

DELAWARE

LONG TERM CARE INSURANCE

PARTNERSHIP PLAN

Delaware Long Term Care Insurance Partnership Plan

Contents

CHAPTER I – THE NEED AND THE BASICS	1
LONG-TERM CARE SERVICES AVAILABLE.....	1
PLANNING FOR A NURSING HOME CONFINEMENT	4
PLANNING, WHEN AND HOW?	4
THE “SANDWICH GENERATION”	5
What Is Long-Term Care?	7
THE RISK OF NEEDING LONG-TERM CARE.....	8
LTC INSURANCE INCLUDED IN FINANCIAL PLANNING	10
WHO NEEDS CARE AND WHY	10
NEED FOR CARE.....	11
LONG TERM CARE INSURANCE BENEFIT “TRIGGERS”	11
ACTIVITIES OF DAILY LIVING (ADLs)	11
INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs).....	11
COGNITIVE IMPAIRMENT	12
THE NEED FOR LONG-TERM CARE.....	12
CHAPTER II - LONG TERM CARE INSURANCE.....	18
POLICIES	18
EVOLUTION OF THE LONG-TERM CARE INSURANCE POLICY	18
REASONS FOR LONG-TERM CARE INSURANCE	19
USING LTCI BENEFITS.....	20
THE COST OF LONG TERM CARE.....	21
PREMIUM INCREASES	21
REQUIRED DISCLOSURE OF RATING PRACTICES TO CONSUMERS	22
EXCEPTIONAL INCREASES.....	23

LOSS RATIO	24
CHAPTER III – POLICY PROVISIONS	29
REIMBURSEMENT OR INDEMNITY?	29
COVERAGE TRIGGERS	30
BENEFIT TRIGGERS UNDER HIPAA (TAX-QUALIFIED).....	31
DEFINITIONS OF ACTIVITIES OF DAILY LIVING	32
COGNITIVE IMPAIRMENT	33
CAUTION TO AGENTS!	34
ELIMINATION PERIOD.....	34
NONFORFEITURE PROTECTION.....	36
DAILY BENEFITS AVAILABLE	40
PRIOR HOSPITALIZATION OR INSTITUTIONALIZATION	41
WHERE CARE OCCURS.....	41
SERVICE PROVIDERS	41
MINIMUM STANDARDS FOR HOME HEALTH CARE & COMMUNITY SERVICES.....	42
HOME CARE AVAILABLE	44
CHAPTER IV – OUTLINE OF COVERAGE	47
Standard Format Outline of Coverage	47
CHAPTER V - MARKETING AND REPLACEMENTS	53
MARKETING STANDARDS.....	53
DIRECT RESPONSE SOLICITATIONS	54
NOTICE TO APPLICANT REGARDING REPLACEMENT	55
COMMISSIONS	56
SUITABILITY	57
NAIC LONG TERM CARE INSURANCE SHOPPER’S GUIDE.....	58
REPLACEMENTS	59
Prohibition Against Pre-Existing Conditions and Probationary Periods in Replacement Policies or Certificates	59
APPLICANT	60
STATEMENT TO APPLICANT	60

CHAPTER VI -- POLICY DETAILS	64
BENEFIT PERIODS	64
DEFINITION AND AVAILABILITY	64
UNINTENTIONAL LAPSE	66
PREEXISTING CONDITIONS	67
UNDERWRITING.....	69
REQUIREMENTS FOR APPLICANT AGE 80 OR OLDER	70
WHAT IS NOT COVERED – EXCLUSIONS	71
SPOUSAL DISCOUNT	72
EXTENSION OF BENEFITS	72
RENEWABILITY	72
PAYMENT OF BENEFITS.....	73
COST DISCLOSURE INFORMATION	74
RIDERS AND ENDORSEMENTS	77
OTHER LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS.....	77
GRACE PERIOD	78
NOTICE OF CANCELLATION.....	78
REINSTATEMENT	79
WHAT AGES OF APPLICANTS ARE ACCEPTED?	79
FREE LOOK	79
CHAPTER VII – INFLATION PROTECTION PROVISIONS	82
INFLATION PROTECTION	82
<i>LONG TERM CARE INFLATION PROTECTION STUDIES</i>	83
LONG-TERM CARE COSTS AND PROJECTED INCREASES.....	83
LIFE INSURANCE WITH LONG-TERM CARE BENEFITS	85
CHAPTER VIII - TAXATION OF LONG TERM CARE INSURANCE	89
LTCI TAX ADVANTAGES.....	89
DISCLOSURE OF TAX CONSEQUENCES	89
TAX-QUALIFIED LONG-TERM CARE INSURANCE POLICIES	89
QUALIFIED LONG TERM CARE TAX INFORMATION	90
REIMBURSEMENT MODEL	91

Indemnity Model	91
Individual Taxpayers	92
SOLE PROPRIETOR	93
PARTNERSHIPS	93
C-CORPORATIONS.....	94
TAX CONSEQUENCES OF C-CORP-PAID PREMIUMS	94
S-CORPORATIONS	95
LIMITED LIABILITY & PROFESSIONAL CORPORATIONS	95
PROFESSIONAL CORPORATIONS/ PROFESSIONAL ASSOCIATIONS (PCS/PAS).....	96
CHAPTER IX - LONG-TERM CARE PROVIDERS.....	98
LONG TERM CARE PROVIDERS	100
HOME HEALTH CARE.....	100
MEDICARE PARTICIPATION	105
HOME & ADULT DAY CARE	107
HOME HEALTH CARE UNDER MEDICARE	108
ADULT DAY CARE	109
FORMAL LONG-TERM CARE SERVICES AND FACILITIES	111
NURSING HOMES	111
LEVELS OF CARE	111
ASSISTED LIVING FACILITY.....	115
ASSISTED LIVING FOR SENIORS DIFFERS FROM BOARD AND CARE HOME, NURSING HOME, OR CONGREGATE HOUSING	116
WHO IS AN APPROPRIATE CANDIDATE FOR ASSISTED LIVING?	117
TYPES OF ASSISTED LIVING FACILITIES	117
SERVICES PROVIDED	118
SPECIAL NEEDS?	118
CHAPTER X - MEDICAID.....	122
MEDICAID vs LONG TERM CARE INSURANCE	123
ESTATE RECOVERY	124
SPOUSAL IMPOVERISHMENT	125
INCOME ELIGIBILITY	126

POST-ELIGIBILITY TREATMENT OF INCOME.....	126
THE ELIGIBILITY REQUIREMENTS	128
PART ONE – MEDICAL REQUIREMENTS	129
PART TWO – AGED, DISABLED OR BLIND	129
PART THREE - FINANCIAL.....	129
INCOME AND ASSET ELIGIBILITY REQUIREMENTS	130
TRANSFERRING ASSETS.....	132
LOOK-BACK PERIODS	133
ANNUITIES.....	134
CHAPTER XI- GROUP LTC INSURANCE.....	139
DEFINITION OF GROUP LTCI	139
GROUP CERTIFICATE	139
IMPACT OF HIPAA ON GROUP LTCI.....	140
Continuation or Conversion.	142
CONTINUATION OF COVERAGE	143
DISCONTINUANCE AND REPLACEMENT	144
CORPORATE TAX OVERVIEW	145
ADVANTAGES OF LTC INSURANCE FOR EMPLOYERS AND EMPLOYEES	146
GROUP LONG TERM CARE FACTS	147
ASSOCIATION AND OTHER “PSEUDO-GROUP” LTCI.....	147
PERSONS COVERED	149
PORTABILITY.....	149
COMMISSIONS	149
ENDORSEMENT.....	149
LONG TERM CARE SPONSORED GROUP DISCOUNT	149
EXCEPTIONS TO EXCLUSIVITY	151
THE VALUE OF EMPLOYERS SPONSORING LTC INSURANCE	152
GROUP LONG TERM CARE INSURANCE BENEFITS TO EMPLOYER.....	153
EMPLOYER EDUCATION	153
TRUE GROUP LONG TERM CARE INSURANCE.....	154
ELIGIBILITY	154
CERTIFICATE REQUIREMENTS.....	155

SPOUSAL PREMIUM DISCOUNT	158
EXHIBIT ONE	162
TYPICAL LONG-TERM CARE SERVICES AVAILABLE.....	162
LONG TERM CARE SERVICES.....	162
ACUTE CARE SERVICES	164
APPENDIX A.....	165
RESCISSION REPORTING FORM.....	165
APPENDIX B.....	166
Personal Worksheet.....	166
Will you buy inflation protection?.....	167
APPENDIX C.....	169
Things You Should Know Before You Buy Long-Term Care Insurance	169
APPENDIX D.....	171
Long-Term Care Insurance Suitability Letter.....	171
APPENDIX E	172
Claims Denial Reporting Form	172
APPENDIX F	173
SPECIFIC REFERENCES	176
REFERENCES.....	180

NOTE: In this text the masculine gender is used primarily, in which case it represents both genders as it is easier to read “his” instead of “his/hers,” etc.

CHAPTER I – THE NEED AND THE BASICS

LONG-TERM CARE SERVICES AVAILABLE

Long-Term Care Service	Medicare	Private Medigap Insurance	Medicaid	You Pay on Your Own*
Nursing Home Care	Pays in full for days 0-20 if you are in a Skilled Nursing Facility following a recent hospital stay. If your need for skilled care continues, may pay for days 21 through 100 after you pay a \$128/day co-payment	May cover the \$119/day copayment if your nursing home stay meets all other Medicare requirements.	May pay for care in a Medicaid-certified nursing home if you meet functional and financial eligibility criteria.	If you need only personal or supervisory care in a nursing home and/or have not had a prior hospital stay, or if you choose a nursing home that does not participate in Medicaid or is not Medicare-certified.
Assisted Living Facility (and similar facility options)	Does not pay	Does not pay	In some states, may pay care-related costs, but not room and board	You pay on your own except as noted under Medicaid if eligible.
Continuing Care Retirement Community	Does not pay	Does not pay	Does not pay	You pay on your own
Adult Day Services	Not covered	Not Covered	Varies by state, financial and functional eligibility required	You pay on your own [except as noted under Medicaid if eligible.]
Home Health Care	Limited to reasonable, necessary part-time or intermittent skilled nursing care and home health aide services, and some therapies that are ordered by your doctor and provided by Medicare-certified home health agency. Does not pay for on-going personal care or custodial care needs only (help with activities of daily living).	Not covered	Pay for, but states have option to limit some services, such as therapy	You pay on your own for personal or custodial care, except as noted under Medicaid, if you are eligible.

It should be noted early that this text contains numerous references to “MEDICAID.” Long Term Care Insurance (LTCI) agents have considered Medicaid as an anathema to their profession, with the feeling that a discussion of Medicaid was not conducive to a greater study of Long Term Care Insurance. However, “things are a-changin’” and like it or not, in order to compete with Medicaid—openly or subliminally in discussion of the client’s future long term care needs—and particularly since Medicaid is the principal (by far) provider of long term care in nursing homes—in order to provide a proper service to a client in discussing future long term care needs the agent must be somewhat familiar with the machinations of Medicaid.

If the person has sufficient income and assets, he is likely to pay for his long-term care needs out of his own private resources. If he can meet functional eligibility criteria and has limited financial resources, or depletes them paying for care, Medicaid may pay for his care. If he requires primarily skilled or recuperative care for a short time, Medicare may pay. The Older Americans Act is another Federal program that helps to pay for long-term care services. Some people use a variety of payment sources as their care needs and financial circumstances change.

The total amount spent on long-term care services in the United States (in 2003) was \$183 billion. This does not include care provided by family or friends on an unpaid basis (often called “informal care.”) It only includes the costs of care from a paid provider.

While most information on “who pays for long-term care” presents these national figures, it is important to remember that each person's individual experience will differ. These figures

combine the experiences of everyone receiving paid care, but there are significant variations from person to person.

On an aggregate basis, the biggest share, nearly 44 percent is paid for by Medicaid. On an individual basis, however, “who pays for long-term care” can look very different. This is because people with their own personal financial resources do not qualify for Medicaid unless they use up their resources first paying for care, so-called “spending down.” If they have reasonable income and assets, most likely they will be paying for care on their own.

Also, while Medicare overall pays for 18 percent of long-term care; it only pays under specific circumstances. If the type of care that one needs does not meet Medicare's rules, Medicare will not pay and the person will likely to pay for their own care.

With the baby boom generation aging and the cost of services going up, paying for long-term care is an issue of pressing importance for policy-makers and individuals alike. While some individuals can count on friends and family to assist with the activities of daily living, many others must determine how to pay for extended home-health services or a potential stay in a nursing facility.

Expenditures on nursing home care make up the largest part of long-term-care costs in the United States.

Almost \$122 billion was spent on services provided by free-standing nursing homes in 2005, with an additional \$47.5 billion spent on home-health care. Medicaid accounted for the largest share, or 43.9 percent, of the total spent on nursing facilities. Consumers covered an additional 26.5 percent of these nursing home costs out-of-pocket and private insurance covered another 7.5 percent.

The Centers for Medicaid and Medicare Services (CMS) reported that the total amount spent for nursing home care in 2005 was \$122 Billion. They also presented the most recent statistics that shows that a 65 year old man has a 27% chance of entering nursing home at some point in his lifetime, while a 65 year old woman has a 44% chance. The cost of a private room in a nursing home averages more than \$70,000 per year and such figures drastically affect state governments who spend 18% of their general fund budgets on Medicaid, so the cost of long term care just keeps escalating.

Learning more about the “rules” for when Medicare, Medicaid, other public programs or private insurance might pay for long-term care is an important part of understanding “who will pay” if and when you need care.

It's difficult to predict if or how much care will be needed and whether there are family or friends who can provide some or all of the necessary care, and how much care may cost. However, it's reasonably easy to predict that if someone needs extensive long-term care services or need services over a long period of time, they will have to pay for some or all of it out of their personal finances. That's why an increasing number of people are using private financing options to help them pay for long-term care if and when they need it.

Private long-term care financing options include long-term care insurance, trusts, annuities, and reverse mortgages. Which option is best for the individual depends on many factors including age, health status, their risk of needing long-term care, and their personal financial situation.

Health Screening May Be Required

Some methods of paying for long-term care may require health screening. Some options require that the person be in relatively good health (not currently needing long-term care and not having a debilitating chronic condition such as Parkinson's disease that would almost certainly mean that they would need long-term care eventually). In contrast, some options are only available to a person in poor health.

The table below shows whether the person's current health is a consideration in eligibility for each option listed.

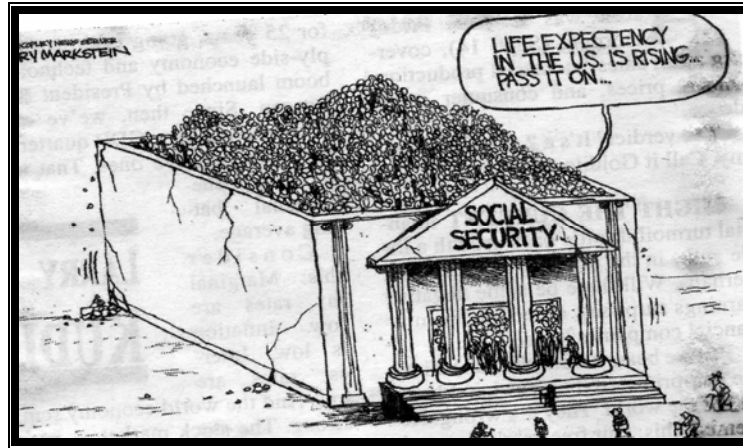
Relatively Good Health	Poor Health or Terminally Ill	Health Considerations are Not Important
Long-term Care Insurance	Accelerated Death Benefits	Annuities
Continuing Care Retirement Communities	Viatical Settlements	Using home equity to fund long-term care services
		Trusts
		Life Settlement

Age Requirements

Some private payment options are good choices for older people; others make more sense for a younger person.

Better Option for Younger Person	Better Option for Older Person
Long-Term Care Insurance	Deferred Annuities
Self-Pay (Save on your own.)	Sell Home
	Home Equity Conversion
	Charitable Remainder Trust
	Life Settlement
	Continuing Care Retirement Community

(And the following illustrates the problem!)



PLANNING FOR A NURSING HOME CONFINEMENT

People are living longer – *surprise, surprise*. This is the good news. The bad news is that because people are living longer, there are more ill older-generation people than ever before. Whereas people used to look forward to living long enough to retire at age 65, now they anticipate living for another 20-30 years. Now, when people think about getting older, they worry about what they will do in their “golden years.”

Each generation is a little wiser than the preceding generation, and even though many of their worries are the same, the later ones have the advantage of building upon the knowledge of the previous generations. One thing that many - if not most - have learned is the need for planning. Many have seen family and friends become disabled because of illnesses or accidents in their later years, and they are also aware that there will be care needed for the older folks as their health deteriorates.

PLANNING, WHEN AND HOW?

Bill has just turned 65 and has retired. His wife, Ann, is now 63, and they have three children, all married with children of their own. Bill’s mother typically outlived her husband, Bill’s father, and has recently moved into an assisted living facility as she has difficulty in “getting around.” One of their grandchildren is autistic and required a lot of attention from her parents – her mother had to give up working to take care of the child. Their son is struggling financially as he has two children in college, one of which will go to law school if there is any way that he can afford to do so. Their daughter has a happy family, with a good husband and three lovely children. All-in-all, each of their children is totally wrapped-up with their own family matters and Bill or Ann would not want to disturb those situations under any circumstances.


Bill remembers visiting with his grandfather in an “old folks home” when he was small and his memory is that the place where his grandfather stayed smelled “funny” and was full of people

who seemed to have no place to go or nothing to do, and every visit was depressing. Bill decided that he never would go to a place like that to stay.

Ann's parents have a "plan" for such contingencies; one that they feel would serve them quite nicely. Her parents are in their early 70's and are just now "starting to slow down." Her father has difficulties in walking any distances at all and her mother is terribly forgetful, so she has to check on her parents very often. Their plan, which they have just now started to fulfill, is to sell their house – it is way too large for them now anyway. They want to be "independent" so they do not want to move to any kind of place that "does for them." They cannot stand the thought of not being independent. Therefore, they are planning on buying a small house or condominium in an area where they can walk to the grocery store, Wal-Mart and Applebee's. They will use the money that they get from the sale of their house so that they will not have a mortgage, and whatever is left over will provide additional funds to supplement their Social Security and a small pension that her father has. That, in a nutshell, is their plan.

For Bill and Ann, there must be additional planning because if either of them become incapacitated, they are going to have to take care of themselves as they would never impose on their children to help as they are all busy raising their own families. If they have sufficient funds to make it worthwhile, they could use the services of an estate planner so that the surviving spouse will not be hit with a large tax burden. Trusts could be established so that the funds will be used to the best advantage of each other and their children when they both pass on, or are not able to handle their own financial matters. Perhaps they may want to use the services of a financial planner also, especially if their income is derived from various sources or they are invested in the stock market or similar investments.

What does this have to do with Long-term Care Insurance (hereinafter referred to as "LTCI")? To jump ahead a little, in those situations where a financial planner or an estate planner becomes involved:

 **There have been, and will probably continue to be, lawsuits involved where a financial planner, estate planner, or sometimes, just an insurance agent – does not make the client aware of the availability and advantages of Long-term Care Insurance.**

Heirs who anticipate inheriting sizeable estates will be quite offended if they learn that the estate has been diminished by nursing home and/or other long-term care expenses, and that the "professional" who assisted in the estate or financial planning, did not make the estate owner aware of such a program.

THE "SANDWICH GENERATION"

A member of the "Sandwich Generation" is so-called because in addition to their own needs, they are burdened with the responsibility of caring for their own parents. Many of the caregivers are married, some with children. There just are not enough hours in a day to care for an invalid parent plus other family responsibilities. Some caregivers do not marry and have families because of their "obligations" to provide care for an ailing parent or other family member.

 **Recent studies show that seven million people in the United States work as unpaid caregivers and seventy-five percent of them are women.**

The National Family Caregivers Association has conducted many studies and these studies show clearly that caregivers who are fulltime and performing the services often (too often) suffer from depression and a variety of physical ailments, notably back pain, besides all of the financial stress arising from these situations.

Family Caregivers Face Challenges

As described above, " the majority of home care is provided by family members and/or close friends and usually, one person assumes the primary role because he or she is closest geographically, closer to the parent emotionally, or a take-charge type of person. While the primary role is probably and usually the most time consuming and stressful, all those involved face similar difficult issues. It can be difficult for adult children to find solutions and assistance that their parents will find acceptable. Deciding on who will be involved may also be difficult and usually it boils down to immediate family and close friends. Limited support can usually be provided by distant relatives, some friends, neighbors, and community organizations. For the person needing care, they often hesitate to ask a child for help in the fear that their relationship can be harmed and the same can apply between siblings when one needs help from another in caring for a family member.

Taking care of a parent can affect all relationships. People may be more involved with brothers and sisters or their spouse and children may feel neglected. Any existing tension in their marriage is likely to increase. Colleagues at work may provide a diversion from caregiving. Even if they are sympathetic to added demands, they still expect people to get their work done on time. Walking tightropes like these can add to caregivers' stress.

One study shows that the average caregiver now devotes 18 hours a week to helping elderly loved ones. To balance the demands of work and home, employees often miss business meetings, decline transfers or business trips, come to work late, reduce their hours or take unpaid leave.

US Senate testimony reveals that family members provide 80% of LTC in America. If these unpaid family members were replaced by paid home care providers, the estimated cost would be nearly \$200 billion dollars annually.¹

Nearly one-quarter of American households (22.4 million) are involved in caregiving to elderly relatives or friends.² The majority of family caregivers—65 per cent— do not receive help from family or friends. In interviewing caregivers, over 40% of family caregivers consider the loss of leisure time, feelings of isolation, and the change in family roles to be the most burdensome aspects of caregiving. Unfortunately Caregiving takes its toll as 49% of family caregivers have suffered from prolonged depression because of their care-giving experience.³


Who are the Caregivers?

It is estimated that one in four households in Delaware is involved in caregiving in some fashion. These caregivers are about 30% daughters, a slightly less percentage by wives, about 10-14% by husbands and the remainder by sons and unrelated friends. A study also discovered that the **predominant class of caregiver was daughters-in-law** (which resulted in many parents taking another look at their children's spouse...).

One set of statistics indicate that between 20 to 40 percent of caregivers also have children under 18. Someone came up with the statistic that the average woman spends 17 years caring for children and 18 years caring for an elderly relative. Be that as it may, nearly 57 percent of care-

givers are age 65 and over, while 40 percent are ages 18 to 64 and 3 percent are children under 18.

What Is Long-Term Care?

 **“Long term care” (LTC) may be defined as “day-to-day care that a patient receives in a nursing facility, in his own home, or some other facility following an illness or injury resulting in the patient being unable to perform (usually) at least two of the five basic activities of daily living: walking, eating, dressing, using the bathroom and mobility from one place to another.”⁴**

Activities of Daily Living (ADLs) will be discussed in more detail later and Long Term Care Insurance (LTCI) extends beyond this definition of ADLs, but is a good place to start. It must be noted that long-term care goes beyond medical care and nursing care and assistance to the patient can be received in several settings. Typically, individuals associate long-term care with nursing homes, and not surprising, the earliest “Long Term Care Insurance” policies were designed to cover those expenses.

Delaware Title 18 (Insurance Code) Chapter 71, 7103(5) defines Long Term Care Insurance as:

"Long-term care insurance" shall mean any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis, for 1 or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance.

Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Such term includes group and individual policies or riders whether issued by insurers, fraternal benefit societies, nonprofit health, hospital and medical service corporations, prepaid health plans, health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance.

The words "long-term care" 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 or related asset-protection coverage or limited benefit health coverage.

With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for 1 or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision contained herein, any product advertised, marketed, or offered as long-term care insurance shall be subject to this chapter.”

Also, although it most often affects older people so they are the primary users, it should be noted that younger persons may suffer a debilitating illness or become involved in an accident, and they can also require long-term care.

Basically, LTC is usually the process of maintaining or improving the ability of (usually) elderly people with disabilities to function as independently as possible and for as long as possible. However, LTC is not strictly a “medical” treatment as it also includes social and environmental needs on a much broader plane than purely medical needs. Mental or Cognitive Impairment results in the need for supervision and monitoring.

Primarily long-term care services are not complex while in a nursing home in most cases; however when elderly persons with complex medical needs are discharged to, or remain in, traditional long-term care settings (including their own homes) then the care can become more detailed and precise. Therefore, in the planning for long-term care, services that may be needed and the location of such services being provided, both must be carefully considered. The care may range from simple assistance with activities in a person's own home or a residential care facility or it can mean highly skilled care in a nursing facility.

Most importantly, the case of long-term care can be quite expensive, even though it basically is personal care as described in the definition above, but such personal care can be extended over a substantial period of time. A person with Alzheimer’s disease, for example, may live for 20 years or more in a nursing home even though they may be oblivious to their environment.


Long-term care does not include hospital care, therefore Long Term Care Insurance benefits do not include hospital benefits—such costs are usually covered by hospitalization insurance and/or Medicare.

☞ The most common definition of “long-term” in this context is 90 days or longer.

To illustrate the problems of those requiring long-term care, many of the activities that a healthy person takes for granted, such as grocery shopping, housecleaning and paying bills and, importantly, taking medication— often present huge difficulties for the ill or disabled person. For a disabled person, the environment in which he or she lives can become formidable or even threatening. Stairways, basements, door sills and long hallways can become physical barriers. The very simplest of household devices such as microwave ovens or remote controls may become confusing to operate. Everyday chores for their very survival, may take hours to complete, such as preparing meals, doing laundry, keeping living quarters clean and sanitary, etc.

THE RISK OF NEEDING LONG-TERM CARE

What are the chances of needing long-term care? This is a reasonable question when a person contemplates spending money for needs that may or may not every occur. Since the introduction of Long Term Care Insurance, actuaries and other statisticians have been hard-at-work trying to answer this question. Obviously, some people may never need long-term care. On the other hand, *statistics* show that, this year (2005), about nine million men and women over the age of 65 (roughly nearly 3.6 %) will need long-term care. By the year 2020, 12 million older Americans will need long-term care most of which will be cared for at home; family members and friends are the sole caregivers for 70 percent of elderly people.

 **The U.S. Department of Health and Human Services statistics show that those who are age 65 face at least a 40 percent lifetime risk of entering a nursing home and nearly 10% will remain there for 5 years or longer.**

The probability of entering a nursing home and staying for longer period of time, increase with age and recent statistics indicate that at any given point in time, about 27% of those age 85 or older, are in a nursing home. No surprise, but women have a 44% greater chance of entering a nursing home than men (as they generally outlive men) after age 65.

The total amount spent on long-term care services in the United States (in 2003) was \$183 billion. This does not include care provided by family or friends on an unpaid basis (often called “informal care”). It only includes the costs of care from a paid provider.

While most information on “who pays for long-term care” presents these national figures, it is important to remember that each person's individual experience will differ. These figures combine the experiences of everyone receiving paid care, but there are significant variations from person to person.

On an aggregate basis, the biggest share, 48 percent, is paid for by Medicaid. On an individual basis, however, “who pays for long-term care” can look very different because people with their own personal financial resources do not qualify for Medicaid unless they use up their resources first paying for care, so-called “spending down.” If you have reasonable income and assets, most likely you will be paying for care on your own.

Also, while Medicare overall pays for 18 percent of long-term care; it only pays under specific circumstances. If the type of care you need does not meet Medicare's rules, Medicare will not pay and you are likely to pay for your care on your own.

Surveys have been made that indicate that throughout the country, the greatest majority of citizens have no idea as to what long-term care would cost. More than 60% felt that the cost of long-term care was \$50,000 a year or less, while nearly 20% thought it was higher and the rest didn't have a clue.

Results of a California study showed that when asked how they will pay for long-term care if it is needed, a third of the respondents believe that their family assets and income will be enough to pay for long-term care should it be needed. Only one out of ten surveyed have invested in a program to cover the costs of this care.

Nearly one quarter of the respondents (24 percent) say their children or family would provide the care or help pay for it if it is needed—and this percentage would be higher in rural America.

 **Interestingly, over 55% of the respondents with private health insurance either believe that their policies will cover all of their long-term care or are uncertain.**

LTCI has become an important consideration for planning because people are living longer and the number of elderly is growing—there are 76 million “Baby-Boomers” (those born between 1946 and 1964) who have very recently retired or will be retiring within the next few

years. There are fewer available caregivers and healthcare costs are increasing at a rate of over 10% per year and prescription costs have increased about 15%.

In addition, and perhaps most importantly for those who expect for the government to take care of them if they need long-term care, both Medicaid and Medicare are unprepared for the onslaught of senior citizens needing long-term care. The future of both of these programs is being closely scrutinized so that they can meet the challenges of the future.

LTC INSURANCE INCLUDED IN FINANCIAL PLANNING

In addition to the legal concern (voiced earlier) that arises when estate/financial planners do not make an effort to provide coverage for the risk of long-term care, Long Term Care Insurance must be considered as a financial planning tool as much as the other important tools, i.e., Wills, Trusts, Guardianship of minor children, and Powers of Attorney.

 **Specialists in Elder Law, who are engaged in long-term care planning, stress that the most important thing that an elder person should have is a Power of Attorney in effect.**

There are two types of Power of Attorney:

- (1) Financial Durable Power of Attorney, which provides for financial control when an individual can no longer make these decisions, and
- (2) Medical Durable Power of Attorney which provides for appointing a health care surrogate to make medical decisions. For reference, this is much stronger than a living will.

WHO NEEDS CARE AND WHY

As indicated previously, seniors are the fastest growing segment of population and the heaviest users of long-term care and health care services and in states where there is a large number of elderly, such as California, Arizona and Delaware, the elderly population (age 65+) is expected to grow more than twice as fast as the total population. The elderly age group will increase an average of 112% during the period 1990-2020. Since women live longer than men, they are disproportionately affected by long-term care as they are more likely to develop the functional ailments that require long-term care services. Two-thirds of residents in long-term care facilities are women.

In the past, families were much more concentrated in a geographic area and this was true all over the country—in New York City it was not unusual to find several generations growing up and living in the same tenement. Much of America was rural and it was necessary for family members to work on the farm for the family's livelihood. During the Depression and WWII, many family members moved to other parts of the country where jobs were waiting, such as the West Coast. Today, families are scattered and family members have their own responsibilities so that in many cases it is nearly impossible to provide for the care of ailing or elderly family members. Another and more recent factor is that more women work outside of the home and traditionally, women were the caregivers for family members.

NEED FOR CARE

Measuring the extent of an individual's functional impairment is essential to determine care needs as well as whether or not the insured has met the coverage triggers in LTCI policies. Much research has gone into defining minimal components of independent functioning. As the need for more long-term care grew, it soon became apparent that some measuring “sticks” must be applied so that meaningful legislation, both in state and federal laws, is developed so as to measure an individual's ability to function independently in the community.

LONG TERM CARE INSURANCE BENEFIT “TRIGGERS”

“Triggers” – as explained later in detail – is the physical or mental condition of the insured that determines when benefits will be paid under a Long Term Care Insurance policy. Although most LTCI policies require a physician's certification that nursing care is required because of illness, injury or medical emergency,



Newer policies are not allowed to require prior hospitalization.

There will be later discussion in respect to Coverage Triggers.

ACTIVITIES OF DAILY LIVING (ADLs)

A physical impairment research in a 1963 study by Stanley Katz introduced the measurement of physical functioning called **Activities of Daily Living (ADLs)**. ADLs are often used by health care experts to determine whether a person is capable of living independently and serve the purposes of measurements to assess a person's need for nursing home, home health or other long-term care services.

In the State of Delaware, ADLs in a Long Term Care Insurance policy defines “Activities of Daily Living” as at least bathing, continence, dressing, eating toileting and transferring.⁵

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

Obviously there are other functions that require assistance so that the individual can be independent and can continue to live outside of a nursing facility. These are called **Instrumental Activities of Daily Living (IADLs)** and usually include cooking, cleaning, doing laundry, household maintenance, transporting themselves, reading, writing, managing money, using equipment such as the telephone, and comprehending and following instructions. Delaware considers these services as “Personal Care” and defines it as the provision of hands-on services to assist an individual with activities of daily living (such as bathing, eating, dressing, transferring, and toileting).⁶

Delaware also provides for the regulation of providers of services: “All providers of services, including but not limited to ‘skilled nursing facility’ ‘extended care facility’ ‘intermediate care facility’ ‘convalescent nursing home’ ‘personal care facility’ and ‘home care agency’ shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.”⁷

In an area between ADLs and IADLs, is a very important function often overlooked—that of taking medication. One might think that it doesn't require assistance to lift a pill box and take a

pill with a glass of water, BUT, there are often (too often) times when a person that can perform the ADLs “forgets” to take medication, “forgets” as to when they took it last, how much they are supposed to take and when. Experienced Caregivers are very aware of these situations and immediately take steps to regulate and schedule medication for their patients. Some LTCI policies consider this as an IADL.

In addition to managing medication managing medications, IADLs include moving around outside of the residence and in particular, going to the “grocery store” and the doctor’s offices. Generally, these patients are unable to drive so the Caregiver will either drive their own car or that of the patient’s. Also, if the patient is ambulatory, and with the physician’s permission, many patients enjoy and derive considerable benefit from going on walks, regardless if they can move on their own, use canes or walkers, or even use a wheelchair.

Preparing meals is another important IADL. A patient that is totally mobile but with mental or cognitive problems can be a danger to themselves and others while operating a stove (for instance). Even operating a microwave can be a problem for some.

The same applies for doing the laundry. A drier can easily start a house fire if improperly operated, or a washing machine can overflow. Even performing light housekeeping duties can be destructive, if not downright unsanitary, if the patient is unable to do what is needed.

COGNITIVE IMPAIRMENT

Cognitive Impairment refers to confusion or disorientation resulting from a deterioration or loss of intellectual capacity that is not related to, or a result of, mental illness, but which can result from Alzheimer's disease, senility or irreversible dementia. Many seniors with mental impairments can perform all of the ADLs, but they need constant supervision to protect themselves and others while performing them. The most feared cognitive impairment is Alzheimer’s disease which has caused grief in families who watch their loved ones “disappear.” In addition, those who have suffered strokes and other diseases and conditions that cause irreversible brain damage, face an uncertain and deteriorating future.

Delaware regulations define this as: “*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.⁸

Policies sold today must include coverage for long-term care required by people who are physically able to perform the tasks but forgot how or why to perform the tasks or can't perform them safely on their own. Approximately one third of all senile people can perform all ADLs, but they need constant supervision, prompting or instructing in order to complete them safely.

DETERMINING EXTENT OF COGNITIVE IMPAIRMENT

Methods used to determine cognitive impairment consist of one of two accepted standard tests that are recognized and accepted throughout the medical profession, the Folstein Mini-Mental State Exam or the Mental Status Questionnaire (MSQ).

THE NEED FOR LONG-TERM CARE

The US Census Bureau estimates that the mean average age of the US population has increased from a little over age 35 in 1990 to nearly age 37 in 2000. In 1900 the average life expectancy in

the US was between 40 and 50 years, but by 2000, this has doubled. The average years of life remaining at representative ages is shown below:

At Age	Average Years of Life Left - Males	Average Years of Life Left - Females	Difference
55	29.40	32.92	3.52
60	25.15	28.42	3.27
65	21.09	24.12	3.03
70	17.31	20.08	2.77
75	13.86	16.34	2.48
80	10.87	12.90	2.03
85	8.31	9.86	1.55

U.S. Senior Population Growth

The US Census Bureau statistics indicate that the older population at age 65 will grow from 54% during the period of 2000 to 2020, compared to 136% from 2000 to 2020. At age 85+ the growth rates for 2000 to 2020 will be 58%, compared to 351% for years 2000 to 2050.⁹

For whatever it's worth, 2/3 of all of the people who ever lived to be age 65 are alive today.¹⁰

- The fastest growing population group in America is age 85 and over.
- Today, statistics indicate that approx. 1 in 75 Americans are more than 85 years old; that number will grow to 1 in 65 in 2010 and 1 in 35 by 2040.
- The older population is increasingly non-white. Minorities who are older than 60 will increase by 350 percent between 2000 and 2040.
- Nearly two-thirds of those in long-term care facilities are covered by Medicaid.
- The influence of the 85 and over age group in retirement states, such as Delaware, California and Arizona will emerge most strongly between 2030 to 2040 as the first of the baby boomers reach 85 years of age.¹¹

Nursing Home Residents Are Predominantly 85 or Older. Even though 22% of persons 85 or older reside in nursing homes they make up half of all persons in nursing homes and many more are receiving care in the home or community. "About 50 percent of all nursing home residents are 85 or older, thus the current nursing home population is frailer than ever before and requires more specialized care."¹²

The Problems of Tax-supported Long-term Care

The cartoon at the first of this Chapter says it pretty well—people are living longer, and older folks have more need for long-term care than do the younger citizens.

Medicaid provides a large proportion of long-term care to those citizens who are disabled or have cognitive impairments and who cannot afford to pay for the necessary care. A special problem exists for Medicaid and Medicare—and the Social Security program—which are tax-supported programs. The major problem can be simply stated: there now are fewer Caregivers and fewer taxpayers to pay for the services. To put it in proper perspective, 92 per cent of all nursing home

costs are paid by the individual patient or by Medicaid nationally, which is undoubtedly the largest unfunded liability in the U.S. For contrast, Medicare only pays 8% of the total costs of long-term care.¹³

The parents of the Baby-Boomer generation produced 3.9 children per family, or nearly 2 children to pay taxes and provide care for each parent. For a variety of reasons, the average number of children born to baby-boomer couples was only 1.1 or about ½ child for each parent. Therefore, there are fewer taxpayers to pay for long-term care costs (and other tax-supported programs) and to provide the care necessary. This means there will be fewer paying in and more taking out of the government programs for seniors.

By 2050, the population aged 65 or older will outnumber children aged 0-14 for the first time in recorded history. By the year 2050, there should be almost a million citizens over age 100!¹⁴

Recent California studies, for instance, in respect to Baby Boomers, show that the Baby Boomers were in their most economically productive years, and they represented 35% of the state's population. By the year 2010, the Baby Boomers will represent only 25% of the population of California, and by 2020 will be in pre- and early-retirement ages (45 to 64 years). During the period of 2000 to 2010, an era of fluctuating births and improving survivorship, from 14% in 1990, the elderly population will grow to 22 % in 2030.

This large elderly statistical group will strain services and programs required by an aging population. At the same time, the 0-19 age groups will decrease by 7 percent, and by 2030 there will be little distinction between any of the age groups.

For America's 77 million Baby Boomers, paying future long-term care costs remains as their largest looming expense. According to the Bureau of the Census, in 2020, one out of every six Americans will be age 65 or older - roughly 20 million more seniors than today. Furthermore, by 2020, the number of Americans 85 and older - the people most likely to use long-term care will double to seven million, and double again to 14 million by 2040.¹⁵

There will be a rapid growth in the number of persons age 60 and over as the Baby Boomers begin turning 60 in 2006. Although baby boomers have a very positive view of aging, there is an overwhelming level of denial regarding the likelihood of needing long-term care.¹⁶

GOVERNMENTAL FINANCING PROBLEMS

Government estimates indicate there will be almost 70 million people over 65 by 2030 and that nearly 8.5 million of those will be over 85. Since that is far-and-away the greatest section of the population who use nursing homes, it is important to note that nursing home stays may cost \$50,000 - \$60,000 a year and more in some areas. There is every reason to believe that these costs will continue to rise as at this time, for example, about 1.5 million people live in nursing homes nationwide and the number could grow to 5 million by 2040.

Nursing homes are big business with 17,000 nursing homes and large corporations dominating the industry and nursing home costs presently exceeds \$85 billion. The time is "a-comin'" when governmental funding will be insufficient to pay LTC, and other health care costs (Medicare, Medicaid, etc.) of the Baby Boomers as they are aging rapidly. As later described, the State and the federal government are working feverishly and closely in various attempts to alleviate this growing problem. An example is the "Partnership Program" with Long Term Care Insurance whereby assets of a Medicaid patient are protected to varying degrees (depending upon the plan and State) using the vehicle of Long Term Care Insurance. Presently there are four states that have provided such cover-

age for several years (California, Indiana, New York and Connecticut) and there are 21 or more states recently offering or who will be offering these plans in the near future.

The Effect of Long-Term Care on Employers

In the more heavily populated states, over half (53 % in California, for instance) of caregivers under age 65 have dual responsibilities, work and caregiving. This is not unusual at all, as in many heavily populated states (such as Delaware), one in four employees provides assistance to elderly relatives and by 2006 that figure is projected to be one in two. An employee that provides caregiving services must be affected by attendance problems and continual concern about the well-being of the person that they provide care for, with the result that there is inevitability a substantial loss in productivity. For the average company, the estimated cost associated with such caregiving is over \$3,000 per employee annually.

STUDY QUESTIONS

1. The largest share of long-term care in the US is financed by
 - A. Long Term Care Insurance.
 - B. Medicare.
 - C. private out-of-pocket funds.
 - D. Medicaid.

2. People are living longer which means
 - A. there are fewer doctors as there are fewer sick people.
 - B. people don't have to worry about long-term care as mostly they are healthy.
 - C. there are more ill elderly people than ever before.
 - D. people take their medications better than ever before.

3. Many people find that when they are nearly ready to retire, they must take care of their parents who are ill. These people, mostly baby-boomers, as also called
 - A. the sandwich generation.
 - B. the unforgiving generation.
 - C. the hard rock generation.
 - D. the wealthy generation.

4. Day-to-day care that a patient receives in a nursing facility, in his own home, or some other facility following an illness or injury resulting in the patient being unable to perform (usually) at least two of the five basic activities of daily living: walking, eating, dressing, using the bathroom and mobility from one place to another, defines
 - A. the need for gerontologists.
 - B. part of the mission statements of most nursing homes.
 - C. long-term care.
 - D. assisted living facility services.

5. When discussing long-term care, this usually relates to
 - A. a period of 90 days or more.
 - B. an assisted living facility or congregational care.
 - C. insurance.
 - D. Medicare benefits.

6. Long Term Care Insurance (LTCI) should be considered as
 - A. an estate planning tool.
 - B. an easy way to make a living as these plans are easy to sell.
 - C. part of a disability policy.
 - D. too expensive for 99% of Americans.

7. Measuring the extent of an individual's functional impairment is essential to determine care needs as well as
 - A. to determine the financial outlay to make the home safer for impaired homeowners.
 - B. whether or not the insured has met the coverage triggers in LTCI policies.
 - C. the need to purchase an LTCI policy, or perhaps, a second one.
 - D. declare bankruptcy so that Medicaid can take over.

8. Often used by health care experts to determine whether a person is capable of living independently and serve the purposes of measurements to assess a person's need for nursing home, home health or other long-term care services, are (is)
 - A. psychological tests performed in a hospital.
 - B. tests to determine whether the person has sufficient funds to enter a nursing home.
 - C. a check of credit reports and police reports.
 - D. Activities of Daily Living.

9. Policies sold today must include coverage for long-term care required by people who are physically able to perform the tasks
 - A. and who have sufficient funds to hire personal duty nurses.
 - B. but forgot how or why to perform the tasks or can't perform them safely on their own
 - C. and who have a driver's license.
 - D. and are presently in a hospice.

10. An employee that provides caregiving services must be affected by attendance problems and continual concern about the well-being of the person that they provide care for,
- A. with the result that there is inevitability a substantial loss in productivity.
 - B. but there is no loss of productivity as caretakers make good employees.
 - C. usually are old enough so that they retire early.
 - D. will usually be promoted because such an employee sets a good example for other employees.

ANSWERS TO STUDY QUESTIONS

1D 2C 3A 4C 5A 6A 7B 8D 9A 10A



CHAPTER II - LONG TERM CARE INSURANCE POLICIES

EVOLUTION OF THE LONG-TERM CARE INSURANCE POLICY

Long-term Care Insurance (LTCI) is a relatively new Health Insurance product. Originally called "Nursing Home Insurance," the policy has evolved over the past 20 years to include many other benefits, other than simply paying a daily amount while the insured is in a Nursing Home.

Shortly after the Nursing Home Insurance policy was introduced, a need for a policy covering home health care was devised. The original Home Health Care policy was simply a daily amount paid if the insured was unable to leave their home for health reasons, etc. The daily amount needed for Home Health Care was less than that needed if the insured was in a Nursing Home, so the premiums were lower. The lower cost, plus the desire of most senior citizens to stay at home if they became disabled, led to the popularity of the Home Health Care policy.

Many companies in this field then integrated the Home Health Care benefits with Nursing Home benefits. The amount payable for Home Health Care (HHC) was either a selected daily maximum, or a percentage of the Nursing Home daily benefit (80% or 50% were the most popular amounts). These policies became known as "Long-term Care" (LTCI) insurance policies. Added benefits were created, such as Assisted Care Facility benefits, Adult Day care, Caregiver Training, Bed Reservations, etc., as described below.

Of more recent invention was the calculation of Home Health Care or Nursing Home Care, or other benefits of the LTC Insurance policy, as a "Pool of Money", "Pot of Money" or "Lifetime Payment Maximum" (term used in states that offer a "Partnership" LTCI program) or similar names, instead of a chosen daily benefit and length of time the benefits are to be paid. One of the problems involved in LTCI policies that allowed a choice of the HHC benefit amount, or a HHC "stand-alone" policy, was that the applicant had to guess as to whether they could become ill and go directly into a Nursing Home; or whether they could become disabled and stay at home; or any combination thereof. The recent development offered a fixed amount to be paid throughout the life of the policy (unless the applicant chose Lifetime Benefit Period, a rather expensive choice). This amount is determined by multiplying the Benefit Period (stated in days) by the Maximum Daily Benefit Chosen. This "pot/pool" could then be used for any of the LTC benefits, until the total amount of the "pot/pool" had been spent. For example, a \$100 Daily Benefit, 3 year Benefit Period (1095 days) would create a "pot/pool" of \$109,500. When this amount has been spent under any benefit or combination of benefits offered by the particular LTC Insurance policy, the policy was then terminated.

For the Partnership Plans used in some other state, the total dollar benefits of a LTCI is of extreme importance in the determination of asset protection under new Medicaid regulations,

LTC Insurance has become very competitive recently. The National Association of Insurance Commissioners (NAIC) developed a standardized policy form that has been adopted by most, if not all, Insurance Departments. Many of the insurance regulations and laws in Delaware were suggested in the NAIC Model Bill.

WHO ARE THE BUYERS?

An HIAA study identified the people who are actually buying LTCI policies by age group, with these results.

- The average age of buyers is 69.
- 32% of buyers are ages 65 to 69.
- 23% of buyers are ages 70 to 74.
- Buyers who are 75 and older buy 26% of LTCI policies.

These figures indicate that about 19% of buyers are younger than age 65. One factor that has contributed to an increase in younger buyers is growth in the employer sponsored LTCI.

REASONS FOR LONG-TERM CARE INSURANCE

The reasons that Long Term Care insurance exists and continues to appeal to a substantial number of persons can be summed up as four basic reasons:

- 1) Risks and Costs are High
- 2) Reduction in Availability of Informal Caregivers
- 3) Gaps in other Long-Term Care Financing
- 4) Stricter Rules and Penalties for Transferring Assets

Breaking this down further, there are four reasons for *purchasing* LTCI:

- 1) The insurance concept of reducing uncertainty is present by providing for peace of mind that the need for long-term care is adequately covered. The consumer pays a relatively-small amount—that they can afford and that falls within their budget—in exchange for a large uncertain expense that could be financially devastating in the future.
- 2) Policies provide for flexibility and freedom of choice in selecting a nursing home or other long-term care facility. If the consumer must rely upon the Medicaid system for their funding of LTC expenses, the decision as to where they may remain for a long time is taken from them.
- 3) Perhaps the most important factor, particularly in the eyes of seniors, is that they are able to maintain their independence and do not have to rely upon family, friends or a government body to provide care if and when the need for such care arises.
- 4) Asset protection is of importance hand-in-hand with their desire for independence. Many seniors have amassed considerable wealth in the form of cash, home equity, bonds, IRA's, cash value in life insurance, etc. They would much rather pass this along to their heirs than to see it all spent on LTC expenses, and then, once their assets were gone, to find themselves dependent on others or on the State.

With a policy the client and their family have many choices when the need for care arises. Children can meet the needs of their parents and still retain control over their own lives. Parents can retain their dignity and independence by not having to depend on the children, or the state, for their care. This allows families to enjoy more quality time together without the physical, mental and financial strains that often accompany the process when there is no insurance coverage available.

USING LTCI BENEFITS

Recent studies indicate that policyholders who have used their benefits have only used 10% overall for Nursing Facilities while they have used approximately 25% of all benefits for Assisted Living and the remaining 65% for home and community based services. Note the following chart:

TYPE OF SERVICE, OTHER THAN CARE MANAGEMENT	This quarter, % of all services rendered to policyholders in benefit by type of service	Cumulative % of all services rendered by Type of Service
Skilled Nursing Facility	8%	10%
Assisted Living Facility/RCF	26%	24%
Other Alternative Housing	1%	2%
Home Health Aide Services	15%	14%
Adult Day Care (health & social)	2%	1%
Attendant Care	8%	15%
Personal Care	20%	19%
Homemaker (no personal care)	1%	< 1%
Chore Services	4%	1%
Personal Emergency Response System	1%	< 1%
Care Planning (benefit cost)	4%	< 1%
Coordination (benefit cost)	3%	< 1%
DME	1%	< 1%

(Services less than 1% not included, total may not equal 100%)

This is significant because it shows what anyone who has worked with seniors knows, that—



Consumers who have an LTCI policy prefer overwhelmingly to receive care in a setting other than a nursing home.

Nursing homes bring back memories of many seniors of the "Old-Folk's Home" where they used to visit relatives and they have unpleasant memories of linoleum floors, poor caregiving, and the odors! On the other hand, the person interested in LTCI might feel just the opposite and would prefer being in a place where professional care is available 24-7. The LTCI can provide such choices and options.

THE COST OF LONG TERM CARE

Long-term care can be very expensive, there is no doubt. Putting aside for now the probabilities of a person entering a nursing home or other covered facility and remaining there for an indefinite period, it is necessary to look at the principal expense of LTCI policyholders in order to understand why it costs so much—or so little if compared to the possible overall costs.

The principal reason for the cost is the cost of nursing home care. Generally, this is the most expensive costs for long-term care.



According to a recent study by AARP, the national average for a nursing home is \$194 per day. The average for Delaware is \$197.

Home health care is less expensive (usually) but it can also be expensive when, for instance, an aide coming to the home just three times a week (two to three hours per visit) to help with dressing, bathing, preparing meals, and similar household chores can easily cost \$1,000 each month, or \$12,000 a year. Add in the cost of skilled help, such as physical therapists, and these costs can be much greater.

A study of Assisted Living facilities indicated estimated that assisted living facilities charged an average monthly fee of \$1,873, including rent and most additional fees. Some residents in the facility may pay significantly more if their care needs are higher. The monthly rates range from \$800 to \$4,000, depending, of course, on what services are offered and quality of the facility.¹⁷

PREMIUM INCREASES

Since Long Term Care Insurance is a relatively recent insurance product, there was—and in some areas, still is—lack of accurate and specific data and loss history necessary in order to create adequate and fair premiums. When the first “nursing home” policies were developed, actuaries had to be cautious in calculating the premiums as premiums must be adequate to cover the losses and provide a reasonable profit for the insurer, but at the same time, the premiums could not be so expensive that they were prohibitive to the purchaser.

At the same time underwriting standards must be devised to protect profitability, so in the early years they were rather strict, and generally required that the insured spend a certain period of time in a hospital or nursing home before claims could be made on the policy.

The reaction of the marketing force and competition from companies newly entering the business and hungry for their market share, forced premiums to be at their lowest. As one could expect, soon the losses were prohibitive without an increase in premium. In addition, consumer groups were complaining that the requirements for benefits were too strict.

The inevitable result was the reduction in the number of companies offering this type of insurance, and some merging of companies and purchasing of blocks of LTCI policies by larger companies. But primarily, there was a necessary increase of premiums.

Insurers, obviously, cannot arbitrarily increase premiums as these policies are, by regulation, guaranteed renewable. Therefore, companies can raise premiums only if premiums are increased on all policies of that specific type in specified areas. Even so, the insurance departments of the states must allow some increase in premiums if it can be shown that the insurers may become insolvent if the existing premiums continue.

The reasons for the increases can be due to a variety of factors, such as new laws or regulations that require a certain risk be covered and the premiums are inadequate to provide such coverage. Also, as with any health insurance product, there is a chance for over-utilization, and if the insurer can show an increased and unexpected utilization, then the insurance department will consider if the premium increase is justified.

REQUIRED DISCLOSURE OF RATING PRACTICES TO CONSUMERS

Delaware regulations state that for certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following January 1, 2006.¹⁸

Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subsection to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this section to the applicant no later than at the time of delivery of the policy or certificate.¹⁹

- ✓ A statement that the policy may be subject to rate increases in the future;
- ✓ An explanation of potential future premium rate revisions, and the policyholder's or certificate holder's option in the event of a premium rate revision;
- ✓ The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase; and
- ✓ A general explanation for applying premium rate or rate schedule adjustments that shall include:
 - A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and
 - The right to a revised premium rate or rate schedule as provided above if the premium rate or rate schedule is changed.

PREMIUM RATE INCREASE INFORMATION

Information regarding each premium rate increase on this policy form or similar policy forms over the past ten (10) years for this state or any other state that, at a minimum, identifies²⁰:

- ✓ The policy forms for which premium rates have been increased;
- ✓ The calendar years when the form was available for purchase; and

- ✓ The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

Reinsured/Purchased Blocks of Business

An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this section or the end of a twenty-four-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase.

If the acquiring insurer files for a subsequent rate increase, even within the twenty-four-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers the acquiring insurer shall make all disclosures required by regulation, including disclosure of the earlier rate increase referenced above.²¹

Applicant Acknowledgement

An applicant must sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant must sign no later than at the time of delivery of the policy or certificate.²²

Notification of Premium Increase

An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, if applicable, at least forty-five (45) days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required as stated above when the rate increase is implemented.²³

EXCEPTIONAL INCREASES

Delaware considers certain increases as “exceptional increases” and addresses such application for increases as follows²⁴:

"Exceptional Increase" means only those increases filed by an insurer as exceptional for which the Commissioner determines the need for the premium rate increase is justified:

- ✓ Due to changes in laws or regulations applicable to long-term care coverage in this state; or
- ✓ Due to increased and unexpected utilization that affects the majority of insurers of similar products.
- ✓ Except as provided in other regulations, exceptional increases are subject to the same requirements as other premium rate schedule increases.
- ✓ The Commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.
- ✓ The Commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

“INCIDENTAL” BENEFITS

In the determination by the Department of Insurance as to whether an additional benefit should be grounds for increasing premium, the Department considered “incidental benefits” to be the value of the long-term care benefits provided that is less than ten percent (10%) of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.²⁵

SIMILAR POLICY FORMS

As mentioned above, increases must be on “similar” policy forms, which are defined by regulation as all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in the regulations are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.²⁶

LOSS RATIO

In order for there to be approval of premium increases, the insurer must make the case that their loss ratio is unacceptable for the risk insured. The Insurance Department looks at the relation to the premium provided to see if it is reasonable.

In this matter, the Delaware regulations state that Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%) for individual policies and at least sixty-five percent (65%) for group policies, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. For general information, the expected loss ratio will be determined by considering the following factors:

- ✓ 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.²⁷

These regulations will not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, must comply with different specific regulations.²⁸

MEDICATION EXPENSES VS LTC EXPENSES

Recently there has been a lot of publicity regarding prescription drugs, particularly for the senior citizens. Even with Medicare's drug program, out-of-pocket spending by seniors for drugs is a small fraction of long-term care costs overall. When added to the other LTC expenses, the combination of prescription drugs and long-term care can be financially disastrous to seniors.

NEED FOR MEDICAID "PLANNING"

Medicaid is the principal payer for nursing home costs—2/3 of nursing home patients are Medicaid recipients and Medicaid pays nearly 45% of nursing home costs. This will be explored in more detail later in this text, but suffice it so say that because of Medicaid abuse Congress (and state legislatures also) have recently introduced legislation to criminalize asset transfers for the sole purpose of qualifying for Medicaid. Governments have become concerned because, frankly, there just are not enough tax dollars available to pay for a national long-term care plan. As it is, 43 percent of all tax income is used to pay for entitlements such as Social Security, Medicare and Medicaid.

An interesting, but not unexpected result of attorneys, insurance agents and financial planners becoming involved in Medicaid planning, or even just in financial or estate planning, is the possibility of conflict of interest situations when representing heirs in protecting their inheritance instead of serving also the best interests of the elderly clients. If these professionals conserve the estate for the children or grandchildren or intentionally impoverishing the nursing home patient (particularly if they are cognitively impaired), they may be guilty of "senior financial abuse" and they should, at least, also be aware of the sharp rise in errors and omissions lawsuits particularly for those involved in Medicaid planning.

CRISIS IN MEDICAL PRACTITIONERS

There has recently been considerable publicity regarding the lack of doctors who specialize in geriatrics because of the low rate of compensation compared to what they would receive in other specialties. This is primarily due to the high level of dependence on Medicare and Medicaid by seniors and the low overall payment rates of these programs, including administrative and claims delays. Also, elderly patients require much more labor-intensive treatments than other types of patients.

Some interesting statistics to prove the point: 80% of all healthcare expenditures occur after age 50 and persons over age 65 in the US represent only 13 percent of the population but account for more than 50 percent of physician visits each year.

Statistics also show that in order to keep up with America's aging population, the country will need 36,000 geriatricians by 2030 - currently there are less than 9,000.

- Of the more than 650,000 physicians in the U.S., less than 2 percent are geriatricians.
- Of the nearly 200,000 pharmacists in the United States, only 720 have geriatric certifications.
- Of the 98,000 academic fellowships funded by Medicare, only 450 are in geriatrics.²⁹

Some medical institutions are providing special classes dealing with "senior sensitivity" to assist doctors in dealing with the special challenges and needs of the elderly population, which will represent a large part of their overall patient load in the near future.

“Longevity is increasing, the baby boom generation is nearing retirement age, and the portion of our population age 65+ is the fastest-growing segment of our society. But while the number of older persons is expected to increase rapidly, demographic changes in families (more childless, one-child, and step-families) and increasing participation of women in the workforce suggest a likely decrease in provision of informal care for aging baby boomers.”³⁰

A national newspaper in 2001, addressing the need for long-term care and caregivers, stated that “Geographic changes are also expected to make it more difficult to obtain care from family members or other relatives. In the past, family members lived close to each other and could rely upon each other for help. But the extended family of yesteryear has all but vanished. Families are increasingly spread apart, with mom and dad living in one part of the country while their children often reside thousands of miles away. Baby boomers and seniors alike would do well to provide for their own care, independent of relying on relatives, and a Long Term Care Insurance policy would help provide the funds to pay for the care you may need.”³¹

There will be a time when there are a smaller number of workers in the future, and those are higher educated and better paid—so who will be the caregivers then? Actually, nursing homes and other similar types of businesses that rely upon the lower-wage less-educated persons may look to recent immigrants for their employees. This can create its own bag of troubles, particularly because of language and cultural differences between them and their patients.³²

STUDY QUESTIONS

1. One of the problems involved in early LTCI policies that allowed a choice of the HHC benefit amount, or a HHC "stand-alone" policy, was that the applicant had to guess as to whether they could become ill and go directly into a Nursing Home; or whether they could become disabled and stay at home; or any combination thereof. This problem has been addressed by
 - A. having higher elimination periods.
 - B. raising commissions.
 - C. introducing policies where benefits are consolidated into a dollar amount, often referred to as a "Pot of Money" or some other similar term, creating a maximum benefit payable.
 - D. selling separate nursing home and home health care policies.
2. One of the reasons that Long Term Care insurance exists and continues to appeal to a substantial number of persons is
 - A. that it is cheap and most people can afford it.
 - B. it pays the highest commissions of any insurance product.
 - C. it is sold by securities dealers as an investment.
 - D. stricter Medicaid rules and penalties for transferring assets.
3. Recent studies indicate that policyholders who have used their benefits have
 - A. only used 10% overall for Nursing Facilities.
 - B. used 95% of the benefits for Nursing Facilities.
 - C. used only a small fraction for home health care.
 - D. overwhelmingly used their policies as collateral for a loan.
4. According to a recent study by AARP, the national average for a nursing home is
 - A. \$300 per day.
 - B. \$275 per day.
 - C. \$194 per day.
 - D. \$3,000 per month.
5. In the same study, the average cost of a nursing home in Delaware was
 - A. \$197 per day.
 - B. \$366 per day.
 - C. \$5,760 per month.
 - D. \$5,820 per month.

6. If the professional estate and financial planners conserve the estate for the children or grandchildren or intentionally impoverishing the nursing home patient (particularly if they are cognitively impaired), by, for instance, using an LTCI policy,
- A. they are to be commended for doing a fine job.
 - B. they may be guilty of a felony of stealing funds from the heirs.
 - C. they may be guilty of “senior financial abuse.”
 - D. no matter what is done to preserve the estate, insurance or anything else, Medicaid can come back at the heirs to replace any assets given them over the past 10 years.
7. There has recently been considerable publicity regarding the lack of doctors who specialize in geriatrics because of the low rate of compensation compared to what they would receive in other specialties. This is primarily due to
- A. the increasing number of doctors who were citizens of other countries.
 - B. the return of the citizenry to their rural roots.
 - C. the lack of podiatrists and other specialties.
 - D. the high level of dependence on Medicare and Medicaid by seniors and the low overall payment rates of these programs, including administrative and claims delays.

ANSWERS TO STUDY QUESTIONS

1C 2D 3A 4C 5A 6C 7D



CHAPTER III – POLICY PROVISIONS

It is not possible at this time to fully discuss all available provisions of a LTC Insurance policy, as it is such a changing product because of regulation and the gathering of statistics by the actuaries. Therefore, any agent should carefully study the provisions of the policies that they have contracted to sell. As an example, one health insurance agency contracted with three insurers to sell their LTCI policies. One company marketed a policy that paid Daily Benefits only up to the amount of reasonable and customary charges and no one in that agency had discovered this. The end result was that all of the policyholders of this particular plan were contacted and this benefit restriction explained. This led to some red faces and some cancellations. These policies are no longer marketed, but it illustrates the necessity for agents to become very familiar with their products.

REIMBURSEMENT OR INDEMNITY?

Basically, there are two types of LTCI policies: reimbursement and indemnity. These may be called something else by a company, but basically they are only of these two types. One company may offer either types or only one type. In Delaware, either form may be used, although the regulations regarding the Outline of Coverage are specific on Indemnity plans, with allowance for change if the plan is a reimbursement plan. For instance, in the Outline of Coverage (described in more detail later), the required statement is : “This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]”³³

Reimbursement Policy

A reimbursement policy pays for the actual services that the insured receives. “Reimbursement benefits payment by the insurance company to the insured for the actual expenses incurred by the insured, such as medical expenses.”³⁴ For example, if a nursing home charges a patient \$250 a day and the LTCI policy limit is \$200 a day, then the policy will only pay the \$200 per day. If the nursing home charges \$150 a day, then that is what the policy will pay – “*up-to*” is what these policy benefits are sometimes called.

Indemnity Plan

Technically, indemnity is compensation for a loss. In a property and casualty insurance contract, where one usually hears of this term, the objective is to restore an insured to the same financial position after the loss that he/she was in prior to the loss. In life insurance, a payment of a predetermined amount does not make a life insurance policy a contract of indemnity. For hospital indemnity and other health insurance plans, “Coordination of Benefits” clauses are designed so that the insured cannot profit from an illness.

In respect to the “pool” of money concept, basically an individual’s total benefits is determined by multiplying the daily benefit chosen by the benefit period. Simply put, if the policy has a \$200 daily benefit and has a 3-year benefit period (1095 days), the amount of the “pool” is \$219,000. Therefore, under an indemnity policy, if the insured had \$200 a day benefit for every day he was disabled and if he required at least one visit each day from a home care provider who

only charged \$100 per day, after 3 years the benefits cease. Under a reimbursement plan, he would have been reimbursed the actual cost, therefore his pool of money would last more than 3 years. This would be important if the insured was still alive and disabled after 3 years (1095 days).

Another advantage of indemnity plans is that under the reimbursement plan, only licensed caregivers can provide services, but with an indemnity plan, it may let the insured pay family members or informal caregivers who cost less than licensed providers. Indemnity policy providers maintain that their claims don't cost much to process, less overhead, so the premiums should be less. Reimbursement insurers maintain that their premiums are lower because claims for reimbursement claims costs tend to be lower. Actually the jury is still out on this and the premiums are nearly the same, but it is possible that the indemnity plan insurers may have to play catch-up in 10 years or so as they would still have funds outstanding earmarked for claims where the reimbursement plan would have paid all their claims.

At claims time, if the plan is indemnity, then the money goes to the insured who writes the checks. With a reimbursement policy, the insurer requires only one claim form a year for each service provider – after that the provider bills the insurer.

The “Care Manager” or Care Coordinator” comes into play in determining the difference between the plans. With an indemnity plan, usually it is up to the insured to provide their own care manager or hire a professional to arrange these things. The reimbursement company provides the insured with a company-paid care manager. This leads to a debate as the indemnity company will maintain that the paid managers are actually paid “gatekeepers” who may be unwilling to certify the care needed by the insured. The reimbursement company will maintain that this is not true, the care managers have no axe to grind and have no motive other than to assist the insured when they need help the most.

Some insurers have blurred lines a little by offering an indemnity option, a cash benefit rider, on its reimbursement plan.



Of the 20 most popular LTCI programs in a *Life Insurance Selling* survey, two were reimbursement for both nursing home and home health care; one was indemnity for home health care and reimbursement for nursing home, all the rest were indemnity for nursing facility and reimbursement for home health care.


COVERAGE TRIGGERS

One of the most important features of a LTCI policy is what must happen in order to receive benefits from the policy — the coverage triggers or "gatekeepers" or "safety net," as they are often called, are activated. These were discussed earlier in the section on tax-qualified/non-tax-qualified policies.

In the early policies, coverage triggers were often highly restrictive as to coverage but this is no longer the case, thanks to customer and regulatory pressure and regulations.

In the discussion of “triggers,” there are two regulations that provide necessary guidance. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)³⁵. This Federal law set forth certain requirements for long term care insurance whereby there would be certain tax benefits, including (for the first time) recognizing LTCI as “health insurance” and benefits paid under a “tax-qualified” policy (i.e., a policy that meets the requirements of this act) would meet these requirements. The IRS adopted these requirements, as Section 7702B(b) of the Internal Revenue Code of 1986. A referral to a “TQ” policy means, obviously, that it meets these requirements and is therefore, “tax qualified.”

 **Delaware law states: “*Qualified Long-Term Care Insurance Policy*” means a policy that provides coverage for qualified long-term care services that is intended to meet the requirements of §7702B(b) of the Internal Revenue Code of 1986 as amended.”³⁶**

 **“*Qualified Long-Term Care Services*” means necessary diagnostic, preventive therapeutic, 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.”³⁷**

The second law is a result of the Deficit Reduction Act of 2005 (DRA) which specifically set forth requirements for the Partnership Plan, based mostly upon the NAIC Model Act which has been adopted by many states. Delaware’s laws closely follow the Model Act, but it does not participate in the Partnership Plan in respect to asset requirement relief under Medicaid.

BENEFIT TRIGGERS UNDER HIPAA (TAX-QUALIFIED)

Under HIPAA, Congress decided that they wanted its tax-qualified plans to contain two, and only two, benefit triggers. Not only did Congress limit the triggers, but within the two, they imposed restrictions that were not there previously.

Congress eliminated “medical necessity” as a benefit trigger. For younger claimants, “medical necessity” is probably the fairest of the benefit triggers. Simply put, this trigger states that due to a diagnosable medical problem, care is needed. The medical problem could be obvious, such as a stroke, cancer, disabling accident, etc. — or less obvious, such as Alzheimer’s or senile dementia.

Delaware regulations define “Chronically ill” as certified by a licensed health care practitioner as:

- (a) 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
- (b) Requiring substantial supervision for protection from threats to health and safety due to severe cognitive impairment.³⁸

As reported in trade publications, Congress effectually eliminated most short-term claims, even those that can be quite costly. Those that suffer from a chronic disability will not necessarily qualify them to receive benefits under a tax-qualified plan. One must still meet the two triggers mentioned above.

'TRIGGERS' REGULATIONS IN DELAWARE

The regulations for Delaware are rather specific as to "triggers: " Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the Outline of Coverage. Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.

They require that a long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment; or

“A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment.”⁴⁰

DEFINITIONS OF ACTIVITIES OF DAILY LIVING

Activities of daily living shall include at least:

- (a) "Bathing," this means washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.
- (b) "Continence," which means the ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for catheter or colostomy bag.
- (c) "Dressing," which means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- (d) "Eating," which means feeding oneself by getting food into the body from a receptacle, such as a plate, cup, or table, or by a feeding tube or intravenously.
- (e) "Toileting," which means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- (f) "Transferring," this means moving into or out of a bed, chair, or wheelchair.

Insurers may use activities of daily living to trigger covered benefits in addition to these as long as they are defined in the policy.⁴⁰

Note: This means that:

- ✓ An issuer of qualified long-term care contracts is limited to considering only the activities of daily living listed above.

- ✓ An insurer may use additional provisions, for a policy described herein for the determination of when benefits are payable under a policy or certificate; however, the provisions shall not restrict and are not in lieu of, these requirements.⁴¹
- ✓ For purposes of this section, the determination of a deficiency due to loss of functional capacity or cognitive impairment shall not be more restrictive than:
 - (a) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living, meaning physical assistance, minimal, moderate, or maximal, without which the individual would not be able to perform the activity of daily living; or
 - (b) Due to the presence of a cognitive impairment, requiring supervision, including verbal cueing by another person in order to protect the insured or others.

Assessment of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses, or social workers.⁴²

Further, Delaware regulations in respect to benefit triggers states: “Activities of daily living and cognitive impairment shall be used to measure an insured’s need for long term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled “Eligibility for the Payment of Benefits.” Any additional benefit triggers shall also be explained in this section. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.”⁴³

COGNITIVE IMPAIRMENT

Cognitive impairment includes any organically-based brain disease, such as Alzheimer's or Parkinson's disease, and is generally characterized by the deterioration of intellectual functioning. Cognitive impairments may manifest in various forms, including loss of memory, disorientation, loss of reasoning ability, inability to make judgments and others. A physician's diagnosis is typically required. Policies usually define exactly what is considered cognitive impairment.⁴⁴

Delaware regulations state "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.⁴⁵

WHAT IS MEDICALLY NECESSARY CARE?

The difference between tax-qualified and non-tax-qualified policies requiring that care is medically necessary is that, today, this is not typically the only requirement, but just one of several that may trigger coverage. The tax-qualified plans under HIPAA have effectively eliminated this “trigger,” but there are many non-tax-qualified plans that either are in force, or are still offered.

HIPAA states that "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.

Medical necessity might result from an injury or illness, the latter possibly including cognitive impairment, depending on how the particular policy reads. The best definitions of medical necessity indicate that the care is "appropriate for the insured's condition." "Experimental" types of care are often excluded.

CAUTION TO AGENTS!

It is the responsibility and the duty of every LTCI agent to be intimately familiar with the policy that he is marketing. In the past (and possibly even now) some agents will contract on a single case basis if his carrier does not have what a prospect is interested in. Nothing wrong with this, but the problem is that rarely will the agent read ALL of the policy as he is interested only in the section that the prospect wants and that does not appear in the policy that he regularly markets. With the interest in the NAIC LTCI Model bill, plus new regulations, now the agent *really* has to be careful. Careful attention must be made to the coverage triggers, whether the plan is reimbursement or indemnity, etc. The best way to keep out of trouble with this is to place a policy that is familiar and which all of the details are known, alongside of the new policy and compare item-to-item. More often than not, there are some surprises. Particularly if another policy is being sought as the prospect did not medically qualify for one policy but can qualify for the new one.

For existing, or non-tax-qualified policies, it is possible that the provision describing the circumstances under which benefits are payable does not spell out the three "gatekeepers" or ADLs described above in precisely that manner. A person would have to "translate" the policy language in order to understand exactly what is required to receive benefits. It is extremely important for the applicant to fully understand these requirements. Some of the problems that arose with early LTCI policies came about because agents told clients they were covered for situations the policy did not cover. Some agents subsequently found themselves in court dealing with errors and omissions lawsuits. In addition, unhappy consumers may file complaints that eventually lead to further government legislation.

ELIMINATION PERIOD

A long-term care policy's elimination period, sometimes called a *deductible* period, is a period of time during which no benefits are paid immediately after the insured is qualified to receive long-term care.

Because the insured absorbs the first costs incurred, the elimination period serves the same purpose as a deductible amount for medical expense or auto or homeowners insurance. The insurance buyer may select a longer period (thus paying more out-of-pocket) in order to lower the premium.

In respect to replacement policies (as covered later in detail) Delaware regulations state: A replacement policy may NOT "...contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group."⁴⁶

LENGTH OF ELIMINATION PERIOD

Insurers typically offer elimination periods ranging from zero days (no elimination period) up to 365 days, with different insurers offering different options. Shorter periods up to about 90 days are most common, but periods currently available include seven, ten, 15, 20, 30, 45, 60, 90, 100, 120, 150, 180, 270 and to as long as 365 days. The actual periods offered vary from insurer to insurer and it's unlikely a single insurer would offer all of these choices. For example, insurer XYZ might offer periods of zero, 20, 60 or 180 days, while insurer ABC offers zero, 30, 90 and 365 days. The insurer may also specify the elimination period with no option for the insured to choose.

Under policies that pay benefits for different kinds of care, a single elimination period usually qualifies the insured for all types of care.

For example, assume the elimination period is 60 days. The insured first requires skilled care for ten days in a Skilled Nursing Facility, followed by 20 days of intermediate care in the same facility, then goes home to receive 60 days of intermittent skilled care and custodial care before recovery is complete. Thirty days of the elimination period is fulfilled in the nursing facility. The insured absorbs the cost of the first 30 days at home to fulfill the 60 day period and benefits are paid for the balance of 30 days. When the same elimination period applies to all types of care, this is sometimes called an "integrated" elimination period.

That same term — integrated elimination period — sometimes means that the elimination period must be fulfilled only once during the life of the policy. For example, suppose insured Potter has a policy with a lifetime benefit period. He has fulfilled the elimination period during a nursing home confinement, has returned home and now, a year later, must enter a nursing home again. Potter's LTC Insurance policy begins paying benefits from the first day of nursing home confinement since the elimination period was previously satisfied. Typical provision.

CARE-RELATED ELIMINATION PERIODS

Insureds may be able to choose different elimination periods for different types of care, such as 30 days for nursing home care and ten days for home health care. At least one insurer specifies that a 90-day elimination period applies for nursing home care and a 30-day period for home and community-based care and the insured may change the periods only by adding a rider to the policy. Another policy offers elimination periods in a range of zero to 365 days for nursing home care, but for home care the insured chooses either seven, 20 or 60 days.

The newer policies generally offer the same care-related elimination periods.

APPLICANTS CONCERNS ABOUT ELIMINATION PERIODS

The length of the elimination period is another critical factor affecting the cost of LTCI policies. First-day coverage (no elimination period) is nice, but costly. On the other hand, an insured whose long-term care begins in a skilled nursing facility will incur fairly high daily expenses that must be paid from personal funds during the elimination period. This means the insured must decide how much he or she can handle financially before the policy begins paying benefits.

For example, let's say the nursing home costs \$90 per day. The insured selected a 90-day elimination period. If this individual becomes very ill and must be in the nursing home for a long period, he or she conceivably could be required to pay:

\$90 per day x 90 days = \$8,100

This \$8,100 comes out of the insured's pocket before any policy benefits begin on the 91st day of care. In addition, remember that most nursing home confinements last fewer than 90 days, so the insured might pay the full cost, having recovered before the elimination period passed, with the result that they will receive no benefit from the policy at all.

The trade-off's are between a shorter elimination period (less out-of-pocket expense) and higher policy premium versus a longer elimination period (more out-of-pocket expense) and lower policy premium. Unlike choosing the benefit period, this decision is less of a gamble because it is based largely on finances and people generally know how much of the cost they can absorb. The problem, however, is that people's financial circumstances change and not always for the better. Someone who believes he could easily absorb the \$8,100 mentioned in the previous paragraph, for example, could suffer setbacks such as unemployment or investment losses that would make such a payment difficult or impossible in the future.

In a discussion about benefit periods, the best choice is probably the longest period the insured can realistically afford. For the elimination period, the advice might well be just the opposite: Choose the *shortest* elimination period that is realistically affordable. An agent should be particularly sensitive to financial circumstances in this regard. People who can afford to buy LTC Insurance, but who are not particularly well-fixed financially, shouldn't be encouraged to stretch out the elimination period extensively in order to lower the premium to where they feel it is affordable. There is a school of thought that believes that even a small Daily Benefit policy is better than no policy. Because of the crowded conditions of the nursing homes, a policy of any amount will help admit a person to a good nursing home. When the benefits expire, they usually cannot be moved to the "Medicaid" ward, particularly in view of recent legislation.

However, if such clients eventually need long-term care, they won't be happy with a policy that pays only after they have depleted their savings unless they fully and completely understand what the situation is. Unfortunately, many insureds that require long-term care are not in any condition to remember the explanation made at the time of the sale – another reason that a true professional stays in touch with their customers. Also, if the insured has to have nursing home care and is in no condition to handle the details, family members – frequently who live some distance away – may not be aware of the financial decisions made at the time of the sale. It is important to gather enough information about the clients' finances to help them make an informed choice and be certain the advice is both financially and ethically sound. (See discussion of "Suitability Standards" later in this text.)

As warned elsewhere in this text and worth repeating is the hazard in suggesting to a prospect, that in order to keep the cost down, since Medicare will cover up to 100 days in a nursing home, therefore the elimination period could be extended by 100 days to help reduce the cost. WRONG! There are certain conditions Medicare imposes, one being that the person's health condition must be improving. The majority of LTCI policyholders purchased the plan for *long-term care* coverage, to cover the prospect of remaining in a nursing home for a long period of time—often for the rest of their life. Substituting Medicare days of coverage for LTCI coverage is just not a good idea.

NONFORFEITURE PROTECTION

For some time, insureds and consumer protection parties and organizations, and even agents, have raised the question as to why there were no premiums returned to long-term LTCI

policyholders, and in particular if they have had no claims. A few states enacted "nonforfeiture" protection, but the NAIC Model Act provided the most comprehensive, and this is what Delaware now requires. (For those not familiar with the term, "nonforfeiture" simply means that the rights of the policyholder cannot be forfeited.)

An insurer that offers a long-term care insurance policy, certificate, or rider in this state must offer a nonforfeiture protection provision providing reduced paid-up insurance, extended term, shortened benefit period, or any other benefits approved by the office if all or part of a premium is not paid. Nonforfeiture benefits and any additional premium for such benefits must be computed in an actuarially sound manner, using a methodology that has been filed with and approved by the office.

No policy or certificate may be delivered or issued for delivery in this state unless the insurer also offers to the policyholder or certificateholder the option to purchase a policy that provides for nonforfeiture benefits to the defaulting or lapsing policyholder or certificateholder.

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

The regulations state that attained age rating is defined as a schedule of premiums starting from the issue date which increases with increasing age at least one percent per year to age fifty (50), and at least three percent (3%) per year beyond age fifty (50).

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

The standard nonforfeiture credit will be equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit must not be less than thirty (30) times the daily nursing home benefit at the time of lapse.⁴⁷

In either event, the calculation of the nonforfeiture credit is subject to the limitation: All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would have been payable if the policy or certificate had remained in premium paying status.⁴⁸

Effective Dates

The nonforfeiture benefit must begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse must be effective during the first three (3) years.

No policy or certificate may begin a nonforfeiture benefit later than the end of the third year following the policy or certificate issue date except that for a policy or certificate with attained age rating, the nonforfeiture benefit must begin on the earlier of:

- ✓ The end of the tenth year following the policy or certificate issue date; or
- ✓ The end of the second year following the date the policy or certificate is no longer subject to attained age rating.⁴⁹

Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.⁵⁰

All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would have been payable if the policy or certificate had remained in premium paying status.⁵¹

There shall be no difference in the minimum nonforfeiture benefit as required under this section for group and individual policies.⁵²

The requirements set forth in this section were effective on May 1, 1997, except for certificates issued on or after the effective date of this section under a group long-term care insurance policy as defined in the regulations which policy was in force at the time this amended regulation became effective.⁵³

Premiums charged for a policy or certificate containing nonforfeiture benefits must be subject to the loss ratio requirements of these regulations treating the policy as a whole.⁵⁴

Rejection of nonforfeiture benefit.

Nonforfeiture benefits that are provided under Delaware regulations, must be included in a long-term care insurance policy or certificate unless an insurer obtains a rejection of a nonforfeiture benefit signed by the policyholder or certificateholder.⁵⁵

The rejection must be considered part of the application and must state: I have reviewed the Outline of Coverage and the nonforfeiture benefit as described therein. Specifically, I have reviewed Plan _____ and I reject the nonforfeiture benefit.⁵⁶

Nonforfeiture benefits for qualified long-term care policies must meet the following requirements⁵⁷:

The nonforfeiture provision shall be appropriately captioned:

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

The nonforfeiture provision must provide at least one of the following:

- ✓ Reduced paid-up insurance;
- ✓ Extended term insurance;

- ✓ Shortened benefit insurance; or
- ✓ Other similar offerings approved by the Commissioner.⁵⁸

If the required offer of a nonforfeiture benefit is rejected, the insurer must provide the contingent benefit upon lapse described below. In the event that a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate must provide either the nonforfeiture benefit or the contingent benefit upon lapse.⁵⁹

The contingent benefit on lapse must be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders must be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.⁶⁰

According to Delaware regulations, the Triggers for a Substantial Premium Increase would be the following percent increase over the Issue Age and Initial Premium as shown:

29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
	40%
	38%
	36%
	34%
	32%
	30%
	28%
	26%
	24%
	22%
	20%
	19%
	18%
	17%
	16%
	15%
	14%
	13%
	12%
	11%
90 and over	10%

On or before the effective date of a substantial premium increase as defined above, the insurer must:

- ✓ Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;
- ✓ Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with regulations. This option may be elected at any time during the 120-day period referenced above; and

- ✓ Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced above shall be deemed to be the election of the offer to convert.⁶¹

The contingent benefit upon lapse will begin not later than the end of the third year following the policy or certificate issue date.

DAILY BENEFITS AVAILABLE


Coverage is written on the basis of a daily benefit amount, with a wide span between the minimum and maximum amounts available. The daily benefit amount generally applies to nursing home care and may or may not vary for care in other types of facilities. Nursing home benefits will be discussed first, and then the text will address various ways policies handle benefit payments for care under other circumstances.

An important point about the daily benefit is that this is usually the *maximum* amount the policy will pay for a day of care. Most policies stipulate that the insurer will pay 100% of actual costs incurred up to the daily benefit amount. See discussion prior in respect as to how this is handled with reimbursement type policies and indemnity type policies.

Policies available as of this writing offer daily nursing home benefits ranging from as little as \$20 per day to as much as \$500 per day with most having a maximum of \$300. Some policies place a minimum on the total maximum benefits, such as \$900,000, and one company has maximum daily benefit of \$10,000 per month and another has a maximum of \$12,000 per month. Some have no maximum published. Insureds generally may choose from the insurer's offerings in \$10 increments after the minimum. If an insurer offers a minimum of \$40 and a maximum of \$200, the insured could choose, for example, \$50 or \$80, (but not \$75) in \$10 increments up to \$200.

The amount of the daily benefit is one of the critical pricing factors—the higher the daily benefit, the higher the premium, all other things being equal. The advent of the “pool” approach has created some confusion in this respect—it used to be simple, just so much per day but now things are different.

People who choose a lower daily benefit may not have all of their care costs covered and must make up the difference.

 **In addition to considering the premium that will be required, selecting the appropriate amount also involves at least two factors: (1) What is the current average charge for one day of nursing home care in the insured's particular geographical region? and (2) Will the daily rate increase to keep pace with inflation?**

A professional agent and his clients should both be aware of average nursing home costs where the insured lives. Even better, the insured may know exactly what nursing home he/she would prefer if it were necessary, find out the daily rate, and use that figure as a guideline.

Determining the exact figure for a specific nursing facility is sufficient only if the policy includes an option to have the daily benefit amount indexed for inflation. Inflation protection will be covered in more detail later, but just be aware that it is very important. Some LTCI policies will be purchased 20 years before they are ever used. Relying on the past as a portent for the fu-

ture, a benefit purchased on the basis of today's costs only is likely to be woefully inadequate 20 — or even ten years — from now.

PRIOR HOSPITALIZATION OR INSTITUTIONALIZATION

Some older policies, which may still be in force, incorporated such requirements, often including prior *hospitalization* lasting at least three days. This limitation excludes the payment of benefits for some of the most common needs for long-term care, for example, people who suffer from Alzheimer's disease rarely require hospitalization, but do need custodial care. In Delaware, LTCI policies pay benefits for any level of care the insured requires *without* a higher level of care as a prerequisite. However, some policies still require a period of confinement in a nursing home before paying home care benefits.

Delaware regulations state: “ No long-term care insurance policy may be delivered or issued for delivery in this State if such policy conditions eligibility for any benefits on a prior hospitalization requirement; or if such policy conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care.”⁶²



No long-term care insurance policy may condition eligibility for any benefits other than waiver of premium, post confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.

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

A long-term care insurance policy or rider which conditions eligibility for noninstitutional benefits on the prior receipt of institutional care must not require a prior institutional stay of more than 30 days.

No long-term care insurance policy which provides benefits only following institutionalization shall—according to Delaware law— condition such benefits upon admission to a facility for the same or related conditions within a period of less than 30 days after discharge from the institution.⁶³

WHERE CARE OCCURS

Associated with the level of care is *where* care occurs. Newer LTCI policies usually pay benefits at skilled nursing facilities, intermediate care facilities and custodial care facilities, but long-term care can occur in a variety of different settings. There is wide variation in what types of settings qualify insureds for LTC Insurance policy benefits. When care is provided anywhere outside the home, policies usually require the facility to be state-licensed.

SERVICE PROVIDERS

“*Qualified Long-Term Care Services*” means necessary diagnostic, preventive therapeutic, 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.⁶⁴

"Skilled nursing care" "intermediate care" "personal care" "home care" and other services are defined in relation to the level of skill required, nature of the care and the setting in which care must be delivered.⁶⁵

 **No long-term care insurance policy may provide coverage for skilled nursing care only, or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.**⁶⁶

All providers of services, including but not limited to **"skilled nursing facility" "extended care facility" "intermediate care facility" "convalescent nursing home" "personal care facility" and "home care agency"** are defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.⁶⁷

MINIMUM STANDARDS FOR HOME HEALTH CARE & COMMUNITY SERVICES

By far the greatest number of policies offered today includes both nursing home and home care. As described in this text, the newer policies offer the "Pool of Money," or "Lifetime Payment Maximum" wherein the Home Health Care payments may not be restricted as to a function of the Maximum Daily Benefits, but the entire amount may be paid (and thereby decreasing the Lifetime Payment Maximum). Many newer policies automatically include home care and home health care benefits, while others offer such benefits as an optional rider for an additional premium. There are also "stand-alone" home care policies that cover only care at home, not in any other type of facility.

First, it may help to understand what may NOT be offered in a Long Term Care Insurance policy in respect to home health care in the state of Delaware.⁶⁸ The regulations state that a long-term care insurance policy or certificate must **not**, if it provides benefits for home health or community care services, **limit or exclude benefits**;

- ✓ By requiring that the insured/claimant would need skilled care in a skilled nursing facility if home health care services were not provided.
- ✓ By requiring that the insured/claimant first or simultaneously receive nursing and/or therapeutic services in a home, community or institutional setting before home health care services is covered.
- ✓ By limiting eligible services to services provided by registered nurses or licensed practical nurses.
- ✓ By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or

certified home care worker acting within the scope of his or her licensure or certification.

- ✓ By excluding coverage for personal care services provided by a home health aide;
- ✓ By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;
- ✓ By requiring that the insured/claimant have an acute condition before home health care services are covered.
- ✓ By limiting benefits to services provided by Medicare-certified agencies or providers;
- ✓ By excluding coverage for adult day care services.

A long-term care insurance policy or certificate, if it provides for home health or community care services, must provide total home health or community care coverage that is a dollar amount equivalent to at least **one-half of one year's coverage** available for nursing home benefits under the policy or certificate. This requirement cannot apply to policies or certificates issued to residents of continuing care retirement communities.⁶⁹

Home health care coverage may be applied to non-home health care benefits provided in the policy or certificate when determining the maximum coverage under the terms of the policy or certificate.⁷⁰

It should be noted that some policies are more generous than others, and while some policies follow the “letter of the law,” other policies may offer services that are more consumer oriented than the regulations allow. Delaware’s laws are quite specific and generous for home health care, but insurers are always looking for more home care services that can be part of the policy benefits. For instance, there are policies that make provisions to pay for training of a family care giver.

It should be kept in mind that the interests of the insurer and the consumer are parallel in this case as most elderly persons much prefer to stay at home if at all possible, and insurers are glad if they do. There are statistics that indicate that in some situations, home health care is more expensive than nursing home care, however typically, this would just be the reverse. It is fair to say that if there were such a thing as a long term care insurance policy that would guarantee that a person would never have to leave their home, regardless of how ill they become, there would be quite a market. This is, of course, not possible.

ALTERNATE CARE PROVIDED

In general, alternate care is care provided anywhere *other than* at home or in a nursing home. Some insurers use just this terminology, but most will further define it, limiting benefits to certain types, such as adult day care, hospice care, assisted living facilities, or whatever facilities a particular policy specifies. Some policies specifically name Alzheimer's centers and Christian Science facilities as covered locations.

One term used in association with alternate care is community-based care, which also might be further defined. Community-based care occurs in assisted living facilities, nursing homes, adult congregate living facilities, adult day care centers and others. Often a physician must indicate that the proper care can be provided in such a facility, especially when only custodial care is needed.

Be careful to determine precisely what facilities are included. Some policies exclude care that occurs in "homes for the aged," for example, a term that must be further defined. Another caution for agents: A policy that pays for "alternate care" does not necessarily pay for *home* care. In the past, agents have mistakenly informed clients that alternate care is home care, but it is not.

HOME CARE AVAILABLE

When a long-term care policy also covers home care, the daily benefit might not be the same as for care received in a nursing home but as indicated, it must be a dollar amount equivalent to at least half of the annual coverage for nursing home care.

Note that the regulation requires an amount "at least"

At least one policy currently on the market has an even more complicated formula for paying home care costs. That particular policy pays:

- For skilled or intermediate nursing care: 100% of actual expenses up to 60% of the daily nursing home benefit.
- For non-skilled custodial type care: 80% of actual expenses up to 60% of the daily nursing home benefit.

Basically, companies are more competitive in their coverage for home care. Typically, home care benefits cover approximately 36 hours a week of care, even though the average beneficiary needs 59 hours and the additional funds comes out of the insured's pocket. But, the benefit amount must still not be less than the 50% of daily benefit requirement. Delaware regulations state: "A long-term care insurance policy or certificate, if it provides for home health or community care services, must provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities."⁷¹

Today, most policies have a weekly benefit for home health care, not a daily benefit. This change was because there were too many situations where an insured had assistance for part of the week from a family member, but the daily benefit did not cover completely the daily charge when a paid caregiver was required. By making the benefit a weekly benefit, this problem was eliminated.

Insurers use many methods to pay for the home care benefits and the same insurer might offer different policies with different funding arrangements. It must be clearly and completely understood how the benefits are determined and applied for the particular policy represented.

STUDY QUESTIONS

1. Basically, there are two types of LTCI policies:

- A. Qualified and Unqualified.
 - B. reimbursement and indemnity.
 - C. expensive and cheap.
 - D. Partnership and NAIC Qualified.
2. Technically, indemnity is
 - A. a fiscal reward for strenuous compliance.
 - B. payment for the action services received.
 - C. compensation for a loss
 - D. a term used only in property and casualty insurance.
 3. One of the most important features of a Long Term Care Insurance policy is what must happen in order to receive benefits from the policy —
 - A. the gatekeeper, usually a Medical Doctor, makes the decision.
 - B. the Claims Committee of the insurance company must make that decision.
 - C. the insured must be admitted to a nursing home.
 - D. the coverage triggers are activated.
 4. An issuer of qualified long-term care contracts is limited to
 - A. marketing only through securities-licensed agents.
 - B. considering only the activities of daily living listed in HIPAA regulations (& IRS Code).
 - C. marketing only a set number of LTCI policies in each nursing home.
 - D. A+ or higher Best's rated companies.
 5. 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 is the definition of
 - A. cognitive impairment.
 - B. mental illness.
 - C. short-term reasoning deficiency.
 - D. old age.
 6. A period of time during which no benefits are paid immediately after the insured is qualified to receive long-term care, is called
 - A. the benefit period.
 - B. the elimination period.
 - C. the nonforfeiture period.
 - D. reserve time.
 7. Care related periods are
 - A. the benefit periods for different types of care.
 - B. different elimination periods for different types of care.
 - C. dictated by the state and usually is broken down by age.
 - D. no longer accepted in LTCI policies.

8. In a discussion about benefit periods, the best choice is probably
- A. the shortest period the insured can realistically afford.
 - B. the longest period the insured can realistically afford.
 - C. to equal the benefit and the elimination periods.
 - D. to let the agent pick the period.
9. " An insurer that offers a long-term care insurance policy, certificate, or rider in this state must offer a protection provision providing reduced paid-up insurance, extended term, shortened benefit period, or any other benefits approved by the office if all or part of a premium is not paid." This describes the regulation regarding
- A. nonforfeiture benefits.
 - B. non-confined benefit.
 - C. the long-term care benefits of an Universal Life Insurance policy.
 - D. cancellation of an LTCI policy.
10. What are the various levels of care addressed in a LTCI policy?
- A. poor, mediocre and professional.
 - B. institutionalized, home care and alternate-care.
 - C. immediate, delayed and end-of-period.
 - D. custodial, intermediate and skilled nursing care

ANSWERS TO STUDY QUESTIONS

1B 2C 3D 4B 5A 6B 7B 8B 9A 10D



CHAPTER IV – OUTLINE OF COVERAGE

Standard Format Outline of Coverage

(In some states, this provision is called the OOB (Outline of Benefits)). This section of the regulation implements, interprets and makes specific provisions in prescribing a standard format and the content of an Outline of Coverage.⁷²

- ✓ The Outline of Coverage shall be a free-standing document, using no smaller than ten point type.
- ✓ The Outline of Coverage shall contain no material of an advertising nature.
- ✓ Text which is capitalized or underscored in the standard format Outline of Coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.
- ✓ Use of the text and sequence of text of the standard format Outline of Coverage is mandatory, unless otherwise specifically indicated.

Format for Outline of Coverage:

FEDERAL TAX CONSEQUENCES.

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

OR

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

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

(a) [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable shall contain the following statement:]
RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of

your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

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

(b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

(c) [Describe waiver of premium provisions or state that there are not such provisions.]

TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

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

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

(a) [Provide a brief description of the right to return—“free look” provision of the policy.]

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

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

If you are eligible for Medicare, review the Medicare Supplement Buyer’s Guide available from the insurance company.

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

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

LONG-TERM CARE COVERAGE.

Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home. This policy provides coverage in the form of a fixed

dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductibles, waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Non-institutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment must be used to measure an insured's need for long-term care and must be defined and described as part of the Outline of Coverage.] [Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities and provider;

(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions and exceptions;

(e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 6 above.]

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

RELATIONSHIP OF COST OF CARE AND BENEFITS.

Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time;

- (b) Any automatic benefit adjustment provisions;
- (c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;
- (d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;
- (e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

PREMIUM.

- [(a) State the total annual premium for the policy;
- (b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

ADDITIONAL FEATURES.

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

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

NOTE: The temptation may be to skim lightly over this "form," however, one should be very familiar with this form if for no other reason than the OOC provides an abbreviated study of the most important points of a Long Term Care Insurance policy.

STUDY QUESTIONS

1. The Outline of Coverage must
 - A. be a free-standing document.
 - B. be part of the policy provisions.
 - C. appear on the Declaration Page of the policy.
 - D. be in 8-point type.

2. The Outline of Coverage (OOC) states that the policy is
 - A. only a non-tax-qualified policy.
 - B. only a tax-qualified policy.
 - C. neither a tax-qualified or non-tax-qualified policy
 - D. either a tax-qualified or non-tax-qualified policy.

3. The OOC also states
 - A. the policy may be considered as a Medicare Supplement policy.
 - B. that there is a “free look” provision and briefly describes such provision.
 - C. the insurance company may not change the premiums under any circumstances.
 - D. there is no refund in case of death or lapse.

4. The OOC states “Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services,
 - A. provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.”
 - B. that is provided only in a skilled nursing facility.”
 - C. excluding services provided in a skilled nursing facility.”
 - D. performed only in the home.”

5. The OOC states that
 - A. “ THIS POLICY WILL COVER ALL YOUR LONG-TERM CARE EXPENSES.”
 - B. “THIS POLICY IS NOT DESIGNED TO COVER ANY EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.”
 - C. “THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.”
 - D. “THERE ARE NO COMMISSIONS PAID TO THE AGENT ON THIS POLICY.”

6. In respect to the Inflation Rider or Provision, the OOC
- A. totally ignores the possibility of benefits being reduced because of inflation.
 - B. informs the policyholder of the dangers of inflation on the benefits and specifies what action is taken and to what degree.
 - C. states that the premium will always be adjusted to reflect a 5% compounded increase in daily benefits.
 - D. refers the applicant/policyholder to the company legal counsel for discussion and clarification of impact of inflation on benefits.
7. The OOC
- A. totally ignores Alzheimer's disease as benefits will not be paid for a policy holder that develops this disease.
 - B. specifies the total amount of premium only.
 - C. specified the total amount of premium and for options, the amount of premium used for each option.
 - D. states emphatically that under no circumstances will Medical underwriting be used.

ANSWERS TO STUDY QUESTIONS

1A 2D 3B 4A 5C 6B 7C



CHAPTER V - MARKETING AND REPLACEMENTS

MARKETING STANDARDS

Delaware, as are all other states, are concerned about the proper marketing of Long Term Care Insurance, if for no other reason than the primary constituency interested in such coverage are the senior citizens. LTCI is a complicated product to the average citizen and it follows that the elderly consumers must require specific attention and care. Therefore, specific marketing standard are established and strictly enforced.



Delaware regulations state: “No agent is authorized to market, sell, solicit or otherwise contact any person for the purpose of marketing long-term care insurance unless the agent has demonstrated his or her knowledge of long-term care insurance and the appropriateness of such insurance by passing a test required by this state and maintaining appropriate licenses.”⁷³

Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall.⁷⁴

- ✓ Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.
- ✓ Establish marketing procedures to assure excessive insurance is not sold or issued.
- ✓ Display prominently by type, stamp or other appropriate means, on the first page of the Outline of Coverage and policy, the following: "Notice to Buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."
- ✓ Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance.

Every insurer or entity marketing long-term care insurance must establish auditable procedures for verifying compliance with this section.⁷⁵

If the state of Delaware is the state in which the policy or certificate is delivered or issued for delivery, the insurer must, at solicitation, provide written notice to the prospective policyholder or certificate holder that the *Elderinfo* Program, a senior counseling program approved by the Commissioner, is available and the name, address and telephone number of the *Elderinfo* Program.^{74A} (302) 674-7364 or 1-800-336-9500—841 Silver Lakes Blvd., Dover, DE 19904)

In addition to the practices prohibited in Unfair Trade Practices,^{76A} the following acts and practices are prohibited⁷⁶:

Twisting

Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer.

High Pressure Tactics

Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

Cold lead advertising

Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

Advertising

Prior to use, every insurer, health care service plan or other entity providing long-term care insurance in this State must provide a copy of any long-term care insurance advertisement intended for use in this State whether through written, radio or television medium to the Insurance Commissioner of the State Delaware for review and approval by the Commissioner.

DIRECT RESPONSE SOLICITATIONS

Delaware regulations address direct response solicitations in their regulations as follows:

In the case of direct response solicitations, the Outline of Coverage must be presented in conjunction with any application or enrollment form.⁷⁷

“At the time of policy delivery, a policy summary must be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer must deliver the policy summary upon the applicant's request, but regardless of request must make delivery no later than at the time of policy delivery.”⁷⁸

Solicitations Other than Direct Response. Upon determining that a sale will involve replacement, an insurer; other than an insurer using direct response solicitation methods, or its agent; must furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage.⁷⁹

REPLACEMENTS WHEN DIRECT SOLICITATION IS USED

Insurers using direct response solicitation methods must deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner⁸⁰:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

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

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within (30) thirty days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy must be identified by the name of the insurer, name of the insured and policy number or address including zip code. Such notice must be made within five (5) working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.⁸¹

Life Insurance policies that accelerate benefits for long-term care must comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced

is a life insurance policy, the insurer must comply with the replacement requirements of Regulation 1204. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer must comply with both the long-term care and the life insurance replacement requirements.⁸²



COMMISSIONS

Permitted Compensation Arrangements

An insurer or other entity may provide commission or other compensation to an agent or other representative for the sale of a long-term care insurance policy or certificate which must not exceed thirty-five percent (35%) of the total premium paid for that policy year.

No entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than twenty-five percent (25%) of the total premium paid for that policy year for the sale of a replacement long-term care insurance policy or certificate.

For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration or any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.⁸³

Reporting Requirements

Every insurer must maintain records for each Delaware-licensed agent of that agent's amount of replacement sales as a percentage of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

Each insurer must report annually by June 30 the ten percent (10%) of its Delaware-licensed agents with the greatest percentages of lapses and replacements as measured by appropriate regulations.

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

Every entity providing long-term care insurance in this state must file annually as an attachment to its annual statement an exhibit that discloses the total number of long-term care insurance policies, by form number, in force in this state and the total number of policies, by form number, that have lapsed over the previous five years. Companies must provide in-force policy and lapsed policy information showing for each year the policy form has been sold, the number sold and the number lapsed in each of the following years.

Every insurer must report, annually by June 30 the number of replacement policies sold as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the preceding calendar year.

For purposes of this section, "policy" shall mean only long-term care insurance and "report" shall mean on a statewide basis.⁸⁴

Penalties

In addition to any other penalties provided by the laws of this state, any insurer and any agent found to violate any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to \$10,000, whichever is greater.⁸⁵

Note that this is a very severe penalty as basically it establishes a minimum penalty of \$10,000. The intent of this Section was to authorize separate fines for both the insurer and the producer in these amounts.

The intention of this section of the regulation is to authorize separate fines for both the insurer and the producer in the amounts suggested above.

SUITABILITY

The following regulations do not apply to life insurance policies that accelerate benefits for long-term care.⁸⁶ (*Also see Suitability letter in APPENDIX B*)

Every insurer, health care service plan or other entity marketing long-term care insurance (“insurer”) shall:

- ✓ Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;
- ✓ Train its agents in the use of its suitability standards; and
- ✓ Maintain a copy of its suitability standards and make them available for inspection upon request by the Commissioner.

Procedures Required-Producers Personal Worksheet.

To determine whether the applicant meets the standards developed by the insurer, the agent and insurer must develop procedures that take the following into consideration:

- ✓ The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
- ✓ The applicant’s goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and
- ✓ The values, benefits and costs of the applicant’s existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

The insurer, and where an agent is involved, the agent must make reasonable efforts to obtain the information required. The efforts must include presentation to the applicant, at or prior to application, the “Long-Term Care Insurance Personal Worksheet.” The personal worksheet used by the issuer must contain, at a minimum, the information in the format contained in Appendix B, in

not less than twelve (12) point type. The insurer may request the applicant to provide additional information to comply with its suitability standards. A copy of the insurer's personal worksheet must be filed with the Commissioner.

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

The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet in **Appendix B** is prohibited.

The insurer must use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

Agents must use the suitability standards developed by the insurer in marketing long-term care insurance.

At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in **Appendix C**, in not less than twelve (12) point type.

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

The insurer must report annually to the Commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.⁸⁷

NAIC LONG TERM CARE INSURANCE SHOPPER'S GUIDE

A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or one developed or approved by the Commissioner, must be provided to all prospective applicants of a long-term care insurance policy or certificate.

In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.⁸⁸

Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but must furnish the policy summary required under Delaware regulation.

REPLACEMENTS

Prohibition Against Pre-Existing Conditions and Probationary Periods in Replacement Policies or Certificates

If a long-term care insurance policy or certificate replaces another long-term care insurance policy or certificate, the replacing insurer must waive any time periods applicable to pre-existing conditions and probationary periods in the new long-term care insurance policy or certificate to the extent that similar exclusions have been satisfied under the original policy.⁸⁹

Life Insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements (of Regulation 1204). If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.⁹⁰

Requirements for Replacement

Application forms must include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and the agent, except where the coverage is sold without an agent, containing such questions may be used. With regard to a replacement policy issued to a group, the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced; provided, however, that the certificate holder has been notified of the replacement.⁹¹

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

Agents must list any other health insurance policies they have sold to the applicant.

- ✓ List policies sold which are still in force.
- ✓ List policies sold in the last five (5) years which are no longer in force.

Solicitations Other than Direct Response

Upon determining that a sale will involve replacement, an insurer; other than an insurer using direct response solicitation methods, or its agent; must furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice must be retained by the applicant and an additional copy signed by the applicant must be retained by the insurer. The required notice must be provided in the following manner:

APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

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

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]: (Use additional sheets, as necessary).

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

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

2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions or probationary periods.

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

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny and future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

Dated and signed by the Agent

Dated and signed by the Applicant

NOTE: For Direct Solicitation replacement, please refer to Section on Direct Solicitation.

REPORTING REQUIREMENTS FOR LAPSES

Every insurer must maintain records for each Delaware-licensed agent of that agent's amount of replacement sales as a percentage of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

Each insurer shall report annually by June 30 the ten percent (10%) of its Delaware-licensed agents with the greatest percentages of lapses and replacement.

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

Every entity providing long-term care insurance in this state shall file annually as an attachment to its annual statement an exhibit that discloses the total number of long-term care insurance policies, by form number, in force in this state and the total number of policies, by form number, that have lapsed over the previous five years. Companies must provide in-force policy and lapsed policy information in a format that indicates the number sold and number lapsed for each year of sales for the period of time since that policy was introduced. Every insurer shall report, annually by June 30 the number of replacement policies sold as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the preceding calendar year. And for purposes of these regulations, "policy" shall mean only long-term care insurance and "report" shall mean on a statewide basis.⁹²

STUDY QUESTIONS

1. No agent is authorized to market, sell, solicit or otherwise contact any person for the purpose of marketing long-term care insurance unless the agent has demonstrated his or her knowledge of long-term care insurance and the appropriateness of such insurance
 - A. and posted a performance bond of \$100,000.
 - B. by passing a test required by this state and maintaining appropriate licenses.
 - C. as attested to by the President of the company which he represents.
 - D. and is a Chartered Life Underwriter (CLU) or comparative designation.

2. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer—this is called
 - A. legal replacement.
 - B. policy improvement.
 - C. twisting.
 - D. malfeasance.

3. Insurers using direct response solicitation methods must deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant
 - A. upon issuance of the policy
 - B. prior to initial contact.
 - C. during the initial contact.
 - D. at time of claim.

4. Every insurer, health care service plan or other entity marketing long-term care insurance (“insurer”) shall:
 - A. develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant
 - B. depend upon the character and integrity of the agent to determine if a plan is suitable for the applicant.
 - C. require all long-term care insurance agents to post a performance bond.
 - D. obtain a signed and notarized financial statement from an applicant prior to taking an application for long-term care insurance.

5. To determine whether the applicant meets the standards developed by the insurer, the agent and insurer must develop procedures that take the following into consideration:
 - A. the income of the application as shown on his last 3 income tax returns.
 - B. the ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage.
 - C. the audit results of the insurer-appointed auditor.
 - D. a warranty from a close relative that they would pay premiums if the insured should inadvertently lapse the policy.

6. If a long-term care insurance policy or certificate replaces another long-term care insurance policy or certificate, the replacing insurer must waive any time periods in the new long-term care insurance policy or certificate to the extent that similar exclusions have been satisfied under the original policy
 - A. in respect to suitability.
 - B. but is not required to waive any existing medical conditions.
 - C. applicable to pre-existing conditions and probationary periods.
 - D. but there shall be no commission paid on the replacement policy.

7. Requirements for replacement of an existing LTCI policy includes asking the applicant if
 - A. he has any long-term care insurance policies in force.
 - B. he agrees that the agent will not receive a commission on the new policy.
 - C. he understands that in most cases, he should keep the old policy and obtain a new policy as they have changed so much over the past few years.
 - D. he agrees to pay a rather substantial replacement fee in addition to the premium.

8. Each insurer shall report annually by June 30 the ten percent (10%) of its Delaware-licensed agents with the greatest percentages of lapses and replacement. These reports are for the purpose of
- A. reviewing more closely agent activities regarding the sale of long-term care insurance.
 - B. policy taxes.
 - C. distributing to all insurers the names and address of those who have replaced their policies in order to encourage more sales.
 - D. alerting Medicaid of possible conflict of interests.

ANSWERS TO STUDY QUESTIONS

1B 2C 3A 4A 5B 6C 7A 8A



CHAPTER VI - - POLICY DETAILS

BENEFIT PERIODS

DEFINITION AND AVAILABILITY

The benefit period, or length of time for which an LTC Insurance policy pays benefits, is another significant factor in the cost of a policy — the longer the period, the greater the premium, assuming everything else is the same. Some LTCI policies offer benefit periods ranging from as little as one year to ten years or more and as long as a lifetime. Not all options are available from all insurers. A single insurer might offer more than one type of LTC Insurance policy, in which case the benefit periods available might differ for each policy type.

As a general rule, the periods are 1, 2, 3, 4, 5 years, and Lifetime. Those policies using the “Pool” concept express their benefit periods as the total amount that can be accumulated in the “Pool.” However, they usually also offer a lifetime policy, in which case there is no actual Benefit Period — the policy pays the costs of the longer-term care up to the Daily Benefit chosen. These policies, obviously, are quite expensive.

A lifetime benefit period might be referred to as "unlimited" or "unlimited lifetime" coverage.

In determining the “proper” or “recommended” benefit period, one statistic to keep in mind is that nearly 90% of all people over age 65 who enter a nursing home stay less than 5 years. Presently the average length of time for current residents is 2 ½ years. Therefore it would seem to be reasonable to purchase a 3 or 4 year benefit period, preferably a 4 year policy, as that way, if nursing home care is needed for a longer time, 4 years should give the insured and family time to prepare for the financial demands of a longer stay. Still, it must be kept in mind that people are living longer so by the time that the insured would need to be admitted to a nursing home, the time that they will stay there will have increased on the average — therefore the 4 years is preferable to the 3 year.

With the Partnership Program, the big factor is usually the maximum benefit amount as that is the amount that the policyholder can protect from Medicaid if he should happen to be in a situation where he needs to qualify for Medicaid.

BENEFITS RELATED TO TYPE OF CARE

Certain insurers whose policies cover nursing home care plus other types of care have different benefit periods for different care settings. For example, the insured may choose up to five years for nursing home care and two years for home health care. Some insurers establish the number of years themselves; others allow the insured to select different periods for each coverage desired. At least one policy currently differentiates the type of care received in a nursing home, with benefits paid for two, three or four years for skilled and intermediate care, but for only 60 days when care is custodial.

BENEFITS RELATED TO AGE

Other companies offer different benefit period options based on the insured's age at the time of purchase. For example, one insurer offers people age 45 to 79, periods of two, four or six years or lifetime coverage, while people who are 80 to 84 may select only one - or two-year benefit periods.

CONCERNS ABOUT BENEFIT PERIOD SELECTION

Be cautious about policies that define their benefit periods as a *one-time maximum period*. This means the insured can receive policy benefits only one time. For example, suppose the benefit period is three years. An insured receives benefits for one year, and then recovers. If that insured should need long-term care again at a later date, there is no coverage even though it would appear two more years worth of benefits are available. Most policies, on the other hand, pay for another round of long-term care. Many policies have a restoration of benefits feature that assures benefits are available for future needs.

What is the best benefit period? Considering all of the variables that affect any given person's situation, the question is difficult to answer. Advocates often suggest three or four years to get the best combination of affordability and adequate coverage time; others recommend a six year minimum. Still another suggests each individual select the longest period he or she can realistically afford. Most people who are confined to a nursing home need care for three months or less, yet the *average* nursing home stay is two and one-half years. And, the average is so long because of the few who will spend the rest of their lifetimes in a nursing home or receiving custodial care at home or elsewhere. In the end, for a healthy person, it's a gamble with nature. For those who can afford to pay for *some* period of LTC Insurance benefits, the shortest period available is probably better than none since the cost of one year of care currently ranges from \$30,000 to \$70,000+.

RESTORATION OF BENEFITS

Most policies do allow for restoration of benefits. The insured must be off-claim before benefits are restored for periods ranging from 180 days to 6 months as a rule, with most policies using the 180 days. Most policies have a maximum number of times that they can restore, usually twice.

The point to remember in discussing restoration of benefits is that the period before benefits are restored must be as indicated (180 days or 6 months usually) in the policy and the insured must have been treatment-free before the claim or the new claim is for a different cause completely. This can be best explained by example: The insured had a hip replacement and as a result, he was eligible for 45 days of benefits. Eight months later he reinjured his hip while working on a home project and went back into the hospital, with several weeks of physical therapy later. He filed for new benefits, however it was discovered that since his hip surgery he had been taking prescription anti-inflammatories for the pain in his hip. Therefore he did not qualify for restoration of benefits as he had continued his treatment for the previous injury.

It helps to remember that this provision is required in many states because it was devised to protect elderly insurers who may have forgotten to pay the premium on time. The insured is still required to pay any back premiums if premiums are in default.

UNINTENTIONAL LAPSE

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

Notice before lapse or termination

No individual long-term care policy or certificate will be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation must not constitute acceptance of any liability on the third party for services provided to the insured.

The form used for the written designation must provide space clearly designated for listing at least one person. The designation must include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver must state:

"Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

The insurer must notify the insured of the right to change this written designation, no less often than once every two (2) years.

When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements need not be met until sixty (60) days after the policyholder or certificate holder is no longer on such a payment plan. The application or enrollment form for such policies or certificates must clearly indicate the payment plan selected by the applicant.

LAPSE OR TERMINATION FOR NONPAYMENT OF PREMIUM

No individual long-term care policy or certificate must lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons so designated at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice must be given by first class United States mail, postage prepaid; and notice may not be given until thirty (30) days after a premium is due and unpaid. Notice must be deemed to have been given as of five (5) days after the date of mailing.

REINSTATEMENT

In addition to these requirements, a long-term care insurance policy or certificate must include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that **the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired.** This option

will be available to the insured if requested within five (5) months after termination and will allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity may not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

Evidence of insurability will not be required; however the insured must pay all back premiums from the date of default and may be required to provide supporting documentation as to their physical or mental conditions at time of lapse.

PREEXISTING CONDITIONS

Long-term care policies frequently include a limitation on the payment of benefits for pre-existing conditions—medical conditions the insured was treated for or knew about before the effective date of the policy. In some policies, a separate provision addresses pre-existing conditions; in others, they are treated as an exclusion. This topic will be discussed separately from exclusions since pre-existing conditions, though often excluded from early coverage, are usually covered after some period of time. Pre-existing conditions, then, more accurately represent a situation that is subject to a policy limitation rather than a complete exclusion.

Delaware regulations state:

“No long-term care insurance policy or certificate, other than a policy or certificate thereunder issued to a group (as defined in the regulations), must use a definition of "preexisting condition" which is more restrictive than the following: ‘Preexisting condition’ must mean 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.”⁹³

No long-term care insurance policy or certificate, other than a policy or certificate thereunder issued to a group shall 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. These requirements are commonly known as the 6/6 month rule.

The Insurance Commissioner has the authority to may extend these limitation periods 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" shall 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 standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether or not it is disclosed on the application, need not be covered until the waiting period expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period.

The point is that any given policy states the precise length of time that the insurer looks back into the insured's past medical history to decide what constitutes a pre-existing condition. If the

time period is six months, then, a condition for which the insured was treated one year ago and not since that time would *not* be a pre-existing condition.

Whatever the period stipulated, if the insured needs long-term care because of any condition that meets the policy's exclusion definition, the insurer will *not* pay benefits. One must be aware that *taking medication* qualifies as "treatment." Typically, policies will eventually pay benefits even for a pre-existing condition after the policy has been in force for a specified period.

The pre-existing conditions are different with tax-qualified plans as they provide that as long as the applicant was fully candid and provided the insurer all details regarding a particular medical problem, including the names of all attending physicians and consulted physicians and all medication in respect to such problem, then once the policy is issued, any disability related to that medical problem would be covered (subject, of course, to the terms of the policy and conditions and waiting period).

Limitations

If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and must be labeled as "Preexisting Condition Limitations."⁹⁴

CONDITIONS USUALLY TRIGGERING BENEFIT PAYMENTS

The conditions that generally trigger the need for long-term care are basically:

- Dementia.
- Diabetes mellitus.
- Fractures.
- Chronic obstructive pulmonary disorder.
- Hypertension.
- Stroke, cerebrovascular accident (CVA).
- Bone or joint disease.
- Cancer.
- Atrial fibrillation, arrhythmia.

Having any of these conditions does not automatically exclude the applicant from LTCI coverage, with a couple of exceptions as noted. But regardless, they are the ones that are the most carefully scrutinized by the underwriters.

Dementia – Forget about it (or as they say in NY, “Foggedabowdit”). If the person has it, they cannot get LTCI as there is no recovery as far as underwriters are concerned.

Diabetes mellitus is different. Juvenile diabetes causes problems, particular if they are seniors with this disease for many years. Adult diabetes can be controlled by diet and/or medication, and underwriters can assess the results better. Of course they are looking for such things as loss of a limb or an eye, kidney disease, neuropathy, hypertension, etc. Many insurers will offer policies to those with diabetes that have it well under control with insulin without complication for some period of time. If the applicant is diabetic, then a good agent will ask about a specific list of complications, instead of just accepting “I’m doing just fine” as a response.

Emphysema or *chronic pulmonary disorders* are rarely insurable. Obviously, if one has a hard time just breathing, they will also have a hard time taking care of themselves. They may

look at the insured's use of tobacco and estimate the use of oxygen, but usually, it is just turned down.

High blood pressure (hypertension) if uncontrolled, can lead to a stroke so it is of concern to underwriters. Medication available today will generally keep it under control, so they may be insurable. If they have ever had a stroke, even a little, teeny, one, they are uninsurable with most insurers.

Fractures, if they are the result of dizziness or falling, or because of osteoporosis, they are of interest to the underwriters. Underwriters may link the fall or dizziness with osteoporosis and if there is a history of falling, they may be declined. Seniors are notorious for losing their balance and falling, with catastrophic results sometimes. Many times those bones don't heal like they used to, therefore there must be nursing home or other type of care, so the underwriters get nervous when they see a history of falling.

Bone diseases and joint diseases send up a red flag for the possibility of arthritis or osteoporosis, either of which can cause fractures. Also, if the person is on prednisone, which is used to treat rheumatoid arthritis, it can cause bone damage if taken in large doses—another underwriting problem.

Cancer covers such a broad spectrum that there is no one hard-and-fast rule. If a person has had cancer at least two years earlier (some companies require a longer period) and is free of treatment for this period of time and the cancer did not spread to other organs, some insurers will approve a policy. If the cancer had affected the lymph nodes, then there could be a 10 year waiting period – which pretty well serves as a decline for the older applicants.

Atrial fibrillation, arrhythmia, irregularities in the heart beat increases the risk of stroke by six times. Certain medications can help the heart work more efficiently, along with anticoagulants such as Coumadin, can reduce the possibility of a stroke by 60%, leaving 40%—therefore underwriters look very closely at those with these conditions.

UNDERWRITING

Several years ago some insurers, in an effort to increase their market share, would accept applicants with health problems that other insurers would decline. Then, at time of claim the claim would be severely investigated in an attempt to deny the claim. This was, of course, unethical, and soon became illegal. Suffice it to say that the companies that were noted (notorious) for post-claims underwriting are no longer in existence. States approached this problem with severe restrictions and Delaware is no exception.

As with any insurance product, underwriting is essential to the ability to insure against specified risks or risk categories. Delaware regulations⁹⁵ state:

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

If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

If the medications listed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate must not be rescinded for that condition.

(Except for policies or certificates which are guaranteed issue:)

The following language must be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate: Caution: If your answers on this application are incorrect or untrue [company] has the right to deny benefits or rescind your policy.⁹⁶

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

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

REQUIREMENTS FOR APPLICANT AGE 80 OR OLDER

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

1. A report of a physical examination,
2. An assessment of functional capacity,
3. An attending physician's statement, or
4. Copies of medical records.⁹⁷

A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.⁹⁸

Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated and shall annually furnish this information to the Insurance Commissioner in the form prescribed by the National Association of Insurance Commissioners.⁹⁹

WHAT IS NOT COVERED – EXCLUSIONS

All policies list certain conditions or circumstances that could lead to long-term care, but for which the policy will not pay benefits. Delaware regulations state:

Limitations and Exclusions. No policy may be delivered or issued for delivery in this state as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows¹⁰⁰:

- ✓ Preexisting conditions;
- ✓ Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;
- ✓ Alcoholism and drug addiction;
- ✓ Illness, treatment or medical condition arising out of:
- ✓ War or act of war (whether declared or undeclared);
- ✓ Participation in a felony, riot or insurrection;
- ✓ Service in the armed forces or units auxiliary thereto;
- ✓ Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or
- ✓ Aviation (this exclusion applies only to non-fare-paying passengers).
- ✓ Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.
- ✓ No territorial limitations are permissible, except that nothing herein shall preclude limiting benefits for specific services to a specific dollar amount, or to that dollar amount which is reasonable and prevailing in a particular geographic area which is defined and clearly delineated in the original offering or solicitation and the initial policy or certificate, or to specific providers within a particular geographic area. Moreover, nothing herein shall prohibit the limitation of services to a particular geographic area when the insured elects to receive services within that specific geographical area. For purposes of this clause, the location of receipt of services must be within 50 miles of the domicile of the insured at the time of entry therein or that area, including the nearest three nursing homes, whichever distance is greater.
- ✓ Expenses for services or items available or paid under another long-term care insurance or health insurance policy.

- ✓ In the case of a qualified long-term care insurance contract expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.
- ✓ This section (6.2) is not intended to prohibit exclusions and limitations by type of provider.

SPOUSAL DISCOUNT

If both the insured and spouse apply for a Long Term Care Insurance policy at the same time with the insurer, and are both approved for coverage, the insured will receive a premium discount on both policies, usually 10-15%. In order for this to apply, the insurer usually requires that the same policy form is issued for both. Some companies may still give spousal credit if one of the spouses is declined, although this is generally not allowed. At one time in the past, when a company would allow the discount if one party was declined, some agents would take applications on both spouses knowing full-well that one would be declined, but the insurable spouse would receive the spousal discount—which might reduce the premium enough so that a sale could be made.

EXTENSION OF BENEFITS

Termination of long-term care insurance must be without prejudice to any benefits payable for institutionalization which began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy¹⁰¹.

RENEWABILITY

LTCI policies sold today are guaranteed renewable, which means as long as the insured pays the premiums the insurer may neither refuse to renew nor cancel the policy, regardless of the insured's health. In addition, the premium for a guaranteed renewable policy may be increased only if the insurance company raises premiums for every other policy of the same type sold to the same group of people. In other words, no single policy may be assessed a premium increase based on an individual insured's experience. However, if everyone in a certain geographical area or of a certain age group holding the same type of policy receives a rate increase, this is permissible. As for age, a guaranteed renewable policy prohibits insurers from increasing premiums solely because a specific insured is growing older. Each policy should clearly spell out the conditions under which an increase may occur. Insurers often guarantee the starting rate for some period, three or five years for example, regardless of external circumstances that might otherwise increase rates for all policyholders.



Premium Increases : The premiums charged to an insured for long-term care insurance shall not increase due to either:(1) The increasing age of the insured at ages beyond sixty-five (65); or(2) The duration the insured has been covered under the policy.¹⁰²

The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without providing further explanatory language in accordance with the disclosure requirements of this regulation which states: "Individual long-term care insurance policies must contain a renewability provision consistent herewith. Such provision must be appropriately captioned, must appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed, subject to section 6.1 hereof. This provision shall not apply to policies which do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder."¹⁰³



No long Term Care Insurance policy may be cancelled, non-renewed or otherwise terminated on the grounds of age or the deterioration of the mental or physical health of the insured individual or certificate holder.¹⁰⁴

No such policy issued to an individual shall contain renewal provisions less favorable to the insured than "**guaranteed renewable**." However, the Commissioner may authorize nonrenewal on a statewide basis, on terms and conditions deemed necessary by the Commissioner, to best protect the interests of the insureds, if the insurer demonstrates that renewal will jeopardize the insurer's solvency.¹⁰⁵

The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums, during which period the insurer has no unilateral right to make any change in any provision of the policy or rider, and cannot decline to renew and cannot revise rates except on a class basis in accordance with the regulations . This cost disclosure must be approved by the Commissioner and included in any solicitation and also prominently displayed on the initial policy.¹⁰⁶

Every long-term care insurance policy or certificate issued or delivered in this State must be "guaranteed renewable" as defined in the regulations.¹⁰⁷

PAYMENT OF BENEFITS

A long-term care insurance policy which provides for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", "reasonable and prevailing", or words of similar import shall include a definition of such terms and an explanation of such terms in its Outline of Coverage.

COST DISCLOSURE INFORMATION

The following cost disclosure information must appear in bold print on the cover page of every certificate and Outline of Coverage issued or delivered in this state: "**This policy provides only the following price protection, and no more. Your premiums are guaranteed to remain the same for the first three (3) years this policy is in force. Your premiums may not increase by more than X% during any three year rating period. Insurers will be allowed a carry forward of the initially disclosed maximum premium increase, but said carry forward is lost within twenty-four (24) months if not utilized.**" Any additional language that appears under the cost disclosure section must be approved in advance by the Delaware Insurance Department.¹⁰⁹

The purpose of this cost disclosure section is twofold: first, to make crystal clear to the purchaser what the maximum cost will be from year to year, and second, to prohibit the practice of low pricing during the early years of a policy followed by dramatic increases designed to produce a high ratio of cancellations when the group insured reaches that age at which its members are more likely to file claims. Therefore, this section does not permit annual increases to be accumulated and applied all at once. For example, if the price is \$100 in the initial year of the policy and 10% is the represented annual maximum increase, then during the second year of the policy, the maximum allowable price is \$110, the third year of the policy the maximum allowable price is not more than 110% of the price actually charges during year two of the policy. It is not permissible to charge \$121 during the third year of the policy unless \$110 had actually been charged during year two of the policy. In other words, any permitted annual price increase not implemented during a calendar year is thereafter waived and may not be considered in calculating future prices.

In addition to other requirements of this subsection, a **tax-qualified long-term care insurance contract must be guaranteed renewable.**¹¹⁰

Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed below to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this section to the applicant no later than at the time of delivery of the policy or certificate.¹¹¹

- a) A statement that the policy may be subject to rate increases in the future;
- b) An explanation of potential future premium rate revisions, and the policyholder's or certificate holder's option in the event of a premium rate revision;
- c) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;
- d) A general explanation for applying premium rate or rate schedule adjustments that shall include:

1. A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and
2. The right to a revised premium rate or rate schedule if the premium rate or rate schedule is changed.

Premium Rate Increase Information

Information regarding each premium rate increase on this policy form or similar policy forms over the past ten (10) years for this state or any other state that, at a minimum, identifies¹¹²:

1. The policy forms for which premium rates have been increased;
2. The calendar years when the form was available for purchase; and
3. The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

An insurer must have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this section or the end of a twenty-four-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company must include the disclosure of that rate increase in accordance with these regulations.

If the acquiring insurer files for a subsequent rate increase, even within the twenty-four-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers the acquiring insurer must make all disclosures required, including disclosure of the earlier rate increase.

An applicant must sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant must sign no later than at the time of delivery of the policy or certificate.¹¹³

An insurer must use the forms in Appendices B and F to comply with the requirements of these regulations.¹¹⁴

An insurer must provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, if applicable, at least forty-five (45) days prior to the implementation of the premium rate schedule increase by the insurer. The notice must include the information required when the rate increase is implemented.¹¹⁵

Loss Ratio

Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%) for individual policies and at least sixty-five percent (65%) for group policies, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

- ✓ 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.¹¹⁶

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

The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

1. The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements;
2. The policy meets the disclosure requirements;
3. Any policy illustration that meets the applicable requirements of the Delaware Insurance Department Regulation 1210; and
4. An actuarial memorandum is filed with the insurance department that includes:
 - a. A description of the basis on which the long-term care rates were determined;

- b. A description of the basis for the reserves;
- c. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
- d. A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;
- e. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
- f. The estimated average annual premium per policy and the average issue age;
- g. A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
- h. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.¹¹⁷

RIDERS AND ENDORSEMENTS

Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy must require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge must be set forth in the policy, rider or endorsement.¹¹⁸

OTHER LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

A long-term care insurance policy or certificate containing any limitations or conditions for eligibility, except in accordance with other regulations, must set forth a description of such limitations or conditions, including any required number of days or confinement, in a separate para-

graph of the policy or certificate and must label such paragraph "Limitations or Conditions of Eligibility for Benefits."¹¹⁹

GRACE PERIOD



A long-term care policy provides that the insured is entitled to a grace period of not less than 30 days, within which payment of any premium after the first may be made.

The insurer may require payment of an interest charge (usually not in excess of 8 percent per year) for the number of days elapsing before the payment of the premium, during which period the policy must continue in force. If the policy becomes a claim during the grace period before the overdue premium is paid, the amount of such premium or premiums with interest may be deducted in any settlement under the policy.

A long-term care policy can not be canceled for nonpayment of premium unless, after expiration of the grace period, and at least 30 days prior to the effective date of such cancellation, the insurer has mailed a notification of possible lapse in coverage to the policyholder and to a specified secondary addressee if such addressee has been designated in writing by name and address by the policyholder.

NOTICE OF CANCELLATION

If a policy is canceled due to nonpayment of premium, the policyholder must be entitled to have the policy reinstated if, within a period of not less than **5 months** after the date of cancellation, the policyholder or any secondary addressee designated demonstrates that the failure to pay the premium when due was **unintentional and due to the cognitive impairment or loss of functional capacity of the policyholder**.

Policy reinstatement shall be subject to payment of overdue premiums. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria for cognitive impairment or the loss of functional capacity, if any, contained in the policy and certificate.

The insurer may require payment of an interest charge not in excess of 8 percent per year for the number of days elapsing before the payment of the premium, during which period the policy shall continue in force if the demonstration of cognitive impairment is made. If the policy becomes a claim during the 180-day period before the overdue premium is paid, the amount of the premium or premiums with interest generally not in excess of 8 percent per year) may be deducted in any settlement under the policy.

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

REINSTATEMENT

If a policy is canceled due to nonpayment of premium, the policyholder shall be entitled to have the policy reinstated if, within a period of *not less than 5 months after the date of cancellation*, the policyholder or any secondary addressee demonstrates that the failure to pay the premium when due was **unintentional and due to the cognitive impairment or loss of functional capacity of the policyholder**.

WHAT AGES OF APPLICANTS ARE ACCEPTED?

Today's LTCI policies are offered to people as young as 18 or 20, or sometimes no minimum age. In practice, most policies are offered to people from age 50 to age 84, though many are now offered to people in their 40's with employer-sponsored or group LTCI. Even insurers who will write LTCI policies for younger people usually direct most of their marketing efforts to people who are older than 50 because younger people generally show less interest. Some agents and insurers may have a different philosophy and choose to actively solicit the younger business. Employer-sponsored or, group LTC Insurance is an exception; as younger age groups are targeted.

There are some policies designed to appeal to much older people and written with special features designed to appeal to the quite elderly. For example, currently some insurers offer older seniors a policy with a premium guaranteed to remain level for the life of the contract. Another allows inflation increases to be applied for the insured's lifetime, rather than expiring at a specified age, such as 85. Insurers will no doubt continue to innovate based on marketing and claims experiences, resulting in new features to appeal to those people insurers particularly want to target.

FREE LOOK

An individual LTCI policyholder or group certificate holder or applicant thereof 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**. Regulations require that a notice to this effect be prominently displayed on the policy.¹²⁰

STUDY QUESTIONS

1. In determining the proper benefit period, one statistic to keep in mind is that
 - A. 94% of all people who enter a nursing home stay less than 10 years.
 - B. 90% of all people who enter a nursing home stay less than 5 years.
 - C. 90% of all people who enter a nursing home stay less than 6 months.
 - D. 90% of all people who enter a nursing home, never leave.

2. While most people that are confined to a nursing home need care for three months or less, the average stay is
 - A. one year.
 - B. 2 ½ years.
 - C. 3 years.
 - D. 5 years.

3. “Preexisting” condition must mean a condition for which medical advice or treatment was recommended by, or received from a provider of health care services,
 - A. within one year preceding the effective date of coverage of an insured person.
 - B. that created a period of at least 6 months of skilled nursing care.
 - C. within 6 months preceding the effective date of coverage of an insured person.
 - D. and such condition must not exceed medical costs of \$1,000.

4. One of the medical conditions that usually trigger benefit payments would be
 - A. dementia.
 - B. syphilis.
 - C. appendicitis.
 - D. pneumonia.

5. If the medications listed in an application for a LTCI policy were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied,
 - A. then the policy may be rescinded.
 - B. then the policy must be voided *ab initio*.
 - C. the policy cannot be rescinded for that condition.
 - D. the policy may not be rescinded but the premium may be increased proportionately to the risk.

6. The insurer must obtain a report of a physical examination, an assessment of functional capacity, an attending physician’s statement or copies of medical records in those situations where
 - A. the applicant is age 80 or older.
 - B. the applicant is under age 55.
 - C. the applicant is a person of prominence.
 - D. medical records indicate the applicant was formerly in a nursing home.

7. Typically, a Spousal Discount is offered when both spouses
 - A. apply for different daily benefits.
 - B. apply for different Long Term Care Insurance policies.
 - C. have poor medical histories.
 - D. apply for the same policy form with the same benefits at the same time with the same insurer and both are approved for coverage.

8. Premium increases in a Long Term Care Insurance policy charged to an insured shall not increase due to either (1) the increasing age of the insured at ages beyond 65; or (2)
- A. the increase in benefits requested by the insured.
 - B. approved purchase of the block of policies by another insurer.
 - C. with approval of the Department of insurance.
 - D. the duration the insured has been covered under the policy.
9. Every long-term care insurance policy or certificate issued or delivered in Delaware must be
- A. guaranteed renewable and noncancellable.
 - B. sold by an insurer whose home office is located in the state.
 - C. "guaranteed renewable" as defined in the regulations.
 - D. a "Partnership Plan" policy.
10. If a policy is canceled due to nonpayment of premium, the policyholder shall be entitled to have the policy reinstated if, within a period of *not less than 5 months after the date of cancellation*, the policyholder or any secondary addressee demonstrates that the failure to pay the premium when due was
- A. because of the financial condition of the policyholder.
 - B. unintentional and due to the cognitive impairment or loss of functional capacity of the policyholder.
 - C. because the policyholder simply forgot to pay the premium.
 - D. because of the insured applying to another insurer for coverage and being turned down.
11. An individual LTCI policyholder or group certificate holder or applicant thereof has the right to return the policy and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason,
- A. within 30 days after its delivery
 - B. within 5 months after delivery of the policy.
 - C. and a notarized statement as to the reason for the declination is sent to the insurer.
 - D. within a period of 6 months provided the agent approves.

ANSWERS TO STUDY QUESTIONS

1B 2B 3C 4A 5C 6A 7D 8D 9C 10B 11A



CHAPTER VII – INFLATION PROTECTION PROVISIONS

INFLATION PROTECTION

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

1. Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%). However, if the insured individual shall reject the inflation protection offer as provided for in this section, the insurer may offer other or alternate forms of inflation protection;
2. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extended until the year in which the offer is made; or
3. Covers a specific percentage of actual or reasonable charges and does not include a maximum specified indemnity amount of limit.

Where the policy is issued to a group, the required offer shall be made to the group policyholder; except, if the policy is issued to a group (defined in regulations), other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder.

This offer shall not be required of life insurance policies or riders containing accelerated long-term care benefits.¹²¹

The following information must be included in or with the Outline of Coverage:

- A graphic comparison of the benefit levels of a policy that increases benefits over the policy period and a policy that does not increase benefits, showing benefit levels over a period of at least 20 years.
- Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

- Inflation protection benefit increases under a policy which contains such benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.
- An offer of inflation protection which provides for automatic benefit increases must include an offer of a premium which the insurer expects to remain constant. Such offer must disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.¹²²

Rejection of Inflation Protection

Inflation protection as provided in the regulations must be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder.

The rejection must be considered part of the application and shall state:

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

The insurer may use a reasonable hypothetical or a graphic demonstration for the purposes of the disclosures.¹²³

LONG TERM CARE INFLATION PROTECTION STUDIES

Rather exhaustive studies conducted by AARP and others have revealed interesting data concerning the Inflation Protection in LTCI policies, and have put some old saws to rest, namely the concern by many agents that since the cost of this protection was relatively high, the insured would forgo more meaningful protection—such as a more realistic daily benefit—but this does not seem to be the case very often.

Some of their interesting findings are:

- About 40 percent of all new buyers purchase inflation riders.
- The probability of having an inflation rider decreases with age: 59 percent of purchasers under age 65 have a rider, whereas only 14 percent of individual over age 75 have one.
- Younger, married individuals with higher levels of income and assets are more likely to have inflation riders than are older, single policyholders with more modest levels of wealth.
- For the most part, individuals who purchase inflation riders are also more likely to have somewhat richer policy designs compared with those who do not purchase riders.

LONG-TERM CARE COSTS AND PROJECTED INCREASES

- Much uncertainty exists regarding the daily costs of long-term care. Claimant data suggest that in 1999, the average daily costs of care were \$123 for nursing home care (compared to \$194 today), \$90 for assisted living, and \$57 per home care visit.

- The inflation rate across all service settings has been declining over the past 15 years.
- Over the past ten years, institutional care costs have increased by 5.78 percent per year, whereas home health costs have increased by 4.37 percent.
- When the variation in price changes over the past ten years is accounted for, the range for annual inflation rates is 3.5 percent to 7.7 percent for institutional care and 2.4 percent to 6.3 percent for home care.
- Assuming a ten-year historical average increase in inflation, by the year 2010, institutional costs will increase by 86 percent and home health care costs by 60 percent.
- The average age at which policyholders access long-term care services is 82. Males typically use services at a somewhat younger age and also access home care at younger ages.

With these findings and various caveats, the survey concluded that



Given the historical trends in long-term care costs, the insurance policy designs that individuals purchase, and the projected trends in use of institutional, home, and community-based care services, a 5 percent compound inflation rider is likely adequate to finance the future long-term care costs of most policyholders: more than 80 percent of the costs of care will be covered by such policies.

However, this conclusion depends on the continued shift in service use away from nursing home care and toward assisted living and home and community-based alternatives. Even in the context of the rider, considerable cost exposure may remain for those entering nursing homes, whereas those using home and community-based care risk overinsurance. Finally, to the extent that individuals purchase initially low daily benefit amounts, even with an inflation rider, it will be difficult to “catch up” and minimize out-of-pocket expenses.

Individuals accessing home and community-based care as well as assisted living care will have the lowest out-of-pocket payments, whereas those entering nursing homes will have the highest--up to 30 percent of the daily costs of care. Even so, given historical increases in costs and the declining use of nursing home care, to purchase a higher rate inflation rider (higher than 5 percent), would result in significant overinsurance and would therefore be inefficient from a consumer welfare perspective.

The purchase of an inflation rider makes the most sense for young buyers. Even in periods characterized by modest rates of inflation, a 5 percent compound rider is warranted. Self-insuring for the inflation risk may make sense only for older purchasers (age 70 and over). The extent of risk aversion influences the perceived value of the rider and will therefore partially determine whether the rider is purchased. Although insurers can take a number of steps to help make the protection more affordable, risk pooling to cover future price increases is still the most efficient means to prepare for the contingency.

LIFE INSURANCE WITH LONG-TERM CARE BENEFITS

In recent years, life insurance policies have been introduced with long-term care benefits available under certain situations (spelled out in the policy), and wherein the insured can receive benefits if he meets the criteria, such amount and criteria varying by insurance. The benefits range from a monthly benefit to a lump sum benefit, and may equal the total amount of cash value at that time, or may be a function of the face amount.

Life insurance policies are used as viaticals in some situations, in which case the policyholder sells the policy benefits to a viatical company, who, then, owns the policy at the time of the death of the policyholder.

With the various types of benefits available, it was necessary to create certain regulations for these situations.

Delaware requires that at the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

- (1) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;
- (2) An illustration of the amount of benefits, the length of benefit and the guaranteed lifetime benefits, if any, for each covered person;
- (3) Any exclusions, reductions and limitations on benefits of long-term care; and
- (4) If applicable to the policy type, the summary must include a disclosure of the effects of exercising other rights under the policy, a disclosure of guarantee related to long-term care costs of insurance charges and current and projected maximum lifetime benefits.

Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report must be provided to the policyholder. Such report shall include:

- (1) Any long-term care benefits paid out during the month;
- (2) An explanation of any changes in the policy, e.g., death benefits or cash values, due to long-term care benefits being paid out; and
- (3) The amount of long-term care benefits existing or remaining.

Any policy or rider advertised, marketed or offered as long-term care or nursing home insurance shall comply with this chapter.¹²⁵

With regard to life insurance policies which provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This rule shall not apply to qualified long-term care insurance contracts.¹²⁶

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

STUDY QUESTIONS

1. In determining the “proper” or “recommended” benefit period, one statistic to keep in mind is
 - A. 67% of all LTCI policies never pay a cent in benefits.
 - B. that nearly 90% of all people over age 65 who enter a nursing home stay less than 5 years.
 - C. more people are admitted to long-term care facilities than die each year.
 - D. agents make more money off commissions than do real estate brokers.

2. No long Term Care Insurance policy may be cancelled, non-renewed or otherwise terminated
 - A. on the grounds of age or the deterioration of the mental or physical health of the insured individual or certificate holder.
 - B. on the grounds that there has not been proper or timely premium payments.
 - C. unless the agent has given written permission.
 - D. if the issuing insurer has its home office out of state.

3. Be cautious about policies that define their benefit periods as a *one-time maximum period* because
 - A. this is an open-ended policy so there is no limit on maximum benefits.
 - B. this means the insured can receive policy benefits only one time.
 - C. this means that they are always tax-qualified and so they are expensive.
 - D. that means that benefits will always be taxed as ordinary income.

4. 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, pertains to
 - A. a durable power of attorney trigger.
 - B. the incontestable clause.
 - C. minor ailments, such as the flu or a cold.
 - D. preexisting conditions in a policy.

5. War-related injuries, self-inflicted injuries, or injuries as a result of the commission of a crime, are
 - A. covered under the non-qualified LTCI policies.
 - B. specifically covered under the Partnership Program.
 - C. exclusions in an LTCI policy.
 - D. automatically forwarded to a special-risk pool.

6. A long-term care policy must provide that the insured is entitled to a grace period of
 - A. at least 90 days.
 - B. not less than 30 days
 - C. one week.
 - D. a period not less than 180 days.

7. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured, such person is referred to as the
 - A. Secondary Addressee.
 - B. Substitute Insured.
 - C. Obligee.
 - D. Trustee.

8. If a policy is canceled due to nonpayment of premium, the policyholder shall be entitled to have the policy reinstated if, within a period of not less than 5 months after the date of cancellation, the policyholder or any secondary addressee designated demonstrates that the failure to pay the premium when due was
 - A. failure of the Social Security check to arrive.
 - B. bankruptcy.
 - C. laziness.
 - D. unintentional and due to the cognitive impairment or loss of functional capacity of the policyholder.

9. An individual LTCI 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,
- A. the benefits were not what were represented only.
 - B. the policyholder is not satisfied for any reason.
 - C. it is obvious that there was some sort of age, sex or racial discrimination.
 - D. the agent makes a minimum of three personal calls to satisfy the reasons for non-acceptance.
10. Under Delaware regulations, inflation protection in an LTCI policy must be not less favorable than three specific requirements, one of which is
- A. a provision that increases benefits annually at a rate of not less than 5 percent, compounded annually
 - B. a provision that equals benefits to equal the Consumer Price Index.
 - C. a provision that increases benefits annually at a rate of not less than 5 percent annually.
 - D. the benefits must equal the highest benefit average among the top three insurers in that state that sell LTCI policies.

ANSWERS TO STUDY QUESTIONS

1B 2A 3B 4D 5C 6B 7A 8D 9B 10A



CHAPTER VIII - TAXATION OF LONG TERM CARE INSURANCE

LTCI TAX ADVANTAGES

The Federal Government and many state governments have provided tax advantages for those who purchase long-term care insurance. Some of the tax regulations are long, lengthy and almost incomprehensible. For purposes of this text, this information is kept as short and concise as possible.

This text does not have the capacity to present full tax information (on any subject) and it is not intended to be a taxation authority. Therefore, because there are many rules, exceptions and limitations, there can be occasions where a general rule or example may not apply to the situation at hand. Legal questions should always be fielded by lawyers or other legal authority. The quickest way to see if the Errors and Omissions insurance is worth the premium is for an agent to provide legal opinions based on a minimum of knowledge.

Besides, laws and regulations change frequently and are subject to differing interpretations. This text or the Continuing Education school does not provide any legal, accounting, or tax planning advice, and nothing herein should be construed as such. If expert advice is needed, then in all likelihood the services of a competent, licensed tax attorney or consultant should be obtained.

DISCLOSURE OF TAX CONSEQUENCES

Delaware regulations state: With regard to life insurance policies which provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This subsection shall not apply to qualified long-term care insurance contracts.¹²⁶

With regard to qualified long-term care insurance policies a disclosure statement shall appear in bold print on the face of the policy and Outline of Coverage indicating the policy is intended to be a qualified long-term care policy under IRS regulation.¹²⁷


TAX-QUALIFIED LONG-TERM CARE INSURANCE POLICIES

In 1996 Congress passed the Health Insurance Portability and Accountability Act (HIPAA) which provided, in part, the criteria for establishing tax-qualified long-term care insurance policies. Essentially, HIPAA provided that benefits paid under a long-term care insurance policy would not be taxable if the long-term care insurance policy met minimum eligibility criteria. As

a result of HIPAA, it is easy to tell which long-term care insurance policies are intended to be tax-qualified because there will be an identifying paragraph on the front page of the contract.

More detailed tax information follows, but at this point it is good to know the difference between a "(tax) qualified" and a "non-qualified" LTCI policy.

QUALIFIED LONG TERM CARE TAX INFORMATION

 **NOTE:** The tax information provided is an interpretation of federal guidelines. Clients should always consult with their financial advisor or a tax consultant regarding tax advantages.

TAX TREATMENT ON PER DIEM CONTRACTS

Qualified Long Term Care Insurance contracts, which provide benefits on a per diem basis (or other flat amount per fixed period) are treated somewhat differently for tax purposes than indemnity policies. The payment of premium by individuals and the tax treatment of the employer-provided coverage is subject to the same rules outlined with respect to indemnity policies. The tax-free receipt of benefits under a per diem policy is limited so that policyholders will be taxed on the amount of benefits which exceeds the greater of: \$260 (2007) per day, or the amount of long-term care expenses incurred by the insured.


Only benefits paid under a policy specifically to reimburse actual expenses are not subject to the cap. Thus, payments made on a daily, monthly, annual, or even a lump-sum basis will be periodic payments subject to the cap, unless limited by the policy to the actual expenses incurred by the insured.

Periodic payments are excluded from the insured's income up to a maximum of \$260 per day (\$94,900 per year). These caps will be indexed for inflation. If the periodic payments exceed the cap, the amount of benefits over the cap may be excluded from the income only to the extent the individual has incurred actual expense for long term care services. The excess payments will be included in income without regard to the individual's basis in the contract from the premium paid for coverage.

UPDATE TO GRANDFATHERED LONG TERM CARE POLICIES

The Treasury Department has released guidelines (Notice 97-31) which provide temporary IRS interpretations of what changes can be made to "Grandfathered/Qualified" status. Per the IRS, if a Grandfathered policy is materially changed after December 31, 1996, it loses its Grandfathered/Qualified status.

A material change, per the guidelines, could include any change in the terms of the contract altering the amount of coverage or timing of any item payable by the policyholder, the insured, or the insurance company. (A material change could eventually be determined by the IRS to be any client-requested increase in benefits.)

 **NOTE: Tax Laws change frequently, so the client's tax attorney should always review information of this type furnished to a client.**

REIMBURSEMENT MODEL

Simply put, Reimbursement Model policies repay the insured for qualifying long-term care expenses that he or she incurred, subject to the amount of coverage purchased.

CONSUMER APPLICATION

Joe purchases a Reimbursement Long-Term Care Insurance Policy with coverage of \$150 per day. He later needs Home Health Care services and the cost is \$80 per day. His Reimbursement insurance coverage would reimburse her for her expenses and as a result she would receive \$80 per day of qualifying services. The remaining \$70 (\$150 per day in coverage **minus** \$80 paid in benefits = \$70) remains with the insurance company and is available for Sandy's use down the road.

CONSUMER APPLICATION

Bubba purchases a Reimbursement Long-Term Care Insurance Policy with coverage of \$150 per day. Bubba later needs Home Health Care services and the cost is \$200 per day. Bubba's Reimbursement insurance coverage would reimburse him for his expenses up to the amount of coverage purchased, and as a result he would receive \$150 per day of qualifying services. Bubba would be personally financially responsible for the remaining \$50 (\$200 per day in expenses **minus** \$150 received in benefits = \$50).

Tax Treatment of Benefits Received

For policies that pay benefits under the Reimbursement Model, the benefits received are considered to be a reimbursement for expenses incurred for medical services. This is true regardless of whether the Tax-Qualified Long-Term Care Insurance policy reimburses pays benefits on a daily, weekly, monthly or other periodic basis.¹²⁸ As a result, benefits under a Reimbursement Model are generally not considered income.

Indemnity Model

Indemnity Model policies pay the insured person a flat amount regardless of the amount of the insured person's expenses.

CONSUMER APPLICATION

Judy purchases an Indemnity Long-Term Care Insurance Policy with coverage of \$150 per day. Judy later needs Home Health Care services and the cost is \$80 per day. Judy's Indemnity

insurance coverage would pay her \$150 per day of service even though her expenses are only \$80. Judy can use the extra \$70 to pay for additional health coverage or to buy a new hat and shoes—whatever she wants.

CONSUMER APPLICATION

Dan purchases an Indemnity Long-Term Care Insurance Policy with coverage of \$150 per day. Dan later needs Home Health Care services and the cost is \$200 per day. Dan's Indemnity insurance coverage would pay him \$150 per day of service even though his expenses are \$200. Dan will have to come up with the additional \$50.

TAX TREATMENT OF BENEFITS

For Tax- Qualified Long-Term Care Insurance policies that pay benefits under an Indemnity Model, benefit payments are subject to a daily dollar cap.

2007 Daily Indemnity (Per Diem) Limit	2006 Daily Indemnity (Per Diem) Limit	2005 Daily Indemnity (Per Diem) Limit
\$260	\$250	\$240

If the individual taxpayer receives Tax-Qualified Long-Term Care Insurance benefits in excess of this annual daily limit, those "excess benefits" will be considered income for tax purposes. However, the taxpayer may exclude from income the "excess benefits" to the extent of the individual's actual unreimbursed Tax-Qualified Long-Term Care expenses. Note, however, according to available reports, the IRS has never gone after a person who receives long-term care benefits (from any source) for not reporting income from LTCI benefits. However, they have the legal right to do so.

Individual Taxpayers

Deductibility of Premium Payments

Individuals who purchase and pay for Tax-Qualified Long-Term Care Insurance policies for themselves, their spouses, and their tax dependents may claim the premiums paid as deductible personal medical expenses if the Individual itemizes his or her taxes.¹²⁹ Tax-Qualified Long-Term Care Insurance expenses are deductible by an individual tax payer only to the extent that the individual's total unreimbursed medical care expenses exceed 7.5% of his or her Adjusted Gross Income. Further, the amount of the Tax-Qualified Long-Term Care Insurance premiums that may be deducted is subject to the following dollar limits based on the insured's attained age before the close of the tax year.¹³⁰

Age	Eligible Premium 2007 Limit	/ Eligible Premium 2006 Limit
< 40	\$290	\$280
41 - 50	\$550	\$530
51 - 60	\$1,110	\$1,060
61 - 70	\$2,950	\$2,830
> 70	\$3,680	\$3,530

SOLE PROPRIETOR

Deductibility of Employer-Paid Premiums

Sole Proprietors who purchase and pay for Tax-Qualified Long-Term Care Insurance policies for themselves, their spouses and their tax dependents may claim a deduction for the premiums paid as medical care expenses.¹³¹

Further, as in the case of individual taxpayers, the amount of the Tax-Qualified Long-Term Care Insurance premiums that a self-employed individual may deduct as Self-Employed Health Insurance is subject to the dollar limits as individuals (above).

PARTNERSHIPS

Business Deductibility of Partnership-Paid Premiums

On Behalf of a Partner

A Partnership that purchases Tax-Qualified Long-Term Care Insurance on behalf of a Partner may deduct the premiums paid as an ordinary business expense—same for Tax-Qualified Long-Term Care Insurance purchased for the Partner's spouse or other tax dependent.

On Behalf of an Employee

A Partnership that purchases Tax-Qualified Long-Term Care Insurance on behalf of an Employee may deduct the premiums paid as an ordinary business expense—same for Tax-Qualified Long-Term Care Insurance purchased for the Employee's spouse or other tax dependent.

TAX CONSEQUENCES OF PARTNERSHIP-PAID PREMIUMS

For the Employee

Employer-paid Long-Term Care Insurance premiums would not be included in the Employee's gross income.¹³³

For a Partner

The entire amount of the Tax-Qualified Long-Term Care Insurance premiums paid by the Partnership is includable in the partner's gross income. The same is true for partnership-paid

Tax-Qualified Long-Term Care Insurance premiums paid on behalf of the Partner's spouse or other tax dependents.

In this case, the partner is treated as a self-employed individual for tax purposes and the Tax-Qualified Long-Term Care Insurance premiums received would be subject to the same tax rules as apply to Sole Proprietors.

C-CORPORATIONS

Business Deductibility of Employer-Paid Premiums

On Behalf of an Employee

A C-Corporation that purchases Tax-Qualified Long-Term Care Insurance on behalf of an Employee may deduct the premiums paid as an ordinary business expense—same for Tax-Qualified Long-Term Care Insurance purchased for the Employee's spouse or other tax dependent.

On Behalf of an Employee Stockholder

A C-Corporation that purchases Tax-Qualified Long-Term Care Insurance on behalf of an Employee Stockholder may deduct the premiums paid as an ordinary business expense—same for Tax-Qualified Long-Term Care Insurance purchased for the Employee Stockholder's spouse or other tax dependent.

On Behalf of a Stockholder (Owner) Who is not an Employee

A C-Corporation that purchases Tax-Qualified Long-Term Care Insurance for a shareholder who is not an employee, does not receive a deduction for the premiums paid.

TAX CONSEQUENCES OF C-CORP-PAID PREMIUMS

For an Employee

Employer-paid Long-Term Care Insurance premiums would not be included in the Employee's gross income.¹³⁴ This would also apply to premiums paid on behalf of the employee's spouse and other tax dependents.

For an Employee Stockholder

Provided that the Stockholder is also a bona fide Employee of the C-Corporation, Tax-Qualified Long-Term Care Insurance premiums paid by the C-Corporation on behalf of the Employee are fully deductible assuming the C-Corporation retains no interest in the policy. This would also apply to premiums paid on behalf of the employee's spouse and other tax dependents.

For a Stockholder who is not an Employee

Tax-Qualified Long-Term Care Insurance premiums paid by a C-Corporation on behalf of a Stockholder who is not an Employee of the C-Corporation would represent dividend income for the Stockholder.

S-CORPORATIONS

Deductibility of Employer-Paid Premiums

For purposes of determining tax liabilities with regards to S-Corporations, the tax code looks to the individual's ownership rights in the company. An employee who owns 2% or more of the S-Corporation is deemed to be an Employee/Owner, while one who owns less than 2% is treated as only an employee.

On Behalf of an Employee (Less than 2% Shareholder)

Tax-Qualified Long-Term Care Insurance premiums paid by a S-Corporation on behalf of an employee are fully deductible providing the S-Corporation retains no interest in the policy. This would also apply to premiums paid on behalf of the employee's spouse and other tax dependents.

On Behalf of an Employee/Owner (Shareholder of 2% or greater)

Tax-Qualified Long-Term Care Insurance premiums paid by an S-Corporation on behalf of a 2%+ shareholder are deductible by the S-Corporation providing the S-Corporation retains no interest in the policy. This would also apply to premiums paid on behalf of the employee's spouse and other tax dependents.

Tax Consequences of Employer-Paid Premiums

For an Employee

Employer-paid Long-Term Care Insurance premiums would not be included in the Employee's gross income.¹³⁵ This would also apply to premiums paid on behalf of the employee's spouse and other tax dependents.

For an Employee/Owner (Shareholder of 2% or greater)

The entire amount of the Tax-Qualified Long-Term Care Insurance premiums paid by the S-Corporation is includable in the employee/owner's gross income. The same holds true for S-Corporation -paid Tax-Qualified Long-Term Care Insurance premiums paid on behalf of the employee/owner's spouse or other tax dependents.

In this case, the employee/owner is treated as a self-employed individual for tax purposes and the Tax-Qualified Long-Term Care Insurance premiums received would be subject to the same tax rules as apply to Sole Proprietors.

LIMITED LIABILITY & PROFESSIONAL CORPORATIONS

A Limited Liability Company is a statutory business that may be treated as a corporation, a partnership, or a sole proprietorship for tax purposes.

As a result, to determine the tax implications of LLC-purchased Long-Term Care Insurance, one must first determine by which method the LLC is treated for federal income tax purposes.

Therefore:

- A LLC treated as Sole Proprietorship would look to the Sole Proprietor regulations for guidance;
- A LLC treated as a Partnership would look to the Partnership regulations for guidance; and
- A LLC treated as a Corporation would look to the Corporation regulations for guidance.

PROFESSIONAL CORPORATIONS/ PROFESSIONAL ASSOCIATIONS (PCS/PAS)

Generally

Professional Corporations and Associations have the ability to select the method by which the entity will be treated for federal income tax purposes.

Also, generally, Professional Corporations may elect to be treated as either a C-Corporation or an S-Corporation. The status is elected by the entity.

As a result, to determine the tax implications of PC-purchased Long-Term Care Insurance, one must first determine by which method the PC is treated for federal income tax purposes.

Thus it follows:

- A PC treated as C-Corporation would look to the C-Corporation regulations for guidance; and
- A PC treated as an S-Corporation would look to the S-Corporation regulations for guidance.

STUDY QUESTIONS

1. HIPAA provided that benefits paid under a long-term care insurance policy would not be taxable if
 - A. the premiums were paid annually.
 - B. the long-term care insurance policy met minimum eligibility criteria.
 - C. the benefits were paid annually.
 - D. there was no inflation protection.
2. For policies that pay benefits under the Reimbursement Model, the benefits received
 - A. are considered to be a reimbursement for expenses incurred for medical services.
 - B. must be paid quarterly or they will all be taxed at capital gains rates.
 - C. will be taxed at capital gains rates.
 - D. must not exceed more than 110% of the daily benefit or the entire amount is taxed as ordinary income.
3. For Tax- Qualified Long-Term Care Insurance policies that pay benefits under an Indemnity Model,
 - A. there is no cap and no floor.
 - B. the minimum payment must be based on a minimum of \$50 per day.
 - C. benefit payments are subject to a daily dollar cap.
 - D. benefits cannot exceed 3 times the required Medicaid daily benefit.

4. Tax-Qualified Long-Term Care Insurance expenses are deductible by an individual tax payer
 - A. are subject to a daily dollar cap.
 - B. regardless of amount.
 - C. as a cost of doing business.
 - D. not to exceed \$500 per month or 6% of the gross annual income, whichever is less.

5. A Partnership that purchases Tax-Qualified Long-Term Care Insurance on behalf of a Partner
 - A. may claim no deduction.
 - B. may deduct the percent of premium that equals the percent of ownership of the business.
 - C. may deduct the premiums paid as an ordinary business expense
 - D. can only claim a tax deduction equal to any claims paid.

6. For taxation of an LTCI policy, an employee who owns 2% or more of the S-Corporation is deemed to be an Employee/Owner, while one who owns less than 2%
 - A. is treated as a corporate owner.
 - B. may be taxed only on the benefits paid.
 - C. must pay capital gains taxes on the premiums paid by the corporation.
 - D. is treated as only an employee.

7. Employer-paid -premiums on a LTCI policy would not be included in the Employee's gross income,
 - A. but would not apply to premiums paid on behalf of the spouse.
 - B. this would also apply to premiums paid on behalf of the employee's spouse and other tax dependents.
 - C. unless the employee was an officer in the company.
 - D. provided the premiums do not exceed \$100 per month.

ANSWER TO STUDY QUESTIONS

1B 2A 3C 4A 5C 6D 7B



CHAPTER IX - LONG-TERM CARE PROVIDERS

Long-term care facilities have come a long ways from the days of the first Long Term Insurance policy when long-term care was nearly synonymous with “nursing home.” It has expanded into a large number of facilities providing various services to those who need long-term care. Even the medical community has changed as there are now not just hospitals, but also “sub-acute” care facilities for those recovering from surgery for instance. Those who do not need 24-hour care can receive services through a residential care facility. This “evolution” can be seen and illustrated at a modern “total” care facility.

This concept has been operating for several years and has proven quite successful, mostly for the patients/residents who have sufficient funds as these places can be quite “pricey.” The concept is that retired persons (usually) will purchase a “condominium” in the facility which offers more than just living accommodations, such as on-site restaurants, shops, etc. As the resident ages and more personal care is needed, such as someone to help with shopping and condo cleaning, etc., such services are available. In case of a health emergency, in one section of the facility there is always a doctor and a Registered Nurse in attendance, with the serious health problems treated on-site and then transferred to a hospital if necessary. For recuperation, the facility will provide caregivers to that the person can stay at home.

If the person needs more nursing care, there is a portion of the facility that is an actual nursing home, properly licensed, etc., but reserved (generally exclusively) for the residents of the facility. If home health care is needed, then experienced and professional caregivers are available on the premises. There is usually a physical therapy section to provide those services by trained professionals.

In other words, whatever is needed is provided, either on the premises or by contract with other medical professionals and facilities. These facilities are very successful, but there is a problem: they are very expensive. In fact, a person who can afford to reside in these facilities would usually not be interested in Long Term Care Insurance as they are in the financial position of being able to provide whatever they need when they need it. But most people cannot afford these facilities.

A list of typical long-term and acute-care providers may be found at **EXHIBIT ONE.**

TYPES OF CARE

In addition to long-term care, medical care can usually be broken down into either acute or chronic care. Acute care is typically the medical problems of the young, such as infectious diseases and broken bones, and childbirth by women. In most cases, the person is able to recover and return to their previous lifestyle, occupation, etc. On the other hand, the elderly suffer mostly from chronic care whereby they cannot be expected to have full recovery, and usually their condition worsens.

Delaware regulations define “Acute Condition” as when the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain their health status.¹³⁶

No surprise to anyone who had needed medical care recently, the differences have become rather blurred as medical care is not entirely concentrated on acute care, but now much of our health system is devoted to chronic care, by a variety of providers and in various settings.

Physicians, nurses and other medical professionals choose and deliver the treatment for acute care. Contrast that with long-term care which heavily involves family members who take on the roles of caregivers and decision-makers.¹³⁷

As described earlier, long-term care involves a very wide range of assistance with help with activities of daily living (ADLs), sometimes also help with instrumental activities of daily living (IADLs). Services include supervisory human assistance and many devices such as canes, walkers, wheelchairs, and newer “high-tech” assistance, i.e. motorized wheelchairs, computerized medication dispensers and emergency alert system. Other “low tech” services involve wheelchair ramps, grab bars in the home and bath, etc.

“Acute Conditions” can be defined as conditions that require a high level of medical care, monitoring and treatment so as to restore the patient to health or the ability to perform. In general usage, this refers to medical conditions that would be life threatening without immediate medical care and attention, usually provided in a hospital until such time that they are stable and can be released or transferred to a nursing home.

“Chronic Conditions,” on the other hand, are those conditions that are long-lasting and that require continuing care, as opposed to emergency medical treatment. These conditions usually require monitoring and some medical treatment, but usually involve non-medical care, such as with ADLs. Chronic care is usually an evolving situation requiring more care as time passes. Long-term care is, then, usually provided for chronic conditions instead of acute conditions.

SCHEDULED/ON-DEMAND CARE

Long-term care usually progresses from necessary services such as supporting services and assistance with ADLs and IADLs to more extensive nursing, physical and/or therapeutic services, depending upon the needs of the patient. Activities of Daily Living eventually fall into either those that can be performed routinely and on a scheduled basis, or those that must be provided when needed—on demand. Examples are the progression of aid for bathing or eating which would require scheduled care, to assistance with toileting or ambulating which would require services on demand.

The reason that this distinction is mentioned here is that it is important to know because the cost of providing long-term care increases when on-demand services are needed as regular and full-time assistance must be provided for on-demand care. This can mean the difference between receiving appropriate care in a nursing home or other facility, and receiving care at home as at-home care is usually not practical when continuous supervision becomes necessary. Of those persons who enter nursing home, over half will have a total lifetime use of at least one year, and 21% will have a total lifetime use of five years or more.¹³⁸

LONG TERM CARE PROVIDERS

There are a multitude of setting in which long-term care can be provided, from nursing homes to home health care, to community care facilities, to care by friend, neighbors, family, etc. The term “Caregiver,” defines the person(s) who provide the care that is needed, regardless of the degree or level of care. Generally, the majority of the care will be provided by a primary care giver, spouse or child for example, and other responsibilities being performed by others as secondary caregivers, such as home health care agencies.

LTCI policies carefully define the benefit limits in accordance with how the provider of care is defined. This is a very important component when comparing policies and benefits. For some time, LTC was defined according to Medicare’s definitions, but in recent years the policies and programs have expanded to provide a wider range of services provided by a number of providers. Since the degree of coverage depends upon the specific definitions of covered services in the contract, policy, or program, it is most important that agents become very well versed on covered services—and what is *not* covered. A professional agent will not only inform the prospect or policyholder as to what is covered, and as importantly, what is not.

HOME HEALTH CARE

In most situations, home health care is provided when the patient insists on staying at home, but can only do so with assistance from a home health care agency, family members, friends or other caregivers. Many, if not most, seniors much prefer to live independently outside of any kind of institution and are quite happy with home health care, even when they depend more and more on the assistance as their physical or mental condition progresses. Home health care can take many forms using a wide variety of medical and personal services in the patient’s home, such as services provided by nurses, therapists and home care aides. Nursing services, social work, physical and rehabilitative therapy, monitoring of medication and medical equipment, plus personal care assistance such as help with personal hygiene, dressing, bathing, exercising, housekeeping, shopping, meal preparation, etc., etc., can be provided in a home environment.

“Home Health Care” encompasses a wide range of health and social services which can be provided at the patient’s residence if they are recovering from health problems, disabled, chronically or terminally ill, and to those who need medical, nursing, social, or therapeutic treatment and/or assistance with the essential Activities of Daily Living (ADL).

Home health care is usually the result of a doctor’s direction, but there are other ways to arrange for home health care, such as telephoning the local Area Agency on Aging, or other similar organizations. References from family members or friends are often used as a good home health care agency will become known to the elderly in the area.

The advantages to the individual are numerous, and depend upon the individual situation, but it would be safe to say that one of the main advantages is that the person receives care in a familiar environment where they feel safe and comfortable. Generally they face an uncertain future with dignity

if they can still maintain their independence by staying in their home where they know their neighbors and family and friends can come to see them.

It should be noted that if a person is unable to perform household chores or some ADLs, they will still want to remain in their home as long as is possible. But, for them to continue to live at home, they will need help—assistance from trained professionals can become expensive. Therefore, most of the simpler chores should, if possible, be performed by family members or friends, leaving the more technical and difficult services to the professionals, such as visiting nurses for medication, therapists, etc.

The type of home health care provider that can best serve the individual in their home can be health care services provided by professions, such as nurses and therapists, or social services provided by organizations or agencies who provide homemaker and personal care. Obviously, the type of care that is needed determines the type of caregiver that is needed.

Home health care can range from help from family members or close friends, or home health care organizations, or independent caregivers such as personal care attendants. Care can be provided from “checking” on the individual at specific times, to specialists on a full-time basis. Services can be usually provided as often as is needed—full-time, part-time, hourly, or on a shift. Generally home health care services can be available 24 hours a day, 7 days a week.

It has been pointed out and often stressed that home health care can be just as expensive as nursing home care. Further, very little of that expense is covered by Medicare, and as any home health care agency can attest, the Medicare rules keep changing all the time. Actually, home health care can average about \$50,000 in some areas.

HOME HEALTH CARE PROVIDERS

Starting “from the top,” physicians can provide home health care services by diagnosing and treating illnesses in the same fashion that they would if the patient were in a hospital. Physicians will interface with home care providers to determine exactly what care and services are needed by the patients and which specialists can perform what is needed in the way of care and services. They can also determine how often services need to be rendered. In effect, the Physicians prescribe the medication and services that are needed and provide a plan of care for the patient. If the patient is covered by Medicare, physicians and home health agency personnel are required to review these plans of care as often as required by the severity of patient medical conditions, and at a minimum, every 62 days. For hospice patients and their families, the care plans are reviewed at least once a month, but usually they are reviewed more often as the condition of the patients deteriorates.

Registered nurses (RNs) and licensed practical nurses (LPNs) provide skilled services that cannot be performed by nonprofessional personnel, including injections and intravenous therapy, wound care, and dispensing of medication. RNs can provide case management services but LPNs are only licensed to work under the supervision of RNs. The severity of the patient’s condition and the treatment that is prescribed determines whether that can be provided by an RN or LPN.

Physical therapists (PTs) apply therapy to patients who are limited or disabled because of physical injuries, in an effort to restore their ability to function and to restore the mobility and strength of patients. In addition to providing exercise and other methods to the patient, they often use specialized equipment to alleviate pain and to help restore injured muscles. Part of their function is to educate the patients and their caregivers in using special techniques and methods to walking and ambulating.

Social workers frequently work as case managers when a variety of services are needed. They provide important information as to available resources within the community, and they also often provide personal counseling.

Occupational therapists, language pathologists and dieticians are all professions that can assist with home health care. The language pathologists, for instance, work with the patient to develop and restore the speech of those with communication disorders, and they may even work with patients who have difficulties in breathing, swallowing and muscle control. Occupational therapists (OTs) work with the patients in the use of special rehabilitation techniques and equipment. They are trained to help individuals who have physical, developmental, social, or emotional problems that prevent them from performing the general activities of daily living (ADLs).

- Dietitians provide information and assistance to those who need help in determining the proper diet when such is required. Homemakers can perform light household duties
- Dietitians provide counseling services to individuals who need professional dietary assessment and guidance to properly manage an illness or disability.
- Homemaker and chore workers perform light household duties such as laundry, meal preparation, general housekeeping, and shopping. Their services are directed at maintaining patient households rather than providing hands-on assistance with personal care.
- Companions provide companionship and comfort to individuals who, for medical and/or safety reasons, may not be left at home alone. Some companions may assist clients with household tasks, but most are limited to providing sitter services.
- Volunteers meet a variety of patient needs. The scope of a volunteer's services depends on his or her level of training and experience. Volunteer activities include, but are not limited to providing companionship, emotional support, and counseling and helping with personal care, paperwork, and transportation.

SERVICES PROVIDED BY HOME CARE AGENCIES

Home care agencies offer a range of services, from assessing an individual's needs to putting together and arranging care. Skilled health care by nurses, therapists, and other licensed health care professionals, may be delivered in the home. Also included are the use of devices, such as crutches, canes, walkers, IV setups, hospital beds, wheelchairs, ostomy supplies, prostheses, and oxygen. Personal care such as assistance with ADLs and IADLs is available.

Home Care providers deliver a wide variety of health care and supportive services, ranging from professional nursing and home care aide care to physical, occupational, respiratory, and speech therapies. They also may provide social work and nutritional care and laboratory, dental, optical, pharmacy, podiatry, x-ray, and medical equipment and supply services. Services for the treatment of medical conditions usually are prescribed by an individual's physician. Supportive services, however, do not require a physician's orders. An individual may receive a single type of care or a combination of services, depending on the complexity of his or her needs.

HOME CARE VS. HOME HEALTH CARE

Home Health Care

Home health care—home health care provides medically-oriented care for acute or chronic illness in the patient's home, usually as a follow-up to acute or other facility care. It is regulated and licensed certified by the DHS for Medicare and Medicaid.

Payment- Funded primarily through Medicare, with limited coverage through Medicaid, private insurance and private payments.

Home health care may include part-time skilled nursing care, such as occasional visits by registered nurses or licensed practical nurses. It may include speech, physical or occupational therapy, and part-time services of home health aides. It almost always includes some degree of custodial care, such as assistance with meal preparations, personal hygiene, and taking medications.

Advances in medical science have made the delivery of health-related care to the home much easier. Smaller, portable equipment enables respiratory therapy, drug therapy and chemotherapy to be done in the home rather than in the hospital. In addition, hospital beds, power lift chairs, walkers, wheelchairs and monitoring devices are available for rent so that most people can return home sooner.

Home health care can be found through State or Area Agencies on Aging, social service agencies, public department of family services, private home care agencies, Red Cross, Visiting Nurses Association, public health department, hospital social services or discharge planning, United Way, and the Yellow Pages.

Home Health Agencies

The term home health agency often indicates that a home care provider is Medicare certified. A Medicare-certified agency has met federal minimum requirements for patient care and management and therefore can provide Medicare and Medicaid home health services. Due to regulatory requirements, services provided by these agencies are highly supervised and controlled. Some agencies deliver a variety of home care services through physicians, nurses, therapists, social workers, homemakers and HCAs, durable medical equipment and supply dealers, and volunteers. For cases in which an individual requires care from more than one specialist, home health agencies coordinate a caregiving team to administer services that are comprehensive and efficient. Personnel are assigned according to the needs of each patient. Home health agencies recruit and supervise their personnel and they assume liability for all care.

Personal Care & Homemaker Services

Personal care services — personal care services are provided for people who need assistance with daily living but do not require nursing. There are no separate licenses required.

Primarily funded through In-Home Supportive Services for those eligible. Some Medicaid funding for those eligible, and private payments.

Personal care means non-medical services to assist older persons with ADLs and/or IADLs provided by a skilled or unskilled person under medical direction.

Homemaker services involve supporting care for the house or environment rather than directly for the care recipient. Services often include yard work, minor household repairs, general maintenance, cleaning or installing ramps or grab bars to make the person's home more accessible to them.

State or Area Agencies on Aging, social services departments, religious groups, and service and civic organizations and clubs may provide chore services. The Red Cross, Visiting Nurses Association, home care agencies, or local area agencies on aging may offer homemaker services. Check the Eldercare Locator for services near you.

If the patient is receiving "skilled" home health care services, paid for by Medicare, Medicare may cover a portion of the cost of a homemaker/home health aide to help with personal care. The local Social Security office can provide information. For those with low incomes, Medicaid will sometimes help. Check with the local Medicaid office.

Homemaker and Home Care Aide Agencies

Homemaker and HCA agencies employ homemakers or chore workers, HCAs, and companions who support individuals through meal preparation, bathing, dressing, and housekeeping. Personnel are assigned according to the needs and wishes of each client. Some states require these agencies to be licensed and meet minimum standards established by the state. Most homemaker and HCA agencies recruit, train, and supervise their personnel and thus are responsible for the care rendered.

OTHER PROVIDERS OF HOME CARE SERVICES

Staffing and Private-Duty Agencies

Staffing and private-duty agencies generally are nursing agencies that provide individuals with nursing, homemaker, HCA, and companion services. Most states do not require these agencies to be licensed or meet regulatory requirements. Some staffing and private-duty agencies assign nurses to assess their clients' needs to ensure that personnel are properly assigned and provide ongoing supervision. These agencies recruit their own personnel. Again, responsibility for patient care rests with each agency.

Registries

Registries serve as employment agencies for home care nurses and aides by matching these providers with clients and collecting finder's fees. These organizations usually are not licensed or regulated by government. Registries are not required to screen or background-check the caregivers, but some do undertake these tasks routinely. In addition, although not legally required to, some registries offer procedures for patients to file complaints. Clients select and supervise the work of a registry-referred provider. They also pay the provider directly and must comply with all applicable state and federal labor, health, and safety laws and regulations, including payroll tax and social security withholding requirements.

Independent Providers

Independent providers are nurses, therapists, aides, homemakers and chore workers, and companions who are privately employed by individuals who need such services. Aides, homemakers, chore workers, and companions are not required to be licensed or to meet government standards except in cases where they receive state funding. In this arrangement, the responsibility for recruiting,

hiring, and supervising the provider rests with the client. Finding back-up care in the event that the provider fails to report to work or fulfill job requirements is the client's responsibility. Clients also pay the provider directly and must comply with all applicable state and federal labor, health, and safety requirements.

Pharmaceutical and Infusion Therapy Companies

Pharmaceutical and infusion therapy companies specialize in the delivery of drugs, equipment, and professional services for individuals receiving intravenous or nutritional therapies through specially placed tubes. These companies employ pharmacists who prepare solutions and arrange for delivery to patients. Nurses also are hired to teach self-administration in patients' homes. Some pharmaceutical and infusion therapy companies are home health agencies, certified by Medicare. In addition, some states require these organizations to be licensed. Each company assumes responsibility for personnel and the services rendered.

Durable Medical Equipment and Supply Dealers

Durable medical equipment and supply dealers provide home care patients with products ranging from respirators, wheelchairs, and walkers, to catheter and wound care supplies. These dealers employ staff who deliver and, when necessary, install these products as well as instruct patients on their proper in-home use. Durable medical equipment and supply dealers usually do not provide physical care for patients, but there are a few exceptions.

Some dealers offer pharmacy and infusion services, where a nurse administers medication and nutritional formulas to patients and teaches them the proper techniques for self-administration. Some companies also provide respiratory therapy services to help individuals use breathing equipment. Durable medical equipment and supply dealers that bill the Medicare program are required to meet federal minimum standards. Some states require that these organizations be licensed. Each dealer is liable for its personnel and the services provided to patients.

MEDICARE PARTICIPATION

Among the large for-profit nursing facility companies, Medicare usually comprises 10-15% of the number of residents and about 25% of revenue. The revenue has dropped because of the Balanced Budget Act of 1997 and the changes in reimbursements in 1998.

While state and federal governments participate to some extent in long-term care costs, a very small percentage of that participation occurs through Medicare. While many people today are aware that Medicare covers very little of the cost of long-term care, there are many that are not so informed. It is important that a summary of the Medicare rules for paying for such care in order be studied so as to advise potential LTC Insurance clients.

Medicare covers nursing home care *only* when:

- **The individual is admitted to a *skilled* nursing facility (SNF).**
- **The SNF is Medicare—certified.**
- **The individual is receiving skilled *medical* care that can be provided *only* in the SNF and only by skilled medical personnel.**

- **The individual was previously hospitalized for at least three consecutive days.**
- **The individual is admitted to the SNF no more than 30 days after discharge from the hospital.**
- **Admission to the SNF is to receive care for the same illness or condition for which the individual was previously hospitalized and the individual must be *improving*.**

Every one of these requirements must be met in order for Medicare to pay any part of nursing home costs. Then, coverage lasts for no more than 100 days.

Medicare pays the full cost only for the first 20 days. The individual must pay part of the cost for days 21 through 100. In the year 2008, the individual's part is \$128 per day. The individual's portion changes every year as prescribed by the Social Security Administration. If more than 100 days of care are required, the individual must pay all costs.

Conversely, what does Medicare *not* pay? There *is no coverage* for:

- Care in an intermediate or custodial care facility or any community-based residential facility. About 75% of nursing facilities are this type; only about 25% are skilled.
- Care in a SNF that Medicare has not approved. Only about 40% of SNF's are Medicare-certified.
- Custodial care, even if it is provided in a Medicare-certified SNF, if that is the primary type of care being provided.
- Admissions not preceded by three consecutive days in the hospital.
- Admissions later than 30 days after hospital discharge.
- Care where the patient does not show increasing improvement in the health condition for which they were admitted.

The facts are that most people who require long-term care (1) do not require the one type of care Medicare pays for—skilled nursing—and (2) are not hospitalized prior to admission to a nursing facility. One study for the U.S. government found that as many as 95% of people requiring long-term care need only custodial care—help with the activities of daily living.

Medicare Supplement regulations do not allow the sale of any insurance policy that duplicates Medicare Supplement coverage; however, a Long-term Care Insurance policy is now excluded.

Some companies require the insured to sign a statement attesting to the fact that the LTC Insurance policy may not cover all long-term care costs incurred and the insured is requested to review the policy carefully. Conversely, some companies or General Agencies, require that an applicant for a Medicare Supplement policy, sign a statement that the Medicare Supplement does not cover most types of long-term care and that the agent has explained how such coverage can be obtained. This accomplishes two things—(1) if a family member would ever accuse the agent of not offering LTC coverage when the insured becomes unable to take care of themselves, and Medicare does not cover the disability, this will avoid an errors-and-omission suit, and (2) it

forces an agent who is making a (relatively) easy Medicare Supplement sale, to introduce his client to possible new coverages.

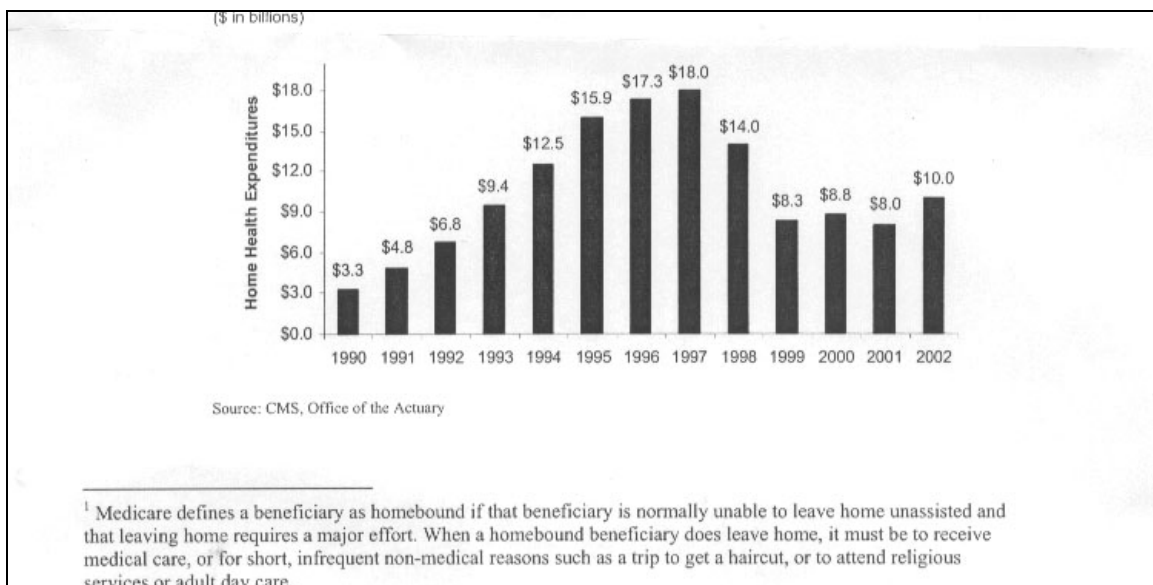
HOME & ADULT DAY CARE

Because so many services are now available in an Individual's home, from professional nursing care to housekeeping, it is difficult to attach an actual dollar figure. People are likely to think of home care as being considerably less costly than care in an institution, and in some cases that's true. For example, a home health aide, earning \$10 an hour in some locales, who helps in the home for two hours a day three times a week does create a large expense. However, HIAA estimates that many people receiving help at home with ADL's alone currently pay as much as \$1000 per month - \$12,000 annually. Skilled professionals such as a registered nurse or physical therapist may be paid up to \$70 per hour for home visits.

Adult day care is no less expensive than day care for children—and is often more expensive because of the availability of extra services, particularly those related to health care. Daily charges can range from \$50 to \$200 according to the American Association of Retired Persons (AARP), probably the best known organization serving older people in the U.S.

These figures emphasize both the lower and upper extremes. Recent figures from a state located in one of the average-cost geographical regions of the, U.S. indicate that home care, adult day care, respite care and hospice care costs average \$15,000 or less per year. However, the more frequently the services are provided and/or the more skilled the person providing them, the more costly they will be in any region.

According to the Centers for Medicare and Medicaid Services, expenditures for home health care dropped from \$18 billion in 1997 to \$10 billion in 2002.



HOME HEALTH CARE UNDER MEDICARE

As quoted in the Medicare Guide: "Medicare pays the full cost of medically necessary home health visits by a Medicare-approved home health agency. A home health agency is a public or private agency that provides skilled nursing care, physical therapy, speech therapy, and other therapeutic services. A visiting nurse and/or home health aide provides services on an intermittent or part-time basis, not full-time."

"To qualify for coverage you must:

- Need intermittent skilled nursing care, physical therapy, or speech therapy,
- Be confined to your home,
- Be under a doctor's care.

A stay in the hospital is not needed to qualify for the home health benefit, and you do not have to pay a deductible or coinsurance for services. You do have to pay 20 percent of the approved amount for durable medical equipment such as wheelchairs and hospital beds provided under a plan-of-care set up and reviewed periodically by a doctor."

"You pay:

- For full-time nursing care and drugs.
- For meals delivered to your home.
- Twenty percent of the Medicare-approved amount for durable medical equipment, plus charges in excess of the approved amount on unassigned claims.
- For homemaker services that are primarily to assist you in meeting personal care or housekeeping needs."

Note the key requirements:

- Services must be skilled nursing care, physical therapy, speech therapy or other therapeutic services. Many Seniors are convinced that they will receive full time care and Medicare or their Medicare Supplemental policy will cover it.
- The patient must be homebound, confined to the house, and not able to go shopping or visiting with friends and family.
- The patient is fully responsible for homemaker services to assist them in personal care or housekeeping needs.

In the past, doctors have been very lenient and have continued Medicare home health care even after the patient no longer needed skilled nursing care. With the recent emphasis on Medicare abuse, these abuses have diminished and ceased almost entirely in most areas.

An important point to remember is that a Medicare Supplement only pays for those costs that are Medicare approved, i.e. as a general rule, if Medicare does not pay, the Supplement will not pay. (There are some exceptions, such as a physical examination under certain Select policies and some drug benefits under the more expensive H, I and J Supplemental plans)

ADULT DAY CARE

Adult Day Care, as mentioned previously, has often been considered as a place to drop off a person who is unable to care for themselves, at a facility that will “baby-sit” them until they can be picked up on the way home from work. There actually is a little truth in that, but Adult Day Care offers much more. They are closely regulated and they offer structured, comprehensive programs providing a variety of health, social, and other related support services. Hours are flexible usually, but they offer less than 24-hour care, usually operating only during normal business hours five days a week, with some offering weekend and holiday services also. They offer medical monitoring, occupational and physical therapy, counseling, and other services to not only the patient, but also for the families.

Delaware regulations define “Home health care services” as medical and nonmedical services provided to ill, disabled or infirm persons in their residences. Such services may include home-maker services, assistance with activities of daily living and respite care services.¹³⁹

Obviously, Adult Day Care centers are designed for the caregiver who must work during the day but who also has a family member to care for. For many situations where the caregiver is a family member, this may be the only way that they can both work and take care of their parent or disabled family member.

It should be remembered that for the person who needs the care, this can be a frightening experience as they will be with strangers initially, therefore care coordinators if they have an LTCI policy, or otherwise, the caregiver, must bring the patient into the decision-making process if at all feasible.

“Adult Day Care” is defined by Delaware regulations as a program for six (6) or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.¹⁴⁰

TYPES OF ADULT DAY CARE FACILITIES

ADULT DAY CARE (ADC) centers are community-based programs that provide non-medical care to persons 18 years of age or older in need of personal care services, supervision or assistance essential for sustaining the activities of daily living or for the protection of the individual on less than a 24-hour basis. These must be licensed by the State community care facilities.

ADULT DAY SUPPORT CENTER (ADSC) is a community-based program that provides non-medical care to meet the needs of functionally impaired adults. Services are provided on a less-than 24 hour basis, according to an individual plan of care in a structured comprehensive program that will provide a variety of social, psychosocial and related support services in a protective setting. These are licensed as community care facilities.

ADULT DAY HEALTH CARE (ADHC) centers are community-based day-care programs that provide medical, rehabilitative and social services to elderly persons and other adults with functional impairments, either physical or mental, for the purpose of restoring or maintaining

optimal capacity for self-care. These centers provide services through an individual plan of care and target adults who are at the institutional level of care or at risk of institutional placement. ADHC is a Medicaid benefit. The health, therapeutic and social services are provided to those who are at risk of being placed in a nursing home.

The centers are licensed by the State certifies each center so that the center can qualify for Medicaid reimbursement. The stated primary objectives of the program are;

- 1) “Restore or maintain optimal capacity for self-care to frail elderly persons and other adults with physical or mental disabilities; and
- 2) Delay or prevent inappropriate or personally undesirable institutionalization.”

The program works closely with the participant, the family, the physician, and the community in working towards maintaining personal independence. This program has been successful in some instances of placing formerly-institutionalized individuals back into the community

ALZHEIMER DAY CARE RESOURCE CENTER (ADCRC) is another community-based program that provides day care for persons in the moderate to severe stages of Alzheimer's disease or other related dementias, and provides various support and educational services for family caregivers and the community at large. ADCRCs identify the psychosocial, mental, functional, and cognitive needs of these participants, and assist participants to operate at the highest level possible within individual degrees of mental and physical capacity. Although the law permits ADCRCs to function without a license, the majority of these programs are located in licensed facilities under an established licensee category.

The ADCRCs work with those who have moderate to severe levels of dementia and to provide support and respite for caregivers. They also provide day care services needed by patients with dementia and they make opportunities for professionals in take care of and treating these patients. They also have a public service function of increasing public awareness and knowledge about Alzheimer's and related disorders. They provide services that support the physical and psychosocial needs of persons with Alzheimer's disease or related dementia. Individual care plans are developed for each program participant with activities scheduled in accordance with these plans. Persons who have been diagnosed as having Alzheimer's disease or other dementia are eligible to participate, without regard to age or financial resources. In particular, they target those persons having moderate to severe levels of care needs and behavioral problems which make it difficult for them to participate in other care programs.

In respect to funding, participants are requested to share in the cost of care through fees based on the cost of services and a sliding fee scale that is specific to each site. Approximately one-third of the sites are administered under Adult Day Health Care licensure and certification, permitting them to accept Medicaid eligible persons.



FORMAL LONG-TERM CARE SERVICES AND FACILITIES

NURSING HOMES

A nursing home is defined as a privately operated establishment where maintenance and personal or nursing care are provided for persons (as the aged or chronically ill) who are unable to care for themselves properly.

Nursing homes are licensed by the state to provide nursing care, personal care (help with things like bathing, dressing, going to the bathroom, and more), and medical services. They also offer different kinds of therapies—physical, occupational, and speech—for their patients when such therapy is medically necessary. Meals, laundry and housekeeping are furnished. Nursing homes provide various activities for its patients, such as art classes, parties, religious services, etc.

Basically, nursing homes or skilled nursing facilities, are designed specifically for those who are in need of 24 hour nursing care. They are usually beyond the physical and emotional resources of family and friends—and often, monetary resources.

Nursing homes provide more than close medical supervision from skilled professionals as they offer care from very skilled to custodial care that can be provided by supervised nursing assistants. Nursing homes are tightly regulated by the states and they continually audit the services and quality of care.

State and federal authorities regulate nursing homes and report that the quality of care has improved over the past few years. However, nursing homes still suffer in the opinion of the public. Isolated incidents, such as the elderly patient in a nursing home who died of fire ant bites while immobile in her bed, gather considerable publicity. The states all license nursing homes and they review the operations of each nursing homes at least once a year. In 1987, the Omnibus Budget Reconciliation Act (OBRA) resulted in national reform of nursing homes. As a result of this act, nursing homes were required to add more and more qualified nursing home staff. Each nursing must have individualized resident care plans and the patients must become involved in the care plan.

LEVELS OF CARE

There are three categories of care and nursing homes usually provide all three types of service, all involving full-time residence and include room and board, monitoring, personal assistance, nursing and other health care for those who cannot take care of themselves, mentally or physically.

Long-term care services are usually classified into three categories: Skilled Care, Intermediate Care and Custodial Care. LTCI policies are not always uniform in describing the care categories, therefore it is very important that policyholders be fully informed as to the various levels of care and is aware of the coverage descriptions and exclusions in the policies.

All of the following levels of care are usually covered under LTCI policies with a nursing facility (nursing home) benefit:

Skilled Nursing Care

Nursing Facilities aka skilled-nursing facilities, nursing homes or convalescent hospitals—facilities provide comprehensive nursing care rehabilitation and specialized medical programs for chronically ill or short-term residents of all ages. They are licensed by the state department responsible for licensing such facilities and certified for Medic and Medicare. Fees are usually provided by Medicaid, with some funding through Medicare, managed care and individual and private payments.

These skilled nursing care facilities provide daily nursing and rehabilitative care performed by or under the supervision of, skilled medical professionals or technical personnel. Basic skilled and custodial care for "activities of daily living" are delivered in addition to one or more of the following: specialized rehabilitation programs, respiratory therapy services, ventilator care, tracheotomy care, IV services for hydration/pain management, hospice services, respite care services, Alzheimer's and dementia units.

Skilled nursing care is available 24 hours a day, must be ordered by a physician and must be performed directly by or under the direct supervision of a registered nurse. Regulations require that there be a formal medical treatment plan.

Subacute-Care Facilities

Subacute-Care Facilities many times operate in a separate section of a nursing facility. They focus on intensive rehabilitation, complex wound care and post-surgical recovery for patients of all ages who no longer need hospital care. These facilities are licensed by the state and Medicaid and/Medicare certified. They are funded through Medicaid primarily, with some from Medicare, managed care and private payment.

Intermediate Care

Intermediate-Care Facilities provide room and board, medical, nursing, social and rehabilitative services for people not capable of full independent living. They are licenses by the state and Medicaid and/or Medicare certified. They are funded primarily by Medicaid, with some funding by Medicare and private payment.

The Intermediate Care facilities provide assistance needed for stable conditions that require daily, but not 24-hour, nursing supervision and it must be ordered by a physician and supervised by registered nurses. It does not take the specialized nursing care of a skilled nursing facility, but usually involved personal care for an extended period of time. The services fall between the skilled nursing care of a hospital or skilled nursing facility, and custodial care. Physician supervisions is needed, care if provided by licensed medical personnel, primarily RNs or LPNs under the direct supervision of an RN.

The typical patient in this setting is relatively independent but may need help with some ADLs, and they do not need continual nursing services or supervision. These are usually lower in cost than the skilled nursing facility.

Maintenance or Personal Care Services Definition

Delaware regulations states that 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."¹⁴¹

CUSTODIAL CARE

Custodial care is the "lowest level" of care and is provided simply to allow the patient to function from day to day. This is an important category as LTCI is designed to provide such services, and such services are not covered under Medicare.

Basically, custodial care (to reiterate) includes assistance in the *activities of daily living* (ADL) For the purposes of LTCI, the state may dictate these "activities of daily living" to include each of the following items (not necessarily in this order):

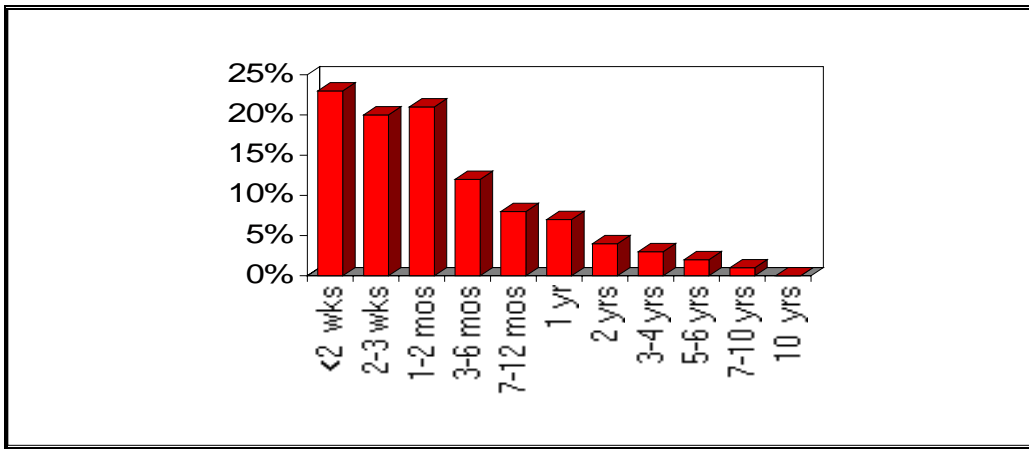
- (1) ***Eating.***) "Eating" means feeding oneself by getting food into the body from a receptacle, feeding tube, or intravenously
- (2) ***Transferring.*** "Transferring" means moving into or out of a bed, chair, or wheelchair.
- (3) ***Dressing.*** "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- (4) ***Bathing.*** "Bathing" means washing oneself by sponge bath in a tub or shower, including the task of getting into or out of the tub or shower.
- (5) ***Toileting.*** "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- (6) ***Continence.*** "Continence" means the ability to maintain control of bowel and bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including care for catheter or colostomy bag.

Custodial Care is the most common type of long-term care and it is provided in a variety of settings, ranging from nursing homes to other facilities, convalescent homes, and the patient's home. These services can be given safely and reasonably by a nonmedical person. This is considered the "lowest level" of care because it does not involve any medical care and unskilled volunteers or family members may provide it. Custodial care is nonetheless essential for a person who cannot be self-sufficient. On a day-by-day basis, custodial care is the least expensive daily cost, however, it can easily become the most expensive level of care because of the length of time-it is needed.

Durations of Nursing Home Stays

How long the average stay in a nursing home is depends on how the statistics are read. In its Annual Report of Long-Term Care Facilities, the Health and Welfare Agency of the California Office of Statewide Health Planning and Development provided the following figures:

DURATIONS OF NURSING HOME STAYS



While it appears that nearly half of all nursing home stays are less than a month, the figures can be misleading because SNFs are increasingly being used for convalescence from acute illnesses and surgeries and nursing facility stays are interrupted by brief hospital visits, the return from which is counted as a new admission.

ASSISTED LIVING/RESIDENTIAL CARE FACILITIES FOR THE ELDERLY

Assisted Living/Residential Care Facilities for the Elderly (RCFE) facilities provide personal care and safe housing for people who may need supervision for medication and assistance with daily living but who do not require 24-hour nursing care. Primarily they are funded through private payments, with about 30% of the RCFE residents relying on SSI/SSP non-medical out-of-home-grants.

These type of facilities have various names in various areas, such as personal care home, adult congregate living facility, home for the aged, etc. They are used by those who require some assistance in their daily activities, but do not require the care provided by a nursing home. Usually these places are structured as condominiums or apartments houses, and the residents can receive assistance with housekeeping, meals and personal care. For those that need additional help in such as eating, bathing, dressing, etc., these services may be provided. There are staff members on duty 24 hours a day to assist the residents when needed.

Assisted living facilities take different forms but usually are part of a retirement community or nursing home. The appearance and grandeur of the surroundings dictate the cost as much, if not more than, the services that are available. They can range from a simple apartment-house type of structure, to that of an exclusive country club or hotel. Such facilities offer a combination of independence and service for individuals where varying levels and intensities of care and supervision, protective supervision, personal care, or health-related services are provided based upon their varying needs. Assisted Living/Personal Care may be included with the monthly fee or residents may be charged according to the level of services used. The fees charged can be based on an hourly rate for different types of services, or according to the level of care provided.

Many facilities now offer specialized Alzheimer's care and the facilities may be used only for the care of people suffering from dementia. They offer special activities and programming, and most

offer enclosed areas where the residents can walk around safely without injuring themselves or others.

Residential Care Facilities for the Elderly

Residential Care Facilities for the Elderly (RCFE) serve elderly persons age 60 and older. They provide room, board, housekeeping, supervision, and personal care assistance and usually offer basic activities like personal hygiene, dressing, eating, and walking. Facilities usually centrally store and distribute medications for residents to self-administer.

They are not medical facilities and so are not required to have nurses, certified nursing assistants or doctors on staff. They may also be called board and room homes, board and care homes, rest homes, assisted living facilities or part of a Continuing Care Retirement Communities (CCRCs) that provide personal care and supervision.

24-hour supervision and assistance are provided for residents with minor medical problems or who need assistance with such things as bathing, grooming, dressing and meals (ADLs & IADLs). Most of these communities offer private, semi-private rooms, or efficiency apartments with or without kitchenettes. They typically provide common living areas (card/games room, library, lounge, social activities, and central dining room), housekeeping, linens (towels and sheets), from one to three meals, and transportation. These facilities are licensed by the State Department of Social Services, Community Care Licensing Division as Residential Facility for the Elderly (RCFE) and they may also supervise and distribute medications to residents.

Not all Assisted Living Facilities are licensed, and therefore, their services may not be covered by the LTCI policies.

As the Baby Boomers enter their retirement years, it's inevitable that some of these seniors, who may once have headed companies or traveled the globe, might start to need assistance with day-to-day activities. But they are understandably reluctant to forfeit their independence. Someone accustomed to managing a business (or a family) can have a difficult time acknowledging that they forget to take their medication, or need help getting bathed and dressed. Because they do not need daily medical care at this point, Assisted Living can be a good housing option.

ASSISTED LIVING FACILITY

An Assisted Living Facility provides care for seniors who need some help with activities of daily living yet wish to remain as independent as possible. A middle ground between independent living and nursing homes, Assisted Living Facilities aim to foster as much autonomy as the resident is capable of. Most facilities offer 24-hour supervision and an array of support services, with more privacy, space, and dignity than many nursing homes—at a lower cost.

There are approximately 33,000 Assisted Living Facilities operating in the U.S. today. The number of residents living in a facility can range from several to 300, with the most common size being between 25 and 120 individuals.

Assisted Living Facilities are also called:

- Personal care homes
- Residential care facilities
- Domiciliary care
- Sheltered housing
- Community residences

An Assisted Living Facility helps seniors with personal care (also called custodial care), such as:

- bathing
- dressing
- toileting
- eating
- grooming
- getting around

Daily contact with supervisory staff is the defining characteristic of an Assisted Living Facility. Medical care is limited in an Assisted Living Facility, but it may be possible to contract for some medical needs.

The key characteristics of Assisted Living Facilities include:

Activities of Daily Living (dressing, personal care)	comprehensive assistance provided
Community Activities (social events, outings, golf, etc.)	some activities offered
Community Services (laundry, cleaning, etc.)	many / most services provided
Health Services (medications, nursing care)	some services provided; not skilled nursing
Environment (personal freedom)	residents are somewhat independent
Overall Health (physical, emotional)	residents have average health problems

Adapted from [SeniorHousingNet®](#)

ASSISTED LIVING FOR SENIORS DIFFERS FROM BOARD AND CARE HOME, NURSING HOME, OR CONGREGATE HOUSING

Assisted Living Facilities offer help with activities of daily living (personal or custodial care), but no or very little medical care. [Board and Care Homes](#) and [Congregate Housing](#) have been around for many decades, and offer about the same services as an Assisted Living Facility. Many Board and Care homes are set up to serve just two to six residents in a converted single family home though some are converted apartments; but Congregate Housing and Assisted Living Facilities generally serve larger numbers of residents. Congregate Housing was originally government subsidized housing, but nowadays various types of senior communities call themselves “congregate housing.” In recent decades, as more and more Assisted Living facilities have been created with different combinations of services, the differences between Board and Care, Congregate Housing, and Assisted Living have become blurred to the point that all three are often considered varieties of Assisted Living.

An Assisted Living Facility differs from a Nursing Home in that:

- an Assisted Living Facility does not offer extensive medical care, as a nursing home does, and
- an Assisted Living Facility places greater emphasis on personal privacy and autonomy.

A nursing home is set up for people who need skilled medical professionals providing care and services on a daily basis.

WHO IS AN APPROPRIATE CANDIDATE FOR ASSISTED LIVING?

It's estimated that one million Americans currently live in Assisted Living Facilities. Assisted Living residents can be young or old, affluent or low income, frail or disabled. A typical resident is a widowed or single woman in her eighties. Residents may suffer from memory disorders, or simply need help with mobility, incontinence or other challenges. Assisted Living is appropriate for anyone who can no longer manage to live on their own but doesn't require medical care.

Assisted Living Facility residents may need help with activities of daily living, including:

- bathing
- dressing
- toileting
- grooming
- cooking/eating
- getting around
- housekeeping
- transportation

If a senior needs a number of services, an Assisted Living Facility may become a more economical alternative to home care services.

An Assisted Living Facility is often the first stop for an elder who needs to get help with daily living. Some residents move on to a Nursing Home; others may come to Assisted Living from a Nursing Home or hospital after a period of rehabilitation.

TYPES OF ASSISTED LIVING FACILITIES

While Assisted Living Facilities are residential in character, there is no standard blueprint because consumers' preferences and needs vary so greatly. Assisted Living residences can range from a high-rise apartment constructed as an Assisted Living Facility, to a converted Victorian home, to a renovated school. They can be free standing or housed with other options, such as independent living or nursing care. They may be studio apartments, or one-bedroom apartments with scaled-down kitchens.

An Assisted Living complex will typically be built with 25 to 110 units, varying in size from one room to a full apartment. This larger type of Assisted Living Facility may have a group dining area and common areas for social and recreational activities.

SERVICES PROVIDED

The basic services an Assisted Living Facility provides include:

- Three meals per day, often served in a restaurant-like setting, with menus and salad bars
- 24-hour supervision
- Personal care assistance (bathing, dressing, grooming, eating)
- Housekeeping and laundry
- Transportation
- Minor medical supervision, such as assistance with medication
- Security and emergency call systems
- Health and exercise programs
- Social, cultural and educational activities

In addition, some facilities offer:

- Recreation rooms
- Exercise rooms
- Outdoor gardens
- Libraries
- Chapels

An Assisted Living Facility may also arrange for residents to receive senior services in the community, such as adult day care, shopping and recreation, and may provide social work assistance to coordinate these services.

SPECIAL NEEDS?

Some Assisted Living Facilities can handle special needs, such as:

- Cognitive disabilities
- Short-term care
- Respite Care (to give regular caregivers a break)
- Interim medical care after a hospital stay
- Alzheimer's
- Parkinson's
- Terminal illnesses (Hospice Care)

STUDY QUESTIONS

1. There are long-term care facilities available that are part of a larger concept, where an elderly person can purchase an apartment and if his health deteriorates, all treatment is available on premises, including long-term care. This may be considered the "optimum" by the residents, but for Long Term Care Insurance purposes
 - A. these facilities are expensive and generally the residents can afford long-term care as it would be in their building.
 - B. this can be a bonanza and agents can set up an office in these buildings as residents of this type of facility will nearly always purchase LTCI policies.
 - C. the policies can usually be sold only if they pay some sort of "tribute" or

- "administrative fee" to the operators of the facility.
- D. agents are forbidden by law to market policies in such a place.
2. In addition to long-term care, medical care can usually be broken down into
- A. geriatrics or family care.
 - B. short-term care and intermediate care.
 - C. either acute or chronic care.
 - D. institutionalized and non-institutionalized.
3. Those conditions that are long-lasting and that require continuing care, as opposed to emergency medical treatment, are
- A. chronic conditions.
 - B. acute conditions.
 - C. personal care.
 - D. covered by Medicare in nearly all situations.

4. In most situations, home health care is provided when the patient insists on staying at home, but can only do so
 - A. when they are covered by some form of long-term care insurance.
 - B. if they have a special form of the LTCI that does not accept nursing home care
 - C. with assistance from a home health care agency, family members, friends or other caregivers.
 - D. if they are covered by Medicaid.

5. For Home Health Insurance coverage, skilled services that cannot be performed by nonprofessional personnel other than medical doctors, including injections and intravenous therapy, wound care, and dispensing of medication must be performed by
 - A. Registered Nurses or Licensed Practical Nurses (RN or LPN).
 - B. Certified Nurse's Assistants (CNA) or Registered Nurses (RN).
 - C. an active member of a Home Health Care organization with special training.
 - D. Medical Doctors and family members who have been personally instructed by the doctor.

6. Those who deliver a wide variety of health care and supportive services, ranging from professional nursing and home care aide care to physical, occupational, respiratory, and speech therapies are
 - A. Home Care providers.
 - B. Adult Day Care providers.
 - C. special trained immediate family members.
 - D. only Registered Nurses (RN).

7. Agencies who employ homemakers or chore workers, HCAs, and companions who support individuals through meal preparation, bathing, dressing, and housekeeping, are
 - A. Hospice services.
 - B. Homemaker and HCA agencies.
 - C. Medicaid.
 - D. Medicare.

8. For those requiring Skilled Nursing Care in a Skilled Nursing Facility, Medicare
 - A. pays for 100 days of coverage in every situation.
 - B. pays nothing at any time.
 - C. may pay up to 100 days of confinements subject to several conditions, including the fact that the patient must be showing improvement.
 - D. does not require any previous hospitalization.

9. To qualify for home health care under Medicare, "To qualify for coverage you must: Need intermittent skilled nursing care, physical therapy, or speech therapy, Be confined to your home, and
- A. Be under the care of a Registered Nurse.
 - B. Be under a doctor's care.
 - C. Have previous hospitalization for at least 3 days.
 - D. Be taking no medication prescribed for the home-confinement illness or condition.
10. Facilities whose aim is to foster as much autonomy as the resident is capable of—most facilities offer 24-hour supervision and an array of support services, with more privacy, space, and dignity than many nursing homes—at a lower cost are generally called
- A. Nursing Homes or Long-Term Skilled Nursing Facilities.
 - B. Continuing Care Community Centers.
 - C. Rest Homes.
 - D. Assisted Living Facilities.

ANSWERS TO STUDY QUESTIONS

1A 2C 3A 4C 5A 6A 7B 8C 9B 10D



CHAPTER X - MEDICAID

Medicaid is the [United States health](#) program for individuals and families with low incomes and resources. It is jointly funded by the states and federal government, and is managed by the states. Among the groups of people served by Medicaid are eligible low-income parents, children, seniors, and people with disabilities. Medicaid is the largest source of funding for medical and health-related services for people with limited income.

Medicaid was created on July 30, 1965 through Title XIX of the [Social Security Act](#). Each state administers its own Medicaid program while the federal [Centers for Medicare and Medicaid Services](#) (CMS) monitors the state-run programs and establishes requirements for service delivery, quality, funding, and eligibility standards.

Medicaid is a joint federal-state program that provides health insurance coverage to certain categories of low-income individuals, including children, pregnant women, parents of eligible children, seniors and people with disabilities. This program has been created in order to help these groups of low-income individuals with any and/or all of their medical bills. Medicaid helps individuals that have no medical insurance or poor health insurance. While Congress and the Centers for Medicare and Medicaid Services set out the main rules under which Medicaid operates, each state runs its own program. As a result, the eligibility rules differ significantly from state to state, although all states must follow the same basic framework.

Both the federal government and state governments have made changes to the eligibility requirements and restrictions over the years. Most recently, the [Deficit Reduction Act](#) (DRA) of 2005 (Pub.L. No. 109-171) significantly changed the rules governing the treatment of asset transfers and homes of nursing home residents. The implementation of these changes will proceed state-by-state over the next few years.

One of the primary requirements for Medicaid eligibility is having a limited income. Medicaid does not pay individuals directly; Medicaid sends benefit payments to health care providers. Medicaid helps individuals that have no medical insurance or poor health insurance. In some states Medicaid beneficiaries are required to pay a small fee (co-payment) for medical services. There are a number of different Medicaid eligibility categories; within each category there are requirements other than income that must be met. These other requirements include but are not limited to age, pregnancy, disabled, blind, old age, income and resources, and being a U.S. citizen or a lawfully admitted immigrant. Special rules exist for those living in a nursing home and disabled children living at home. A child may be covered under Medicaid if she or he is a U.S. citizen or a legal immigrant of the U.S. Regardless if their parent is eligible for Medicaid, a child can still be covered based on their individual status, not their parents. Also if a child lives with someone that is not their parent, they may still be eligible because once again their eligibility is based on their individual status.

The DRA requires that anyone seeking Medicaid must produce documents to prove that he or she is a United States citizen or [resident alien](#).

Unlike Medicare, which is solely a federal program, Medicaid is a joint federal-state program. Each state operates its own Medicaid system, but this system must conform to federal guidelines in order for the state to receive matching funds and grants. The federal matching formula is different from state to state, depending on each state's poverty level. The wealthiest states only receive a federal match of 50% while poorer states receive a larger match.

Medicaid funding has become a major budgetary issue for many states over the last few years, with the program, on average, taking up 22% of each state's budget. According to CMS, the Medicaid program provided health care services to more than 46.0 million people in 2001. In 2002, Medicaid enrollees numbered 39.9 million Americans, the largest group being children (18.4 million or 46 percent). It is estimated that 42.9 million Americans will be enrolled in 2004 (19.7 million of them children) at a total cost of \$295 billion. **Medicaid payments assist nearly 60 percent of all nursing home residents** and about 37 percent of all childbirths in the United States.

Medicaid is also the program that provides the largest portion of federal money spent for health care on people living with [HIV](#). Typically, poor people who are HIV positive must progress to [AIDS](#) before they can qualify under the "disabled" category. More than half of people living with AIDS are estimated to receive Medicaid payments. Two other programs that provide financial assistance to people living with HIV/AIDS are the [Social Security Disability Insurance \(SSDI\)](#) and the [Supplemental Security Income](#).

Medicaid planners typically advise retirees and other individuals facing high nursing home costs to adopt strategies that will protect their financial assets in the event of nursing home admission. State Medicaid programs do not consider the value of one's home in calculating eligibility, therefore it is often recommended that retirees pursue home ownership. By adopting the recommended strategies, many seniors hope they will quickly qualify for Medicaid benefits if the need for long-term care arises.

During the 1990s, many states received waivers from the Federal government to create Medicaid managed care programs. Under managed care, Medicaid recipients are enrolled in a private health plan, which receives a fixed monthly premium from the state. The health plan is then responsible for providing for all or most of the recipient's healthcare needs. Today, all but a few states use managed care to provide coverage to a significant proportion of Medicaid enrollees. Nationwide, roughly 60% of enrollees are enrolled in managed care plans. Core eligibility groups of poor children and parents are most likely to be enrolled in managed care, while the aged and disabled eligibility groups more often remain in traditional "fee for service" Medicaid.

MEDICAID vs LONG TERM CARE INSURANCE

A logical question may be “Why should a Long Term Care Insurance agent care about Medicaid? Isn’t that program designed for the elderly and indigent folks who can not afford insurance anyway?” It is important to understand that for decades many “middle-class” persons have considered Medicaid as their “parachute” if they should have to be sent to a nursing home to live out their days. Elder law attorneys have discovered (and helped write) loopholes in the Medicaid regulations where assets could be hidden away from the prying eyes of Medicaid, or simply become exempt under existing laws—like automobiles, houses (sometimes including

second home or vacation cottages, certain insurance plans and annuities, and the hottest tool of them all, trusts. If a person was able to exempt or hide considerable assets, why would they need Long Term Care insurance?

At one time, it was easy to convince a prospect that nursing homes had two classes, those with insurance or private pay, and those on Medicaid. However, laws now do not allow any differentiation between paying patients and Medicaid.

Realizing that Medicaid paid for at least 60% of the nursing home costs of its patients, states and the federal government have tightened up these exemptions so that a “middle-class” patient could easily spend nearly every cent they have for nursing home expenses, leaving little if anything for the surviving spouse—and then when the spouse died, if the nursing home costs have not been recovered in its entirety Medicaid will go after the estate for the remainder.

Medicaid should not be looked upon as the “enemy,” but only as a vehicle for those who cannot afford to pay their own way and are content to be wards of the state. It is becoming more and more important to understand Medicaid as recent regulations (such as the recent Deficit Reduction Act) has really tightened up the eligibility requirements. By understanding Medicaid, an agent is better prepared to discuss the advantages of Long Term Care Insurance, which not only helps the marketing aspect, but as importantly, a prospect can be educated so that he will not be in a position in the future where his assets, most or all of them, are going to the government instead of to his heirs and estate.

ESTATE RECOVERY

People with Medicare are notified of the Medicaid estate recovery program during their initial application for Medicaid eligibility and annual redetermination process. Individuals in medical facilities (who do not return home) are sent a notice of action by their county Department of Social Services informing them of any intent to place a lien/claim on their real property. The notice also informs them of their appeal rights. Estate recovery procedures are initiated after the beneficiary's death.

The Omnibus Budget Reconciliation Act (OBRA) of 1993 defines "estate" and requires each state to seek adjustment or recovery of amounts correctly paid by the state for certain people with Medicaid.



The state must, at a minimum, seek recovery for services provided to a person of any age in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution.

The State may, at its option, recover amounts up to the total amount spent on the individual's behalf for medical assistance for other services under the state's plan. Dying is no protection, it seems, as in addition, states that had state plans approved after May 14, 1993 that disregarded assets or resources of persons with long-term care insurance policies must recover all Medicaid costs for nursing facility and other long-term care services from the estate of persons who had such policies. States that had a "partnership program" long-term care insurance policy are exempt because they had state plans approved as of May 14, 1993 and are exempt from seeking recovery from individuals with long-term care insurance policies. For all other individuals, these states are required to comply with the estate recovery provisions as specified above.

States are also required to establish procedures, under standards specified by the Secretary for waiving estate recovery when recovery would cause an undue hardship. "Undue hardship" is generally not solidly defined.

SPOUSAL IMPOVERISHMENT

The expense of nursing home care, which ranges from \$4,000 to \$6,000 a month or more, can rapidly deplete the lifetime savings of elderly couples. In 1988, Congress enacted provisions to prevent what has come to be called "spousal impoverishment," which can leave the spouse who is still living at home in the community with little or no income or resources. These provisions help ensure that this situation will not occur and that community spouses are able to live out their lives with independence and dignity.¹⁴²

RESOURCE ELIGIBILITY

The spousal impoverishment provisions apply when one member of a couple enters a nursing facility or other medical institution and is expected to remain there for at least 30 days. As part of the procedures, when the couple applies for Medicaid, an assessment of their resources is made. The couple's resources, regardless of who owns what and who inherited what from Great Aunt Vinnie, and regardless of present or past ownership, are combined. The couple's home, household goods, automobile and burial funds are not included in the couple's combined resources. The result is the couple's combined countable resources. This amount is then used to determine the Spousal Share, which is one-half of the couple's combined resources.

Note: If one looks around some of the retirement homes and spots more than a few Mercedes, Cadillacs and Lincolns, this is a good way to shield assets from Medicaid. True, they lose value rather rapidly, but the attitude a lot of the time, is that "Old Jim is in the nursing home and I'm going out for lunch with the girls and I'm driving my MB 500! And mean old Uncle Sam (he gets blamed for a lot) is not going to get that money..."

Now comes the arithmetic: To determine whether the spouse residing in a medical facility meets the state's resource standard for Medicaid, the following procedure is used: From the couple's combined countable resources, a Protected Resource Amount (PRA) (new term) is subtracted. The PRA is defined as the greatest of:

1. The Spousal Share, up to a maximum of \$101,640 in 2007;
2. The state spousal resource standard, which a state can set at any amount between \$20,328 and \$101,640 in 2007;
3. An amount transferred to the community spouse for her/his support as directed by a court order; or
4. An amount designated by a state hearing officer to raise the community spouse's protected resources up to the minimum monthly maintenance needs standard.

The PRA is then subtracted from the couple's combined countable resources; the remainder is considered available to the spouse residing in the medical institution as countable resources. If the amount of countable resources is below the State's resource standard, the individual is eligible for Medicaid. Once resource eligibility is determined, any resources belonging to the community spouse are no longer considered available to the spouse in the medical facility.

INCOME ELIGIBILITY

The community spouse's income is not considered available to the spouse who is in the medical facility and the two individuals are not considered a couple for income eligibility purposes. The state uses the income eligibility standard for one person rather than two, and the standard income eligibility process for Medicaid is used.

POST-ELIGIBILITY TREATMENT OF INCOME

Once a person is determined to be eligible for Medicaid, then the post-eligibility process is used to determine how much the spouse in the medical facility must contribute toward his/her cost of nursing facility/institutional care, while, at the same time, determining how much of the income of the spouse who is in the medical facility is actually protected for the use by the community spouse.

The process starts by determining the total income of the spouse in the medical facility. From that spouse's total income, the following items are deducted:

1. Personal needs allowance of at least \$30;
2. A community spouse's monthly income allowance (between \$1,650.00 and \$2,541.00 for 2007), as long as the income is actually made available to her/him;
3. A family monthly income allowance, if there are other family members living in the household;
4. An amount for medical expenses incurred by the spouse who is in the medical facility.

The community spouse's monthly income allowance is the amount of the institutionalized spouse's income that is actually made available to the community spouse. If the community spouse has income of his or her own, the amount of that income is deducted from the community spouse's monthly income allowance. In the same vein, any income of family members, such as dependent children, is deducted from the family monthly income allowance.

Once the above items are deducted from the institutionalized spouse's income, any remaining income is contributed toward the cost of his or her care in the institution.¹⁴³

These provisions apply when assets are transferred by individuals in long-term care facilities or receiving home and community-based waiver services, or by their spouses, or someone else acting on their behalf. At state option, these provisions can also apply to various other eligibility groups.

States can "look back" to find transfers of assets for 60 (was 36 months previously) months prior to the date the individual is institutionalized or, if later, the date he or she applies for Medicaid.

If a transfer of assets for less than fair market value is found, the State must withhold payment for nursing facility care (and certain other long-term care services) for a period of time referred to as the penalty period.

The length of the penalty period is determined by dividing the value of the transferred asset by the average monthly private-pay rate for nursing facility care in the State. Example: A trans-

ferred asset worth \$90,000, divided by a \$3,000 average monthly private-pay rate, results in a 30-month penalty period. There is no limit to the length of the penalty period.

For certain types of transfers, these penalties are not applied. The principal exceptions are:

1. Transfers to a spouse, or to a third party for the sole benefit of the spouse;
2. Transfers by a spouse to a third party for the sole benefit of the spouse;
3. Transfers to certain disabled individuals, or to trusts established for those individuals;
4. Transfers for a purpose other than to qualify for Medicaid; and
5. Transfers where imposing a penalty would cause undue hardship.

Bad news for the seniors – if they are applying for Medicaid benefits to pay for their nursing home care, they must be prepared to be denied. As the result of some catastrophic (to many elders) changes—on February 1, 2006 Congress voted 216 to 214 in favor of sweeping "reforms" to restrict senior's access to benefits used to pay for long term nursing care as part of a fundamental and sweeping change of the Medicaid program. Many attorneys who practice elder law are of the opinion that nearly every nursing home resident who applies for Medicaid benefits will be disqualified. The obvious reasoning seems to be that this is a desperate attempt to get the rapidly increasing costs of Medicaid under control. The laws had been relative stable for over 10 years, but now, there are new rules regarding eligibility, rather draconian in the opinion of many.

Basically, the new laws changes how gifts can be affected when the giftor soon after gifts are made, goes into a nursing home. Making gifts prior to entering a nursing home can, and will, disqualify a person from Medicaid benefits.

Taking a look at how it was and how it is now may help to explain what happened. Prior to the new law if a person gave any assets away, whether or not they thought they might be going to a nursing home they were disqualified for benefits, but the period of disqualification was determined by how much they have gifted. For instance, if a person gave away \$33,000, then they were disqualified for 10 months (using a typical \$3,300 figure), and if they gave away \$66,000, they would not be qualified for 20 months. Almost two years! The key here, however, is not necessarily how long of a penalty period but when did the disqualification period start.

Under the old law the period of disqualification started immediately after the giving of the gift, which makes sense as the smaller gifts never disqualified an applicant and larger gifts with the resulting penalty, would probably expire before the person actually went to the nursing home.



According to DRA, every single gift that a person makes for five years prior to their entering into a nursing home, will now be added together as a "super gift."

Never mind that Grandpa Joe always gave away his income from junk bonds to his grandkids every Christmas over the past 5 years and there was no gift tax involved. The person will be disqualified not from the date the transfer was made, but from the date they apply for Medicaid after entering the nursing home. The bad part is that when the person most needs benefits—when they enter a nursing home—they are penalized for being generous.

Some numbers may help: Grandpa gives his three kids \$500 each at Christmas. He gives \$20 each week to his church, \$1,000 to the Salvation Army, and \$1,000 to his Masonic

Lodge. That leaves him with \$25,000 in the bank each year, which is just the way he wants it. But when he goes into a nursing home and applied for Medicaid benefits, Oh, oh!

First, he will have to spend his \$25,000 (good for about 5 months of care) until his assets are down to \$2,000, then he can apply for Medicaid benefits. However, Grandpa gave away nearly \$15,000 over the past 5 years, so he will be disqualified for Medicaid benefits for the next approximately 5 months. Where is he to get the funds?

Every so often on television, a situation arises where the (actor) lawyer states that it is just the "law of unintended consequences." One of the unintended consequences is that the nursing home has a nonpaying guest on its hands, and in nearly all cases, it would be illegal to put Grandpa out on the street.

The unintended consequences can be severe if this happens very often—the nursing home could go bankrupt. The best bet at this time is to hope that Congress comes to its senses and changes that law before nursing homes dump their patients to hospitals, who already are overcrowded.

Other changes to the Medicaid rules include the increase in the look-back period for gift/transfers from three years to five years. Now all transfers, whether to individuals or trusts, will be subject to a five year look-back period.

In previous years, annuities were often used because there was an actual "loophole" in Medicaid regulations for some time which created an industry of "Medicare Annuities." Annuities used to not be counted toward assets or income when determining Medicaid eligibility. Lots of annuities were sold but as expected, soon the states said "Whoa, Nellie." Now, annuities will be counted. The exact language states that the state "be named the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant." This appears to mean that the state could demand the entire annuity even though the Medicaid beneficiary pays for only a month of care. There are some problems with exactly how this is going to work at this time, as perhaps current Medicaid recipients may have to change their existing annuities to make the state the beneficiary upon their annual recertification review.

And then there is the last bastion of the hard-working man—the family homestead. Homes used to be sacrosanct and were exempt from Medicaid consideration. No more—the home is exempt if it is worth less than \$500,000, but there are allowances to change this to \$750,000 on a state-by-state basis. Obviously, a \$500,000 home may be a mansion in rural Kansas, but it would be a two bedroom one bathroom hut in San Jose.



THE ELIGIBILITY REQUIREMENTS

In order to qualify for Medicaid the applicant must meet the Medicaid program's requirements for eligibility. The specific requirements the applicant must meet include: (1) Basic "medical" need (also referred to as a level of care); (2) age or disability; and (3) the financial situation of the applicant including the applicant's income and assets. In order to be eligible for Medicaid the applicant must satisfy all three requirements.

PART ONE – MEDICAL REQUIREMENTS

Basically, Medicaid requires that the applicant have a **significant** inability to care for him or herself. Okay, what degree of care or level of care is significant enough? Simply put, the person must have an impairment or illness severe enough to limit his or her activities of daily living to a point where a nursing home is the appropriate placement.

The specific standards used to determine if the medical need is present are:

- The need must require twenty-four hour nursing care in a "skilled care facility." A skilled care facility is one where professional nursing services such as physicians, respiratory therapists, audiologists, physical and occupational therapists are available;
- The person's needs are so medically complex that he or she requires supervision, assessment or planning by a registered nurse;
- The person must need the care on a daily basis;
- The person needs ongoing involvement of a registered nurse or other professional in the individual's medical evaluation and the implementation of a treatment plan;
- The person needs continuous observation in order to monitor for complications or changes in the status of his or her condition; and
- The care the person needs should not be of a degree which would normally be provided by a hospital.

These requirements are not as difficult as they may seem as by the time that help is needed, the medical need is already well in place. As a general rule people delay putting their loved ones into a nursing home until they just absolutely must do so. Therefore, by the time that placement is actually made, the time that they should have been so placed has long passed. However, something like Alzheimer's can sneak up on a person so that it is difficult to determine when the best time for commitment actually is.

PART TWO – AGED, DISABLED OR BLIND

In order to be eligible for benefits the applicant must be either over 65, be characterized as "disabled," or blind. Disabled is defined as the inability to perform gainful activity for a period of time that is expected to exceed one year. For example, a 60 year-old with Alzheimer's would satisfy this requirement if the Alzheimer's disease sufficiently impairs his or her ability to work to such a degree that he or she is qualified as disabled. It is noteworthy that the person does not actually be declared disabled by the Social Security Administration or be receiving Social Security Disability payments. A 70 year-old, on the other hand, clearly meets the age requirement and need not be disabled as long as he or she has the medical need and passes the financial requirements.

PART THREE - FINANCIAL

The financial requirement is the most confusing and difficult to attain. It consists of two parts, the assets of the applicant (income cap states) and in some states, the income of the applicant. Nine of the states eligibility is determined by income, and the other states are known as "medical needy states" that use income just to determine the amount that the state will con-

tribute to the person's care. Income cap states presently are Florida, Arizona, Arkansas, Colorado, Iowa, Louisiana, Oklahoma, Oregon and Texas.

ASSET REQUIREMENTS

Welcome to a new term: "Community Spouse." Whether a spouse of a person that had to go into a nursing home would be able to take care of her/him financially, was of obvious concern to the lawmakers that changed Medicaid laws in 1986, hence the term "community spouse." The community spouse has special considerations. However, if both spouses are in the nursing home—even if only one spouse applies for Medicaid—then there is no community spouse and both patients must use the single-applicant limits.

The allowed asset maximum amount for a typical married couple may keep up to \$101,540 in countable assets. (\$99,540 for the community spouse and \$2,000 for the applicant spouse.) Contrast that with the limit for a single person, including widows, which is only \$2,000 in countable assets. (The \$2,000 limit increases to \$5,000 if the income of the applicant is under \$731 per month.) The following chart summarizes the eligibility levels for assets and income in Delaware:

APPLICANT	COMMUNITY SPOUSE	ALLOWED ASSETS	ALLOWED MO. INCOME
Single	\$2,000	N/A	\$1,809
Married	\$2,000	\$99,540*	(\$1,809 for Applicant only)

*Add \$3,000 more in allowed assets for applicants with income less than \$731 per month



INCOME AND ASSET ELIGIBILITY REQUIREMENTS
DETERMINATION OF AN ASSET

Assets are considered as either countable or non-countable. This is an important division because many applicants have assets that are not counted and are considered non-countable assets for purposes of determining Medicaid eligibility. As an example, the first \$500,000 of the value of the primary residence is not counted. Any home value above that figure is considered as an asset. A natural question here is what happens to the home after the Medicaid recipient dies—a good question which is discussed later.

This can be important as often those who approach an Elder Law attorney have already sold their home in desperation in order to pay nursing home bills. That, of course, is not the thing to do as the value of the house is exempt from being considered as an asset in determining the Medicaid eligibility. There are other exempt assets, such as the car and a burial account, but these are not as significant as the home.

Bank accounts are another area of confusion to many. Many people feel that if the bank account is a joint bank account, it is only treated as half an asset—not so, all (100%) of the account is treated as an asset. Many try to avoid this by having a close relative on the account—son or

daughter usually—withdraw most of the account so that it will not all be counted as an asset. Not only does this not work, it is illegal and is specifically forbidden by law.

Other assets may have been overlooked, such as the cash value of a life insurance policy, or a pre-paid burial plan (if it is not irrevocable it will be considered as an asset). IRAs and burial contracts are counted if they are not adjusted to change them to non-countable assets.

INCOME LIMIT

In Delaware, the 2006 income limit is set at a maximum of \$1,809 per month. This amount is determined on the applicant's gross income, not his or her net income. This means that a deduction such as the Medicare premium and any withholding tax must be added back to determine the applicant's gross income.

An applicant for Medicaid can be ineligible even if they have no other assets or other means to generate cash. If the applicant is entering a nursing home, the cost could be \$5,000 a month. Being over income imposes the harsh result of ineligibility for the applicant who is over the income cap even though he or she has no other assets and no other means to generate additional cash flow. While he may have a relatively high income he may not be able to produce the \$5,000 each month. This is known as the Medicaid Gap—too much income to qualify for benefits, to little income to pay for care.

In these difficult situations, the first thing is to identify just exactly what is income. Simply put, every source of income is considered countable income, such as Social Security, pensions, disability, VA benefits, interest income, non-taxable income, IRA distributions, annuity income (regardless of whether it is taken out of the annuity or not), dividends, and everything else that the applicant receives is considered income—with only rare exceptions. Actually, payments from long-term care insurance policies are usually counted as income and just might push the applicant over the income cap. (If the LTCI policy had inflation protection, then they probably would not have to ask for Medicaid protection—unless, of course, the policy term had been exceeded. Still, a person in a nursing home that had been covered by an LTCI policy that stays beyond the policy term will not "end up in the street." But, they will start paying their own money from now on.)

When a person is on Medicaid his or her income is used to help pay for the care in the nursing facility, which is, appropriately enough, called the patient responsibility. This entails minor arithmetic, though, as the applicant must contribute all of his income to the nursing facility, minus \$35 (for the purchase of toiletries, etc.) If there is a community spouse, the spouse can keep a portion based on his/her need—usually the spouse can divert his/her income to \$1,603.75 (2006)...but wait! If the community spouse has significant expenses for housing such as rent or mortgage payments, property taxes, etc., then they may be able to divert income from the applicant up to (2006) \$2,488.50.

The patient responsibility also includes those amounts that are being deposited into an income trust and which are then forwarded to the nursing home as part of the patient's responsibility. However the arrangement, the entire patient's income, except for a few small deductions for personal needs or a spousal diversion, must go to the nursing home. Income trusts are discussed later also.



TRANSFERRING ASSETS

Transferring assets improperly violates the first commandment of Medicaid law, "Thou shalt not give your assets away to qualify for Medicaid benefits." If the applicant has too many assets and wants to qualify for Medicaid benefits, the tendency for most people is to just give the excess assets away. This solution sounds too easy, and as with most things, if it sounds too easy, you can't do it. This has been discussed earlier, but it is so important a revisit does not hurt.

The government will not allow you to simply give assets away in order to become qualified. As discussed, there are very strict rules prohibiting gifts of assets to become eligible for Medicaid. Any uncompensated transfer or even an under-compensated transfer will disqualify the applicant from receiving Medicaid benefits.

Assets may be moved and preserved if done under what the rules allow. It may not be called a gift or a transfer but nonetheless the assets can be moved, and if moved properly the assets become protected. This is the essence of Medicaid planning, the movement of assets to preserve and protect them.

The DRA wording makes it seem that it would be a criminal act to transfer assets to become eligible for Medicaid benefits, however Congress tried to make it illegal in 1997, but the resulting public outrage forced Congress to amend the law. Congress's next attempt at Medicaid reform made it a crime for someone, even an attorney, to tell a client how to legally transfer assets in order to qualify for benefits. It was as if they were saying that while it is legal to transfer assets it would be illegal to tell anyone about it. The absurdity of such a law has been recognized by the courts and has been overturned for restricting constitutionally guaranteed free speech. Under the DRA, it remains to be seen how this is played out. Some attorneys practicing Elder Law feel that it is again a crime to try to shield assets by transferring them in order to qualify for Medicaid.

Transfer Ineligibility

If someone gives assets away, how long does the person have to wait before he or she can become eligible for Medicaid? —this is the fundamental question for most people. The Deficit Reduction Act has changed how people would be penalized for giving assets away. For example, prior to February 2006 a person was disqualified from the date the transfer was made, but now the Medicaid applicant is penalized from the date of application for Medicaid benefits after he or she enters the nursing home.

A simple exercise to determine the length of time an improper transfer disqualifies a person for Medicaid is to take the amount of money (or worth of an asset) transferred and then divide that by the state's transfer divisor (presently typically \$3,300). The answer is the number of months the person is ineligible for Medicaid starting from the date of application for Medicaid benefits after entry into the nursing home.

The amount of time the person has to wait for benefits is calculated by dividing the amount of assets transferred by the average cost of care, (\$3,300 in Delaware). This "average cost of care" figure does not nor is it intended to reflect the actual current average cost of care, but is simply a part of the state's formula to determine the ineligibility period.

As an example, using Delaware's average cost of care of \$3,300 per month, if a person transferred \$33,000 to a son or daughter (for instance) within the look-back period of 60 months, the person would be ineligible for benefits for a period of ten months from the date of application for Medicaid. ($33,000 \div 3,300 = 10$ months.)

Under the DRA, every gift a person makes during the five years prior to the person's entry into the nursing home will be added together as a "super transfer." The person will be disqualified not from the date the transfer was made, but from the date they apply for Medicaid after entering the nursing home.



This effectively penalizes a person for giving something away at the time the person most needs benefits—when they enter the nursing home.

A word on transfers between spouses. As of the printing of this book inter-spousal transfers, transfers between spouses, are not considered transfers. No penalties are assessed for transferring assets between husband and wife.

LOOK-BACK PERIODS

The transfer of asset penalty disqualifies an applicant only if they transfer assets within a certain period of time before you apply for benefits. This period of time is called a look-back period.

A transfer that falls within the time line must be disclosed at the time of the eligibility hearing. In the example, if a \$33,000 transfer was made 10 months ago, it must be disclosed at the time of the Medicaid application, and will now, under the new law, disqualify the applicant for 10 months into the future as would a transfer of \$66,000 made 20 months ago would disqualify the applicant for 20 months into the future.



The transfer does not necessarily have to be one big transfer. It can be an aggregate of all the transfers made by the applicant in the prior five years before the application.

Transferring or giving assets away has been one of the most basic techniques used to qualify for Medicaid but under the new laws, this almost guarantees a denial. Since it is impossible to predict the future, transfer of assets are rarely recommended when a person attempts to qualify for Medicaid.

Patient Responsibility

"Patient responsibility" when used in the Medicaid regulations, refers to the amount that the nursing home resident is required to pay to the nursing home each month and is usually the applicant's gross monthly income minus a \$35 personal deduction (used for personal items, such as toiletries, etc.). If there is a community spouse, such deduction is also applicable.

Incremental Transfers

Prior to the DRA, those attempting to qualify for Medicaid benefits would move assets on a monthly basis as that would reduce the asset transfer to suit the Medicaid requirements. Such is no longer the case as any monthly incremental movement of the assets now are added together

with the penalty being assessed at the time of Medicaid application instead of when the asset was given away. These small transfers can even include Christmas gifts and charitable donations.

Other transfer strategies include paying the asset to a family member, moving it to a specialized pooled trust or loaning the asset out. Assets can be protected by changing their character and converting them from countable assets to non-countable assets, such as improvements to a home. Purchasing a car (the famous "Mercedes" ownership) and the purchase of a burial or funeral contract is another. Again, legal expertise is needed.



ANNUITIES

Another category of preservation strategies uses specifically crafted investments called annuities to convert assets into income. By changing the asset into an income stream with an annuity the applicant's assets are reduced below the asset cap. As simple as this may seem, this has the most possibility of danger as if the annuity is not written with the correct terms, if the applicant's situation is not just right, the use of an annuity can do more damage than good. After the annuity is purchased it is an irrevocable act and cannot be undone. Under recent legislation enacted February 8, 2006, annuities and their use in Medicaid planning have been severely restricted.



The State must be made the beneficiary of the annuity if they are to be considered in Medicaid eligibility.

MEDICAID ESTATE RECOVERY

Medicaid Estate Recovery refers to the fact that the state tries to recoup what it has paid to take care of the person from his or her estate after he or she has died. When a Medicaid recipient dies, the state has an enforceable debt against the estate of the Medicaid recipient as the state wants to be repaid for all of the care that it gave to the deceased. OK—but from what does the state expect to be paid? When the deceased became eligible for Medicaid the recipient's assets were depleted or repositioned, therefore when the Medicaid recipient dies his or her estate has already been moved or spent. However, they can go after the home, business property and personal injury settlements (if that is involved). Principally, the big concern would be to protect the home.

The law regarding recovery of assets from a Medicaid recipient is very state specific and Delaware has its own set of unique rules and policies concerning paying back Medicaid. The home, though not counted as an asset when determining eligibility, is, at death, in nearly every state, an attachable asset available to pay back Medicaid.

Typically, safeguarding assets other than the home from Medicaid estate recovery requires a change of estate plan from a will to a trust. If the assets pass to the beneficiaries from the revocable living trust instead of through the will/probate process, these assets will be protected

from recovery and if this problem is not addressed, the death of the community spouse will destroy the surviving spouse's eligibility for Medicaid.

This is a legal point, but it is good to know when discussing what is left in an estate upon the death of the husband or wife. Most wills or estate plans state that upon the death of one spouse, all of his/her assets go to the surviving spouse. To be safe, Elder Law attorneys recommend (strongly) that the will or estate plan be changed to direct that the assets go to a trust for the benefit of the surviving spouse or to family members other than the surviving spouse.

It is beyond the purpose of this text to go into these laws in much detail, but recently some states have recently made critical policy changes regarding continuing eligibility of Nursing Home Medicaid (ICP) recipients. The Problem: When one spouse is on Medicaid in a nursing home, and the spouse who is still at home dies, the spouse in the nursing home may lose his or her eligibility for Medicaid. Even if the well spouse changes his or her will to bypass the ill spouse, this may not be enough.

Medicaid can collect additional money even if the non-confined spouse has willed all of her assets to her children and then she should die while the other spouse is in a nursing home as a Medicaid patient. If this happened, it would seem that the patient's assets have not increased, but under the "elective share" requirement of the Medicaid regulations, which would amount of up to 30% of the estate. Legal help time again.

STUDY QUESTIONS

1. Medicaid is
 - A. part of Social Security.
 - B. provided by the DHS to those over age 65 and those disabled.
 - C. divided into two parts, Part A and Part B
 - D. a United States program for individuals and families with low incomes and resources.

2. Under Medicaid, each state operates its own Medicaid system, and in order for the state to receive matching federal funds and grants,
 - A. each state must spend a pre-determined amount of money for Medicaid health care.
 - B. every citizen over age 65 must be a Medicaid patient.
 - C. the state must conform to federal guidelines.
 - D. only extremely poor citizens can receive health care under Medicaid.

3. An agent should be prepared to discuss the advantages of LTCI over Medicaid so that
 - A. the agent can get a higher commission if the client goes on Medicaid later as the insurer would not have to pay for his long-term care.
 - B. the client will not be in a position in the future where his assets are going to the government for his long-term care, instead of to his heirs and estate.
 - C. he can better pass the test if the Partnership Plan is introduced in his state.
 - D. the client can move his assets into an area where they will be exempt from Medicaid asset seizure, such as a more expensive home, etc.

4. Federal law requires the state, at a minimum to seek recovery for services provided to a person of any age in a nursing facility, intermediate care facility for the mentally retarded or
 - A. any other medical institution.
 - B. any other institution that treats mentally impaired persons.
 - C. at a day care center for adults.
 - D. for assistance in any activity of daily living.

5. For Medicaid recovery purposes, the items that are exempt from Medicaid are a couple's home, burial plan and
 - A. any assets in a trust.
 - B. securities held in both names.
 - C. transfer of assets to children or grandchildren.
 - D. automobile.

6. Congress has enacted rather "draconian" reforms on a senior's access to his benefits used to pay for long-term nursing home care because
 - A. the Democrat congress wants more assets to spend on other projects.
 - B. the President wants more money into the US treasury without obviously raising taxes.
 - C. it is (desperately?) trying to get Medicaid costs under control.
 - D. the government is always looking for ways to steal citizen's assets.

7. According to the Deficit Reduction Act of 2006 (DRA) every single gift that a person makes for five years prior to their entering into a nursing home
 - A. will now be added together to form a "super gift."
 - B. will be sorted to where any gifts to immediate families are exempt.
 - C. will suffer a gift tax if the value is more than \$20,000 to any one person from any one person.
 - D. will be exempt from Medicaid seizure.

8. All transfers of assets, whether to individuals or trusts, will
 - A. be exempt.
 - B. will be exempt up to value of \$500,000.
 - C. subject to a five year look-back period.
 - D. be considered as a criminal evasion of taxes.

9. A home is exempt from Medicaid seizure if
 - A. it is a vacation or second home.
 - B. the home is not less than 5 years old.
 - C. has a present value of up to \$500,000.
 - D. has a present value of up to \$1 million.

10. In order to qualify for Medicaid, the applicant must have
 - A. debts exceeding 200% of net worth.
 - B. no home or car.
 - C. a significant inability to care for him or herself.
 - D. a doctor's statement saying that they would be better off in a nursing home.

11. Also, in order for an applicant to be eligible for Medicaid benefits the applicant must be either over 65, characterized as "disabled," or
 - A. be mentally incompetent.
 - B. in the case of a female, pregnant with no visible means of support.
 - C. blind.
 - D. have a severe psychosis.

12. For Medicaid income limit, the 2006 income limit is set at a maximum of
 - A. \$500 per month.
 - B. \$2,000 per month.
 - C. \$1,809 per month.
 - D. \$100 per week.

13. The transfer of asset penalty for Medicaid disqualifies an applicant who transfers assets within a certain period of time before applying for benefits. This period of time is called
 - A. the disqualification period.
 - B. the termination dates.
 - C. asset manipulation period.
 - D. look-back period.

14. Annuities are not used as much to protect assets from Medicaid seizures as in prior years because of recent regulations, in any respect, if the annuity is to be included in Medicaid eligibility
- A. the state must be made the beneficiary.
 - B. the estate must be the beneficiary.
 - C. the beneficiary must be a blood relative.
 - D. the annuity must be immediately annuitized.

ANSWERS TO STUDY QUESTIONS

1D 2D 3B 4A 5D 6C 7A 8C 9C 10C 11C 12C 13D 14A



CHAPTER XI- GROUP LTC INSURANCE

DEFINITION OF GROUP LTCI

Group long-term care insurance is defined according to Delaware regulations as a long-term care insurance policy which is delivered or issued for delivery issued to:

- a. One or more employers or labor organizations, or to a trust or to the trustees of a fund established by 1 or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof, or for members or former members or a combination thereof, of the labor organization; or
- b. Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and such association has been maintained in good faith for purposes other than obtaining insurance; or
- c. An association or a trust or the trustee(s) of a fund established, created or maintained for the benefit of members of 1 or more associations. Prior to advertising, marketing or offering such policy within this State, each such association or the insurer of such association, shall file evidence with the Commissioner that the association has at the outset a minimum of 100 persons; has been organized and maintained in good faith for purposes other than that of obtaining insurance; has been in active existence for at least 1 year; and has a constitution and bylaws which provide that:
 1. The association holds regular meetings not less than annually to further purposes of the members;
 2. Except for credit unions, the association collects dues or solicits contributions from members; and
 3. The members of the association have voting privileges and representation on the governing board and committees.Thirty days after such filing the association shall be deemed to satisfy such organizational requirements, unless the Commissioner makes a finding that the association or associations do not satisfy those organizational requirements; or
- d. A group other than as described in the regulations, subject to a finding by the Commissioner that:
 1. The issuance of the group policy is not contrary to the best interest of the public;
 2. The issuance of the group policy would result in economies of acquisition or administration; and
 3. The benefits are reasonable in relation to the premiums charged.¹⁴⁴

GROUP CERTIFICATE

A certificate issued pursuant to a group long-term care insurance policy which policy is delivered or issued for delivery must include:

- (1) A description of the principal benefits and coverage provided in the policy;
- (2) A statement of the principal exclusions, reductions and limitations contained in the policy; and
- (3) A statement that the group master policy determines governing contractual provisions.¹⁴⁵

IMPACT OF HIPAA ON GROUP LTCI

Group Long Term Care Insurance has become more “interesting” because of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as for the first time, the taxation of employers who provide Long Term Care Insurance for their employees have been published. Several insurers have entered the Group Long Term Care Insurance business as a result of the Act, but success has been limited so far. The primary provisions of this act involving Group LTC or Employers furnishing LTC Insurance coverage for employees. With some reiteration of these provisions:

- Employers who pay LTCI premiums on behalf of an employee will be entitled to deduct that premium as a business expense, as they do for medical insurance.
- LTC Insurance premiums paid by an employer on behalf of an employee will not be treated as income to that employee.
- Long Term Care Insurance is not permitted under Section 125 cafeteria plans; nor can long term care expenses be reimbursed by a Flexible Spending Account.
- Long Term Care Insurance premium is, however, an acceptable expenditure for the new medical savings accounts that this law makes available to self-employed and small businesses of fewer than 50 lives.
- Long Term Care Insurance premiums are tax deductible to the self-employed within the overall self-employed deductible limits.

NOTE: Please refer to previous Chapter on Taxation of Long Term Care Insurance as it covers the taxation of Group Long Term Care Insurance as well as Individual LTCI policies

EMPLOYER-SPONSORED LTC INSURANCE

In 1987 insurers began offering the first employer-sponsored or group Long Term Care Insurance plans. As has been the case with policies marketed to individuals, insurance companies have both entered and withdrawn from the market since that time. HIAA reports that in 1994, of the 121 companies marketing LTC policies, less than 20% offered employer-sponsored plans. Still, the number of employers offering group LTC has begun to rise dramatically, with the most noticeable increase being in small businesses with less than 500 employees.

Many of the employer-sponsored LTC plans in place are located in very large employee environments such as IBM, Ford Motor Company, Proctor & Gamble, and state government employee groups. In addition, most of these plans are not "off the shelf" policies. Instead, they have been designed specifically for a given group through consultation between the employer

and the insurance company. As can be seen from the figures above, some insurance companies have begun to target small companies as lucrative markets for their plans, though the numbers show that only a very small percentage of all U.S. employer groups have been affected to date.

FACTORS AFFECTING THE GROUP MARKET

For insurance companies and agents, the employer-sponsored market appears ripe. Why, then, are so few insurers involved? Observers generally cite the high cost of entering this market. A significant start-up investment, including case management structures to deal with a myriad of variables in long-term care, is required. With less than a decade of experience in group LTC, insurance companies do not yet have a large body of statistical data to finely hone policy provisions and pricing-factors that can either promote profitability or contribute to high losses. With such a large segment of the employer market untapped, however, this situation is likely to change as those insurers who have decided to stay in this field increase their sales efforts.

Insurer reluctance is not the only factor responsible for the small number of employer-sponsored LTC plans. Employers who aren't exactly scouring the marketplace for additional employee benefits to offer have not yet fully embraced the concept. An agent can be a persuasive force in changing this attitude toward group coverage by promoting the following advantages.

- ✓ LTC Insurance can be especially appealing as an addition to an employee benefits package, although the employer must commit a certain amount of time and money to handle administrative details, including payroll deduction.
- ✓ The HIPAA of 1996 (as described in detail in this text) The trade-off's are between a shorter elimination period (less out-of-pocket expense) and higher policy premium versus a longer elimination period (more out-of-pocket expense) and lower policy premium.
- ✓ There is still another factor that makes employer-sponsored LTC Insurance attractive. Employers are beginning to recognize the economic loss that occurs when an employee must deal with the financial stresses of long-term care for a spouse or for elderly parents. Group LTC Insurance can help relieve the burden, both financially and by reducing employee work hours lost from providing care for a family member. LTC Insurance can help maintain or restore employee productivity by removing one of the reasons for loss of productivity.

GROUP PLAN FEATURES

With Group LTC Insurance, some of the conventional features of group plans remain intact while other features are more similar to individual insurance policies. First of all, the policies might actually *be* individual LTCI policies. If so, the policies are fully "portable" if the employee leaves the plan and need not be converted in the traditional way. Optionally, the employer-sponsored LTCI plan may be set up like other group coverages, requiring employees who want to continue the insurance to convert to individual policies within a certain period after termination. This is called a conversion privilege and not all group insurance plans offer it.

ELIGIBILITY

A feature that sets group LTCI coverage apart from other types of group insurance is who may be covered. Most plans are offered not only to employees and their spouses, but also to the parents of both parties and, sometimes, to children and to retired workers. In most cases, employees are exempt from medical underwriting - they won't have to have a medical exam - but it is likely that other family members must have some type of medical screening. Know the requirements for policies marketed because some insurers require medical underwriting for all parties, including employees, while other group plans might not require medical information about any of the parties. In some cases, even if medical underwriting is required, it is less stringent than for individual policies, especially for older parents. The NAIC's shopper's guide encourages older people to investigate their children's Group LTCI coverage if available, indicating that, while medical screening is likely, group coverage might be more advantageous than individual policies.

The age at which individuals may purchase employer-sponsored LTCI coverage is often earlier than the age minimums for individual policies. Typical existing plans specify ages 30, 35 and 40 as the minimums and at least one plan designed by a large corporation is offered to 20-year-olds. While there are individual policies insuring at these earlier ages, they are fairly rare. Upper age limits vary considerably, generally similar to individual policies, ages 79 to 85 being typical maximums for purchasing coverage.

BENEFITS AND OTHER PROVISIONS

Employer-sponsored LTC Insurance may be virtually identical to individual policies marketed. In fact, this would apply to the policy discussed in the Pseudo-Group discussion later in this text. Most offer a range of daily benefit amounts, benefit periods and elimination periods. One should always be aware that in many of the existing plans, the employer has worked with the insurance company to decide on the range of features from which employees can choose.

While the employee makes the final choice, the options available may be pre-selected and, therefore, more limited than with an individual policy.

As for the availability of other benefits and provisions that are found in individual policies, group LTC plans vary considerably but there is a trend toward including more benefits. Some existing employer-sponsored plans include or make available inflation protection, Nonforfeiture or return of premium features, death benefits, reinstatement, restoration of benefits, home care benefits, and others. Group plans usually pay for care at several levels, have no prior institutionalization requirements, and cover care for Alzheimer's and other organic brain disease. Exclusions and pre-existing conditions limits are similar to those in individual policies.

Continuation or Conversion.

Group long-term care insurance issued in Delaware on or after the effective date of this section shall provide covered individuals with a basis for continuation or conversion of coverage.¹⁴⁶

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

der the existing policy. The Commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.¹⁴⁷

"A basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.¹⁴⁸

"Converted policy" means an individual policy of long-term care insurance providing benefits identical to or determined by the Commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made.¹⁴⁹

Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers and/or facilities, the Commissioner, in making a determination as to the substantial equivalency of benefits, will take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity. When the policyholder or certificate holder is no longer in the geographical area of the provider system or available services, the insurer must calculate the financial worth of the group policy and make a cash contribution toward the purchase of any health insurance policy the policyholder may select.¹⁵⁰

Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer no later than thirty-one (31) days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.¹⁵²

Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.¹⁵³

CONTINUATION OF COVERAGE

Continuation of coverage or issuance of a converted policy shall be mandatory, except where¹⁰⁸ termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

The terminating coverage is replaced no later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and the premium for which is calculated in a manner consistent with the requirements of applicable regulations.

A converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in **payment of more than 100 percent of incurred expenses**. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.¹⁵⁴

The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.¹⁵⁵

Notwithstanding any other provision of this section, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.¹⁵⁶

(A "**Managed-Care Plan**" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.)

DISCONTINUANCE AND REPLACEMENT

If a group long-term care insurance policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and the premiums charged under the new group policy shall not result in any exclusion for pre-existing conditions that would have been covered under the group policy being replaced; and shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.¹⁵⁶

GROUP LTC COSTS

Another way group LTC Insurance differs from other group coverages is that the rates typically vary by the age of the individual. Although there might be some premium savings over individual policies, this is not always the case, unlike group medical insurance, for example, which may be less expensive than individual medical policies. Depending on the insurer offering the plan, the age of the buyer, and the actual provisions included, group savings might be as little as 2% up to as much as 30%. One major advantage of some employer-sponsored plans, however, is that the premium might be guaranteed for as long as the employee remains in the group, no matter how old he or she is—a real bonus for an employee who can lock in a low premium at perhaps 30 years of age. Not all group plans guarantee rates for life, but in most cases the premiums will increase only if they increase for everyone in the group.

It is important to stress that an agent must learn about the specific details of employer-sponsored plans he/she wants to install in the workplace. Your insurers will provide guidelines concerning policies that may be offered to employers and provide assistance to the agent on customization to meet client needs. However, each insurer probably has certain conditions it

will not change, so an agent needs to determine exactly where to be flexible and what provisions are not negotiable prior to making a presentation to a prospect.

ASSOCIATION GROUP LTC INSURANCE


Group LTC Insurance may also be offered by an association such as the American Medical Association, the American Association of Retired Persons (AARP), and others at both national and state levels. Association plans, which are available only to members of the particular group, vary as widely as other group plans and LTC coverage in general. Some associations offer more than one type of LTC Insurance policy to members, as is the case with the AARP.

While the AARP policy is written by a strong nationally-known insurer, that is not the case with all association policies, so it is important that both the agent, and the customers know with whom they are negotiating. Buyers are especially warned by consumer advocates to avoid association policies that do not originate with bona fide associations. Unfortunately, a few insurers "invent" associations as a way to sell LTC policies that are cheap in both price and benefits. This is not likely to be a concern for most agents since this type of insurer usually operates by direct mail rather than through agents.

Later in this text, the Pseudo-Group plans are discussed. Associations as discussed here, are examples of "Pseudo-groups."

CORPORATE TAX OVERVIEW

Information similar to the following can be provided to an employer, either as part of an informational brochure or as a memorandum. It can be especially useful to Board Members when a Corporate Resolution pertaining to the furnishing of Long Term Care Insurance to their officers and dependents. Please refer to previous discussion in Chapter

 **NOTE: Tax Laws change frequently, so the client's tax attorney should always review information of this type furnished to a client.**

PARTICIPANTS:

With closely held companies, the plan is typically provided only for officers, but could be provided to a wider range of Employees. If non top-salaried Employees are covered under the plan, participation should be limited to fewer than 100 Employees if ERISA's full reporting and disclosure requirements are to be avoided.

INCOME TAXATION OF THE PLAN:

Participants in an employer-paid, Long Term Care

TAXABILITY OF PREMIUMS

Treatment of Long Term Care Insurance premiums, as of January 1, 1997 under the Health Insurance Portability and Accountability Act (HR3103), and that are provided for Long Term Care Insurance for officers and their spouses to cover the costs of an extended stay in long term care, are summarized as follows.

OVERVIEW:

Long-term care insurance protects the insured against financial hardship caused by an extended stay in a nursing home or similar facility. It was unclear for some time whether such insurance qualified for favorable tax treatment as health and accident insurance under Internal Revenue Code (Code) Sections 104, 105, and 106. Legislation passed in 1996 (Health Insurance Portability and Accountability Act) cleared up the confusion by characterizing qualified Long Term Care Insurance as health and accident insurance making it eligible for favorable income tax treatment under Code Sections 104, 105, and 106.

Insurance plan may exclude from income any premiums paid by the employer for such insurance.¹⁵⁷ Employer expenses for Long Term Care Insurance premiums are deductible under Code Section 162 as a business expense.

The employee's exclusion of the premium paid by the employer and the employer's deduction for such premiums are permitted even if the plan is discriminatory in favor of highly compensated Employees. Benefits payable under the policy are excluded from taxable income as defined in Code Sec. 213 to the extent such amounts reimburse the insured for actual expenses incurred.¹⁵⁸

There are significant advantages to an employer-paid plan because qualified Long Term Care Insurance premiums paid by an employee - instead of his or her employer - may be deducted as medical expenses under Code Sec. 213 only to the extent that the premiums, along with all other non-reimbursed medical expenses, exceed 7.5% of adjusted gross income. In addition, the maximum allowable Sec. 213 deduction for such premiums is further limited by the following amounts that vary by attained age at the end of each tax year:

Attained age 40 and Under— \$200; 41-50— \$350; 51-60— \$750
61-70— \$2,000; 71 and above— \$2,500

ADVANTAGES OF LTC INSURANCE FOR EMPLOYERS AND EMPLOYEES

Employers like it because:

- It's easy to administer and implement
- There's no cost to the company.
- Increases productivity by lessening the demands of eldercare on Employees.

Employees like it because:

- Long term care Insurance protects their assets, pension and savings
- Reduces the demands of being a caregiver
- Provides the means for affordable home health care, adult day care or even nursing home care.
- Includes spouses, parents and parents-in-law.
- Coverage is portable.

GROUP LONG TERM CARE FACTS

- ❑ 34% of the people who need help with the basic activities of daily living are between the ages of 18 and 65.
- ❑ The annual cost to companies for lost productivity from eldercare responsibilities is \$30 billion a year or \$3,142 per employee.
- ❑ By 2020, one in three workers will provide some type of eldercare.
- ❑ 50% of employed caregivers said they missed work time to care for elders, up from 42% a decade ago.
- ❑ 77 million Americans will turn 50 over the next 18 years ... that's one person every 7.5 seconds.
- ❑ 43 percent of individuals age 65 will enter a nursing home sometime in their lifetime, with 50 percent staying an average of 2 1/2 years.
- ❑ A year in a nursing home can average \$40,000 and can exceed \$70,000 in metropolitan areas.
- ❑ 50 percent of all couples and 70 percent of single persons are impoverished within one year of entering a nursing home.
- ❑ For every person receiving care in a nursing home, there are four people receiving care outside of a facility.

ASSOCIATION AND OTHER "PSEUDO-GROUP" LTCI

While there is a true group Long Term Care Insurance product, at this particular time several companies are using an individual product with a discounted rate structure for use within a group environment. There are many names for these plans, so for purposes of this discussion they will be referred to as "Pseudo-Group" plans, as they are actually neither individual or group policies. For those not familiar with "pseudo", the definition of "closely resembles" is used in this context. Companies may use other terms – one such plan is called the "Affinity" plan (defined as "kinship in general; similarity") - which is certainly an appropriate term.

There are usually no "discounts" of this type with true group plans but the discounts under the pseudo-group plans will be in the 10-15% range. (True Group may offer other discounts)

While the advantage of using a "True" Group product is that of underwriting, in a group situation, the underwriting is either considerably more liberal and/or individual health situations are not taken into consideration. Depending upon the size of the group, it is possible to have a guaranteed issue product.

Conversely, there are several disadvantages to true group, which may weigh more heavily in considering whether to offer a discounted individual product or the group product.

One of the biggest problems with group products is that the plans are all "boiler-plate" and cannot be customized or individually designed to meet the needs of each individual.

For true group plans, there are requirements that often are difficult or impossible to meet (as any group insurance specialist will state). The most difficult one is that of participation. An insurer will require that a certain percentage of those eligible for the plan, must participate. LTC Insurance has not risen to the level of health insurance, or even group life insurance, to where it is considered as a "necessity." Therefore, rarely would enough persons enroll for the LTC Insurance coverage, especially if they had to pay for part of the premium. Individual plans sold on a

group basis will generally have some sort of participation, but the participation requirements are much lower.

Another requirement is that the employer must participate and pay for part of the premium. Automatically, this eliminates Associations from this coverage. In the environment of high group health insurance premiums, many employers are hard-pressed to offer another benefit to their employees. With the pseudo-group plans, the employer does not have to participate. For example, with true group products, most insurers require at least 10 participants for pseudo-group coverage, as few as three are acceptable. Also, most insurers require that the participation number continues each year and if participation falls below the required number, the plan will no longer be offered. Note, however, that the insured employee will be able to continue with the issued policy on the same basis.

Also, there are normally rather rigid guidelines as to the eligibility of groups. For group underwriting reasons, certain groups would not be eligible for coverage. With an individual product, underwriting guidelines would allow some persons to purchase LTC Insurance.

Most individual policies allow for a Spousal discount, and some plans allow a “preferred” rating for those in very good health. With true group, these discounts would not be allowed, whereas with an individual plan, both the group discount and the Spousal &/or Preferred discounts would be available.

One of the major Long Term Care Insurance carriers offers the pseudo-group type of plan. A review of their product and procedures will help in understanding how such a program works. The insurer also offers a true group product, conveniently making a comparison possible.

In this case, the insurer bases their product on a popular individual product that offers a “modified” guaranteed issue to groups with more than 200 employees (number of employees will vary, depending upon the company’s experience, competition, and market interest).

For an employee to be eligible they cannot have been diagnosed with HIV/AIDS, Neuro-Muscular Disorder, suffered a stroke or TIA in the last 5 years, have Insulin -Dependent Diabetes or limitations in any ADL.

Group (true group) Benefits are limited to:

- Nursing Home only
- 2 year maximum benefit
- 90 day elimination period
- \$50 daily benefit

30-hour full time employees (not actual participants) and 5% discount for groups under 200 members. In addition, this insurer also offers a 10% spousal discount, and a 15% preferred rating discount, plus a 2% list bill discount for groups with over 200 members. For pseudo group plans, the discounts are 10%, plus 10% spousal discount, with no discount for list bill.

For the pseudo group, the insurer required a minimum of 10 applications during the first six months. For true group the insurer has a production requirement of twenty-five applications within the first six months and a total of 50 applications within the first year to continue the program.

PERSONS COVERED

Generally, both true group and pseudo-groups (Associations, etc.), cover full-time Employees (or members) and their spouse who are over the age of 18. The extended coverage is one of the biggest attractions for group and pseudo-group coverage, as some carriers extend coverage to parents, in-laws, grandparents and retirees.

PORTABILITY

If an employee terminates, with the true group product, the employee will be able to convert to an individual product and continue the coverage on their own. With the pseudo-group plan, they are automatically portable since the employer does not own them. Also all discounts (except list bill) continue with the contract even upon termination or retirement.

COMMISSIONS

With true group, as with any such group product, generally the commission paid is relatively small in comparison to the individual product. However, even using the pseudo-group plans, will cause a reduction in both the first year compensation and renewal years as well.

ENDORSEMENT

For the pseudo-group plans, an endorsement letter and question form must be completed and submitted for approval before beginning the enrollment process with most, if not all, carriers. Once approval is secured, solicitation may proceed, with each submitted application being encoded in some fashion, usually with the specific group number assigned by the carrier.

LONG TERM CARE SPONSORED GROUP DISCOUNT

The Group Discounts provide lower premiums and as such, bears more discussion.

The published purpose of the discount, according to some insurers, would be to help the insurer's agents reach an additional segment of the Long Term Care Insurance market. In the group and association market the sponsoring group typically wants to offer something to its members that they could not buy elsewhere - such as a special discount. Notice that some emphasis on the discount explanation is on the Association Group market, as contrasted to the employer-employee group market.

For the larger insurers, a 5% "sponsored-group discount" (as opposed to a true group discount of 10%, and some companies offer 10% for the sponsored-groups also) is available for eligible groups and is available in most states. As discussed earlier, first year and renewal compensation for these products are slightly reduced ("slightly" is not defined).

10% (or 15%, rarely) marital discount is available to applicants who are married and approved for coverage even if spouse does not apply or does not qualify for coverage (this is a liberalization of most individual policies). If both spouses apply for coverage and both are issued and remain in force, each receives a 20% discount (includes marital discount).

PREFERRED RATE CLASS DISCOUNT

Some Long Term Care Insurance companies allow a Preferred Rate Class Discount. Generally, qualifying for the Preferred Rating Class decreases the Standard Annual Premium by 15%.

In order to qualify, one insurer requires that the applicant must be able to answer "NO" to the following questions on the application:

1. Have you ever been treated for or diagnosed as having any of the following: heart disease, emphysema, or COPD?
2. During the past 10 years, have you ever been confined to a hospital or treated by a physician for any of the following?: cancer, hypertension, stroke, osteoporosis (or any bone or joint disorder), phlebitis, dizziness, epilepsy or any type of peripheral vascular disease?
3. During the past 10 years have you been given a prescription for medications to treat arthritis?
4. During the past 10 years have you been diagnosed or treated for alcoholism drug or substance abuse, mental or emotional disorder?
5. Do you now or have you during the past 5 years used any tobacco products, including cigarettes, pipe, cigar or chewing tobacco?
6. Can you walk 4 blocks at a normal pace without any difficulty such as: shortness of breath, dizziness or leg cramps? (Must answer yes)

Applicants should not have any current health problems or take any medications.

All applications will be submitted to the insurance company, accompanied by a check for the amount of the Standard Premium. If the applicant is approved and qualifies for the Preferred Rate Class, a refund check will be issued and delivered with the policy.

ELIGIBILITY

For this particular insurer, members of groups, their spouses, parents and parents-in-law are eligible when:

- the group was formed for purposes other than obtaining insurance ;
- solicitation of the group is expected to generate a minimum of ten paid policies;
- the group indicates its sponsorship of the LTC Insurance plan to its members in writing.

THE MARKET

Particularly for the pseudo-group coverages, there are many (a multitude, in fact) of groups and associations that would be eligible, such as:

Employers Retiree Associations	Travel Clubs
Country Clubs	Trade Associations
Professional Associations	Churches
Fraternal Organizations	Credit Unions

PROCEDURES

With any insurance company, there are certain procedures to be followed in order to take an application for group long-care insurance. As a general rule, companies will require that:

Generally, the Insurer's LTCI Marketing Department approves the discount after determining that the group meets the sponsored group discount criteria:

1. The group was formed for purposes other than obtaining insurance.
2. The group will generate at least 10 (+ or -)paid policies.
3. The group will indicate its sponsorship to members in writing.

EXCEPTIONS TO EXCLUSIVITY

The agent who brings the group to the insurer will have an exclusive on the group and the discount with the following exceptions:

If another agent licensed with the insurance company, has an existing client who is a member of this group, but who has not yet purchased the insurer's LTC Insurance policy, the agent can offer the group discount without going through the "exclusive" agent.

- At the discretion of the "exclusive agent," the insurer's agent can offer the discount to a new prospect who is a member of the sponsoring group by submitting the business through the "exclusive" agent at an agreed upon commission split.
- Current *LTC Insurance* policyholders of the insurer, who are members of the sponsoring group can only get the discount if they replace their policy with the policy being offered by the sponsoring group. (This will not be in the best interest of the policyholder in most cases because they would likely pay higher age rates, making the discount a wash.)

If a policy is replaced, and it is replaced by the original writing agent the agent will be charged back the difference between standard first year commission and the lower sponsored group discount.

If it is replaced by the "exclusive" agent (which is discouraged and done only at the request of the client) renewal commission will be paid.

LONG TERM CARE SPONSORED-GROUP DISCOUNT REQUEST FORM

This form will vary from company-to-company, but a sample of an insurer's form is provided here as an illustration.

1.	Name of Firm/Sponsoring Organization & Nature of Business
2.	Total Number of Employees/Members
3.	How many locations to be solicited? In what states? Are you currently licensed in these states?
4.	Please describe the demographics of the LTC prospects that are to be solicited. (age groups incomes - assets)
5.	How many Employees/members are included in the above profile?
6.	Explain how the sponsoring group will sponsor/promote The Insurer independent care plan to its Employees/members?
7.	Is this LTC plan replacing another company's LTC plan for this group? if yes, Please provide a separate sheet, the name of other company; time period when other company's LTC plan was sold; and why group is replacing other company's plan with The Insurer. Please Include any materials describing the plan that is being replaced.)
8.	What is your marketing plan? How will you solicit. How will the applications - - be taken? How will the case be serviced? (Use reverse side or attach plan)
9.	What penetration/sales do you expect during the initial 18 months (_____%)
10.	Is there any need for statement list billing or is direct billing (our preference) ~ acceptable?

THE VALUE OF EMPLOYERS SPONSORING LTC INSURANCE

Employers are finding that sponsoring group Long Term Care Insurance shows concern for the welfare of their Employees and helps to build morale and loyalty. Yet it is easy to administer and does not put pressure on employee benefit dollars.

With the passage of the Health Insurance Portability and Accountability Act of 1996, the federal government now provides special tax incentives for employers who offer Long Term Care Insurance . Employers may now deduct premium paid on behalf of Employees as a business expense, the same as they do for medical insurance. Employers may also pay premiums for selected classes of Employees (i.e. as part of an executive compensation package) without being required to pay the premiums for all Employees.

GROUP LONG TERM CARE INSURANCE BENEFITS TO EMPLOYER

- Long Term Care Insurance enhances the attractiveness of your company as an employer and helps you to retain your most qualified, highly skilled Employees.
- Long Term Care Insurance is easy to administer and implement. It is also portable, so if an employee leaves, the policy becomes an individual one at no additional cost and the person is billed directly.
- Long term care encourages Employees to focus on financial and retirement planning. It also eases the burden on Employees who act as caregivers for spouses or parents, resulting in increased productivity and decreased absenteeism.
- The current cost to companies for lost productivity is estimated at \$3,142 per employee according to a recent Wall Street Journal article, and USA Today estimates it is in excess of \$17 billion a year.
- An American Medical Association study estimates that long term care can cost a company with 1,000+ Employees as much as \$400,000 per year.
- 10- 15% of workers are struggling to balance the responsibilities of work with those of caring for aging, ill relatives.
- A study by the Health Action Forum of Greater Boston reported that due to long term care demands, 33% of Employees missed work, 45% used vacation or sick days and 33% came to work late or went home early^{108A} (*Employee Benefit Plan Review, 1995*).
- By the year 2020, one in three workers will provide some kind of care for an aged parent or other relative.

EMPLOYER EDUCATION

In addition to the above-illustrated points, the education of the employer (or head of the Association, etc.) is the most important step in marketing these products. Most insurers will furnish material that can be used for educational purposes, most prepared in a professional manner. Basically, the outline the advantages to the employer of LTCI, such as what Medicare does not provide for long-term care, the restrictions on Medicaid, and the lack of long-term care in their medical plans.

This should be followed up by information in respect to the tax ramifications to the employer and the employee.

Other assistance from the insurer's Home Office is usually provided. Some companies have their own Enrollers, with others it is the responsibility of the General Agent. A few (very few) companies have installed a computerized method whereby each enroller uses a laptop computer to enroll the employee. The information submitted is sent electronically to the Home Office at the end of each workday, thereby allowing for immediate enrollment. If underwriting is needed, this speeds up that process tremendously.

A toll-free telephone number is important, and the Home Office should be ready for numerous inquiries by employees and their relatives, both during the enrollment period and afterwards.

TRUE GROUP LONG TERM CARE INSURANCE

The discussion of Group LTC Insurance has been primarily on the individual policy sold on a group basis, with certain distinctions as shown above. The following information pertains to Long Term Care Insurance sold on a (true) group basis. The details are of a plan offered by a major insurance company and should not be considered as an industry “standard.” Also, this plan has been offered for more than a year, so some changes will probably already be made, however, they should not be significant.

Also, please be aware that the plan outlined herein is a “Preferred” plan that has somewhat more liberal benefits than another plan that is also available from this company. The “Preferred” plan is discussed, as experience has shown that benefits increase and become more liberal as more experience in this field is gained and actuarial statistics are verified through actual claims experience, plus the ever-encroaching of the Federal government.

ELIGIBILITY

The eligibility criteria are typical of most companies in the group LTC Insurance market. The following individuals would be eligible for coverage under an endorsed group Long Term Care Insurance plan.

Employees

Full-time (30 hours minimum) Employees who are actively at work. Also, regular part-time Employees may be eligible for this benefit if other benefits are typically offered to them.

Spouses of Employees

Spouses of Employees may apply even if the employee does not participate.

Retirees and Spouses

Retirees and their spouses under 80 years of age may apply.

Children of Employees

Children of the employee or member are eligible to participate.

Parents, Parents-In-Law, Grand Parents and Grand Parents-In-Law

The most unusual feature of Group LTCI is that parents, parents-in-law, grand parents and grand parents-in-law may apply even if the employee or spouse does not choose to participate. (Companies may have some restrictions or qualifications if this feature is offered). This broad eligibility should create anti-selection, as it would appear that any employee, who has an elderly parent or grandparent, etc., would want the insurance, especially since the employee does not have to participate. Therefore, the premiums must be actuarially structured to compensate for this contingency.

BILLING PROCEDURE

Billing is a little different than usual group health insurance, and is specifically stated as it is anticipated that the plans will be portable when the employee leaves or retires (Delaware regulations so require). The insurer provides direct billing for terminated Employees and their

spouses, divorced spouses, retirees and their spouses, parents, parents-in-law and grandparents. Employees on leave can also be direct billed. The insurance company bills quarterly, semi-annual or annual modes. There is no charge for direct bill. A grace period of 30 days is extended when premium is not paid.

ELIGIBILITY

The insurance company that offers this particular issues for ages 18 to 84, with some restriction of benefits for those ages 80-84. Other insurers may have different eligibility age rules.

CERTIFICATE REQUIREMENTS

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:

- (1) A description of the principal benefits and coverage provided in the policy;
- (2) A statement of the principal exclusions, reductions and limitations contained in the policy; and
- (3) A statement that the group master policy determines governing contractual provisions.

COVERAGE

Again, using this particular company's policy and rules, the following coverages are offered. Other policies may offer more liberal or restrictive benefits.

- Pool of funds concept.
- All Levels of Care: Skilled, Intermediate and Custodial.
- Nursing Home: 100% of actual expenses up to the daily maximum limit.
- Home Health Care: Choice of daily maximum benefit of 50% or 100% of daily nursing home benefit. 100% of actual charges up to the daily maximum home health care benefit for Skilled Services. 100% of actual charges up to the daily maximum home health care benefit for Personal Care Services (example - Home Health Care Aide).
- Adult Day Care: 100% of the expense incurred up to the daily maximum limit. Based on Home Health Care benefit.
- Alternate Care Facility: Pays the lesser of your daily nursing home maximum or 100% of the incurred expenses. Includes hospice, assisted living (not nursing home) community-based care setting and adult congregate living facility.

MAXIMUM DAILY BENEFITS

- Daily Benefit Amounts - ranging from \$40 to \$250 for nursing facilities.
- Home Health Care Amounts: choice of 50% or 100% of daily long term care benefit amount.

QUALIFICATION FOR BENEFITS

The qualification for benefits follows the HIPAA guidelines by offering the following two ways to qualify for benefits:

- Inability to perform two of six specified activities of daily living (90 day certification required) eating, dressing, bathing, toileting transferring, continence or
- Cognitive impairment

BENEFIT PERIODS

As with most LTC Insurance policies, the Benefit Periods are expressed as days with explanation as to number of years. This is typical of a “Pooled” policy, as the amount of the Pool is calculated as the number of days (Benefit Period) times the Daily Benefit. Using a stated number of days eliminates any difficulty in calculations, such as providing for leap years.

Ages 18 - 79: 730 times (2 years), 1095 times (3 years), 1460 times (4 years), 1825 times (5 years) the LTC daily benefit amount or Unlimited. Ages 80 - 84: 730 or 1095 times the LTC daily benefit (1460 and Unlimited times are not available.)

DEDUCTIBLE PERIODS

Deductible Periods follow those in Individual policies. This particular insurer has restrictions on Deductibles at the older ages, and with the 730-day (2 year) policy. The employee may select the number of consecutive days at the beginning of their covered stay and before the benefit payments actually begin.

- Ages 18 - 79: 0 days, 30, 90, 180 or 365 Days.
- Ages 80 - 84: 30, 90, 180 or 365 Days.
- Deductible periods of 180 or 365 days are not available with 730 (2 years) times daily benefit period.

INFLATION BENEFIT

The Inflation Benefit requirement as described in the discussion of individual policies, pertains to Group or individual policies. Where the policy is issued to a group, the required offer in section 13.1 above shall be made to the group policyholder; except, if the policy is issued to a group as defined in the regulations, other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder. 13.2

HOME AND CONDOMINIUM BASED CARE BENEFIT

One insurer specifically offers “Condominium” based care benefits, attractive to many elderly retired persons. Originally, this was unique because there were no previous-care requirements. Under the recent regulations in Delaware and most states, these restrictions are unlawful.

Requirements for benefit payment is the same as under individual policies—Inability to perform two of six specified activities of daily living, or Cognitive impairment.

Covered services are those that are provided by a licensed or accredited home health care agency and adult day care center, and follow a plan of treatment established by the physician.

Some group LTCI plans are quite liberal in providing for home health care services and may offer more benefits that available under individual policies.

ALTERNATE PLAN OF CARE BENEFIT

Under the insurer’s Alternate Plan of Care provision, if the insured, their doctor and the insurer agree, then the insurer will pay for medically appropriate services and supplies in another setting when a nursing home confinement would otherwise be required. It should be emphasized the Alternate plan Alternate Plan of Care is a completely voluntary program.

ALTERNATE CARE FACILITY BENEFIT

If the insured is confined in an alternate care facility, the insurer will pay the insured a percentage of the expenses incurred, ranging up to 100% depending upon the state, up to the nursing home daily benefit amount, for each day for care received in an alternate care facility, which occurs after the long term care elimination period, and before the specified lifetime maximum dollar amount is reached.

BED RESERVATION BENEFIT

The Bed Reservation Benefit is usually provided wherein if the insured is hospitalized or temporarily leave during a covered stay in a nursing home, the insurer will continue to pay the insured's benefits or credit their elimination period for up to 21 days per year to cover charges or to reserve the insured's accommodations. Unused days cannot be carried over into the next calendar year.

RESPITE CARE BENEFIT

Respite Care Benefit is generally provided wherein the Insurer will pay up to the nursing home daily benefit for respite care in a nursing home or alternate care facility, and up to the home and community-based care daily limit for respite care in a residence or adult day care center. The Insurer will pay for up to 21 days in a calendar year and benefits will be payable during the elimination period. After the insured reached their elimination period, respite care will not be paid in addition to the daily benefit amount.

MEDICAL HELP BENEFIT

The Medical Help Benefit is a newer benefit, and offered by only a few of the major insurers. The insurer will pay the actual expenses incurred, up to 25% of the home and community-based care daily benefit amount for the rental or lease of a medical help system for the insured's home during a plan of treatment. This benefit is limited to a system installed in the home while the policy is in effect and to a maximum of 12 months during the insured's lifetime.

CAREGIVER TRAINING BENEFIT

This is a popular benefit which states that if the insured requires long term care or home and community based care, the insurer will pay 100% of the expenses incurred for caregiver assistance training, not to exceed five times the home and community based care maximum daily benefit amount. Some companies allow family members to take the caregiver training and some specify a dollar amount (usually \$500) for the training.

PRE-EXISTING CONDITIONS

The Pre-existing Condition requirement has become popular in Long Term Care Insurance policies, and in effect, are quite liberal compared to other health insurance products. Conditions that are disclosed on the application are covered immediately. Pre-existing conditions not disclosed on the application may be covered if confinement begins at least six months after the start of coverage under the policy. However, if important medical information is omitted from the application, the policy may be voided.

Large groups may not have any pre-existing condition limitations. For the smaller groups, the following regulation applies: "No long-term care insurance policy or certificate, other than a policy or certificate there under issued to a group as defined in these regulations, shall use a defi-

dition of "preexisting condition" which is more restrictive than the following: "Preexisting condition" shall mean 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."¹⁵⁹

Limitations


If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."¹⁶⁰

WAIVER OF PREMIUM

The Waiver of Premium is more liberal with the "Preferred" plan as it does not require that the insured be confined in a Nursing Home. Waiver of Premium begins when the insured receives 12 days of covered care or services (Long-Term Care Facility stay and/or Home and Community-Based Care) - in a quarter. The initial 12 days need not be consecutive, but must be incurred within a 90-day period.

The Waiver of Premium must be described in the Outline of Coverage, and if there is no such provision, that must be spelled out also.

POLICY PREMIUMS

 **In keeping with the stated Guaranteed Renewable provision, the policy premium will never increase because of age or health of the participants individually. In keeping with the concept of a "true" group, premiums may be raised or lowered, depending upon the claims history of the group as a whole.**

SPOUSAL PREMIUM DISCOUNT

The Spousal discount with this plan differs from the plan earlier discussed and is more typical of individual and group policies inasmuch as both insured and spouse must be approved for coverage. If both the insured and spouse apply for a Long Term Care Insurance policy at the same time with the insurer, and are both approved for coverage, the insured will receive a 10% premium discount on both policies.

EXCLUSIONS

The Long Term Care Insurance plan from the insurer does not include benefits for the following:

- Losses resulting from war or any act of war, or
- Losses for which benefits are payable under Workers' Compensation or Occupational Disease Act or Law, or
- Losses due to mental, psychoneurotic or personality disorders without evidence of organic disease. (Alzheimer's disease or similar organic brain syndrome is covered.)
- Benefits under the policy will not duplicate benefits available under Medicare.

STUDY QUESTIONS

1. One of the differences between Group LTCI and other Group plans is
 - A. Group LTCI insurance is more restrictive as to who can be insured.
 - B. Group LTCI allows parents, grandparents and sometimes in-laws to be covered.
 - C. Group insurance costs more than all other Group insurance benefits combined.
 - D. only securities-licensed agents can sell the plan.
2. Group Long Term Care Insurance
 - A. may be less expensive than individual policies.
 - B. is not available for groups under 50 employee participants.
 - C. policies have the same identical benefits as individual LTCI policies.
 - D. does not cover Skilled Nursing Care.
3. Employers who pay LTCI premiums on behalf of an employee
 - A. are actually contributing to a widows and orphans fund.
 - B. can deduct the premiums from each employees Social Security taxes.
 - C. are called non-contributory employers.
 - D. can deduct those premiums as a business expense.
4. Long Term Care Insurance premiums for the self employed.
 - A. are not tax deductible.
 - B. are tax deductible only for the amount that exceeds 7.5% of the AGI.
 - C. are tax deductible within the overall self-employed deductible limits.
 - D. are taxed at capital gains rates.
5. The ABC Widget Co. has a Section 125 (Cafeteria) plan for their employees. It wants to add a group Long Term Care Insurance plan to their benefit package on a non-contributory basis.
 - A. The premiums paid by the employer will be deductible from Social Security taxes.
 - B. Long Term Care Insurance is not permitted under a Section 125 plan.
 - C. Long Term Care Insurance will be treated the same as short-term disability and other plans marketed under the Cafeteria plan.
 - D. Benefits payable to the insured will be considered as earned income.
6. The difference between “Pseudo-Group” and “True Group” LTCI plans is
 - A. True Group plans allow for coverage of all family members.
 - B. that Pseudo-Group is basically individual policies sold to a member of a group or association and the employer/group does not have to contribute to the premiums.
 - C. Pseudo-Group LTCI is sold only to employers and is subject to participation and contribution rules.
 - D. True Group LTCI premium is about twice the True Group premium

7. LTCI benefits received under a group LTCI plan
 - A. are not taxable to the employee.
 - B. are taxable to the employer.
 - C. are taxable to the employee.
 - D. must be paid directly to the nursing home.

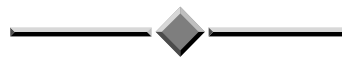
8. A Subchapter "S" Corporation purchasing LTCI for an employee
 - A. is not allowed to take the premiums as a business expense on their tax forms.
 - B. for tax purposes, is treated the same as a Partnership.
 - C. is treated the same as an individual would be for tax purposes.
 - D. is not allowed to purchase LTCI for employees.

9. If a Group LTCI plan pays an employee \$5,000 for a 30-day period of chronic illness,
 - A. for tax purposes, it would be treated the same as if it were a Partnership plan.
 - B. this is called a Per Diem contract and periodic payments are excluded from the insured's income up to a certain cap.
 - C. this is called a Per Diem contract and the entire amount received is excluded from the employee's income.
 - D. the entire amount is considered as ordinary income for the employee for tax purposes.

10. Employers like providing long term care plans to employees because
 - A. it is easy to administer and implement and it increased productivity by lessening the demands of eldercare on employees.
 - B. the employer is not allowed to consider the premiums they pay as a business expense.
 - C. benefits are paid directly to the employer.
 - D. discrimination laws do not apply to Group Long Term Care Insurance.

ANSWERS TO STUDY QUESTIONS

1B 2A 3D 4C 5B 6B 7A 8B 9B 10A



Just to emphasize the long-term care services available, this chart is repeated here:

Long-Term Care Service	Medicare	Private Medigap Insurance	Medicaid	You Pay on Your Own*
Nursing Home Care	Pays in full for days 0-20 if you are in a Skilled Nursing Facility following a recent hospital stay. If your need for skilled care continues, may pay for days 21 through 100 after you pay a \$128/day co-payment	May cover the \$119/day copayment if your nursing home stay meets all other Medicare requirements.	May pay for care in a Medicaid-certified nursing home if you meet functional and financial eligibility criteria.	If you need only personal or supervisory care in a nursing home and/or have not had a prior hospital stay, or if you choose a nursing home that does not participate in Medicaid or is not Medicare-certified.
Assisted Living Facility (and similar facility options)	Does not pay	Does not pay	In some states, may pay care-related costs, but not room and board	You pay on your own except as noted under Medicaid if eligible.
Continuing Care Retirement Community	Does not pay	Does not pay	Does not pay	You pay on your own
Adult Day Services	Not covered	Not Covered	Varies by state, financial and functional eligibility required	You pay on your own [except as noted under Medicaid if eligible.]
Home Health Care	Limited to reasonable, necessary part-time or intermittent skilled nursing care and home health aide services, and some therapies that are ordered by your doctor and provided by Medicare-certified home health agency. Does not pay for on-going personal care or custodial care needs only (help with activities of daily living).	Not covered	Pay for, but states have option to limit some services, such as therapy	You pay on your own for personal or custodial care, except as noted under Medicaid, if you are eligible.

EXHIBIT ONE

TYPICAL LONG-TERM CARE SERVICES AVAILABLE

LONG TERM CARE SERVICES

Adult Companion Services. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services.

Adult Day Health Services. Services are furnished in an outpatient setting and encompass a broad range of health and social services needed to ensure optimal functioning of an enrollee.

Assisted Living Services. Service includes personal care services, homemaker services, chore services, attendant care, companion services, medication oversight, and therapeutic social and recreational programming provided in a home-like environment in an assisted living facility.

Case Management Services. Services that facilitate enrollees gaining access to other needed services regardless of the funding source for the services, and which contribute to the coordination and integration of care delivery.

Chore Services. Services needed to maintain the home as a clean, sanitary, and safe living environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, and moving heavy items of furniture in order to provide safe entry and exit.

Consumable Medical Supply Services. Disposable supplies provided to the enrollee and caregiver, which are essential to adequately care for the needs of the enrollee. Consumable medical supplies include adult disposable diapers, tubes of ointment, cotton balls and alcohol for use with injections, medicated bandages, gauze and tape, colostomy and catheter supplies, and other consumable supplies.

Environmental Accessibility Adaptation Services. Physical adaptations made to the home to allow the enrollee to function with greater independence in the home and without which the enrollee would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems to accommodate the medical equipment and supplies.

Escort Services. Escort providers assist enrollees in gaining access to services. Escorts may provide language interpretation for people who have hearing or speech impairments or who speak a language different from that of the provider. Escort providers assist enrollees in gaining access to services.

Family Training Services. Training and counseling services provided to the families of enrollees. Training includes instruction and updates about treatment regimens and use of equipment specified in the plan of care to safely maintain the enrollee at home.

Financial Assessment/Risk Reduction Services. Financial assessment and guidance provided to the caregiver and enrollee. This service provides instruction for and/or actual performance of routine, necessary, monetary tasks for financial management such as budgeting and bill paying. In addition, this service also provides financial assessment to prevent exploitation by sorting through financial papers and insurance policies and organizing them in a usable manner. This service provides coaching and counseling to enrollees to avoid financial abuse, to maintain and balance accounts that directly relate to the enrollee's living arrangements at home, or to lessen the risk of nursing home placement due to inappropriate money management.

Home Delivered Meals. Nutritionally sound meals delivered to the residences of enrollees who have difficulty shopping for or preparing food without assistance. Each meal must provide one-third of the Recommended Dietary Allowance (RDA) and may be hot, cold, frozen, dried, canned or a combination of hot, cold, frozen, dried, or canned with a satisfactory storage life.

Homemaker Services. General household activities (meal preparation and routine household care) provided by a trained homemaker.

Nutritional Assessment/Risk Reduction Services. Nutritional assessment and guidance for both caregivers and enrollees.

Nursing Facility Services. Services furnished in a health care facility licensed under *Delaware* Statutes. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet client needs.

Occupational Therapy. Therapy provided to restore, improve or maintain impaired functions to increase or maintain the enrollee's ability to perform tasks required for independent functioning as determined through a multi-disciplinary assessment to improve an enrollee's capability to live safely in the home setting.

Personal Care. Assistance provided to the enrollee to eat, bathe, dress, maintain personal hygiene, and participate in activities of daily living. This service includes assistance with meal preparation, but does not include the cost of the meals. This service may also include house-keeping chores such as bed-making, dusting and vacuuming, which are essential to the health and welfare of the enrollee, rather than the enrollee's family.

Personal Emergency Response Systems (PERS). The installation and monitoring of electronic devices that allows enrollees at high risk of institutionalization to secure help in an emergency.

Physical Therapy. Therapy provided to restore, improve or maintain impaired functions determined through a multi-disciplinary assessment to improve an enrollee's capability to live safely in the home setting.

Respite Care Services. Short term relief provided to an enrollee's caregiver. Respite care is provided in the home/place of residence, Medicaid licensed hospital, nursing facility, or assisted living facility.

Speech Therapy. The identification and treatment of neurological deficiencies related to feeding problems, congenital or trauma-related maxillofacial anomalies, autism, or neurological conditions that affect oral motor functions to improve an enrollee's capability to live safely in the home setting.

Transportation Services. Transportation may be provided within Medicaid guidelines at the option of the contractor. These services cover arranging and providing appropriate modes of transportation for participants to receive necessary medical services.



ACUTE CARE SERVICES

Community Mental Health Services. Community-based psychiatric rehabilitative services provided by a psychiatrist or other physician.

Home Health Care Services. Intermittent or part-time nursing services provided by a registered nurse or licensed practical nurse, or personal care services provided by a licensed home health aide, with accompanying necessary medical supplies, appliances, and durable medical equipment.

Independent Laboratory and Portable X-ray Services. Medically necessary and appropriate diagnostic laboratory procedures and portable x-rays ordered by a physician or other licensed practitioner.

Inpatient Hospital Services. Medically necessary services provided under the direction of a physician or dentist in a hospital maintained primarily for the care and treatment of patients with disorders other than mental diseases.

Outpatient Hospital/Emergency Medical Services. Medical services provided in an outpatient center or emergency department necessary to maintain the health of the enrollee. These services include outpatient preventive, diagnostic, therapeutic, or palliative care provided under the direction of a physician at a licensed hospital and supplies necessary for the clinical treatment of a specific diagnosis or treatment.

Physician Services. Those services and procedures rendered by a licensed physician at a physician's office, patient's home, hospital, nursing facility or elsewhere when dictated by the need for preventive, diagnostic, therapeutic or palliative care, or for the treatment of a particular injury, illness, or disease.

Prescribed Drug Services. This service provides medications ordered by physicians. These services include all legend drugs dispensed (including Medicaid-reimbursable psychotropic drugs) to enrollees in outpatient settings.

Transportation is an optional rather than a required service. If they choose, providers can also offer expanded services such as vision and hearing services.

APPENDIX A

RESCISSION REPORTING FORM FOR

LONG-TERM CARE POLICIES

FOR THE STATE OF DELAWARE

FOR THE REPORTING YEAR 19[]

Company Name: _____

Address: _____

Phone Number: _____

Due: March 1 annually

Instructions:

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission
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Detailed reason for rescission: _____

Signature

Name and Title (please type)

Date

APPENDIX B

Long Term Care Insurance

Personal Worksheet

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

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _____

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

Type of Policy (non-cancelable, guaranteed renewable): _____

The Company's Right to Increase Premiums:

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

Rate Increase History

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

Questions Related to Your Income

How will you pay each year's premium?

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

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

What is your annual income? (check one)

- Under \$10,000 \$[10-20,000] \$[20-30,000]
 \$[30-50,000] Over \$50,000

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

- No change Increase Decrease

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

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

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

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

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

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

Question Related to Your Savings and Investments

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

- Under \$20,000 \$20,000-\$30,000 \$30,000-\$50,000 Over \$50,000

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

- Stay about the same Increase Decrease

If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

<input type="checkbox"/> The information provided above accurately describes my financial situation.	<input type="checkbox"/> I choose not to complete this information.
--	---

Signed:

(Applicant) (Date)

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

Signed:

(Agent) (Date)

Agent's Printed Name:]

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

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

Signed:]

(Applicant) (Date)

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

The company may contact you to verify your answers.

Drafting Note: When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.

APPENDIX C

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

Long-Term Care Insurance A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.

[You should not buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

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

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

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

Medicaid Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.

Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.

When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.

Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insur-

ance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

APPENDIX D

Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

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

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet “Shopper’s Guide to Long-Term Care Insurance” and the page titled “Things You Should Know Before Buying Long-Term Care Insurance.” Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

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

Drafting Note: Choose the paragraph that applies.

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

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

Please check one box and return in the enclosed envelope.

Yes, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

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

No. I have decided not to buy a policy at this time.

APPLICANT’S SIGNATURE & DATE

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

APPENDIX E

Claims Denial Reporting Form

Long-Term Care Insurance

OMITTED

NOTE: **APPENDIX E** is omitted in the Delaware regulations, and is shown here in case the future regulations require a specific Claims Denial Reporting Form.

APPENDIX F

Instructions:

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

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

Potential Rate Increase Disclosure Form

1. [Premium Rate] [Premium Rate Schedules]: [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [filed][approved] for an increase [is][are] [on the application][(\$_____)]

Drafting Note: Use "approved" in states requiring prior approval of rates.

2. The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.

3. Rate Schedule Adjustments:

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

4. Potential Rate Revisions:

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

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

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

* **Contingent Nonforfeiture**

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

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

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

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

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

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

Example:

"You bought the policy at age 65 and paid the \$1,000 annual premium for 10 years, so you have paid a total of \$10,000 in premium.

"In the eleventh year, you receive a rate increase of 50%, or \$500 for a new annual premium of \$1,500, and you decide to lapse the policy (not pay any more premiums).

"Your "paid-up" policy benefits are \$10,000 (provided you have a least \$10,000 of benefits remaining under your policy.)

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

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

Issue Age Percent Increase Over Initial Premium

29 and under 200%

30-34 190%

35-39 170%

40-44 150%

45-49 130%

50-54 110%

55-59 90%

60 70%

61 66%

62 62%

63 58%

64 54%

65 50%

66 48%

67 46%

68 44%

69 42%

70 40%

71 38%

72 36%

73 34%

74 32%

75 30%

76 28%

77 26%

78 24%

79 22%

80 20%

81 19%

82 18%

83 17%

84 16%

85 15%

86 14%

87 13%

88 12%

89 11%

90 and over 10%



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