

Chapter Eight

What Is Long-Term Care and Who Needs It?

- 1. What is Long-Term Care?** Long-term care (LTC) is a general term that includes a wide range of services that address the health, medical, personal care, and social needs of people with chronic or prolonged illnesses, disabilities, and cognitive disorders (such as Alzheimer's). These services are most typically required by the elderly, but may also be used by disabled people of any age. LTC is different from traditional medical care. Traditional medical care treats physical problems directly in an attempt to permanently cure or control them. LTC helps one live as he or she is now; it may not help to improve or correct medical problems.
- 2.** Someone with a physical illness or disability often needs assistance with activities of daily living (ADL). People with cognitive impairments usually need supervision, protection, or verbal reminders to do everyday activities. In the past LTC was thought of as strictly nursing home care. Today the term can refer to a variety of services including home health care, assisted living, adult day care, continuing care retirement communities (CCRCs), hospice care, and more.
- 3. Who Needs Long-Term Care?** The decision to purchase LTC insurance must be based on a personal assessment. Factors to consider include:
 - 1. Longevity:** The longer you live, the more likely it is that you will need long-term care.
 - 2. Family Structure:** Society and the family structures are changing. Traditionally, family members took care of aging parents. But this type of care is less feasible today. If family care is unavailable, a nursing home may be the only alternative.
 - 3. Gender:** Women are at a much higher risk of needing long-term care because they have longer life expectancies and often out-live their husbands.
 - 4. Health Factors:** If chronic or debilitating health conditions run in your family, you could be at greater risk than another person of the same age and gender.

5. *Hospital Stays*: People are no longer staying in hospitals to recuperate from an illness or an operation. After short stays for treatment or surgery, people often must be moved to nursing homes until they are well enough to return to their own dwellings (or must receive care or services in their homes if they return there from the hospital.)

Counseling people on LTC & How to Pay for It (Coverage)

4. Note that there is a distinction between counseling on long-term **care** (the service and care itself), and counseling on long-term care **insurance** (or other coverage methods). Clients may need information on one, the other, or both.
5. In some cases it is impossible to separate the two types of decisions completely. What kind of care is wanted or needed, how soon or urgently it may be needed, and how much risk the client is willing to assume, will all factor into what type of payment option or coverage is most appropriate. The reverse can also be true: the kind of coverage a person has (or doesn't have) can determine what care options are open to them.
6. Therefore, both issues – type of long-term *care* and type of LTC *coverage* (how to pay) – will often be considered together, although they are distinct issues. You should be prepared to assist in both types of evaluation processes.
7. **Counseling on Long-Term Care.** Consumers must be allowed to make educated decisions without pressure to buy something they may not need or want; and consumers should be encouraged to consider an area of long-term financial planning that is crucial but that is usually not considered.
8. Let the client know beforehand that as a HICAP (AAA) volunteer you can give information, help them understand their options, and make referrals, but you are not in a position to advise as to a final decision. Suggest that a financial or legal advisor, insurance agent, social worker, family member or friend may also be needed to help finalize a plan.
9. When dealing with only the *possibility* of needing care, rather than being face-to-face with an actual current need, many people are less willing to spend money. Long-term care insurance coverage is expensive, and it is usually tempting to do without coverage in the hope that it will never be needed. But if care is needed, and the client has

not provided for adequate coverage and is unable to afford the necessary/preferred care options, the lack of planning can result in a costly and painful situation. This is the tightrope that the client walks when choosing how to cover future long-term care needs.

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

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

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

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

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

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

Basic Review/Assessment Process

Review with the client:

- ❖ What is long-term care?
- ❖ What does it cost?
- ❖ How does LTC insurance work?

Client should consider:

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

Does the client want to protect:

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

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

14. **Medicare.** Despite a persistent myth to the contrary, Medicare covers *only minimum long-term care costs*. Medicare will help pay for skilled nursing care for a maximum of 100 days *under specific conditions*:

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

15. If ALL the above conditions are met, then Medicare will pay for the first 20 days in full, after which the patient will have to assume a co-insurance payment for the next 90 days of coverage.

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

17. Medicare will cover home health care – skilled nursing care in the home – if a physician certifies that the patient is confined to the home and needs skilled nursing care or rehabilitative therapy on an intermittent basis. Home health care includes part-time skilled nursing care, physical therapy, speech-language therapy, home health aide services, 80% of durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), supplies, and other services.

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

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

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

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

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

Resources on Medicaid

- ✎ To learn more about Medicaid eligibility contact your local *Texas Department of Human Services* office and ask for an Aged and Disabled Medicaid Eligibility Specialist at 1-800-228-1570.
- ✎ You can also call the *Legal Hotline for Older Texans* at 1-800-622-2520.

23. **Accelerated Death Benefits.** Accelerated death benefits in a life insurance policy may be used to obtain cash out of the policy while the policyholder is still alive. An accelerated death benefit is a payment of all or part of a life insurance policy's death benefit before you die. If your client's life insurance policy contains this type of benefit, he or she can receive an early benefit payment based on your need for long-term care services, with the same benefit eligibility requirements as a long-term care insurance policy. It also can be paid for a specified disease (a disease or condition likely to cause permanent disability or premature death, such as AIDS or a malignant tumor) or terminal illness (life expectancy of two years or less).

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

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

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

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

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

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

1. how LTC insurance works in general
2. how policies differ specifically

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

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

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

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

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

- ◆ Has few or no assets to protect (less than the cost of one year in a nursing home, about \$30,000 to \$40,000 minimum, is one rule of thumb that may be used).
- ◆ Is unable to afford insurance premiums, either now or in the future (client should not have to use assets to pay for premiums, or significantly compromise current lifestyle).
- ◆ Is already disabled or has a serious health problem (and would probably not pass the medical underwriting required to get coverage).

- ◆ Has an income level that meets Medicaid eligibility limits.
- ◆ Has no children, grandchildren, or favorite causes to whom to leave assets.

Tips:
The client who is a good candidate for a long-term care policy will usually (but not always) save money by buying the policy sooner rather than later. Premiums are based on age at the time of purchase and will increase each year you wait to purchase, regardless of health status.
Long-term care insurance is an ongoing commitment. The policyholder must be able to continue to pay the premium for many years – not just now – until they may need LTC. A high percentage of people who buy policies stop paying premiums; many of them lose policy benefits and the money spent on past premiums (even plans with nonforfeiture and refund of premiums benefits do not allow total recovery of all premiums paid.

33. **Types of Coverages.** Any long-term care policies sold in Texas must provide at least twelve consecutive months of coverage.

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

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

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

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

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

39. **Expense-incurred Method.** This type of policy will pay less than the daily maximum if the actual cost is less. If the actual cost is higher than the daily maximum purchased, it will only pay the daily maximum. Most policies limit the total benefit they will pay over the term of the policy, but a few don't. Some policies state the maximum benefit limit in years (one, two, three, or more, or even lifetime). Others write the policy maximum benefit limit as a total dollar amount. Policies often use words like "total lifetime benefit," "maximum lifetime benefit," or "total plan benefit" to describe their maximum benefit limit. When you look at a policy or certificate be sure to check the total amount of coverage. If the policy has a stated limit in years it is important to understand what happens to the excess daily maximum that may not be used. For example, if an individual purchases a policy for 2 years of coverage with a \$100-a-day benefit but actual expenses are only \$80-a-day for care, what happens to the \$20 difference? Some companies have what is referred to as a pool of money. If a policyholder does not use their entire daily maximum, the remainder is placed in a pool to

be used later. This way the policy may actually last longer than the 2 years purchased. However, if a company does not use a pool of money then the policy may end after 2 years even if you never used your full daily maximum while in claim.

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

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

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

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

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

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

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

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

47. **Tax Qualified Policies.** Federal law now allows individuals to deduct a portion of the premium of a tax-qualified long-term care policy from their taxes. In addition, benefits received from a tax-qualified long-term care policy are generally not taxable as income. You should suggest that your client consult with their attorney, accountant, or tax advisor regarding the tax implications of purchasing long-term care insurance.

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

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

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

51. Eligibility for benefits under a non-tax qualified policy may not be more restrictive than the inability to perform any two activities of daily living or the impairment of cognitive ability. Under Texas law non-tax qualified plans may offer

benefit eligibility requirements that are more favorable, such as “medical necessity,” “one of six ADLs,” or even “two of seven ADLs.” The seventh ADL would be “mobility.” It will be easier to qualify for benefits when there are few ADLs to be met.

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

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

54. **Required Policy Features.** State law requires that Texas LTC policies provide the following mandatory features, options, and outline of coverage (paragraphs 55-71 and 73):

55. **30-day Free Look Period.** Texas state law requires long-term care insurance policies to contain a 30-day “free look” provision. The free look provision allows the purchaser the right to review the policy or certificate for 30 days. If the individual decides not to buy the policy, for any reason, they may return the policy to the insurer or the agent without explanation, and all the money paid will be refunded.

56. **Guaranteed Renewable.** Most individual LTC policies are issued on a “guaranteed renewable” basis. This means that the policy cannot be cancelled except for nonpayment of premiums, and the insurer cannot change any provision of the policy without the consent of the insured person. The insurance company may change the premium if it is changed for all persons of a particular class, such as all policyholders in the state. If the individual LTC policy is not offered on a guaranteed renewable basis then it must be issued as a “noncancellable” policy. This means that the policy cannot be cancelled except for nonpayment of premium and the insurer has no right to make any change in any provision of the contract or in the premium rate charged. In either case, the policyholder retains the right to cancel the LTC contract and receive a return of any unearned premium to the policyholder.

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

58. **Grace Period.** Under Texas law all individual LTC policies must contain a 65-day grace period in which to pay late premiums. If the policyholder, for any reason, does not pay their premium when it is due, they will have 65 days in which to pay their premiums.

59. **Reinstatement.** Long-term care insurance policyholders in Texas have the right to reinstate coverage after a lapse or termination due to nonpayment of premiums if the insurer is provided proof of the insured's cognitive impairment or loss of functional capacity, and if reinstatement is requested within five months (some policies may allow a longer time) after the policy lapse or terminated.

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

61. **Nonforfeiture Benefit.** Nonforfeiture benefits guarantee the policyholder a percentage of the benefits bought even if the policy is later cancelled or coverage is lost because of non-payment of premium. The methods for determining the type and amount of nonforfeiture benefits can vary. In one type of benefit, when the policyholder stops paying premiums the company provides a paid-up policy with a shorter benefit period. That means the policy will pay the same daily benefit that you bought but for fewer years. The company must begin providing nonforfeiture benefits no later than the end of the third year of coverage if the policyholder loses or cancels the policy after that date. A nonforfeiture benefit can add significantly to a policy's cost, depending on factors like age at the time of purchase and the type of benefit offered.

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

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

1. Benefits automatically increase by at least 5% each year, compounded annually;
- or
2. The policyholder has the option to increase the benefit by 5% compounded each year on each renewal date; or

3. The policy can cover a specified percentage of actual or reasonable charges for as long as you own it, with no maximum daily limit or policy limit.

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

63. **Third Party Notice of Lapse.** All policies must permit the insured to designate at least one additional person to receive notice of lapse or termination for nonpayment of premium. If the premium is not paid 30 days after the due date, a notice is mailed to the insured and the third-party designee, if any. The notice is considered to be received 5 days after mailing and the insured is given an additional 30 days to pay the late premium. This amounts to a 65-day grace period.

64. **Optional Benefit Offers/Riders.** Below is a list of some of the possible policy features or riders that might be offered with a long-term care policy. Each may add to the cost of the policy. You should discuss each of these benefits with your clients because not all benefits work the same. Two policies may name their benefit the same, but they do not pay the same or they have different conditions to meet in order to receive the benefit. **Please be sure to read each policy benefit carefully.**

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

66. **Waiver of Premium.** This option lets you stop paying the premium once you are in a nursing home and the insurance company has started to pay benefits. Some companies waive the premium as soon as they make the first benefit payment. Others wait 60 to 90 days. The waiver of premium may not apply if you are getting home health care.

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

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

69. **Alternative Plan of Care.** Alternative care is care or a service not specified in a policy, but that may be provided if appropriate and agreed upon by the insurance company, the insured person and his or her physician. These benefits are then provided in lieu of normal contract benefits.

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

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

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

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

- 1) Policy Designation (Individual vs Group Coverage)
- 2) Purpose of Outline of Coverage
- 3) Terms Under Which The Policy or Certificate May be Returned and Premium Refunded
- 4) Medicare Supplement Insurance Disclaimer
- 5) Long-Term Care Coverage
- 6) Benefits Provided By This Policy
- 7) Limitation and Exclusions
- 8) Relationship of Cost of Care and Benefits
- 9) Terms Under Which The (Policy) (Certificate) May Be Continued In Force and Is Continued
- 10) Alzheimer's Disease, Other Organic Brain Disorders, and Biologically Based Brain Diseases/Serious Mental Illness
- 11) Premium
- 12) Texas Department of Insurance Consumer Help Line
- 13) Denial of Application
- 14) Offer of Inflation Protection
- 15) Offer of Nonforfeiture Benefits
- 16) Disclosure Regarding Federal Tax Treatment of Long-Term Care Insurance Policy
- 17) Additional Features

Shopping Tips and Other Resources

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

- ✓ **Take your time and compare outlines of coverage.** Do not be pressured into buying a policy or making a quick decision. Ask for an outline of coverage.
- ✓ **Talk to several agents and companies.** Policies differ as to coverage and cost. Companies differ as to service.
- ✓ **Know about the agent and company.** Check with the Texas Department of Insurance at 1-800-252-3439 to make sure that the agent and company are licensed in Texas. You also can request a written company profile showing the company's history, complaint record and financial rating.
- ✓ **Keep the agent's and company's name,** address and telephone numbers.
- ✓ **Never buy a policy or sign something you do not understand.** Ask questions and be sure you understand what the policy covers and when. Discuss the policy with a trusted friend, relative, or advisor before you buy.
- ✓ **Don't buy more than one policy.** You don't need to buy more than one policy to get enough coverage. If you want to increase your daily benefit or policy maximums, check to see if the company will allow you to increase your coverage. If you have a nursing home only policy and want to add home health care coverage, check to see if the company can offer the additional coverage as a rider.
- ✓ **Never sign a blank application.** If the agent fills out the application for you, don't sign it until you have read it carefully to be certain that all information has been properly recorded. Make sure all medical information is right. If it isn't and the company used that information to decide whether to insure you, they can refuse to pay your claims and may even be able to cancel your policy upon a showing of misrepresentation with an intent to deceive.
- ✓ **Never pay in cash.** Always pay by check made payable to the insurance company.

Other Resources:

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

Glossary of LTC Terms

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

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

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

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

Benefit Triggers – Term used by insurance companies to describe when to pay benefits.

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

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

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

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

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

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

Grace Period – The number of days after your premium due date in which it can still be paid without cancellation. Long-term care policies provide a 65 day grace period.

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

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

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

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

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

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

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

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

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

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

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

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

Rescind – When the insurance company voids (cancels) a policy.

Spend Down – A requirement that an individual use up most of his or her income and assets to meet Medicaid eligibility requirements.

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

Third Party Notice – A benefit that lets you name someone who the insurance company would notify if your coverage is about to end due to lack of premium payment. This can be a relative, friend, or professional such as a lawyer or accountant, for example.

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

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

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

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

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