benefits of a qualified LTC policy are excluded as taxable income. Insurance companies selling LTC policies are required to disclose via a statement on the policy as to its tax-qualified or non-tax qualified status.

The Deficit Reduction Act of 2005 (Pub. L. No. 109-171) created a national clearinghouse to encourage states to undertake education campaigns on planning for long-term care services. As part of the campaign CMS required state SHIPs to conduct training for benefits counselors on LTC planning.

Long-Term Care Partnership. CMS seed money given to states helped create the Texas Own Your Future, Texas Long Term Care Partnership. Additionally, provisions of the bill allowed states to obtain a state Medicaid amendment that “provides for the disregard of any assets or resources in an amount equal to the insurance benefits”. The partnership includes the state insurance agency and the state Medicaid agency working with private insurers.

Sources of Law – State S.B. 22, 80<sup>th</sup> Regular Session, 2007, by Sen. Nelson authorized the Texas LTC Partnership program. The state agencies impacted include the Texas Department of Insurance, the Health & Human Services Commission and the Department of Aging & Disability Services. The act allows TDI and HHSC to adopt rules for and to undertake an ongoing education campaign. The Benefits Counseling program is referenced in regard to the education campaign. The official web site is [www.OwnYourFutureTexas.org](http://www.OwnYourFutureTexas.org)

## **What Is Long-Term Care and Who Needs It?**

1. **What is Long-Term Care?** Long-term care (LTC) is a general term that includes a wide range of services that address the health, medical, personal care, and social needs of people with chronic or prolonged illnesses, disabilities, and cognitive disorders (such as Alzheimer's). These services are typically required by the elderly, but may also be used by disabled people of any age. LTC is different from traditional medical care in several aspects. Traditional medical care treats physical problems directly in an attempt to permanently cure or control them. LTC helps one live as he or she is now; it may not help to improve or correct medical problems.

There are four main categories of LTC:

- a) Custodial Care- defines a level of care, may be administered in the client's home or in a facility setting.
- b) Skilled Nursing Facility Care- would be required to staff Registered Nurses (R.N.) that can provide 24 hour care for people no longer able to care competently for themselves.
- c) LTC Hospitals- furnish extended medical and rehabilitative care to individuals who are clinically complex and have multiple acute or chronic conditions. LTC Hospitals must be certified as an acute care hospital to meet criteria to participate in the Medicare program.
- d) LTC Custodial Care- at home or in a facility (which is not Hospice Care).

2. Someone with a physical illness or disability often needs assistance with activities of daily living (ADL). People with cognitive impairments usually need supervision, protection, or verbal reminders to do everyday activities. In the past LTC was thought of as strictly nursing facility care. Today the term can refer to a variety of services including home health care, assisted living, adult day care, continuing care retirement communities (CCRCs), hospice care, and more.

3. **Who Needs Long-Term Care?** The decision to purchase LTC insurance must be based on a personal assessment. Factors to consider include:

- *Longevity*: The longer you live, the more likely it is that you will need long-term care.
- *Family Structure*: Society and the structures of families are changing. Traditionally, family members took care of aging parents; however this type of care is less feasible today. If family care is unavailable, a nursing facility may be the only alternative.
- *Gender*: Women can be at a much higher risk of needing long-term care because they have longer life expectancies and often out-live their husbands.
- *Health Factors*: If chronic or debilitating health conditions run in your family, you could be at greater risk than another person of the same age and gender.
- *Hospital Stays*: People are less likely to stay in hospitals to recuperate from an illness or an operation. After short stays for treatment or surgery, people often must be moved to nursing homes until they are well enough to return to their own dwellings (or must receive care or services in their homes if they return there from the hospital).

Questions:

Long Term Care can be provided in which of the following settings.

- A. Assisted Living Facilities.
- B. An individual's home with Home Health Care.
- C. A facility for the care of drug addicts or alcoholics.
- D. All of the above.
- E. A & B only.
- F. A & C only.

Answer: \_\_\_\_\_

Activities of Daily Living (ADL) are personal care functions such as bathing, continence, dressing, eating, toileting and transferring.

True \_\_\_\_\_ False \_\_\_\_\_

## **Counseling People on LTC Options & LTC Insurance.**

4. Note that there is a distinction between counseling on long-term **care** (the service and care itself), and counseling on long-term care **insurance** (or other coverage methods). Clients may need information on one, the other, or both.

5. In some cases it is impossible to separate the two types of decisions completely. What kind of care is wanted or needed, how soon or urgently it may be needed, and how much risk the client is willing to assume, will all factor into what type of payment option or coverage is most appropriate. The reverse can also be true: the kind of coverage a person has (or doesn't have) can determine what care options are open to them.

6. Therefore, both issues – type of long-term *care* and type of LTC *coverage* will often be considered together, although they are distinct issues. You should be prepared to assist in both types of evaluation processes.

7. **Counseling on Long-Term Care.** Consumers must be allowed to make educated decisions without pressure to buy something they may not need, want, or can afford. Consumers should be encouraged to consider an area of long-term financial planning that is crucial but that is usually not considered.

8. Let the client know beforehand that as a HICAP (AAA) volunteer you can give information, help them understand their options and make referrals, but you are not in a position to advise someone toward a final decision. Suggest that a financial or legal advisor, insurance agent, social worker, family member or friend may also be needed to help finalize a plan. And that the best decision is always the one that is most comfortable for the person potentially receiving the care.

Question:

What is the primary role of the benefits counselor or volunteer benefits counselor regarding counseling with clients about LTC insurance?

- A. Provide financial planning advice.
- B. Advise about possible future eligibility for Medicaid.

- C. Provide unbiased information about the insurance products that will allow the consumer to make their own informed choice.
- D. All of the Above.
- E. None of the Above

Answer: \_\_\_\_\_

9. When dealing with only the *possibility* of needing care, rather than being face-to-face with an actual current need, many people are less willing to spend money. Long-term care insurance coverage is expensive, and it is usually tempting to do without coverage in the hope that it will never be needed. But if care is needed, and the client has not provided for adequate coverage and is unable to afford the necessary/preferred care options, the lack of planning can result in a costly and painful situation. This is the tightrope that the client walks when choosing how to cover future long-term care needs.

10. To have the most effective counseling session on LTC, the client(s) or guardian/representative *ideally* should be prepared with everything pertaining to the *complete financial picture* that cannot be determined from memory. This may include all bills payable monthly, all income information (SSI, pension, employment), savings and other liquid assets, investments, amount of home equity, and other assets.

11. In reality, this will not be feasible for some clients, and it is possible to counsel a client without all of these items. However, it is essential to providing the client the best information, and the client should be encouraged to provide as much information as possible.

12. You can help the client consider age, relevant long-term care risk factors, financial assets, potential support network, and goals. Both you and the client must understand that preparing for the possibility of long-term care means different things for different people, but ultimately it comes down to helping protect three things:

- ✓ money/assets (for yourself or heirs);
- ✓ family/loved ones; and
- ✓ ones lifestyle/independence/dignity.

Questions that help form a better picture of a client's needs fall into three categories:

- Questions about health.
- Questions about living situation/circumstances and preferences (including potential support system(s) and how they feel about needing help from others).
- Questions about finances.

#### **Basic Review/Assessment Process**

Review with the client:

- ❖ What is long-term care?
- ❖ Who needs it?
- ❖ What is LTC insurance?

Client should consider:

- ❖ Age
- ❖ Current health status and health history
- ❖ Financial assets, if any
- ❖ Potential support network

Does the client want to help protect:

- ❖ Money
- ❖ Family/loved ones
- ❖ Lifestyle/independence/dignity

Question:

Which of the following issues are important in assisting the client to determine an individual's or couple's need for planning ahead for the costs of Long Term Care (LTC)?

- A. Their financial situation.
- B. Their goals (i.e. Do they want to protect their assets for heirs or a charity?)
- C. Their health history including family health history.
- D. All of the above.
- E. A & B only.
- F. B & C only.

Answer: \_\_\_\_\_

13. **Counseling on Coverage (Who pays for LTC?).** Once the client has a realistic sense of the likelihood of needing LTC, and an idea of how much it will cost, the client can look at ways to cover those costs. Payment methods for long-term care vary, and can include the following methods (paragraphs 14 – 29). A Long-Term Care Planning kit is available from the Texas Long-Term Care Partnership.

14. **Medicare.** Medicare covers *only minimum long-term care costs*. Medicare will help pay for skilled nursing care for a maximum of 100 days *under specific conditions*:

- ◆ Patient is admitted to a hospital for at least 3 consecutive days (not counting day of discharge).
- ◆ The physician certifies that the patient needs *skilled* nursing or rehabilitative services.
- ◆ The patient goes to a Medicare-participating facility for skilled nursing care within 30 days after release from the hospital, for the same condition for which the patient was hospitalized.
- ◆ The patient is in a Medicare-designated bed in a Medicare-approved skilled nursing facility.

15. If ALL the above conditions are met, then Medicare will pay for the first 20 days in full, after which the patient will have to assume a co-insurance payment for the next 80 days of coverage.

16. It is *extremely* important to note that if a patient is in a qualified skilled nursing facility that does not mean that they are receiving skilled nursing care. A skilled nursing facility (SNF) is *equipped* to provide medical care under the supervision of licensed nursing personnel. That means that such care is available there – it doesn't mean it is necessarily required and being provided.

17. Medicare covers medically necessary home health care – skilled nursing care in the home – if a physician certifies that the patient is confined to the home and needs skilled nursing care or rehabilitative therapy, which must be administered by a Medicare-certified home health agency. Home health care includes part-time skilled nursing care, physical therapy, speech-language therapy, home health aide services, 80% of durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), supplies, and other services.

Question:

True or False:

Anybody who receives Medicare doesn't need additional LTC coverage since it will cover custodial care in full.

Answer: \_\_\_\_\_

Question:

Medicare does not cover home health care services unless the person was just released from the hospital and it can be proven that it is cheaper to care for the person at home versus the hospital.

Answer: \_\_\_\_\_

18. **Medicare Supplement Insurance.** Medicare supplement coverage is private insurance you can buy to supplement the gaps Medicare. While these policies typically cover Medicare's deductibles and co-insurance amounts, they do not provide benefits for long-term personal or custodial care.

19. **Personal Resources (Self-funding).** Self-funding for long-term care involves use of personal or family money to pay for care should the need arise. This would include savings and investments, assets, pensions, benefits, and contributions for children or other relatives, as well as reverse mortgages, annuities, or trusts. Generally, self-funding is possible only for individuals with above-average wealth and/or an extraordinary commitment from the family to assist with care. Individuals whose disposable income exceeds the cost of care are the best candidates for self-funding, because they have the luxury of taking the chance on never needing care.

Question:

True or False:

Other sources for funding LTC or purchasing LTC insurance include looking at reverse mortgages, annuities or trusts?

Answer: \_\_\_\_\_

20. Because self-funding for LTC can result in exhaustion of all assets, eventually leading to Medicaid eligibility, it is impossible to completely separate a discussion of self-funding from the discussion of Medicaid. Such plans are best made with the advice of an Elder Law attorney (familiar with Medicaid eligibility and estate planning) and perhaps an estate planner.

21. **Medicaid.** Medicaid is not insurance; it is a medical assistance program that is jointly funded by state and federal government. State government (the Texas Department of Human Services) administers it with federal assistance (Centers for Medicare and Medicaid Services). Medicaid assistance, including long-term care, is available only to people whose income and assets are below certain levels. Medicaid is an extremely intricate and complex subject with many possible variables and many legal and financial ramifications. It is important to know that you are not required to be an expert on all the details involved in Medicaid.

22. One important aspect of counseling clients on long-term care is determining when to refer the client to the appropriate agency, attorney, or planner. Clients with issues and questions involving Medicaid will probably need support from several different sources.

Question:

True or False:

A household would have to exhaust their entire savings and resources before they could qualify for Medicaid?

Answer: \_\_\_\_\_

**Resources on Medicaid**

- ✓ To learn more about Long-Term Care Medicaid review Chapter Eleven, Long-Term Care Medicaid.
- ✓ You can also call the *Legal Hotline for Older Texans* dedicated counselor telephone number.

Question:

Which agency would you call for help if the client has been denied eligibility for Medicaid long-term care?

- A. Department on Aging & Disability Services, Ombudsman Program
- B. Legal Hotline for Texans
- C. Texas Department of Health & Human Services Commission
- D. B and then A

Answer: \_\_\_\_\_

23. **Accelerated Death Benefits.** Accelerated death benefits in a life insurance policy may be used to obtain cash out of the policy while the policyholder is still alive. An accelerated death benefit is a payment of all or part of a life insurance policy's death benefit before you die. If your client's life insurance policy contains this type of benefit, he or she can receive an early benefit payment based on your need for long-term care services, with the same benefit eligibility requirements as a long-term care insurance

policy. It also can be paid for a specified disease (a disease or condition likely to cause permanent disability or premature death, such as AIDS or a malignant tumor) or terminal illness (life expectancy of two years or less).

Question:

True or False:

Someone with a life insurance policy may be able to use that policy to cover LTC only if the policy has an Accelerated Death Benefit.

Answer: \_\_\_\_\_

24. **Viatical Settlements.** Another step that can be taken by seriously ill individuals with decreased income and increased medical costs is a viatical settlement. Viatical settlement providers are third-party settlement companies that purchase the rights of the insured in an existing policy, paying the policyholder a percentage (usually a fraction) of the full face value of the policy but always more than the cash value.

25. In a viatical settlement, the insured sells all rights in the policy to the viatical company. The payment is computed with reference to the face value of the policy and the insured's likely survival. The insured typically retains no further ownership in the policy – the viatical company becomes the owner, paying the premiums and collecting the proceeds (the face amount of the policy) upon the death of the insured, thus recovering the initial investment and a substantial profit. The insured's original beneficiary gets nothing.

Question:

True or False:

In a viatical settlement, the insured can sell their life policy to a third party??

Answer: \_\_\_\_\_

26. **Long-Term Care Insurance.** Long-term care insurance may consist of an individual insurance policy, or group coverage including a master policy and certificates of insurance. These policies will pay benefits for a specified range of long-term care services when an eligible claim is made. Whether someone should buy a long-term care insurance policy will depend on his or her age, health status, overall retirement goals, income, and assets. For instance, if their only source of income is a Social Security benefit or Supplemental Security Income, they probably shouldn't buy long-term care insurance.

27. On the other hand, if they have a large amount of assets but don't want to use them to pay for long-term care, they may want to buy a long-term care insurance policy. Many people buy a policy because they prefer to stay independent of government aid or family help. They don't want to burden anyone with having to care for them. However, an individual should not buy a policy if they cannot reasonably afford the premium or they are not sure they can pay the premium for the rest of their life. Look closely at their needs and resources, and also advise them to talk with a family member to decide if long-term care insurance is right for them.

28. You may be dealing with a broad spectrum of consumers representing different age groups with different financial priorities. People become aware of the need for long-term care and coverage for this possibility at different times, usually because of family health issues that may arise, financial issues, and other events. Most people know little or nothing about long-term care, its costs, or how LTC insurance works.

29. To explore if insurance is the best option for your client (or for family member), you must understand two things:

- how do LTC insurance works in general
- how do policies differ specifically

Then you can decide which type of policy will offer the best and most appropriate protection.

Question:

Which of the following can finance Long Term Care?

- A. Medicare/Medicare supplemental insurance.
- B. Medicaid
- C. Long Term Care Insurance
- D. All of the above
- E. A & B only
- F. B & C only.

Answer: \_\_\_\_\_

30. **Texas LTC Partnership Program Policies.** Texas created the LTC Partnership Program as an incentive for Texans to plan for their long-term care needs. The partnership is a joint effort between private insurers and the state. Insurers must follow state and federal guidelines to sell partnership policies. Partnership policies have an asset disregard benefit that is useful when you need to apply for Medicaid. Partnership policies, however, do not guarantee you will be accepted into Medicaid. You would still have to meet income, medical and other eligibility criteria.

31. With the asset disregard benefit, every dollar of LTC benefits that the partnership policy pays will equal one dollar of countable assets that will be disregarded to determine eligibility for Medicaid. This means assets can be retained above the normal limit and the need to “spend down” assets to qualify for Medicaid are reduced or eliminated. In addition, the assets that were disregarded in the Medicaid eligibility process will not be subject to Medicaid liens and recoveries after death of the policyholder. If there are assets

that remain, those assets would be subject to state recovery. For more information on this topic please refer to Chapter 7 on Medicaid.

32. Partnership policies will be accompanied by a disclosure statement identifying the policy as a LTC partnership policy. Be aware that if you make any changes to the partnership policy, you could lose your partnership policy status.

33. **Partnership Policy Inflation Protection Requirements.** LTC partnership policies must also include inflation protection. Partnership policies provide varying levels of inflation protection based on age:

34. **Under 61 years old:** The insurer is required to offer the option to purchase a five (5) percent compound annual inflation protection. You can choose to purchase protection at a lower rate, but you must retain some form of compound inflation protection. Upon attaining 61 years of age, you can amend the inflation protection provision to comply with requirements of the next age bracket.

35. **Ages 61 to 76:** You must purchase and retain some form of inflation protection until you are 76 years old.

36. **After age 76:** Insurers must offer inflation protection, but you don't have to purchase or retain it.

Question:

True or False:

A person under the age of 61 must purchase 5% compound inflation protection in order to have a partnership policy.

Answer: \_\_\_\_\_

Question:

True or False:

An individual who purchases a partnership policy at the age of 60 must maintain their compound inflation protection for the life of the policy.

Answer: \_\_\_\_\_

37. **Tax Qualification.** All Partnership policies are intended to be tax qualified which means you may be able to deduct part of the premium from your taxes as a medical expense, and policy benefits are generally not taxable as income. See paragraph 57 for more information about tax qualified policies.

38. **Exchange Requirements.** All insurance companies that sell a partnership policy are required to offer a one-time exchange to their current policyholders that purchased a long-term care policy on or after February 8, 2006. Companies are required to make this exchange offer within 18 months of selling or marketing their partnership policy.

39. **Listing of Companies Selling Partnership Policies.** A list of companies selling partnership program policies in Texas can be found at <http://www.tdi.state.tx.us/consumer/hicap/partnershipcomp.html>.

40. **How do Long-Term Care Insurance Policies Work?** Today, long-term care insurance policies are not standardized like Medicare supplement insurance. Companies sell policies that combine benefits and coverage in different ways.

Question:

True or False:

LTC policies are standardized in Texas, just like Medicare Supplements.

Answer: \_\_\_\_\_

41. **Who is a good candidate for a long-term care policy?** A long term care insurance policy *may* be right for a person who:

- ◆ Has an asset the person would like to protect or leave to others, that have sentimental value, or that will involve large capital gains consequences if given away.
- ◆ Is able to afford monthly premiums.
- ◆ Would be unable (or is unwilling) to pay out-of-pocket for a long duration of long-term care if the need arose.
- ◆ Is not currently disabled or seriously ill, but has a health history and lifestyle strongly suggesting risk for disabling disease or injury.
- ◆ Wants to help maintain independence and control over money and assets.
- ◆ Wants to help protect family members and their lifestyle from the burdens of providing long-term care to a family member.
- ◆ Has an income level too high to qualify for Medicaid.

42. **Who should not buy a long-term care policy?** A policy is probably *not* the right option for a person who:

- ◆ Have few or no assets to protect (less than the cost of one year in a nursing home, about \$30,000 to \$40,000 minimum, is one rule of thumb that may be used).
- ◆ Is unable to afford insurance premiums, either now or in the future. The client should not have to use assets to pay for premiums, or significantly compromise current lifestyle.

Is already disabled or has a serious health problem (and would probably not pass the medical underwriting required to get coverage).

- ◆ Has an income level that meets Medicaid eligibility limits.

- ◆ Have no children, grandchildren, or favorite causes to whom to leave assets.

Tips:
The client who is a good candidate for long-term care insurance will usually (but not always) save money by buying the policy sooner rather than later. Premiums are based on age at the time of purchase and will increase each year you wait, regardless of health status.
Long-term care insurance is an ongoing commitment. The policyholder must be able to pay the premium for many years – not just now – until they may need LTC.

Question:

Which of the following would be a candidate/candidates for considering LTC insurance?

- A. A couple in their late 50's who are both on Social Security disability under \$1200 per month
- B. A widow in her late 60's who owns her own home and receives QMB
- C. A widower in his 80's whose only asset is a 2000 acre ranch where he lives and Social Security under \$1000 per month
- D. A couple in their late 60's with retirement income of \$3000 per month and investments of \$200,000
- E. None of the above
- F. All of the Above
- G. A, C & D only

Answer: \_\_\_\_\_

43. **Types of Coverages.** Any long-term care policies sold in Texas must provide at least twelve consecutive months of coverage. Individual policies will vary on benefit period, waiver of premium and other provisions. It is best to have the client consult with a licensed agent to explore all of the options available to an applicant for LTC.

44. **Nursing Home.** Nursing home coverage is coverage for confinement in a nursing home for all levels of care (skilled, intermediate and custodial care). A definition of such home or facility may not be more restrictive than one requiring that it be operated pursuant to state and federal law. Many policies that have nursing home coverage may also cover care in an assisted living facility. Policies cannot require prior hospitalization before benefits will be covered.

Question:

True or False:

Long Term Care policies similar to Medicare can require prior hospitalization before nursing home benefits will be covered.

Answer: \_\_\_\_\_

45. **Home Health Care.** Home health care coverage is medical or nonmedical services provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living, respite care services, case management service, and maintenance/personal care services. All policies sold in Texas that cover home health care must also cover adult day care services and maintenance or personal care services provided by a home health aide. Policies cannot require a prior nursing home stay or hospital stay before benefits will be covered.

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

Question:

True or False:

Policies currently sold in Texas that cover home health care must also cover adult day care services and maintenance or personal care services provided by a home health aide.

Answer: \_\_\_\_\_

47. **Comprehensive Policies.** Comprehensive long-term care policies include both nursing home coverage and home health care coverage. These policies may also cover hospice services and respite care. If a long-term care insurance policy or certificate provides for home health or adult day care services, the dollar amount of benefit available for this coverage shall equal one-half of one year's coverage available for nursing home benefits under the policy or certificate. This is important when the home health care benefit has a separate maximum from the nursing home benefit. For example, if the daily nursing home benefit is \$100 then one year of coverage for the nursing home would equal \$36,500 (100 x 365). Therefore, the policy must provide, at a minimum, \$18,250 of coverage for home health care. Most policies sold today only have one lifetime maximum that can be used for nursing home or home health care.

Question:

Comprehensive LTC policies that provide both nursing home coverage and home health coverage must:

- A. Pay similar maximum benefits in either a nursing home or in a home
- B. Set different maximum benefits for each coverage
- C. At minimum abide by a formula that requires that home health coverage equal at least one-half of a year's worth of nursing home benefit coverage
- D. None of the Above
- E. B & C only

Answer: \_\_\_\_\_

48. **Payment Methods.** Insurance companies that sell long-term care insurance generally pay benefits using one of two methods: the expense-incurred method or the indemnity method. It is important to read the literature that accompanies the policy or certificate and to compare the benefits and premiums.

49. **Expense-incurred Method.** This type of policy will pay less than the daily maximum if the actual cost is less. If the actual cost is higher than the daily maximum purchased, it will only pay the daily maximum. Most policies limit the total benefit they will pay over the term of the policy, but a few do not. Some policies state the maximum benefit limit in years (one, two, three, or more, or even lifetime). Others write the policy maximum benefit limit as a total dollar amount. Policies often use words like “total lifetime benefit,” “maximum lifetime benefit,” or “total plan benefit” to describe their maximum benefit limit. When you look at a policy or certificate be sure to check the total amount of coverage. If the policy has a stated limit in years it is important to understand what happens to the excess daily maximum that may not be used. For example, if an individual purchases a policy for 2 years of coverage with a \$100-a-day benefit but actual expenses of only \$80-a-day for care; what happens to the \$20 remainder? Some companies utilize what is referred to as a pool of money. If a policyholder does not use their entire daily maximum, the remainder is placed in a pool to be used later. This way, the policy may actually last longer than the 2 years of benefit period originally purchased. However, if a company does not use a pool of money then the policy may end after 2 years even if you never used your full daily maximum while in claim.

50. **Indemnity Method.** This type of policy pays the actual dollar amount of benefit in the policy, regardless of the cost of services. For example, if a \$100-a-day benefit was purchased, the policy will pay \$100 even if the actual cost is \$75 or \$125. With the indemnity method a long-term policy that is purchased for 2 years will expire after 2 years of claim because the full daily maximum will be paid each day while in claim.

Question:

True or False:

In an expense –incurred policy payment method, the company will pay less than the maximum benefit if the actual cost is less.

Answer: \_\_\_\_\_

51. **When will benefits be paid?** Virtually all long-term care policies have benefit triggers, a choice of an elimination period and possibly a pre-existing condition provision. They help the company to limit the number of eligible claims, manage their risks, and control their losses. Therefore, policies with a more restrictive number of benefit triggers, a longer elimination period, or a pre-existing provision, can be cheaper to buy. That is why it is crucial to understand how to identify and interpret benefit triggers, as well as any further policy limitations.

52. **Benefit Triggers.** Terms and conditions that must be met before the policyholder can receive policy benefits are called benefit triggers. This is an important part of a long-term care insurance policy. Different policies may have very different benefit triggers. The policy and the outline of coverage will describe the benefit triggers. Look for a section called “Eligibility for the Payment of Benefits” or simply “Eligibility for Benefits.”

Question:

A "Benefit Trigger" on LTC policies is defined as which of the following?

A. How long before a policy begins to pay

- B. What method of payment will be used (i.e. indemnity or expense-incurred method)
- C. Conditions that must be met before a policy begins to pay
- D. All of the Above
- E. None of the Above

Answer: \_\_\_\_\_

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NOTE: Companies may use different benefit triggers for home health care coverage than for nursing facility coverage.

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53. Companies selling long-term care policies in Texas must offer a policy that provides payment of benefits based on the policyholder's inability to perform two ADLs (see glossary for definitions) and cognitive impairment. Separately, companies may offer a policy based on the inability to perform two ADLs, three ADLs, and cognitive impairment.

54. Unless the coverage is offered through a group employer plan, a company cannot offer a policy with benefits based on three ADLs unless it also offers coverage with benefits based on only two ADLs and cognitive impairment. The applicant must either reject the two ADL and cognitive impairment policy in writing or acknowledge in writing that it was offered.

55. Companies must provide a description of the premiums and benefits payable for two ADLs, three ADLs, and cognitive impairment in their long-term care marketing materials and applications, and in the policies themselves.

56. Although a policy that includes a three ADL benefit level may offer more benefits, remember that it will be more difficult to reach the three ADL level. Balance the difference in cost for these policies against the greater difficulty in reaching the trigger for the additional benefits.

Question:

A consumer should be made to understand the following about a LTC policy's treatment of Activities of Daily Living (ADLs).

- A. It will be cheaper to select a policy with three versus two ADLs
- B. The company must offer three ADLs and is required to get an applicant rejection of the same in writing
- C. The company must describe the premium and benefits for the cost of two versus three ADLs in all of their marketing, applications and policy materials
- D. The company can dictate the number of ADLs offered based on an applicant's pre-existing conditions
- E. All but D above

Answer: \_\_\_\_\_

57. **Tax Qualified Policies.** Federal law now allows individuals to deduct a portion of the premium of a tax-qualified long-term care policy from their taxes under certain conditions. In addition, benefits received from a tax-qualified long-term care policy are generally not taxable as income. Amounts received in excess of charges incurred (as with an indemnity policy) may have tax consequences. You should suggest that your client consult with their attorney, accountant, or tax advisor regarding the tax implications of purchasing long-term care insurance.

58. An individual must also meet the eligibility requirements for a tax-qualified long-term care policy. A licensed health care practitioner must certify that an individual is "chronically ill" and prescribe a plan of care. An individual is considered chronically ill if care is needed to perform at least two of six activities of daily living for at least 90 days or a severe cognitive impairment exists.

59. Long-term care policies issued before January 1, 1997 are automatically considered tax-qualified. Any policy issued after January 1, 1997 must meet the federal requirements to be considered tax-qualified.

60. **Non-Tax Qualified Policies.** Premiums paid for a non-tax qualified policies bought after January 1, 1997, are not tax deductible. Benefits paid under a non-tax qualified long-term care policy may be considered taxable income.

61. Eligibility for benefits under a non-tax qualified policy may not be more restrictive than the inability to perform any two activities of daily living or the impairment of cognitive ability. Under Texas law non-tax qualified plans may offer benefit eligibility requirements that are more favorable, such as “medical necessity,” “one of six ADLs,” or even “two of seven ADLs.” The seventh ADL would be “mobility.” It would be easier to qualify for benefits when fewer ADLs are required to be met or the policy has more ADL’s listed, e.g., seven ADL’s versus six ADL’s.

Question:

True or False:

One thing a benefits counselor or volunteer benefits counselor should always do is inform a client about whether they should purchase a Tax-Qualified LTC policy or a Non-Tax-Qualified LTC policy?

Answer: \_\_\_\_\_

62. **Elimination Period.** A policy elimination period (sometimes called a “Waiting Period” or “Deductible”) is the amount of time that needs to pass after the individual begins receiving a long-term care service and before the policy begins to pay. Usually the individual will choose the length of the elimination period when they buy the policy. Companies can offer elimination periods ranging from zero days to 365 days. The most common elimination periods are 0, 30, 60, 90, or 100 days. During an elimination period the policy will not pay the cost of long-term care services; hence, the premiums can be lower for longer elimination periods. It is also important to determine how the company will apply the elimination period. Some companies require the elimination period to only

be met one time, others may require the policyholder to satisfy a new elimination period with each confinement.

Question:

Which of the following could be offered by an insurance company as an "Elimination Period" on a LTC policy?

- A. 0
- B. 100
- C. 365
- D. 30
- E. All of the Above
- F. A, B & D only
- G. None of the Above

Answer: \_\_\_\_\_

63. **Pre-existing Condition Limitation.** A long-term care insurance policy may not define a pre-existing condition more restrictively than a condition for which medical advice was given or treatment was recommended by, or received from, a physician within six months *before* the effective date of coverage. Many companies will sell a policy to someone with a pre-existing condition; however, treatment for that condition will not be covered for the first six months *after* the effective date of coverage. For example, if treatment for a pre-existing condition begins within the first six months of coverage, the company may deny the claim during the six-month period but then must begin to cover that expense six months after the effective date of the policy. Some companies have shorter pre-existing periods and others have none.

Question:

Which statement(s) below is/are not true regarding LTC policies?

- A. A company can choose not to sell a LTC insurance policy to a person with pre-existing conditions.
- B. A company may impose a preexisting wait period for longer than six months after the effective date of coverage.
- C. LTC insurance companies are allowed to have up to a six (6) month waiting period for preexisting conditions.
- D. A company can be more restrictive in how they define a "preexisting condition".
- E. A & C only
- F. B & D only

Answer: \_\_\_\_\_

64. **Required Policy Features.** State law requires that Texas LTC policies provide the following mandatory benefits, options, and outline of coverage (paragraphs 55-61):

65. **30-day Free Look Period.** Texas state law requires long-term care insurance policies to contain a 30-day “free look” provision. The free look provision allows the purchaser the right to review the policy or certificate for 30 days. If the individual decides not to buy the policy, for any reason, they may return the policy to the insurer or the agent without explanation, and all the money paid will be refunded.

66. **Guaranteed Renewable.** Most individual LTC policies are issued on a “guaranteed renewable” basis. This means that the policy cannot be cancelled except for nonpayment of premiums, and the insurer cannot change any provision of the policy without the consent of the insured person. The insurance company may change the premium if it is changed for all persons of a particular class, such as all policyholders in the state. If the individual LTC policy is not offered on a guaranteed renewable basis then it must be issued as a “noncancellable” policy. This means that the policy cannot be

cancelled except for nonpayment of premium and the insurer has no right to make any change in any provision of the contract or in the premium rate charged. In either case, the policyholder retains the right to cancel the LTC contract and receive a return of any unearned premium to the policyholder.

67. Group LTC policies are issued with either a continuation or conversion of coverage provision. The term “continuation of coverage” means a policy provision which will allow the certificate holder to maintain coverage under the existing group policy when the certificate holder is no longer a member under the group. The term “conversion of coverage” means a policy provision that allows an individual whose coverage under the group policy has terminated, including discontinuance of the group policy in its entirety, to convert to another policy with substantially equivalent benefits.

68. **Grace Period.** Under Texas law all individual LTC policies must contain a 65-day period in which to pay late premiums. If the policyholder, for any reason, does not pay their premium when it is due, they will have 65 days in which to pay their premiums. Most policies will show the “grace period” as 30 or 31 days; however, under a provision titled “unintentional lapse” or similar wording, the policy will provide a breakdown of the 65-day period for paying late premium payments. See paragraph 60 for additional information.

69. **Reinstatement.** Long-term care insurance policyholders in Texas have the right to reinstate coverage after a lapse or termination due to nonpayment of premiums if the insurer is provided proof that the insured had cognitive impairment or loss of functional capacity that began with in the 65 day period following the lapse date, and if reinstatement is requested within five months (some policies may allow a longer time) after the policy lapse or termination.

70. **Third Party Notice of Lapse.** All policies must permit the insured to designate at least one additional person to receive notice of lapse or termination for nonpayment of premium. If the premium is not paid 30 days after the due date, a notice is mailed to the insured and the third-party designee, if any. The notice is considered to be received 5

days after mailing and the insured is given an additional 30 days to pay the late premium. This amounts to a 65-day grace period.

Question:

Which of the following is aimed at protecting a person's benefits when they have not paid their policy 30 days after it was due?

- A. Reinstatement
- B. Grace Period
- C. Nonforfeiture Benefit
- D. Third Party Notice of Lapse
- E. Waiver of Premium

Answer: \_\_\_\_\_

71. **Rate Increase Notification.** Companies must notify policyholders at least 45 days before premiums with rate increases are due.

72. **Mandated Benefit Offers.** Companies selling LTC policies in Texas must offer certain optional benefits that can enhance the policyholder's coverage. These optional benefits are Nonforfeiture and Inflation Protection. The application or a separate form will include an election to accept or reject these benefits. If the applicant decides not to purchase these benefits, they must be sure to reject them in writing or the benefits will be automatically added to the policy with an additional premium.

73. **Nonforfeiture Benefit.** Nonforfeiture benefits guarantee the policyholder a percentage of the benefits bought even if the policy is later cancelled or coverage is lost because of non-payment of premium. The methods for determining the type and amount of nonforfeiture benefits can vary. In one type of benefit, when the policyholder stops

paying premiums the company provides a paid-up policy with a shorter benefit period. That means the policy will pay the same daily benefit that you bought but for fewer years. The company must begin providing nonforfeiture benefits no later than the end of the third year of coverage if the policyholder loses or cancels the policy after that date. A nonforfeiture benefit can add significantly to a policy's cost, depending on factors like age at the time of purchase and the type of benefit offered. If nonforfeiture is not selected then the offer must be rejected in writing and then the policy's built-in contingent nonforfeiture benefit will be activated. This benefit allows the policyholder to either choose a reduced benefit amount to prevent premium increases or to convert the policy to a paid-up status. If no election is made within 120 days of the due date of the premium increase, the election can be converted to a paid-up status. The paid-up status will be the greater of either the total sum of all premiums paid for the policy or 30 times the daily nursing home benefit at the time the policy lapsed. A contingent nonforfeiture benefit can only be used if the company raises the premiums substantially. The policy and the outline of coverage will provide a chart showing what accumulate percentage of increase from the effective date of coverage must occur based on the age of the policyholder at the time of purchase.

74. **Inflation Protection Benefit.** Inflation protection provides a way to help cushion today's LTC policy buyers from the full effects of future increases in long-term care costs. This may be important to people who are buying a policy many years before they will use it. Unless the daily benefit increases over time, it may not keep up with the rising cost of long-term care.

Inflation protection must be offered in at least one of the following three ways:

- Benefits automatically increase by at least 5% each year, compounded annually;  
or
- The policyholder has the option to increase the benefit by 5% compounded each year on each renewal date; or
- The policy can cover a specified percentage of actual or reasonable charges for as long as you own it, with no maximum daily limit or policy limit.

Companies are allowed to offer other forms of inflation protections but only after they receive a written rejection of one of the mandated offers listed above.

Question:

True or False:

An "Inflation Protection Benefit" or rider in a LTC policy is aimed at protecting future increases in LTC costs. The 5% compound inflation protection is a required offering that must be rejected in writing.

Answer: \_\_\_\_\_

Question:

All of the following are mandatory features or options (required by Texas State law) on LTC policies sold in Texas except?

- A. Policyholders must have a 60-day Free Look Period.
- B. If a policyholder does not pay their premium when it is due, for any reason, they will have a 65 day grace period in which to pay their premiums.
- C. Protection against inflation must be offered in at least one of three options.
- D. All policies must permit the insured to designate at least one person to receive any notice of lapse or termination for nonpayment of premium.

Answer: \_\_\_\_\_

75. **Optional Benefit Offers/Riders.** Below is a list of some of the possible policy features or riders that might be offered with a long-term care policy. Each may add to the

cost of the policy. You should discuss each of these benefits with your clients because not all benefits work the same. Two policies may name their benefit the same, but they do not pay the same or they have different conditions to meet in order to receive the benefit. **Please be sure to read each policy benefit carefully.**

76. **Refund of Premium.** Upon cancellation or death of the insured, this option will provide for a refund of all or a stated portion of the premiums paid, minus claims paid, during a specified time or interval. Refund upon death will be made to the beneficiary. The refund of premium can also be applied as a reduction in future premiums or to increase the future benefits of the policy. Adding this benefit to a policy will increase the premiums.

77. **Waiver of Premium.** This option lets you stop paying the premium once you are in a nursing home and the insurance company has started to pay benefits. Some companies waive the premium as soon as they make the first benefit payment. Others wait 60 to 90 days. Usually the waiver of premium is included with the nursing home benefit but not always with home health care although some companies will allow you to purchase this with your home health care benefit.

78. **Restoration of Benefits.** If the insured received benefits, then later gets well and does not enter a new claim period (make any more claims) for a specified amount of time (usually 6 months), the benefits that were used may be restored – that is, they become once again available, not counted as used.

79. **Bed Reservation.** Most LTC policies today have a bed reservation benefit. This benefit pays to reserve the nursing home bed space left temporarily by the policyholder if he or she needs to go into the hospital, usually up to a designated maximum number of days per year.

80. **Alternative Plan of Care.** Alternative care is care or a service not specified in a policy, but that may be provided if appropriate and agreed upon by the insurance

company, the insured person and his or her physician. These benefits are then provided in lieu of normal contract benefits.

81. **Paid-Up Survivor.** This benefit is available to couples and may be included in the policy or added as a rider to the policy at an additional cost. This benefit provides for a paid-up policy at some future date if your spouse dies. Some insurers may require that both spouses have a policy for 10 years, live for 10 years, incur no claims during the first 10 years, and then if one spouse dies the other's policy will be paid in full. Other insurers may be more lenient in their qualification to receive this benefit. For example, this benefit may provide for a paid-up policy even if one spouse dies within the first 10 years as long as the surviving spouse continues to pay their premiums for the full 10 years. You need to carefully read the policy/rider language.

82. **Shared Care.** This benefit is usually available for married couples to purchase. This benefit will allow for one spouse to tap into the benefits of the other spouse's policy if they use up all the benefits under their own policy first.

Question:

Which policy provision is triggered when there is a substantial rate increase?

- A. Nonforfeiture
- B. Contingent Nonforfeiture
- C. Refund of Premium
- D. None of the Above
- E. All of the Above

Answer: \_\_\_\_\_

83. **How to Compare LTC Policies.** Now that you understand the basic terms that define policies, you can ask clients relevant questions to help them evaluate policies they may be considering purchasing. Their needs will help determine which of the above-described common features and other policy aspects are of concern or interest to them. In reviewing existing or potential policies with the client, as a Benefit Counselor you must determine whether the policy allows the options desired and whether it will limit benefits in ways that could be detrimental. Long-term care insurance can be presented in a bewildering array of options that can make it difficult to compare apples to apples among policies. This is where the outline of coverage can be helpful.

84. **Outline of Coverage.** An Outline of Coverage, summarizing the terms of any policy or certificate, must be delivered at the time of an insurance agent's solicitation. If purchasing insurance through the mail, it must be delivered with the application or enrollment form. The text of the outline of coverage is required to be in 12-point type and the sequence of text is mandated to be in a standard format. Because this document is in a standard format it is a useful tool in helping your clients compare different policy's benefits. Below is the prescribed text and sequence of text:

- 1) Policy Designation (Individual vs. Group Coverage)
- 2) Purpose of Outline of Coverage
- 3) Terms Under Which The Policy or Certificate May be Returned and Premium Refunded
- 4) Medicare Supplement Insurance Disclaimer
- 5) Long-Term Care Coverage
- 6) Benefits Provided By This Policy
- 7) Limitation and Exclusions
- 8) Relationship of Cost of Care and Benefits
- 9) Terms Under Which The (Policy) (Certificate) May Be Continued In Force and Is Continued
- 10) Alzheimer's Disease, Other Organic Brain Disorders, and Biologically Based Brain Diseases/Serious Mental Illness
- 11) Premium

- 12) Texas Department of Insurance Consumer Help Line
- 13) Denial of Application
- 14) Offer of Inflation Protection
- 15) Offer of Nonforfeiture Benefits
- 16) Disclosure Regarding Federal Tax Treatment of Long-Term Care Insurance Policy
- 17) Additional Features

Question:

True or False:

The Outline of Coverage in LTC policies and its sequence of text is mandated to be in a standard format.

Answer: \_\_\_\_\_

## 85. Shopping Tips and Other Resources

Below is a list of shopping tips to share with your clients:

- ✓ **Take your time and compare outlines of coverage.** Do not be pressured into buying a policy or making a quick decision. Ask for an outline of coverage.
- ✓ **Talk to several agents and companies.** Policies differ as to coverage and cost. Companies differ as to service.
- ✓ **Know about the agent and company.** Check with the Texas Department of Insurance at 1-800-252-3439 to make sure that the agent and company are licensed in Texas. You also can request a written company profile showing the company's history, complaint record and financial rating.
- ✓ **Keep the agent's and company's name,** address and telephone numbers.
- ✓ **Never buy a policy or sign something that you do not fully understand.** Ask questions and be sure you understand what the policy covers and for how long. Discuss the policy with a trusted friend, relative, or advisor before you buy.

- ✓ **Don't buy more than one policy.** You do not need to buy more than one policy to get enough coverage. If you want to increase your daily benefit or policy maximums, check with the company to determine if they will allow you to increase your coverage. If you have a nursing home only policy and want to add home health care coverage, check to see if the company can offer the additional coverage as a rider.
- ✓ **Never sign a blank application.** If the agent fills out the application for you, don't sign it until you have read it carefully to be certain that all information has been properly recorded. Make sure all medical information is right. If it isn't and the company used that information to decide whether to insure you, they can refuse to pay your claims and may even be able to cancel your policy upon a showing of misrepresentation with intent to deceive.
- ✓ **Never pay in cash.** Always pay by check made payable to the insurance company.

#### 86. **Other Resources:**

- What Texans Should Know About Long-Term Care Insurance, *Texas Department of Insurance*
- A Shopper's Guide to Long-Term Care Insurance, *National Association of Insurance Commissioners*

Brochures from the Texas Long-Term Care Partnership that promote planning for long-term care expenses.

#### 87. **Glossary of LTC Terms**

**Accelerated Death Benefit** – A feature of a life insurance policy that lets you use some of the policy's death benefit prior to death.

**Activities of Daily Living (ADLs)** – Everyday functions and activities individuals accomplish without help. ADL functions include bathing, continence, dressing, eating, toileting, and transferring.

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

**Bathing** – Washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.

**Benefit Triggers** – Describes the requirements necessary to activate benefits under the policy.

**Cognitive Impairment** – Deterioration or loss in intellectual capacity requiring substantial supervision for protection of self and others, as established by the clinical diagnosis of any licensed practitioner in this state authorized to make such a diagnosis. Such diagnosis shall include the patient's history and physical, neurological, psychological and/or psychiatric evaluations, and laboratory findings.

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

**Daily Benefit** – The amount of insurance benefit in dollars a person chooses to buy for long-term care expenses.

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

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

**Elimination Period** – A type of deductible; the length of time the individual must pay for covered services before the insurance company will begin to make payments.

**Grace Period** – The number of days after your premium due date when the policy premiums can still be paid without cancellation. Long-term care policies provide a total of 65 days to make a late premium payment.

**Guaranteed Renewable** – A policy that can't be cancelled as you grow older or your health worsens, unless you fail to pay your premiums. The company still retains the rights to increase your premiums. This can only be given on a class basis, not on an individual basis.

**Health Insurance Portability and Accountability Act (HIPAA)** – Federal health insurance legislation passed in 1996 that allows, under specified conditions, long-term care insurance policies to be qualified for certain tax benefits.

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

**Inflation Protection** – A policy option that provides for increases in benefit levels to help pay for expected increases in the costs of long-term care services.

**Loss of Functional Capacity** – Same definition as the Activities of Daily Living.

**Maximum Benefits** – A time limit or dollar amount that an insurance policy will pay for covered services in a benefit period.

**Medicaid** – A joint federal/state program that pays for health care services for those with low incomes or very high medical bills relative to income and assets.

**Medicare** – The federal program providing hospital and medical insurance to people age 65 or older and to certain ill or disabled persons. Benefits for nursing home and home health services are limited.

**Medicare Supplement Insurance** – A private insurance policy that covers many of the gaps in Medicare coverage.

**National Association of Insurance Commissioners (NAIC)** – Membership organization of insurance commissioners. One of its goals is to promote uniformity of state regulation and legislation related to insurance.

**Noncancellable Policies** – Insurance contract that cannot be cancelled and the rates cannot be changed by the insurance company.

**Preexisting Condition** – A condition for which medical advice was given or treatment was recommended by, or received from, a physician within six months before the effective date of coverage. Preexisting conditions may be excluded for a specific period of time, as stated in the policy, not to exceed six months.

**Rescind** – When the insurance company voids (cancels) a policy as if it had never been issued.

**Spend Down** – A requirement that an individual spend most of his or her countable assets to meet Medicaid eligibility requirements.

**Tax-Qualified Long-Term Care Insurance Policy** – A policy that conforms to certain standards in federal law and offers certain federal tax advantages.

**Third Party Notice** – A benefit that lets you name someone who the insurance company would notify 30 days after a premium is due and unpaid. This can be a relative, friend, or professional such as a lawyer or accountant, for example.

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

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

**Underwriting** – The process of examining, accepting, or rejecting insurance risks, and classifying those selected, in order to charge the proper premium for each.

**Usual and Customary Charge** – The fee most commonly charged by physicians or providers for a particular service, treatment, or supply. The fee may vary from area to area throughout the state.

**Waiver of Premium** – A provision in an insurance policy that relieves the insured of paying the premiums while receiving benefits.

Question:

Match the following terms with the correct definition:

\_\_\_\_\_ The number of days after the premium due date in which it can still be paid without cancellation.

A. Activities of Daily Living (ADLs)

\_\_\_\_\_ Defines deterioration or loss in intellectual capacity requiring substantial supervision for protection of self or others as established by a clinical diagnosis of any licensed practitioner authorized to make such a diagnosis.

B. Elimination Period

\_\_\_\_\_ Everyday functions and

C. 65 days

activities individuals usually do without help. These include bathing, continence, dressing, eating, toileting, and transferring.

\_\_\_\_\_ A type of deductible: the length of time an individual must pay for covered services before the insurance company will begin to make payments.

\_\_\_\_\_ Another phrase that defines the Activities of Daily Living.

D. Loss of Functional Capacity

E. Cognitive Impairment